Allied Health Solutions

Enterprise Innovation Partnership

inclusion health

Qni The Queen's Nursing Institute

Inclusion Health: Education and Training for Health Professionals

EXECUTIVE SUMMARY

INCLUSION HEALTH

The concept of Inclusion Health is founded on the premise that not all UK citizens have access to the highest standards of healthcare. Meeting the health needs of a small group of socially excluded individuals and their communities remains a challenge. This population has poorer predicted health outcomes[1] and a shorter life expectancy than the average population.

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

ACKNOWLEDGEMENTS

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[1] Department of Health (2010) Inclusion Health: Improving Primary Care for Socially Excluded People.

Contents

EXECUTIVE SUMMARY

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

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

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

Key messages

- This study has prompted the education providers to reflect on the extent to which they embed Inclusion Health in their courses. It has also enabled practitioners to express their views about how well the education sector prepares them to care for vulnerable groups and supports them throughout their careers.

- All four devolved administrations recognise the importance of national policy that embeds Inclusion Health in the education and training of healthcare professionals. Each nation has published guidelines to address improvements in health outcomes for national patterns of social exclusion. However, we did not find any evidence of government departments, or national organisations, setting out a plan of work to ensure that healthcare professionals have the appropriate knowledge and skills to care for vulnerable communities.

- Inclusion Health is an area that is generally underdeveloped by healthcare regulatory bodies. The Nursing and Midwifery Council gives the most detailed guidance about Inclusion Health. Some of the regulatory bodies make reference to social determinants or health inequalities, whereas others make no reference at all to Inclusion Health. Without clear regulatory bodies' standards and guidance about Inclusion Health, which in turn enforces the education sector to incorporate this topic in the curricula, there is no guarantee that aspects of Inclusion Health will be taught and assessed.

- The extent to which professional bodies guide their members and the education providers about aspects of Inclusion Health varies enormously. Fewer than half make specific reference to a particular aspect of Inclusion Health. However, The Royal College of General

Practitioners has an exemplary resource which is widely available to all healthcare practitioners and the Royal College of Nursing supports an online resource about Inclusion Health for its members.

- The evidence published by organisations, which employ staff to work with vulnerable groups, states that many healthcare practitioners lack the knowledge and skills to effectively support service users from socially excluded communities. The majority of the literature discusses the education and training needs of staff who work with the homeless communities and those who live in insecure accommodation. Nevertheless, many of these needs are considered generalizable to staff who work with Gypsies and Travellers, Roma, sex workers and vulnerable migrants.

- There are stated intentions to improve the knowledge and skills of the staff and to harness the potential that a well-qualified and well-informed healthcare workforce brings to the care of these vulnerable groups. Nevertheless, there is a sizeable gap between what the workforce needs to know, the skills they need to be able to demonstrate, and the readily accessible high quality specialist education and training that will guarantee these achievements.

- This study has consistently highlighted some key areas for study by healthcare professionals who work to support the socially excluded communities (outlined in the executive summary and detailed in the full report). Many of these topics could be introduced at pre-registration level and developed for the qualified practitioner.

- The education providers report teaching health inequalities and health risks to the five vulnerable groups and their healthcare needs, nonetheless, there is much less evidence that these topics are assessed. This absence of assessment weakens the knowledge base and the value of studying this subject in the eyes of the student and those providing the service. It also limits the chances of the staff securing essential resources to underpin the provision.

- There is limited academic expertise in the education sector. This situation may be an indicator of the level of commitment of the sector to promote Inclusion Health in the curricula, or the lack of resources available to employ academic staff with the appropriate expertise, or simply that there are insufficient experienced practitioners with expertise in caring for Gypsies and Travellers, Roma or sex workers. We found very little evidence that the education providers involve service users and carers to help deliver the curricula.

- Much of the experience gained by professionals is through 'learning on the job' and work experience, rather than through formal education and training. The vast majority of pre-registration/undergraduate students are unlikely to experience placements with socially excluded communities. Although the specialist practitioners report that the practice placement experience with vulnerable groups is one of the strong points of the Specialist Community Nursing courses.

- It is important to reduce the social distance between healthcare professionals and those from vulnerable groups. Appropriate education and training should empower healthcare professionals to reach out to these groups.

- The voluntary sector has a major role in developing and supporting the healthcare professionals. Closer partnership working between the education sector and the third sector would enhance the quality of all education provision.

- Specialist practitioners report difficulty in accessing specialist training programmes to help them develop their clinical and non-clinical knowledge and skills to care for patients from socially excluded groups.

Main limitations to the data

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

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

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

The main recommendations

National policy

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

Professional and regulatory bodies

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

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

Education and training

4. All healthcare education providers should review their pre-registration/undergraduate curricula to ensure that Inclusion Health learning outcomes are demonstrated across all their programmes.

5. Higher Education Institutions should ensure that healthcare education programmes are appropriately assessed in relation to aims and learning outcomes of the curriculum that relate specifically to Inclusion Health.

6. Higher Education Institutions need to urgently review their staffing arrangements to ensure that they have sufficient staff with the appropriate knowledge and skills to support the Inclusion Health agenda.

7. Higher Education Institutions must work even more closely and strengthen their links with a broad range of organisations that support socially excluded groups, particularly the voluntary sector, to enable a greater number of students to experience working alongside specialist practitioners, socially excluded service users and their carers.

8. Higher Education Institutions that offer specialist Inclusion Health courses should review how easy it is for the wider multi-professional community, as part of ongoing continuing professional development, to access these courses and develop the appropriate level of knowledge and skills to confidently and competently provide high quality care to vulnerable groups.

Chapter 1. Introduction

'Inclusion Health: Improving the way we meet primary healthcare needs of the socially excluded' was published by the Department of Health in 2010[2]. In this report it was stated that '*many practitioners (especially in non-specialist settings) lack awareness, skills and training to cope effectively with the most excluded'*.

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

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

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

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

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

Chapter 2. Existing evidence

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

Each nation has produced specific guidelines concerning improved health outcomes for the homeless[3,4,5,6,7]. The Scottish and Welsh Governments have published country specific policies and action plans around developing staff to support the healthcare needs of sex workers and vulnerable migrants. The Welsh Government leads the way in promoting healthcare for Gypsies and Travellers.

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

[3] HM Government (2010) Social Exclusion Taskforce. Inclusion Health.

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

[5] The Scottish Government (2013) Everyone Matters: 2020 Workforce Vision.

[6] Welsh Government (2008) Refugee Inclusion Strategy.

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

None of the government departments across the four nations promote safeguarding rights to protect the Roma community despite a Directive from the European Commission.
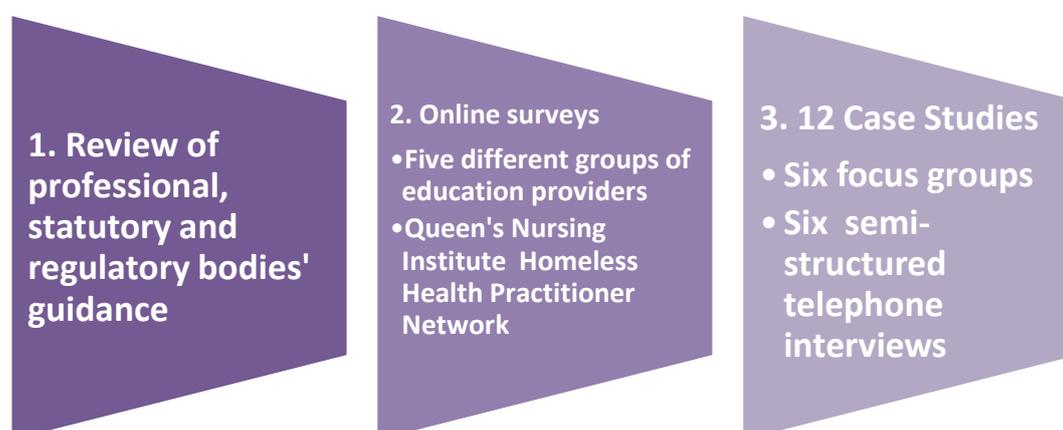
A review of the literature suggests four important conclusions:

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

Chapter 3. Study design and data collection

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

Data collection methods used in the study

1. Review of professional, statutory and regulatory bodies' guidance

2. Online surveys
- Five different groups of education providers
- Queen's Nursing Institute Homeless Health Practitioner Network

3. 12 Case Studies
- Six focus groups
- Six semi-structured telephone interviews

The data collection sources were:

1. An extensive review of the standards and guidance, published by the regulatory and professional bodies that relate specifically to Inclusion Health.

2. Five online surveys, which captured the extent to which aspects of Inclusion Health are embedded in the curricula, were circulated to education providers:

      a. Healthcare education providers that are members of the Council of Deans of Health (55 out of 88 responded).
      b. Medical schools (14 out of 31 responded).
      c. Dental schools (8 out of 18 responded).
      d. Schools of pharmacy (12 out of 27 responded).
      e. Education providers of healthcare scientist programmes (2 out of 56 responded).

3. Online survey to members of the Queen's Nursing Homeless Health Practitioner Network (106 out of a possible 730 responded).

4. Focus groups or interviews with staff were held in 12 different organisations that support people from socially excluded communities.

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

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

Chapter 4. Main findings

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

Professional, statutory and regulatory bodies' guidance on Inclusion Health
Documentation was reviewed for eight out of the nine regulatory bodies. The Nursing and Midwifery Council Standards of Competence[8] provide the most comprehensive guidance. The General Dental Council; the General Medical Council, and the General Osteopathic Council also make reference to social determinants and or health inequalities. The Health and Care Professions Councils' standards of conduct, performance and ethics[9] refer to social status, culture and vulnerable adults; there is also reference to Inclusion Health in the standards of proficiency for the 16 professions it regulates. There is no reference to Inclusion Health in the guidance published by the remaining regulatory bodies.

Documentation produced by 37 healthcare professional bodies was reviewed. 16 of them make specific reference to Inclusion Health in their curriculum guidelines. The most comprehensive set of guidelines are produced by the Royal College of General Practitioners[10]. Their vision for general

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[8] Nursing & Midwifery Council (2010) Standards for competence for registered nurses.
[9] Health and Care Professions Council (2012) Standards of conduct, performance and ethics.
[10] Royal College of General Practitioners (2012) A core curriculum for learning about health inequalities in UK undergraduate education.

practice[11] highlights that in 2022 the NHS will have *'a growing intolerance of long standing inequalities in health'*, and their vision for the GPs' role in 2022 includes supporting a reduction in health inequalities and increasing community self-sufficiency. A number of other royal medical colleges have produced guidelines, notably the Royal College of Psychiatrists, which has produced competency based training guidelines[12] about mental health and social inclusion.

Other than the Royal College of Nursing[13], that has produced an online resource about social inclusion for its members; the only other non-medical professional associations that guide education providers to cover all aspects of Inclusion Health are those that support social workers[14].

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

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

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

The medical schools, dental schools and schools of pharmacy reported that they teach all six aspects of health inequalities[15] to their undergraduate students:

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

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

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

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

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

[13] https://www.rcn.org.uk/development/practice/social_inclusion.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Findings from the case study sites

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

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

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

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

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

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

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

The support for professionals working in this arena was reported to be very variable. Some healthcare professionals, particularly the loan workers, conveyed that they have little or no support especially those staff who care for minority socially excluded groups such as the Roma community. Some specialist healthcare networks have been developed and they often provide the only support to staff.

Some of the networks are well established e.g. the network to support staff working with people who are homeless, but networks are less well established for those working with other vulnerable communities.

Chapter 5. Education and training institutions

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

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

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

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

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

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

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

One option to strengthen the learning opportunities about aspects of health inequalities is for key stakeholders to develop a Local Partnership Alliance with a specific remit for education and training

in Inclusion Health. This proposed formal tripartite partnership would be between the publicly funded service providers, the third sector providers and the education providers.

Chapter 6. General discussion and conclusions

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

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

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

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

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

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

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

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

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