From Jackie Doyle Price MP
Parliamentary Under Secretary of State for Mental Health, Inequalities and Suicide Prevention

The Rt Hon Mrs Maria Miller MP
Chair, Women and Equalities Select Committee
House of Commons
London
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24 January 2019

Dear Maria,

Following the evidence session on 9 January 2019 I said I would write to you with further information on two issues:

- the Voluntary Community and Social Enterprise (VCSE) Health and Wellbeing Alliance (the Alliance) and its relationship with the NHS Equality and Diversity Council
- CQC inspections of general practice

The Voluntary, Community and Social Enterprise (VCSE) Health and Wellbeing Programme was launched in April 2017 as a joint initiative by the Department of Health and Social Care (DHSC), Public Health England (PHE) and NHS England. The aim is to work together with VCSE organisations to drive transformation of health and care systems; promote equality; address health inequalities and; help people, families and communities to achieve and maintain wellbeing.

The core objectives of the Programme are to:

- build evidence of sustainable, scalable solutions to mitigate and prevent inequalities from impacting on health and wellbeing of communities;
- encourage co-production in the creation of person-centred, community-centred health and care which promotes equality for all; and
- enable the voice of people with lived experience and those experiencing health inequalities to inform national policy making and shape the delivery of services.

A component of the Programme is the VCSE Health and Wellbeing Alliance (the Alliance).
The Alliance is a partnership arrangement with the aim to facilitate integrated working between the voluntary and statutory sectors, to promote equality and reduce health inequalities. It seeks to build on the productive and transparent relationships between system partner organisations and the VCSE sector, bringing the sector’s voice and expertise into national policy making.

The Alliance is made up of 21 VCSE members that represent communities who share protected characteristics or that experience health inequalities. Full membership is enclosed with this letter.

Through their networks Alliance Members can link with communities and VCSE organisations across England. Individuals and VCSE organisations who would like to share their experiences and ideas with NHS England, DHSC and PHE can do so via Alliance Members.

It receives £1.2 million for core work. The core work of Alliance members involves a range of activity, including:

- making sure the VCSE sector are aware of key developments within health and care, and can respond appropriately;
- cascading important health and public health announcements and messages to key networks and communities;
- facilitating input from the VCSE sector on different aspects of policy;
- gathering intelligence from the sector and sharing emerging evidence, for instance on:
  > areas of good practice and effective interventions to prevent or improve health inequalities
  > trends or areas of concern from the VCSE sector to ensure that these are escalated as appropriate
- undertaking regular engagement with policy colleagues, particularly the equalities and health inequalities teams, across system partner organisations; and
- engaging with policy teams and supporting the development of new policy by providing insight and advice on behalf of the wider networks.

Furthermore, Alliance members can bid from a budget of £870K for bespoke additional work that is identified by policy leads in DHSC, PHE and NHS England. An example includes the development of the Inclusion Health Audit Tool for the voluntary sector which enables organisations to audit their work with Inclusion Health groups (including Gypsy, Roma and Traveller communities) and offers bespoke guidance on how they can improve their work.
The tool consists of five sections and takes around 15 minutes to complete. Once the audit tool is completed, it will provide a unique and tailored guide which will help organisations to embed action on tackling health inequalities into its everyday activities.

Friends, Families and Travellers have supported the Department on a range of work to date including the Inclusion Health Audit Tool, on maternal health, mental health, end of life care and dementia. A summary of projects carried out by the Alliance to tackle health inequalities faced by Gypsy, Roma and Traveller communities is enclosed with this letter for your information.

NHS England’s Equality and Diversity Council is chaired by Simon Stevens and Joan Saddler of the NHS Confederation. It consists of all the main NHS arm’s length bodies¹ and leads for equality, diversity and inclusion from a patient safety and workforce perspective.

The Council has representation from the Association of Young People’s Health and the Association of Mental Health Providers on behalf of the other Alliance members. Council members have also attended workshops with inclusion health representatives in development of the NHS Long Term Plan – a really important part of the development process.

The Care Quality Commission (CQC) have helpfully provided a contribution which details their approach to inspections and the regulation of general practice services in relation to the Gypsy Roma and Traveller community.

Within the CQC regulatory framework (enclosed with this letter), the key line of enquiry R2 looks at how well services take into account of the needs of different people, including those in vulnerable circumstances which can include gypsies and travellers. As well as inspecting and rating GP practices against the five key questions, CQC also inspect and rate six population groups. The GRT community is covered by the population group of “people whose circumstances make them vulnerable” under the CQC methodology for regulating GP practices. The relevant paragraph gives the following guidance:

> This population group may include a number of different groups of people. It includes those who live in particular circumstances that may make it harder for them to access primary care, or mean they are more at risk of receiving poor care (including GRT community). When we look at a group, inspectors will

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focus on access to general practice services generally, rather than the physical access to a practice for an appointment. This includes registration with a practice, and the ability to book appointments and receive services.

The CQC would take into account if they had evidence that discrimination was taking place which led to low levels of GP registration i.e. that members of the Gypsy, Roma and Traveller community (GRT) were attempting to register with a practice but were unable to do so. The CQC have produced a guidance note to GP practices around patient registration (enclosed with this response) that covers this and specifically mentions gypsies and travellers. This would affect the GP practice rating in relation to whether services are responsive.

The CQC also have a role in encouraging improvement in GP and community services response to specific communities as well as taking regulatory action when providers discriminate. If GP practices work to provide an excellent service to the GRT community, this can contribute to receiving an Outstanding rating. We also use this inspection evidence to share good practice. For example, in our Equally Outstanding resource, we highlight the work of First Community CIC in proactive work to meet the needs of the Gypsy, Roma and traveller community.

I hope this information is helpful. I look forward to receiving your report in due course.

I am copying this letter to Lord Bourne of Aberystwyth and Nadhim Zahawi.

JACKIE DOYLE-PRICE