HM Government

inclusion health

Improving the way we meet the primary health care needs of the socially excluded

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Page 8: Your Blood 2 – using visual arts and food to educate people, particularly Bangladeshi families, about Iron and Vitamin D deficiency (Bromley by Bow Centre)

Page 12: Arteast – visual arts-based skills workshop for people with learning disabilities (Bromley by Bow Centre)

Page 16: Bromley by Bow Centre

Page 24: Artwork produced at Your Blood 2 (Bromley by Bow Centre)

Page 32: Artwork produced by a resident of St Mungo's Mare Street Hostel (St Mungo's)

Page 38: Self portrait series (St Mungo's)

Social Exclusion Task Force
Cabinet Office
4th Floor
Admiralty Arch
The Mall
London
SW1A 2WH

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setfpublic-enquiries@cabinet-office.x.gsi.gov.uk

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CabinetOffice
Social Exclusion Task Force

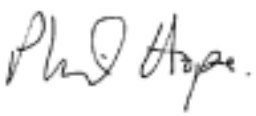
Ministerial Foreword

The last ten years have seen some of our most ambitious and successful reforms in health as we work to ensure we meet the needs of every citizen.

Now, the challenge is to accelerate this quality improvement, creating services that are not just good, but universally great. And as we support the development of services from 'good to great', it is critical that our health service delivers high quality and affordable care to all – including those most in need.

Inclusion Health aims to ensure we meet this goal. It is about driving improvements in the way we meet the primary health care needs of the most excluded. It aims to support innovation and productivity, while enabling delivery of personalised and responsive care to those who need it most. It is an ambitious agenda, but one which will make a notable difference to the lives of the most vulnerable members of society, and to the effectiveness of services.

We are pleased to be able to launch this exciting and ambitious agenda, and look forward to working with you to ensure that everyone gets the care they need.



Phil Hope
Minister of State for Care Services
Department of Health

Investment and reform in public services are delivering a transformation in the accessibility and quality of health care. We have a lot to be proud of: 99% of the public are registered with a GP, and NHS waiting times are now the shortest they have been since NHS records began.

But we know we can go further. This framework and the associated evidence pack highlight that socially excluded groups continue to experience complex health conditions and disproportionately poor health outcomes. Following extensive research and consultation, we are pleased to be able to launch the Inclusion Health agenda.

Inclusion Health is based on what we have seen and heard up and down the country from dedicated professionals and clients. It seeks to respond to the challenges and build on the promising practice and innovation.

We are grateful to the individuals and organisations who have been involved in this work, and look forward to taking this forward. Together, through Inclusion Health, we can make a difference to the way we meet the health care needs of the most vulnerable, and in doing so, make a lasting and positive change to the lives of the most at risk.

Rt Hon Angela Smith
Minister of State for the Cabinet Office

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Introduction

Building on progress: the 'journey of improvement'

1. The last few years have seen modernisation and reform in health services lead to a transformation in the accessibility and quality of care: investment in the NHS is at record levels; waiting times are shorter than they have ever been; more people than ever report satisfaction with the NHS; more people than ever before are registered with a GP.

2. This has led to a transformation in health outcomes: life expectancy is at a historic high and infant mortality at a historic low. Mortality rates for the big killers – heart disease and cancer – have decreased for the under 75s by 47% and 19% respectively since 1995-97.

3. These improvements will continue. The *NHS Next Stage Review* described the journey of improvement that will build on this progress and take the NHS 'from good to great'.[1]

4. While significant progress has been made in delivering improvements in health outcomes across the population, meeting the needs of the small population of people with the most complex health needs remains a considerable challenge. A world-class health service needs to deliver high quality and affordable care to all, and the ambition of driving services 'from good to great' must be an ambition for all our citizens.

5. New analysis[2] by the Social Exclusion Task Force in the Cabinet Office and the Department of Health (DH) into the primary health care needs of socially excluded groups,[3] highlights that these groups experience poor health outcomes across a range of indicators including self-reported health, life expectancy and morbidity.

[1] *High Quality care for all: NHS Next Stage Review final report* NHS (London, 2008)

[2] For the Inclusion Health evidence pack please go to: http://www.cabinetoffice.gov.uk/social_exclusion_task_force/short_studies.aspx

[3] For the purposes of this project we have taken a broad definition of social exclusion and are concerned with those who experience multiple, complex problems, and enduring disadvantage.

Health outcomes of socially excluded groups

Socially excluded groups experience a range of poor health outcomes. For example:

- Just 30% of Irish Travellers live beyond their 60th birthday
- 85% of street sex workers report using heroin and 87% using crack cocaine
- People with learning disabilities are 58 times more likely to die prematurely than the general population
- Hepatitis B and C infection among female prisoners are 40 and 28 times higher than in the general population

Socially excluded people often make chaotic and disproportionate use of health care services, and experience a range of barriers and issues relating to their access and quality of care. For example:

- **Homeless people**[4] each consume an estimated eight times more hospital inpatient services than an average person of similar age, and their secondary care costs around £85 million in total per year. Compared to the general public, they are 40 times more likely not to be registered with a GP and have about five times the utilisation of A&E. 81% of GPs interviewed by Crisis thought that it was more difficult for a homeless person to register than the average person.
- **Street sex workers**, who have the most acute health needs of sex workers, are more likely to be in contact with health care services than the general population. They are over five times more likely to report visiting a GP in the past year: 58% reported seeing a GP; 29% had visited A&E; 24% had been to an STI clinic; 21% to inpatient clinics; and 17% to outpatient clinics in the previous year. They are also more likely than the general population to use acute care, but are less likely to have taken up routine screening, health checks and vaccinations.

6. The health needs of socially excluded groups are often complex and require a sophisticated, coordinated and flexible response from services. The costs of failure are great not only to the individual life chances of socially excluded clients, but also to the taxpayer, services and the communities who pick up the pieces.

7. Throughout the course of this work, the Cabinet Office and Department of Health have engaged a wide range of individuals and organisations with experience and interest in this area. The extensive programme of research and consultation highlights the inspiring work which dedicated professionals are providing up and down the country to support some of the most vulnerable clients in their communities. We also heard about a range of specific challenges in driving improvements in health outcomes for socially excluded groups:

[4] Defined as rough sleepers plus those in temporary hostel accommodation – an estimated 40,500 people in England.

The challenges	
Clients	• Complex needs and chaotic lifestyles can make it difficult to access services and navigate systems • Many socially excluded clients have low health aspirations, poor expectations of services and limited opportunities to shape their care • Even when they access services, they often report feeling 'invisible' or discriminated against
Practitioners	• Many practitioners (especially in non-specialist settings) lack awareness, skills and training to cope effectively with the most excluded • In many mainstream settings, there is a tendency to focus on treating the immediate presenting symptoms rather than supporting recovery and sustained behaviour change • Specialist practitioners often work in isolation and feel undervalued, and can lack the support networks and supervision to deal effectively with high-need clients
Providers	• There is a limited evidence base on what works for these clients and, particularly in small specialist services, a lack of capacity and/or capability to evaluate effectiveness and impact • Services often lack the flexibility to respond to complex needs and chaotic lifestyles • There are few incentives to promote partnership working around clients with complex needs • It is easy for clients to fall between the gaps of different services leading to expensive unplanned care and clients 'revolving' through the system • There are gaps in and barriers to provision e.g. access to mental health services for those with dual diagnosis • There is an artificial divide between clinical and social models of care
Commissioners	• There is considerable variation in the provision of specialist services between different areas of the country • Socially excluded clients often do not show up on needs assessments, even though they do tend to cluster around particular services or places • Some groups are very small or geographically dispersed, and there are important differences *between* and *within* groups • In many areas there is limited join-up between primary care trusts, local authorities and the Third Sector in sharing knowledge about the most excluded clients • There is a limited focus on health promotion, prevention and recovery with the hardest to reach
Leaders	• There is no national voice for the socially excluded and the diverse range of professionals who work with them • Health care for socially excluded groups is often of low priority and the needs of these groups tend not to be at the forefront in strategic planning • Health and wellbeing outcomes often do not adequately reflect the specificity and complexity of socially excluded clients' needs and circumstances

Inclusion Health: a framework for action

8. From frontline service providers, commissioners, practitioners, service leaders, local managers and clients themselves, we have heard a consistent message – there needs to be a greater focus on addressing the primary health care needs of the socially excluded.

9. To achieve this, some services and local areas are generating momentum and action for change through the establishment of an Inclusion Health agenda – an agenda which champions innovative, integrated and focused work to improve the way we meet the health needs of the most vulnerable. ***Inclusion Health*** **provides a framework for driving improvements in health outcomes for socially excluded groups**. The agenda is owned by the many and diverse professionals who deliver or contribute to achieving improved health outcomes for those in greatest need. We hope Inclusion Health will be embraced not just by those who are already undertaking committed and excellent work, but also by those who acknowledge the need to make a difference and seek impetus for change.

10. The objectives of Inclusion Health are:

- **Focus:** to increase the understanding and visibility of the health needs and outcomes of socially excluded groups; and to establish clear accountability at local and national levels
- **Voice:** to provide a strong 'voice' and advocacy for the most disadvantaged and those who work with them, ensuring that strategic planning and commissioning processes adequately address their needs
- **Personalisation:** to promote flexible and tailored responses to complex needs that bridge specialist and mainstream services and ensure continuity of care
- **Quality and innovation:** to drive improvements in quality and standards of services; promoting innovation in service design and delivery; and to build evidence about what works
- **Recovery:** to ensure services support clients to continually improve by raising health aspirations, improving continuity of care, and building capabilities and capacity for individuals to take control of their lives
- **Professional development:** to recognise the achievements of professionals and researchers in this demanding specialist field and support their progression; to build connections *between* professionals and *across* disciplines; and to exploit the synergies between clinical and social models of care

Inclusion Health: the building blocks

11. To achieve these aims, we are, for the first time, setting out a framework for action. This framework is borne out of evidence and expertise gathered from all parts of the system. As well as setting out a picture of success and the principles underpinning Inclusion Health, this document sets out the six building blocks and a series of practical actions which will lay the foundations for an Inclusion Health approach:

    - **Leadership:** Strong, clear national and local leadership of a new Inclusion Health agenda, and a dynamic movement for change
    - **Workforce:** A strong, stable and capable workforce to drive change and make a difference to the lives and health outcomes of the most vulnerable
    - **From needs to outcomes:** Capability to build a better picture of needs, set priorities and know that health services are making a difference
    - **Responsive and flexible services:** Innovative models of joined-up, cost-effective and equitable care
    - **Health promotion and prevention:** Improving health aspirations, prevention and early intervention
    - **Assurance and accountability:** Making best use of available resources and levers to focus on the most excluded and track progress

12. Government will support delivery of the Inclusion Health agenda by **establishing a National Inclusion Health Board**. The Board will be chaired by a senior health professional and will be the advocate for change, providing expertise and leadership to drive Inclusion Health. It will have responsibility for taking forward the actions set out in this framework.

13. There are of course no simple solutions to these complex issues. Achieving sustained progress on entrenched and complex social challenges will require the determination of all those dedicated professionals, managers and leaders working to address the needs of their clients. It will also require the empowerment of the clients themselves to make positive choices and changes.

14. Inclusion Health will provide the impetus to bring partners together around the common goal of improving the health outcomes of some of the most vulnerable members of our society, and act as a constant reminder that everyone should have access to the highest standard of care, no matter what their circumstances.

1. Leadership

Strong, clear national and local leadership of a new Inclusion Health agenda and a dynamic movement for change

1. The *NHS Next Stage Review*, led by Lord Darzi, signalled the importance of high quality leadership in driving transformational change in the health service.[5] Leadership in Inclusion Health will be a significant driver of change, providing an opportunity for inspiring individuals and organisations to set the direction of an emerging agenda.

2. While there are examples of local champions making their voices heard against the odds, on the whole, the socially excluded and the professionals who work with them can lack influence at both national and local levels. Leadership in this field has received relatively little focus, and professional excellence has historically been inadequately recognised and rewarded.

3. Developing leadership capacity both nationally and locally will be critical to sustaining this important work and providing a focus point around which professionals can coalesce and drive continued improvements in outcomes. Particularly strong leadership is required at a community health level in deprived areas where there are significant concentrations of socially excluded clients.

The **NHS Leadership Qualities Framework** sets the standard for outstanding leadership in the service. It can be used to underpin leadership development for individuals, teams and organisations – and could be applied to Inclusion Health.

NHS Leadership Qualities Framework

[5] *High Quality Care for all: NHS Next Stage Review final report,* NHS (London, 2008)

4. The *NHS Next Stage Review's* final report, *High Quality Care for All,* makes quality the organising principle of the NHS.[6] At a national level, this has been underpinned by the establishment of the NHS National Leadership Council, the NHS National Quality Board and the NHS Equality and Diversity Council. And at a local level, all Strategic Health Authorities are now developing talent and leadership plans. All provide opportunities to drive the Inclusion Health agenda.

Making a difference through Inclusion Health

5. Leadership in Inclusion Health builds on these foundations to provide the framework to drive improvements in health services and outcomes across the different professionals working with socially excluded groups. It aims to ensure that they are better able to advocate for change and improvement, and to better determine what services and approaches are most effective in improving the health care experiences of socially excluded groups.

6. Throughout fieldwork and consultations, there has been a consistent message – there needs to be a stronger focus on the primary health care needs of socially excluded groups. We need greater visibility and understanding of the challenges, and to highlight the successes so we can capitalise on the good work out there.

7. The formalisation of an Inclusion Health agenda endeavours to unite colleagues (clinical and non-clinical, mainstream and specialist) around the goal of improving the health outcomes of socially excluded groups through the delivery of high quality care and by providing a visible leadership community.

8. Leadership across clinical and academic communities aims to enrich the evidence base and professional development of those who work with at risk and chaotic clients. This should also drive accountability and ownership of the agenda locally, resulting in improved strategic awareness and planning around socially excluded groups.

[6] Ibid

9. Leadership in Inclusion Health will make a difference by:

- Providing a strong 'voice' and advocacy for the most disadvantaged and those who work with them
- Building connections and communities between professionals and across disciplines
- Building a shared vision and raising awareness of the health and wider needs of the most excluded
- Supporting innovation in service design and delivery
- Building understanding of which services and approaches work

To achieve this...

The National Inclusion Health Board will take forward a programme of work aiming to:

- Establish a Chair in Inclusion Health providing professional and academic leadership within the sector
- Set up a Faculty of Inclusion Health
- Support primary care trust clinical and medical directors to ensure that local services are compliant with the requirements of the Equality legislation
- Develop within the NHS leadership development objectives, standards and criteria that reflect competence in Inclusion Health for all current and aspirant clinical leaders
- Establish awards or other means of recognition that acknowledge the contribution of those who lead change for Inclusion Health

children's centre

2. Workforce

A strong, stable and capable workforce to drive change and make a real difference to the lives and health outcomes of the socially excluded

1. The delivery of world-class services is dependent upon world-class professionals. This is especially true when it comes to working with those most in need, where we know an effective workforce can make a significant impact on the life chances of those it serves. There are many inspiring examples of professionals in mainstream and specialist services providing tireless care to those with the most complex needs. Their expertise and dedication is critical to the life chances of some of the most vulnerable in our society.

2. There are specific challenges facing professionals working in this field. Socially excluded clients often have a longstanding mistrust of services and may not understand or engage in appropriate ways. For mainstream practitioners, it can be hard to tune into the complex needs of socially excluded groups and allocate sufficient time and tailored interventions to meet the complexity of their needs. For specialist practitioners, it can be stressful and isolated work, with insecure resource arrangements.

A Queen's Nursing Institute Homeless Health Initiative survey[7] of homeless and non-homeless health specialists found that:

- Only 36% of all specialists and 8% of non-specialist nurses had ever received any training on homelessness and health
- 71% of non-Homeless Health Specialists were not confident in their ability to care for homeless people
- 74% of all respondents (mainstream and specialist) are lone workers always, often or sometimes

3. The Government is committed to developing and sustaining a world-class workforce. The NHS alone spends over £4 billion on education and training. Nationally and locally, there are opportunities to build the Inclusion Health agenda into workforce development. To improve the link between investment in education and new ways of working, the Department of Health is leading a multi-professional training and education review to incentivise and reward quality in education. Locally, Health Innovation and Education Clusters will bring together the NHS, universities, industry and other organisations to work with commissioners, to align training and education with the local vision for improved services and workforce planning.

[7] *On The Ground: Mapping Homeless Healthcare,* The Queen's Nursing Institute (London, 2007)

4. Much has been done improve the way we engage and care for our workforce. The *NHS Operating Framework 2010-11* puts the improvement of staff satisfaction and engagement as one of its top five 'Vital Signs'.[8] The Boorman Review, *NHS Health and Wellbeing 2009*, sets out the ways by which organisations can work to improve the health and wellbeing of all staff groups and is an opportunity for services to consider how best to support practitioners working in the challenging field of Inclusion Health.

- Employing more than 1.4 million people, the **National Health Service (NHS)** is the world's largest publicly funded health service.
- Of those directly employed by the NHS, around half are clinically qualified and this includes 90,000 hospital doctors, 35,000 general practitioners, 400,000 nurses and 16,000 ambulance staff.
- The English NHS is by far the most substantial element of the overall NHS, with over 1.3 million staff providing services to 50 million people.

5. It is critical to underline that the Inclusion Health workforce is diverse – spanning multiple sectors and disciplines. There are valuable opportunities to build on the current infrastructure, and to share training and learning.

Great Chapel Street (Soho, London) offers an integrated model of care with a full multi-disciplinary team to help reduce the health inequalities among the homeless. Offering a range of health and social services under one roof, the medical centre offers placements to trainee medical and nursing undergraduates, giving them insight into the challenges of treating clients with complex and multiple needs.

NHS Newham, in conjunction with their Pacesetters Programme, run a Roma Cultural Awareness programme for staff which aims to:

- Introduce the history, culture and language of Roma people
- Inform on health-related issues, customs and taboos
- Improve communications skills with Roma people
- Improve access and experience of using health services for the Roma community

Supporting the workforce

There are a range of informal and practitioner-led support structures. Networks such as the Queen's Nursing Institute Homeless Health Initiative, UK Network of Sex Work Projects, and more local initiatives such as the London and South East Sex Workers Forum, can provide effective routes of communication and information.

[8] *The Operating framework for 2010/11, for the NHS in England,* NHS (London, 2008)

Making a difference through Inclusion Health

6. What we have heard from professionals (across disciplines and at all levels) highlights an important opportunity to examine the training, supervision and development of the Inclusion Health workforce so we support highly skilled and motivated professionals, equipped to engage and meet the needs of socially excluded clients.

7. In addition to enhancing and supporting today's workforce, we also need to be building and planning for the Inclusion Health workforce of tomorrow.

8. An Inclusion Health approach to the workforce will make a difference by:

   - Uniting motivated and dedicated Inclusion Health professionals
   - Equipping staff (clinical and non-clinical) with the skills and expertise to deal with some of the most complex and challenging clients of the NHS
   - Recognising and rewarding dedication and successes, however small
   - Ensuring services treat socially excluded clients with dignity and understanding, with clients reporting trust and improved outcomes
   - Ensuring practitioners have suitable supervision and support
   - Providing a structure of professional development and progression

To achieve this...

The National Inclusion Health Board will take forward a programme of work aiming to:

- Partner with early adopter universities to develop training for Inclusion Health within existing undergraduate and professional courses
- Embed Inclusion Health in undergraduate training for all nurses, doctors and dentists
- Design a requisite training package in Inclusion Health
- Influence the primary care postgraduate curriculum so that competence in Inclusion Health is mainstreamed
- Work to determine specific HR support (including models of supervision) and career development for practitioners in this field
- Establish and initiate a support network of professionals working within the Inclusion agenda
- Set out how careers in Inclusion Health are best recognised and rewarded

3. From needs to outcomes

The capability to build a better picture of needs, set priorities and know that services are making a difference

1. Information is key to delivering the best possible services, particularly given that every area will have its own unique patterns of social exclusion. The introduction of the Joint Strategic Needs Assessment (JSNA) has been a key step forward in improving our understanding of population needs, and World Class Commissioning is the vehicle for delivering a world leading NHS, equipped to tackle the challenges of the 21st Century.

2. Despite this progress, we have heard that there is still further to go. Although socially excluded groups are not hard to find or identify within communities, the picture of their needs is often incomplete. And while it is well established that socially excluded groups experience poor health outcomes on a range of indicators including self reported health, life expectancy and morbidity, hard data on outcomes remains relatively poor. The most vulnerable are not always picked up within area-based approaches, and are frequently invisible and/or of low priority to the system. Furthermore, the complexity of the picture requires sophisticated ways to gauge and understand the differences between and within groups. This makes it difficult to ascertain which services are making a difference, to whom, and by how much.

World Class Commissioning Cycle

National datasets offer limited monitoring of socially excluded groups. For example:

- There is little ethnic monitoring for the identification of Gypsy, Roma and Traveller communities
- NHS hospital episode statistics only identify ethnicity, age and place of residence of patients
- The General Household Survey often uses proxy measures to capture vulnerable groups
- The GP patient survey only captures those who are registered with a GP, and requires a certain level of literacy to complete

3. Understanding people's needs must start at a local level. For the last three years, local authorities and their primary care trust partners have been fulfilling their obligations under the Health and Social Care Act (2006) to carry out Joint Strategic Needs Assessments. This process has brought together public service partners, led via the typically jointly-appointed Directors of Public Health, to assess and prioritise people's needs within commissioning processes. To achieve a step change in the way we meet the primary care needs of the socially excluded, it is critical that we also think about whom we are *not* working with, as well as those who are visible to services. This should include identifying why access to services may have been poor for specific groups. While data specific to the health and care needs of the socially excluded may be limited, commissioners and providers can consider alternative sources to build this understanding.

The NHS Constitution

(3) You have the right to expect your local NHS to assess the health requirements of the local community and to commission and put in place the services to meet those needs as considered necessary.

(7) You have the right to expect NHS organisations to monitor, and make efforts to improve, the quality of healthcare they commission or provide.

4. As set out in *Putting the Frontline First: Smarter Government*,[9] a key task now is to develop smarter government that works in partnership with individuals and communities to deliver the services people want, in the way they want them.

5. We have seen how working alongside key local partners – and clients themselves – enables commissioners to develop the confidence and tools to determine which models of provision are most appropriate for their specific local population and circumstances. Through stronger joint commissioning (between health, the Third Sector and local authorities, including housing, education and the police) primary care trusts are supporting and stimulating innovation and increasing the impact of the services they have commissioned.

Homeless Link is piloting a health needs audit tool across primary care trusts in nine regions which will enable homelessness agencies to record and evidence the health needs of their clients. By gathering improved data about those needs, the project aims to improve the capacity of agencies to inform commissioning of health services that are both responsive and flexible to the needs of homeless clients.

[9] *Putting the Frontline First: Smarter government,* HM Government (London, 2009)

Westminster homeless people needs assessment

This needs assessment informs the *Westminster Rough Sleeping Strategy 2010-2013*. It is undertaken jointly by Westminster City Council and NHS Westminster as part of the Joint Strategic Needs Assessment process, and is informed by:

- Collection of primary care data
- Three primary care teams that deliver specialist health care to homeless persons in Westminster
- Homeless Health Survey
- Hepatitis Focus Group
- Housing and Voluntary Sector Health Summit
- A&E attendances
- Service User Day

A recent **Joint Strategic Needs Assessment for the homeless and those at risk of homelessness in Cambridgeshire** has identified some key recommendations for improving the complex interrelations between health, housing and social care of the homeless, which include:

- Developing multi-agency joint commissioning
- Provision of more integrated multi-agency services including funded posts for liaison and coordination between services
- Development of a Multi-Agency Assessment Conference (MARAC) approach for the most chronically excluded adults
- Encouraging service user engagement in the commissioning process
- Developing integrated information systems and data collection tools to obtain a clearer picture of service user need
- Tailoring care across pathways to allow more holistic and person-centred identification of need and service provision

6. Joint working can also result in stronger economic cases for intervention as costs associated with the health needs of the socially excluded can extend both beyond primary care and beyond health. Getting care packages right, shifting unplanned care to planned care, and a greater alignment of what is on offer with what people need, will in time be a more cost and time efficient route to higher quality outcomes.

The **Quality, Innovation, Productivity and Prevention (QIPP)** agenda aims to focus efforts on using innovation to improve the quality of patient care and to unlock productivity gains. Making QIPP a reality requires all levels of the system to design and implement more efficient services without compromising client care. Improvements are led at a local level, with incentives linked to specific quality goals. This enables clinicians to design services based on what is best for clients in their area, and should ensure that those with the greatest need (including socially excluded groups) get the greatest help.

Making the case for change:

In addition to the moral case for improving primary health care for socially excluded groups, there is emerging evidence that it makes economic sense to invest in improved services. These savings will be felt not only in health care, but across a wide range of services and require a long-term investment for long-term benefits. Key to this are:

- Innovative, people-centred design of services with robust evaluation built-in
- Coordinated and intelligent delivery and
- Early intervention to minimise the risk of escalating health problems

Total Place involves 13 pilot areas looking at how a 'whole area' approach to public services can lead to better services at lower cost. Key to this are collaboration and the design of services around the needs of individuals and communities, not institutions. Total Place pilots in Leicester and Leicestershire, Birmingham, South Tyneside, Sunderland and Gateshead are working to address alcohol and drug misuse.[10]

[10] www.localleadership.gov.uk/totalplace/

Making a difference through Inclusion Health

7. There is an opportunity to take stock and develop the data and tools which support local and national partners to shape, commission and evaluate services that best meet the primary health care needs of the socially excluded.

8. We have seen how innovative use of data can enable commissioners and public health practitioners to identify and engage groups that are seldom heard. These may be small in number, and include clients with particularly complex needs. Professionals and clients may also hit barriers around the definition of social exclusion and 'in need'. Designing services that are most likely to lead to high levels of quality and satisfaction requires a better understanding of the needs and priorities of those most likely to use them. By seeking to identify and aggregate common needs across vulnerable groups, there is a valuable opportunity to influence local priority setting processes to ensure that local systems have the capacity and capability to support the most disadvantaged.

9. We have also heard how better economic analysis can help commissioners to allocate resource against needs and stimulate a more stable provider market. In line with the commitments in *NHS 2010-2015*: *from good to great*, we can further support commissioners to drive local change by working systematically to realise the local visions for changing patient pathways agreed during the *NHS Next Stage Review*.

10. By understanding local needs of vulnerable and at risk populations and reshaping and challenging the provider sector, commissioners will be at the heart of change and driving the Inclusion Health agenda. Key to this is the requirement for primary care trusts to work with local authorities and other partners across the public and third sectors to consider how services can be designed around individuals' and families' needs, and to build on the opportunity of the Joint Strategic Needs Assessment to engage partners in this process. Inclusion Health requires careful planning and partnership working to ensure the right services are in place, without destabilising mainstream services.

11. Inclusion Health needs and outcomes will make a difference by:

- Buildling a clear, consistent and accurate picture of the health outcomes and wider needs of socially excluded groups, both nationally and locally
- Ensuring the best possible services for the socialy excluded, at the best value
- Enabling areas and services to systematically identify, assess and monitor the health needs, outcomes and experiences of the socially excluded
- Highlighting the complexities and diversities within individual socially excluded groups that will drive a sensitively tailored response from service providers
- Ensuring information from outside the health system (academic, local authority, third and private sector) is sufficiently hooked in at local and national levels, and exploited to inform commissioning decisions around care solutions

To achieve this...

The National Inclusion Health Board will take forward a programme of work aiming to:

- Update and refresh current Joint Strategic Needs Assessment guidance to better reflect the specific challenges of assessing the needs of socially excluded groups and how to map the community assets available to them
- Work across academic partners to build a best practice and research hub capability which could link to the proposed faculty of Inclusion Health
- Work with National Institute for Health and Clinical Excellence to consider how quality indicators for primary care operate in relation to socially excluded groups

The Department of Health will publish new *Inclusion Health* commissioning guidance, which will:

- Set out clear steps for commissioners to support them in improving primary care services for socially excluded groups
- Identify practical methods for sourcing and triangulating data and information locally, to better identify the needs, experiences and outcomes of socially excluded groups and inform priority setting
- Showcase evidence-based best practice to support commissioners in specifying high quality, flexible and responsive local services for socially excluded people
- Highlight available contractual and procurement options for working with partners to secure services for socially excluded groups and ensure continuous improvement

NHS
See a GP Today
Open Now
Walk in

4. Responsive and flexible services

Innovative models of joined-up, cost-effective and equitable care

1. Huge progress has been made in the delivery of efficient and effective services through public service reform. This has included developments specific to socially excluded groups. Across the country, there are examples of innovation in the delivery of services to those with the most complex needs and a clear appetite to accelerate progress and spread innovation to other areas.

Valuing People Now[11] sets out policies and actions to improve access to health care and outcomes for people with learning disabilities. The development of a Model Enhanced Service specification to support the local commissioning of better primary care services for people with learning disabilities provides an exemplar template to develop similar specifications for other excluded and vulnerable groups locally.

New Horizons[12] sets out the vision that by 2020 physical and mental health will be seen as equal priorities, based upon personalised services, equality, and improved understanding. Services will be characterised by high quality care for all with a guiding principle that there is no health without good mental health. It sets out a commitment to a new public mental health framework promoting whole population mental health and well being.

The NHS Operating Framework 2010-11[13] sets out the commitment that 'We shall work to transform community services and drive greater service integration. We will build up proven models such as NHS Foundation Trusts and the power of social enterprise and the Third Sector to reach out to marginal groups and communities. We will make the most of the skills and expertise of the independent and third sectors where they can contribute best'.

2. However, despite successes, provision for meeting the health needs of the most excluded varies considerably – both in terms of vulnerable groups gaining access to services and the systemic delivery of good quality service.

[11] *Valuing People Now: A new three-year strategy for people with learning disabilities,* Department of Health (London, 2009)

[12] *New Horizons: A shared vision for mental health,* Department of Health (London, 2009)

[13] *The Operating Framework for 2010/11 for the NHS in England,* NHS (London, 2009)

Primary care access and socially excluded groups

- 45% of sex workers who had difficulty accessing their GP also reported fear of being judged by staff
- In the homeless community, only 67% of frequent movers (5+ moves) found it easy to access a GP compared to 74% of other residents
- Street homeless people are 40 times more likely than the general population not to be registered with a GP
- 80% of street workers reported difficulties in accessing GP surgeries
- One in three residents in St Mungo's hostels has a condition for which they are receiving no treatment at all and 86% of their new clients have untreated conditions

Specialist access – Sex workers

The legal framework surrounding sex work can make sex workers reluctant to disclose their status to health services and authorities. While 83% of street workers surveyed were registered with a GP, nearly two thirds had not disclosed that they were working in the sex industry.[14]

3. Relationships of trust with socially excluded clients are fragile and can take time to develop, and just a single episode of poor treatment or care can result in a lifetime of mistrust of public services. Consequently, for many socially excluded groups, their access to and experience of primary health care can often be determined by their circumstance, and not their need. As some of the best services have demonstrated, **chaotic lifestyles do not have to mean chaotic care**. But in the absence of suitably flexible and responsive services, chaotic lifestyles can frequently mean unplanned and expensive care.

4. It is therefore critical that socially excluded clients and practitioners are clear what health care is available in their area and how it can be accessed. The NHS Constitution provides a valuable route to this.

14 N Jeal and C Salisbury, 'Self-reported experiences of health services among female street-based prostitutes: a cross sectional survey' in *British Journal of General Practice* (July 2004)

NHS Constitution

This Constitution establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. Fundamental to this is the principle of a comprehensive service, available to all, which is based on clinical need, not an individual's ability to pay. Furthermore, this NHS service must reflect the needs and preferences of patients, their families and their carers. Of particular interest are the following provisions:

(2) You have the right to access NHS services. You will not be refused access on unreasonable grounds

(5) You have the right not to be unlawfully discriminated against in the provision of NHS services including on grounds of gender, race, religion or belief, sexual orientation, disability (including learning disability or mental illness) or age (subject to new provisions in the Equality Bill)

(6) You have the right to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets the required levels of safety and quality

(11) You have the right to be treated with dignity and respect, in accordance with your human rights

(20) You have the right to be involved, directly or through representatives, in the planning of health care services, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services

To support its development, the Government is launching a consultation to enable a better understanding about what flexible and responsive primary care services should entail, and will use the experiences of socially excluded groups to inform and shape this

5. The provision of information and flexibility of services are crucial, as socially excluded clients may lack the capability to effectively access and navigate the care to which they are entitled. Often, third sector providers have particular expertise in bringing vulnerable groups into contact with services. Services which build in flexibilities (such as flexible registration with care providers), support structures (such as Health Navigators), and which build clients' capabilities (such as the Family Nurse Partnership) can be particularly effective with vulnerable service users.

6. Effective use of new digital technologies and tools such as practical, portable health records for those with transient lifestyles, can better connect different parts of the service together, empowering both patients and staff. The new Summary Care Record Service and Electronic Prescription Service have the potential to improve links between providers and the continuity of care for the socially excluded.

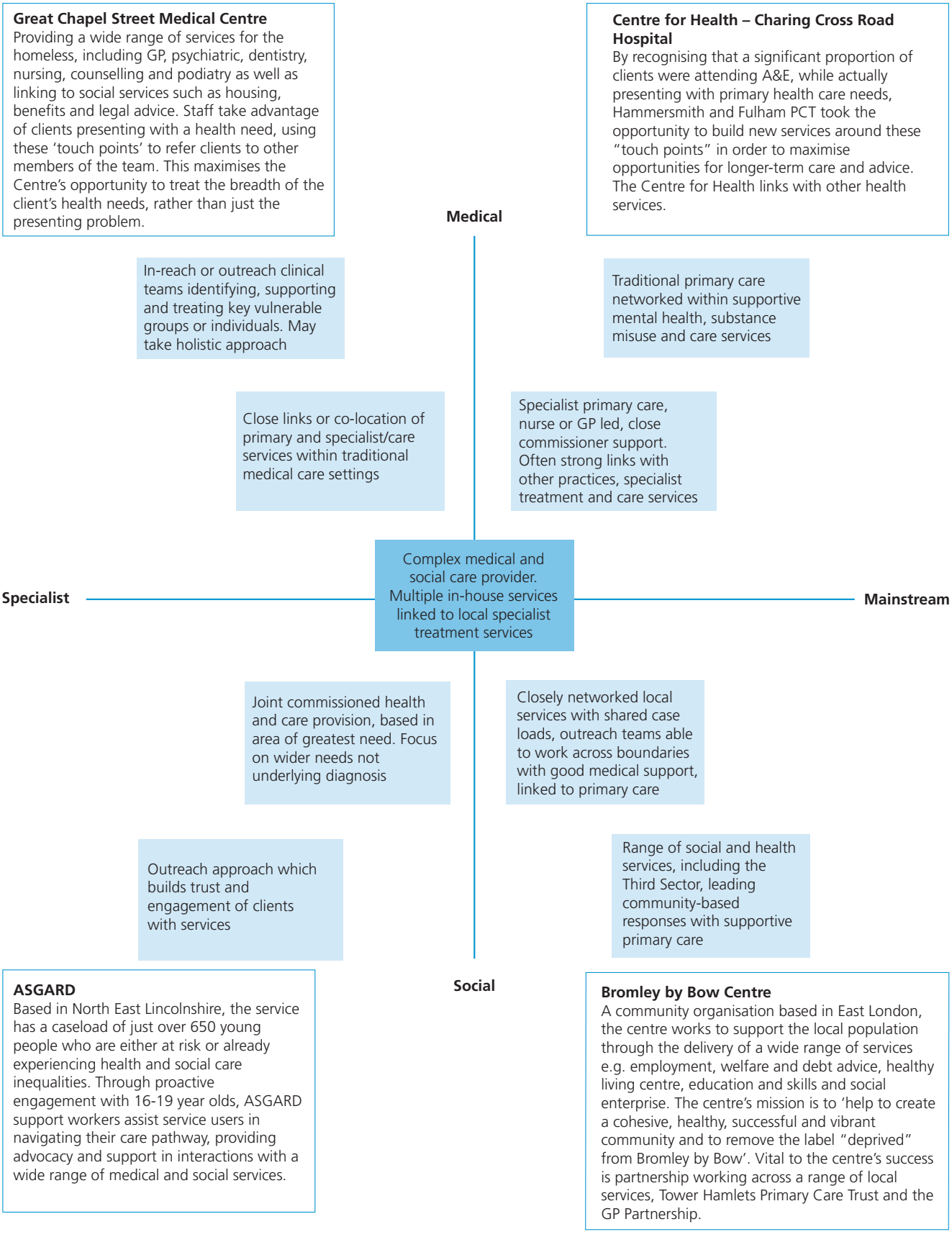
7. At the heart of Inclusion Health service delivery lies innovation and personalisation. Put simply, we need to deliver the best possible care to match the complexity of need and circumstance of the client and their family. This requires a tailored and flexible response from services, where professionals may need to work across traditional boundaries for the benefit of patients.

8. Individual and personal budgets are a valuable asset in empowering clients and providers as they support the flexibility required to get the most out of scarce resources and enable individual investments to shape the market. The NHS is supporting successive waves of requests by more entrepreneurial professionals providing NHS services to establish social enterprises.

9. Personalisation in Inclusion Health also means recognising the inter-generational and family-based nature of exclusion. Failing to identify wider family needs when treating vulnerable individuals will reduce the likelihood of a successful outcome for the individual while also potentially placing dependents, including children, at risk. This type of family-based identification and assessment of need, along with the coordination of support provided to vulnerable families by both adult and children's services is often described as *Think Family* practice.[15] It offers opportunities for improving health care provision and outcomes for both adults and children alike.

[15] *Think Family: Improving the life chances of families at risk,* Cabinet Office (London, 2008)

10. There are a range of service models that provide care for socially excluded groups:



11. The most promising approaches shared common characteristics:

Characteristic	For example...
Focus	• Clear objectives and outcome measures, which are agreed with commissioners and other stakeholders • Excellent knowledge of, and regular input from, their clients to inform service design, delivery and metrics
Voice	• Use a range of methods to ensure user involvement even where these people and groups are hard to engage with. This includes: – Designated champions and dedicated advocates – Peer advisory groups, expert patients and health ambassadors – Working across boundaries to maximise knowledge, capacity and influence
Personalisation	• The service is flexible and tailored to meet and be sensitive to the particular needs, behaviour and values of patients • Clients are actively engaged in the design of their own care • Service adjustments, such as thoughtful, easy read leaflets and alternatives for form-filling, easy to complete forms and information • Use of individual and personal budgets • Services are delivered in comfortable and relaxing settings which are accessible for clients
Quality and innovation	• Use of research and evidence in service design, delivery and adjustment • Collaborating with partners to share knowledge and devise joint solutions and clear measures of quality • Use of 'touch-points' to engage patients wherever they present and to offer opportunities for accessing the wider range of services they may need • Culture of continuous evaluation, review, adjustment and improvement
Recovery	• Services not only treat clients' immediate health symptoms but also address their long-term conditions, wider lifestyle needs and choices to improve chances of living healthy and fulfilling lives • Providers take a 'holistic' view of health and wellbeing and offer a wide range of services such as counselling sessions, basic life skills classes and access to the local housing services • Services which seek longer term goal of mainstreaming clients including a clear focus on prevention
Professional development	• Set up and operate as 'learning organisations' • The provision of effective, continuous human rights, equality and diversity training and development for practitioners, with a particular emphasis on understanding the cultures of the socially excluded groups they are most likely to encounter in their local area. Ensuring that staff are more confident and knowledgeable in dealing with certain groups • Reflective practice, supervision and support networks (across and within professional groups; and across mainstream and specialist services) • Shared posts and rotations to prevent burnout

12. It is important to recognise that mainstream and specialist services that work with socially excluded clients are likely to have to offer more intensive and person-centred services in order to achieve the same (or better) outcomes for that individual as the rest of the population. However, the impact of better designed and delivered services should be felt in improved outcomes and efficiencies.

Making a difference through Inclusion Health

13. Innovative models of joined-up care that put the socially excluded at the forefront of health care planning and delivery can make a real difference. It is also important to ensure that vulnerable clients know exactly what they should expect from the NHS, and that the most chaotic clients are supported to use services responsibly at all times.

14. The Inclusion Health agenda will be important in providing constructive challenge of perceptions and attitudes, capitalising on the choice agenda for the most vulnerable in our society, and working to ensure all providers fulfil the legal responsibility to tackle discrimination.

15. Underpinning this, Inclusion Health services encourage clients to shape their support and give confidence to practitioners to personalise care. *Inclusion Health* builds on the principle that social and medical models of care can be delivered by a number of different providers and from different networked settings. Importantly, we need to encourage support that navigates vulnerable clients towards mainstream service reintegration, without destabilising the client or service.

16. Furthermore, there is value in driving excellence and innovation in providing for complex groups through the showcasing of promising primary care models and, where appropriate, encouraging high-performing NHS Foundation Trusts to expand their services to areas such as primary medical services.

17. Responsive and flexible Inclusion Health services will make a difference by:

- Ensuring care is sufficiently tailored to complexity of need
- Enabling clients to have a say in the design and delivery of their services
- Enabling mainstream and specialist services to better meet the health care needs of the socially excluded, with better outcomes for better value
- Providing unobstructed access to health services
- Ensuring continuity of care
- Ensuring clear accountability between services and practitioners
- Supporting innovation

To achieve this...

The National Inclusion Health Board will take forward a programme of work aiming to:

- Review how the approach of the Model Enhanced Service specification for learning disabled groups might be applied more broadly to other socially excluded groups
- Use the NHS Constitution consultation process to strengthen understanding, operation and enforcement of the rights of socially excluded groups to receive first class care
- Increase personalisation and the use of individual budgets for socially excluded groups
- Consider how to improve access to and quality of care for socially excluded groups including building on proposals for opening up choice by removing the current system of GP practice boundaries

The Department of Health will publish evidence on the current patterns of secondary care use by homeless people, their current cost and potential alternative models of care

5. Health promotion and prevention

Improving health aspirations, prevention and early intervention

1. *High Quality Care for All*[16] states that for the NHS to be sustainable and fit for the 21st Century, it needs to focus on improving health as well as treating sickness. This principle is particularly important with regard to the health care of socially excluded groups, where the cost of treatment can often be very high.

2. Over the last ten years, life expectancy in some of the poorest areas with the biggest avoidable health problems has increased for men by almost four years and for women by over two years. Infant mortality is at an all-time low.

3. Despite these improvements, the chaotic lifestyles and complex needs of socially excluded clients have tended in the past to mean that the focus has been on treating harm rather than preventing it – and responding to presenting problems rather than working collectively to tackle the underlying causes.

> **'At present only 4% of NHS funding is spent on prevention. Yet, the evidence shows that partnership working between primary care, local authorities and the third sector to deliver effective universal and targeted preventive interventions can bring important benefits' (The Marmot Review, 2010)**[15]

Cancer: some key facts[16]

- Unskilled workers are twice as likely to die from cancer as professionals
- Women with manual/routine occupations are less like to attend cervical and breast screening than women in professional or managerial occupations
- Uptake for breast screening is 76% of women in the UK but between just 17% (family care) and 53% (formal care) for women with learning disabilities

4. *NHS 2010–2015: from good to great* underlines that we need to build an NHS that starts with prevention and seeks a paradigm shift in healthcare away from 'diagnose and treat' and towards an approach of 'predict and prevent'.[19] The *NHS Operating Framework 2010-11*[20] places a strong

[16] *High quality care for all: NHS New Stage Review final report,* Department of Health (London, 2008)
[17] The Marmot Review: *Fair Society, Healthy Lives* (2010)
[18] *Cancer and Health inequalities: An introduction to current evidence*, Cancer Research UK (2009)
[19] *NHS 2010-2015: from good to great preventative, people-centred, productive,* NHS (London, 2009)
[20] *The NHS operating framework for England for 2010/11,* Department for Health (London, 2008)

emphasis on improving capacity to anticipate future health needs of communities, but must not ignore those in greatest need. Much progress has also been made through the expansion of strengths-based prevention programmes such as the Family Nurse Partnership. Furthermore, World Class Commissioning is supporting a shift from treatment and diagnosis to prevention and the promotion of well-being. All primary care trusts are now expected to commission comprehensive promotion and prevention services to help engage all sections of society in preventing ill-health. This is crucial for delivering a fair health service as lifestyle choices are responsible for as much as half of the gap in health outcomes.[21]

Marmot Review: Fair Society, Healthy Lives (2010) – Summary of key findings[20]

- There is a social gradient in health – the lower a person's social position, the worse their health. Action should focus on reducing the gradient in health
- Health inequalities result from social inequalities. Action on health inequalities requires action across all the social determinants of health
- To reduce the steepness of the social gradient in health, actions must be universal but with a scale and intensity that is proportionate to the level of disadvantage
- Reducing health inequalities will require action on six policy objectives:
  - Give every child the best start in life
  - Enable all children, young people and adults to maximise their capabilities and have control over their lives
  - Create fair employment and good work for all
  - Ensure healthy standard of living for all
  - Create and develop healthy and sustainable places and communities
  - Strengthen the role and impact of ill health prevention

5. Reaching out to engage people at critical moments, and building trust and engagement will make better use of the investment in primary care locally and help people access and use it more appropriately. As we move into a more challenging financial climate, research and development will become even more important in ascertaining new ways of identifying, preventing and intervening in complex health needs.

6. Investment in prevention and early intervention is important because of the benefits over the medium and longer-term. It will rely on partnerships between organisations and the skills of those who are 'at the front door' of prevention, such as health visitors, and will require maximising the services and professionals who are 'touch points' for the vulnerable (such as pharmacists, housing officers and A&E). Third sector organisations and innovations such as Health Trainers potentially offer good return on investments to establish these links and pathways to care. Parents and families also have a vital role to play as carers and promoters of health.

[21] http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/DH_083197

[22] The Marmot Review: *Fair Society, Healthy Lives* (2010)

Isle of Wight NHS Hepatitis B and C Dry Blood Spot Testing and Hepatitis B Vaccination Service

This project involved the integration of community pharmacists into the care pathway of injecting drug users to undertake Hepatitis B and/or C testing and vaccination linked to supervised methadone consumption. This project:

- Improves uptake of vaccine administered under an ultra rapid schedule (three vaccines on days 0, 7 and 21)
- Identifies patients with undiagnosed Hepatitis B and/or C infection through dry blood spot testing
- Sign-posts infected patients into secondary care (sexual health services) for assessment and, potentially, treatment.
- Promotes working with the Island drug and alcohol, and sexual health services
- Prioritises referral arrangements to sexual health services

The service was further developed in December 2009 when the dry blood spot testing was expanded to include syphilis and HIV. This is the first commissioned pharmacy-based HIV screening service in England

Increasing access to breast screening for women with learning disabilities

Walsall Integrated Learning Disabilities Service, in partnership with the Department of Health's Pacesetters programme, has successfully addressed the historically low take-up of breast screening by women with learning disabilities. Through a combination of user engagement and raising staff awareness of the needs of this group, the project has improved screening rates from 62% to 100% for those women who are able to be screened. When the project began in August 2006, only 17 women with learning disabilities had attended breast screening in recent months. By August 2009, this had risen to more than 140 women who attended screening as part of a rolling programme. 'Everyone counts', *NHS Values 2009*

The **Family Nurse Partnership** is a high-intensity, health-led, early intervention and prevention programme available to vulnerable, first time young parents. Nurses work to build relationships with families, guiding mothers to adopt healthier lifestyles, improve their parenting skills, become self-sufficient and encourage families to make use of local community resources. The programme is now running in 50 sites across England.

A London-based **Mobile X-ray Unit (MXU)**, provides TB screening for socially excluded groups such as the homeless and offenders. The unit assessed over 25,000 people during the pilot phase of the project, with approximate savings of £1,912 per case prevented. Targeted MXU screening of hard to reach groups substantially reduces delays in diagnosis and is therefore likely to make a significant impact on disease transmission and could also result in less severe disease.

NHS Stop Smoking Services have saved the equivalent of 70,000 lives since they were established and, together with wider national, regional and local action on tobacco control, already deliver annual savings of £380 million to the NHS.[21]

[23] *Analysis of 10 years of NHS Stop Smoking Service data,* Department of Health (London, 2009)

Making a difference through Inclusion Health

7. Inclusion Health seeks to raise the health aspirations of the most vulnerable and increase the focus on prevention and longer-term behaviour change by identifying the investment opportunities that are accrued from primary, secondary and tertiary prevention.

8. Socially excluded clients' priorities may not necessarily reflect the choices and changes sought by most. People may be isolated and not have access to lifestyle support that the rest of society takes for granted. Immediate concerns, such as seeking a meal or a place to sleep, may be of higher priority than long-term health changes such as an alcohol and smoke-free life.

9. In these populations, the role of primary health care also includes a preventative role in the recognition and early treatment of particular problems which can lead to social exclusion such as alcohol addiction or conduct problems in young people.

10. Inclusion Health therefore emphasises the critical importance of applying health prevention and promotion to support excluded groups. Though it of course recognises that compared to the average member of the public, a greater intensity of support is likely to be required to halt the escalation of problems.

11. An Inclusion Health approach requires us to find new ways to ensure that practitioners and services who engage with people earlier in their pathway to recovery get the recognition and reward they deserve for this critical work. It also calls for us to support people to ultimately take responsibility for their own health and wellbeing.

12. For clients, this means taking increased responsibility for being physically active, stopping smoking and drinking sensibly. For practitioners, this means that in supporting the recovery of clients, they should seek to both stabilise immediate conditions and put in place strategies for prevention and reintegration towards mainstream services. For commissioners and providers, this means providing multiple and compelling pathways to better lifestyle choices that help socially excluded groups achieve the same health status as others. This could include the provision of intermediate care services which prevent hospital admissions or the expansion of smoking cessation services to include 'hard to reach' groups. In primary care, this also includes the equitable and appropriate use of medicines that are likely to help people live longer healthier lives.

13. Health promotion and prevention in Inclusion Health will make a difference by:

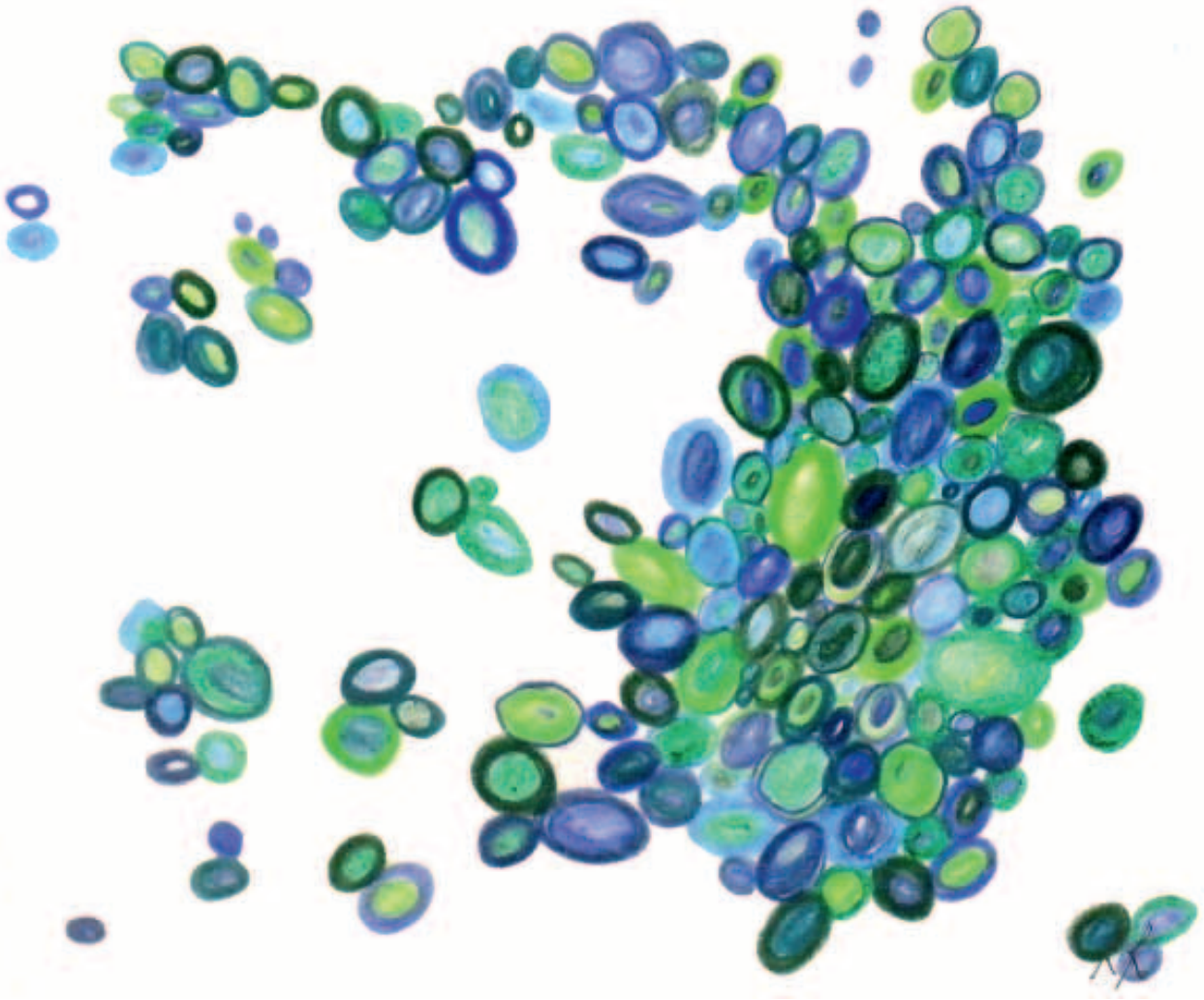
- Switching the focus of investment from curing harm, to preventing it occurring in the first place
- Collating and showcasing innovative preventative work
- Promoting consistent provision of health promotion and preventation packages which are appropriately targeted to meet the needs of socially excluded groups
- Building the health aspirations of socially excluded groups and boosting their expectations from services

To achieve this...

The National Inclusion Health Board will take forward a programme of work aiming to:

- Set out effective models of prevention and promotion for socially excluded groups
- Raise the profile of prevention in relation to socially excluded groups
- Promote active case finding and the role of Health Visitors and Health Trainers through the Inclusion Health guidance
- Build upon the findings of the Total Place pilots to strengthen actions that promote inclusion and prevent exclusion locally

The Department of Health will ensure any response to the Marmot Review on Health Inequalities reflects the Inclusion Health agenda



6. Assurance and accountability

Making best use of available resources and levers to drive a focus on improving outcomes for the socially excluded

1. As set out in *Putting the Frontline First*,[24] not only are demands for accountability and transparency increasing, but there is also a renewed focus on value for money. A lack of focus on the health needs and outcomes of the socially excluded, and limited data and information, has meant that historically there has been relatively weak accountability and transparency in this field. The agenda is often of low priority and those most in need have tended not to be at the forefront of strategic planning. Differential use of the resources and levers in the system has contributed to variation in the provision of services across the country, gaps in accountabilities and limited understanding of progress made.

2. The new duties under the Equality and Diversity legislation make it increasingly important to understand outcomes across the full spectrum of society, including for those with complex needs. To make a reality of this goal, commissioners and providers must ensure that they are able to fully understand the needs within their local area and develop suitable service provision. The NHS Performance Framework provides a dynamic assessment of the performance against which NHS providers and commissioners are assessed.

3. The importance of people's experiences and outcomes is at the centre of many of the fundamental reforms of our public services. *Putting the Frontline First* sets the clear ambition that in a fair and decent society people should expect to have a bigger say and more accountability in how they lead their daily lives. This is especially true and particularly challenging for those who need our help the most. *NHS 2010-2015: from good to great* places a strong focus on patient experience. The NHS CQUIN quality scheme[25] will this year treble the amount of contracts that relate to high quality care.

[24] *Putting the Frontline First: smarter government,* HM Government (London, 2009)

[25] The Commissioning for Quality and Innovation (CQUIN) payment framework makes a proportion of provider' income conditional on quality and innovation. The original guidance, published in 2008, introduced the CQUIN payment framework in context. http://wwwdh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_110431.pdf

4. Outcomes for socially excluded groups depend upon the joint working and cooperation of many local services, but especially their health, local authority and third sector services at local and neighbourhood levels. Both World Class Commissioning Assurance[26] and Comprehensive Area Assessment[27] processes are strong drivers to help report whether the needs of the most vulnerable are being met.

5. Existing local partnership and scrutiny mechanisms have a significant role in assuring that whatever the complexion of social exclusion is in an area, the most vulnerable receive the care they deserve. It is important to consider whether systems effectively enable people to access care, and whether the quality of that care is as high as we would expect. This should include meaningful engagement of the socially excluded groups themselves. Overview and Scrutiny Committees have a unique insight into how local services join up and the outcomes achieved. Local measures should be determined that best reflect local needs and outcomes, including measures of 'expected' versus 'reported' activity for the most vulnerable groups. The key is that accountability and assurance structures ensure the system is delivering, as well as it can, even for the most in need.

Improvement and Development Agency (IDeA) for Local Government: Health Inequalities Scrutiny Programme

In 2009, the Healthy Communities Programme commissioned the Centre for Public Scrutiny to lead a two-year programme to raise the profile of overview and scrutiny as a tool to promote community well-being and help councils and their partners in addressing health inequalities within their local community. The programme has two main outputs, the recruitment of four Scrutiny Development Areas which will help to design, develop and test a Scrutiny Resource Kit.

[26] Commissioning assurance is an annual process which reviews primary care trusts' progress towards achieving better health outcomes for their populations and provides a common basis for agreeing further development. This will drive peformance and development, and reward PCTs as they move towards becoming world-class commissioners.
http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/Assurance/DH_085142

[27] Comprehensive Area Assessment is a new way of assessing local public services in England. It examines how well councils are working together with other public bodies to meet the needs of the people they serve. It is a joint assessment made by a group of six independent watchdogs. Assessments will be made publicly available every year and will provide an annual snapshot of quality of life in the area. http://www.audit-commission.gov.uk/caa/

Making a difference through Inclusion Health

6. Assurance and accountability in Inclusion Health is about enhancing processes and incentives (such as commissioner assurance and efficacy of needs assessments) in order to drive a greater focus on those most at risk, and encourage service innovations and improvements for socially excluded groups. Provider accreditation offers the potential to ensure that services mirror expected local need. Inclusion Health accountability and assurance also seeks to provide services that demonstrate excellence in meeting the primary health care needs of the socially excluded with the incentives to expand and spread their innovation elsewhere.

7. Inclusion Health assurance and accountability will make a difference by:

- Increasing the status and priority of the health needs and outcomes of socially excluded groups
- Reinforcing clear accountabilities
- Encouraging the services that demonstrate real excellence in meeting the primary health care needs of the socially excluded to expand or spread their approach elsewhere
- Ensuring the approach to commissioning is sufficiently based on outcome measures or those that reflect the equality and diversity agenda
- Supporting socially excluded groups to report on and influence the services they receive
- Ensuring that the supply of services for socially excluded groups matches demand

To achieve this...

The National Inclusion Health Board will take forward a programme of work aiming to:

- Set achievement of level four of World Class Commissioning to be dependent upon evidence that primary care trusts have assessed and provided for the needs of socially excluded
- Develop new Joint Strategic Needs Assessment guidance that clarifies primary care trusts responsibilities to feed the needs of socially excluded groups into local priority setting processes, and how this is best reported and assured.
- Work with the Care Quality Commission to explore how their regulatory activities, including assessments of quality, can address access to quality care for people who are socially excluded
- Work with the Royal College of General Practitioners and the Care Quality Commission to understand the implications of primary care registration developments on socially excluded groups
- Build upon the NHS Constitution progress report to ensure the rights and responsibilities of vulnerable groups are adequately reported and monitored locally
- Support primary care trusts to ensure they are compliant with new equalities legislation
- Work with the Centre for Public Scrutiny and IDeA to produce new specific guidance to improve Overview and Scrutiny Committees engagement in the social exclusion agenda
- Ensure Local Involvement Networks (LINks) guidance and support emphasises and supports the improved engagement within localities of socially excluded groups
- Work with the Audit Commission to understand the findings of the first year of the Comprehensive Area Assessment and see how it builds upon partnership work to reduce health inequalities across and within areas
- Review how best to report the experiences of socially excluded groups

Making it happen

1. There is evidence that socially excluded groups experience poor health outcomes and often present with a range of complex needs. Those in greatest need of public services often do not get the care they require.

2. We have seen and heard the challenges clients, providers, commissioners, managers and leaders in all sectors face with regards to meeting the primary health care needs of the socially excluded.

3. *Inclusion Health* sets out how we can respond to these challenges and build on the promising practice and innovation. It outlines the objectives of an agenda specifically focused on the health outcomes of the most vulnerable and provides the steps for change.

4. To bring about changes, we need action in all parts of the system, not just within health and social care, and over different time scales. Taking this forward will require a focused and coordinated effort, both nationally and locally.

5. Nationally, we will establish a National Inclusion Health Board which will champion the agenda across professions and disciplines, and drive and implement the actions set out in this document in order to:

    - Build clear national and local leadership of Inclusion Health
    - Support and develop a strong, stable and capable workforce
    - Develop the capability to build an accurate picture of need and set priorities
    - Promote joined-up, cost-effective and equitable care
    - Raise health aspirations, and promote prevention and early intervention
    - Make best use of available resources to drive a focus on improvements and develop ways of demonstrating excellence in delivering this agenda

6. In addition, we will publish new *Inclusion Health* commissioning guidance to support commissioners and providers to further improve primary care services for socially excluded groups.

7. We will also ensure that Inclusion Health builds on work already in motion, and takes into account what is happening in other areas such as mental health, health inequalities and developments within social care.

8. Locally, individuals and organisations will shape and build on this framework to agree what action is required to achieve further improvements.

9. Together, through Inclusion Health, we can ensure that everyone gets the care they need, no matter what their circumstances.

Social Exclusion Task Force
Cabinet Office
4th Floor
Admiralty Arch
The Mall
London
SW1A 2WX

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