

# MANCHESTER JOINT STRATEGIC NEEDS ASSESSMENT ADULTS AND OLDER PEOPLE

## CHAPTER: Key Groups

### TOPIC: New Refugees and Migrant Groups

#### WHY IS THIS TOPIC IMPORTANT?

An estimated 65 million people throughout the world have been forced to flee their homes due to conflict and persecution, creating more than 22 million refugees worldwide.<sup>1</sup> In 2016, there were around 39,000 applications for asylum in the UK, with the top five countries of origin being Iran, Pakistan, Iraq, Afghanistan and Bangladesh.<sup>2</sup> There are an estimated 123,000 individuals granted refugee status living in the UK and 39,389 asylum seekers being supported under Section 95.<sup>3</sup> These figures do not include those who are not supported by Section 95 of the Immigration and Asylum Act 1999<sup>4</sup> or undocumented migrants.

These individuals may have experienced mental and physical torture in their country of origin, coupled with an arduous journey during which their health needs could not be prioritised, often resulting in complex health needs on arrival to the resettlement country. This population are at the margins of society and getting services right for this excluded group will generate learning for the care and inclusion of other marginalised groups in Manchester and beyond.<sup>5</sup>

Understanding the health and wellbeing issues of refugees and people seeking asylum is important for everyone concerned with providing healthy environments, health and social care, particularly the commissioners of such services. Paying attention to the needs of refugees and asylum seekers will benefit the health and social care economy, and society more generally, by addressing the harm caused by misdiagnoses and iatrogenesis (i.e. an injury or illness that occurs because of medical care, such as chemotherapy used to treat cancer which may cause nausea, vomiting, hair loss, or depressed white blood cell counts) and reducing inappropriate use of costly emergency services. Putting this population at the forefront of strategic planning gives a voice to this population and the professionals who work with them.

The UK is signatory to the 1951 Refugee Convention and people who claim asylum are exercising a legal right to seek protection and are entitled to health care during this period under the Geneva Convention and UK law.<sup>6</sup> In addition, Clinical Commissioning Groups (CCGs) have an obligation under the Health and Social Care Act 2012 to tackle health inequalities.<sup>7</sup> Despite this, there has been a piecemeal approach to refugee health in the UK, with different areas providing gateway services, core services or no services.<sup>8</sup> To date there has been no unifying strategy in Greater Manchester.<sup>9</sup>

<sup>1</sup> The Red Cross. *Refugee Facts and Figures* (2016).

<http://www.redcross.org.uk/What-we-do/Refugee-support/Refugee-facts-and-figures> [accessed 24/02/18]

<sup>2</sup> Full Fact. *Refugees in the UK* (2017).

<https://fullfact.org/immigration/uk-refugees/> [accessed 24/02/18]

<sup>3</sup> Full Fact, *Refugees in the UK*.

<sup>4</sup> Asylum Seekers Appeal Project: Summary Fact Sheet <http://www.asaproject.org/uploads/Factsheet-1-section-95.pdf>

<sup>5</sup> Farrington et al, *Proposal*

<sup>6</sup> Farrington, R., Maffia, C., Eida, T., Worthington, E. (2016) *Proposal for specialist primary care inclusion service: People Seeking Asylum and new refugees in Greater Manchester*. Grey paper for Manchester CCG.

<sup>7</sup> Farrington et al. *Proposal*

<sup>8</sup> Aspinal, *Inclusive Practice*

<sup>9</sup> Farrington et al. *Proposal*

It is vital to note that migrants are far from a homogenous group and the experiences of some (e.g. overseas students) may be markedly different to the experiences of others e.g. 'failed' asylum seekers with no recourse to public funds. As result, it is impossible to generalise on either the assets or the health and social needs of refugees and people seeking asylum. There is a great diversity of health experiences pre-migration and during the journey, and health and wellbeing needs will change over time.

The website of the Refugee Council includes a [glossary of terminology relating to asylum seekers and refugees in UK](#). This provides a basic explanation of terms used across the refugee sector.

### Definitions

**Refugee:** a person who 'owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country...' (Definition quoted from the 1951 Refugee Convention)

**Asylum Seeker:** someone who has lodged an application for protection on the basis of the Refugee Convention or Article 3 of the European Convention of Human Rights

Source: Refugee Council (<https://www.refugeecouncil.org.uk/glossary>)

Many Asylum seekers and refugees face the same health problems as the UK population. However, they are likely to have poor awareness of how the NHS operates, and face barriers to treatment resulting in delay accessing care. Indeed, the research points to poor physical and mental health outcomes for this group, even many years after arriving in the UK.<sup>10, 11, 12</sup>

Below is a discussion of some of the specific health needs of this population, taken from the British Medical Journal and World Health Organisation reports.<sup>13,14</sup>

### Physical health

Many refugees and asylum seekers experience a deterioration of health within the first 2-3 years of arriving in the UK. Physical health problems include:

- Injuries, impairment or disabilities resulting from war, torture and /or trauma from the migration journey.
- Acute conditions such as respiratory infections.
- Chronic conditions, undiagnosed or untreated conditions such as diabetes or cardiovascular disease. There are elevated levels of smoking. Malnutrition and vitamin deficiencies are common and can persist after resettlement. Dental and ophthalmic health may have been neglected.

<sup>10</sup> Campbell, M. (2012). *Social determinants of mental health in new refugees in the UK*. The Lancet.

[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(13\)60383-9/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)60383-9/fulltext)

<sup>11</sup> Burnett, A., Peel, M. (2001) *Health Needs of Asylum Seekers and Refugees*. British Medical Journal.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1119741/> [accessed 24/02/18]

<sup>12</sup> Marmot M. *Fair Society, Healthy Lives, Strategic Review of Health Inequalities in England post 2010*. The Marmot Review 2010.

<sup>13</sup> Burnett, *Health Needs*

<sup>14</sup> WHO. *Migration and Health: Key issues*. <http://www.euro.who.int/en/health-topics/health-determinants/migration-and-health/migrant-health-in-the-european-region/migration-and-health-key-issues#292933>

### **Infectious diseases**

Many migrants to the UK arrive from a country with a high burden of infection. In the UK, the majority of cases of HIV, tuberculosis, enteric fever and malaria are diagnosed in people who were born abroad. These diseases stem from a lack of (or disruption in) immunisation or screening in their country of origin but may be exacerbated by poor living conditions during the journey and can deteriorate after arrival to the UK due to difficulty accessing services.<sup>15</sup>

Some groups of migrants, such as asylum seekers and refugees, unskilled workers or undocumented migrants, may be economically disadvantaged, live in over-crowded conditions, and live and meet socially with other at-risk groups, putting them at increased risk of infection whilst living in the UK.

### **Women and maternity**

The Royal College of Obstetrics and Gynaecologists reported this population are three times more likely to die in childbirth and seven times more likely to experience complications than the general population.<sup>10</sup> Additionally, there is a higher prevalence of risk factors such as hepatitis, HIV, conception resulting from rape, post-natal depression and domestic violence which require specialist antenatal care.<sup>16</sup>

Several factors have been implicated in poor obstetric outcomes, including inadequate or absent interpreting, racism, a lack of understanding of cultural differences, and late 'booking' leading to more limited antenatal care.<sup>17</sup>

Refugees and people seeking asylum come from countries with different sexual health practices, understandings and access to family planning. Some are fleeing persecution because of their sexual orientation and may fear that being open about sexual health issues will stimulate a negative response. Some refugees and people seeking asylum are particularly vulnerable to sexual exploitation or abuse by traffickers, before and during their journey as well as after arrival in the UK.

Female genital mutilation (FGM) is prevalent in some refugee-generating countries. FGM can lead to genito-urinary infections, painful intercourse, childbirth complications, menstrual and fertility problems and psychological and sexual problems. The children of mothers who have suffered FGM are at higher risk of FGM themselves.

### **Men's health**

Many refugees and people seeking asylum come from countries where gender roles are much more defined than in the UK. For some men, it is difficult to maintain those roles and associated self-esteem. A prime example would be not being able to work and provide for the family. They may be incapacitated by feelings of guilt at surviving persecution or shame because they were unable to protect their family.

Men are less likely to go to the GP, and may be reluctant to access counselling services, which are often an unfamiliar concept.

There are some lifestyle factors that are seen more in males than females, such as smoking tobacco or chewing qat which is associated with head and neck cancer.<sup>18</sup>

### **Children and young people**

Whilst children are extremely adaptable and may find resettlement easier than their parents, they are very vulnerable. Children may have been exposed to violence and war, been living with traumatised and stressed adults, witnessed family members being assaulted or killed and experienced rape or torture themselves. Some have been forced to become child soldiers or sexual slaves. More than 50% of refugee children experience some psychiatric symptoms.<sup>19 20</sup> Often their schooling will have been

disrupted or they may never have been able to attend. It is important to get them back into education and learn to play again.

Unaccompanied and age disputed children are particularly at risk of exploitation and need rapid identification and safeguarding.

### Mental Health

Refugees and asylum seekers are likely to experience grief of some description. This may be the loss of friends and family members, social status, culture and environment. They may be unable to communicate, to socialise, to use their skills or to worship or practice their faith. Many have lived with persecution, torture or the fear of such, and many have experienced or witnessed war and chaos, exploitation, violence and rape.

Refugees and people seeking asylum also experience compounding stressors that commence, continue and sometimes worsen after arrival in the UK, retraumatising the individual. These include poverty, isolation, loss of self-esteem, racial harassment or discrimination and frequently, a sense of powerlessness. The Royal College of Psychiatrists states "the psychological health of refugees and asylum seekers currently worsens on contact with the UK asylum system".<sup>21</sup>

It is not surprising to find that refugees and people seeking asylum are considerably more likely than the general population to have psychological ill-health, mental health needs and psychiatric disorders.<sup>22</sup> However, it is important to distinguish the difference between natural reactions to very stressful circumstances and what might be termed 'clinical' mental health problems.

Signs and symptoms may manifest soon after arrival or up to many years later. They can include:

- A feeling of helplessness and hopelessness
- Low mood and frequent crying, depression
- Flashbacks and intrusive thoughts of trauma
- Sleep disturbances and nightmares
- Poor concentration, memory loss, difficulty in retaining information
- Irritability and anger
- Anxiety, jumpiness or easily startled
- Relationship problems and a reluctance to trust others
- Sexual dysfunction
- Heavy smoking, alcohol or drug abuse, eating disorders manifesting from underlying mental distress

Psychiatric conditions could include depression, anxiety, post-traumatic stress disorder, phobias, dissociative disorders, psychosis, personality problems and suicidal ideation,

<sup>15</sup> Public Health England. *Communicable diseases: migrant health guide*. <https://www.gov.uk/government/collections/communicable-diseases-migrant-health-guide> Last updated 27 June 2017

<sup>16</sup> Asif, S. et al. (2015). *The obstetric care of refugees and asylum seekers in the UK*. The Obstetrician and Gynaecologist. <http://onlinelibrary.wiley.com/doi/10.1111/toq.12224/full> [accessed 24/02/18]

<sup>17</sup> Asif et al, *Obstetric Care*

<sup>18</sup> El-Wajeh, Y.A.M., Thornil, H. (2009). *Qat and its health effects*. Nature. <https://www.nature.com/articles/sj.bdj.2008.1122> [accessed 24/02/18]

<sup>19</sup> Kaplan et al. *Cognitive assessment of Refugee children: Effects of trauma and new language acquisition*. (2015). Sage. <http://journals.sagepub.com/doi/pdf/10.1177/13634615155612933> [accessed 24/02/18]

<sup>20</sup> MIND. *A Civilised Society. Mental health provision for refugees and asylum seekers in England and Wales*. Mind. 2009 <https://www.mind.org.uk/media/273472/a-civilised-society.pdf> [accessed 24/02/18]

<sup>21</sup> The Royal College of Psychiatrists (RCP), *Improving services for refugees and asylum seekers: position statement*, Summer 2007. [accessed 24/02/18]

<sup>22</sup> Kirmayer et al. (2011). *Common mental health problems in refugees and immigrants: general approach in primary care*. CMAJ. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5428192/> [accessed 24/02/18]

with severe cases leading to hospital admission. The prevalence of such problems is much higher in detained individuals.<sup>23</sup>

It is not uncommon to have physical and psychological problems at the same time. Somatisation or medically unexplained symptoms are common and often lead to expensive over-investigation and medicalisation of mental distress.

Prompt identification of mental health problems helps reduce the risk of crises such as self-harm or suicide. However, refugees and people seeking asylum are less likely to engage with mental health services, and communication challenges, stigma and cultural misunderstandings can thwart correct diagnoses.<sup>24</sup>

The therapeutic activities of socialising, work, study, exercise and participating in community life are often inaccessible, leaving many bored, inactive and with little to distract them from haunting memories.<sup>25</sup>

### **Torture**

Research indicates that up to 30% of this population have survived torture in their country of origin.<sup>26</sup> Experience of torture compounds other health and social difficulties and can cause post-traumatic stress disorder and complex trauma. Exposure to torture is typically accompanied by shame and a reluctance to disclose, leading to misdiagnosis and late diagnosis. For example, many survivors of torture have only experienced hospitals as the place where they were taken to be made well enough to be re-tortured.<sup>27</sup> Survivors of torture often need specialist long-term rehabilitation. Standard mental health services often do not possess these characteristics or are unable to offer the duration and flexibility required.

This traumatic association often leads to avoidance of medical settings and significant lack of trust in medical professionals. Health professionals often misinterpret anxiety, compounded by a heightened fear of disclosure and confidentiality breaches as a lack of engagement. This leads to inappropriate discharge from services, consequent frustration for all parties and loss to care.

Rape(s) may have occurred in their country of origin, during the journey or in the UK. This will inevitably impact on their mental, physical and social wellbeing. The violation may have caused physical damage, pregnancy and sexually-transmitted infections.

Furthermore, this population may experience domestic violence, forced marriage and honour-based violence. Victims can be additionally vulnerable if they are socially isolated and unaware of available support enabling them to leave.

### **Determinants of health and wellbeing**

The health of refugees and asylum seekers is profoundly impacted by socio-economic determinants of wellbeing, some of which are discussed below.<sup>28</sup> Whilst the healthcare service cannot address all these factors, it is important for healthcare workers to be aware of the impact of these determinants on health, and at a higher level for greater joined-up thinking between social and health policies.

<sup>23</sup> Fassil Y., Burnett A., *Commissioning mental health services for vulnerable adult migrants. Guidance for commissioners*. MIND. 2014 [www.crisiscareconcordat.org.uk/wp-content/uploads/2015/02/Vulnerable-Migrants-guidance-for-commissioners-August-2014-FINAL.pdf](http://www.crisiscareconcordat.org.uk/wp-content/uploads/2015/02/Vulnerable-Migrants-guidance-for-commissioners-August-2014-FINAL.pdf) [accessed 24/02/18]

<sup>24</sup> MIND, *Civilised Society*

<sup>25</sup> Campbell, *Social Determinants*

<sup>26</sup> Kalt et al. (2013). *Asylum seekers, violence and health: a systematic review of research in high income host countries*. American Journal of Public Health. <https://www.ncbi.nlm.nih.gov/pubmed/23327250> [accessed 24/02/18]

<sup>27</sup> Rose N, Stirling S, Ricketts A, Chappel D. (TS4SE) *Including migrant populations in Joint Strategic Needs Assessment: a guide*. 2011. <http://ts4se-health-resources.org.uk/etraining/pdf/isna.pdf> [accessed 24/02/18]

<sup>28</sup> Campbell, *Social determinants*

Country of origin	The socio-economic level, the state of education and health systems and the prevailing culture, customs and languages.
Socio-economic	Most people are living in poverty during the asylum process, and at the point when they receive permission to stay. Many unsupported people seeking asylum are destitute and homeless, increasing their risk of abuse, exploitation and poor mental health. This impacts their ability to engage or continue with services.
Housing	Asylum seekers have no choice about where they live and may be distant from familiar communities. They may be moved many times disrupting their social and health service connections. Accommodation may be of inadequate quality and of multiple occupancy. Homelessness is a recurring experience for a sizable proportion of asylum seekers and even following successful asylum claims.
Education and Language	There is a wide range of educational experience. Whilst many refugees and people seeking asylum are highly educated and qualified, 26% had less than six years in education. <sup>29</sup> Being able to communicate is integral to a sense of wellbeing and facilitates participation in society and the sharing of knowledge and skills. In terms of healthcare, language barriers complicate the simplest of tasks, for example the understanding of instructions, filling out of forms or making appointments. Single women and lone parents have reduced opportunities to access English language classes, work and social activities and, therefore, are more likely to be isolated and living in poverty. This makes them vulnerable to poor health and exploitation.
Hostility and racism	This population can bear the brunt of societal and neighbour antipathy and institutional racism. Discrimination causes and compounds mental distress. <sup>30</sup>
Employment and unemployment	People seeking asylum are not permitted to work (except in very limited circumstances), while refugees (who do have permission to work) may find difficulty getting work because of limited English or because their skills and qualifications are not recognised.
Cultural bereavement	This is the term given to the sense of dislocation and loss arising from leaving behind everything familiar. This psychological impact of loss is also compounded by loss of occupation or employment and social status.

The asylum process itself can also engender a sense of powerlessness, fear and uncertainty. This loss of agency will often aggravate and amplify responses to trauma and is a prominent feature of the experience of asylum seekers. Limited access to legal advice, interpreters and gender sensitivity may intensify anxiety. The environment in which they are living is also in perpetual flux with constant changes in the political environment, asylum system and services, including the NHS (in particular new charging

<sup>29</sup> Cebulla., A et al. (2010). *Spotlight on refugee integration: findings from the survey of new refugees in the UK*. [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/116062/horr37-report.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/116062/horr37-report.pdf) [accessed 24/02/18]

<sup>30</sup> MIND. *Civilised society*

regulations), social care, statutory provision and benefits. People seeking asylum live with the additional uncertainty about the outcome of their asylum application and a constant fear of being forced to return home.

### Accessing Healthcare

A lack of knowledge and understanding between vulnerable migrants and the NHS engenders fear on both sides. Many refugees and asylum seekers come from countries with a disrupted health service and no social care provision. Their only experience of doctors may be in a context of torture and they may not be aware of their entitlement to free healthcare or understand how primary and secondary care operate in the UK. However, others will come from countries with more established health structures which may be notably different from that in the UK in terms of access, referrals and expectations. For example, these patients may be used to self-referring to secondary care and are frustrated by the gatekeeping role of NHS primary care. Additionally, screening may also be an unfamiliar concept and this population have low rates of cervical and breast screening.<sup>31</sup>

In the UK, refugees and asylum seekers are entitled to free primary and secondary healthcare. Registration for primary care allows the continuity of care necessary to address complex health needs over time and prevents individuals from getting “lost in the system”. Accessing primary care also reduces emergency admissions, which are costly both in terms of an individual’s health and Government resources.<sup>32</sup> Studies have shown registration rates among refugees and asylum seekers can be as low as 33% and it is therefore vital to facilitate access to primary care for refugees, by breaking down some of these barriers.<sup>33</sup>

Research has highlighted a range of other barriers to accessing healthcare, including linguistic difficulties, distrust of authorities, socio-cultural barriers, difficulties navigating services, relocation during the asylum process, practice staff refusing to register people and financial constraints.<sup>34 35 36 37 38 39 40</sup>

These barriers to accessing healthcare are likely to increase due to confusion of both patients and staff surrounding the new migrant charging agenda. The suspension of the data sharing Memorandum of Understanding (MoU) between the Home Office and NHS Digital gives GP practices and clinicians an important opportunity to give patients clear assurances about confidentiality.

<sup>31</sup> Aspinall P, Watters C. *Refugees and asylum seekers. A review from an equality and human rights perspective*. University of Kent. Equality and Human Rights Commission. 2010.

<sup>32</sup> The Kings Fund (2010), *Avoiding Hospital Admissions*. Available at: <https://www.kingsfund.org.uk/sites/files/kf/Avoiding-Hospital-Admissions-Sarah-Purdy-December2010.pdf> (Accessed 22nd December 2017).

<sup>33</sup> Stagg, H.R., et al. (2012) *Poor uptake of primary healthcare registration among recent entrants to the UK: a retrospective cohort study*, *The British Medical Journal*, 2(4).

<sup>34</sup> Burnett highlights a study showing more than 2/3 of PCTs in London had issued incorrect guidance to GPs resulting in practices unnecessarily demanding evidence of immigration and residency status before registering some patients

<sup>35</sup> Jayaweera H., *Health and access to health care of migrants in the UK. A Race Equality Foundation Briefing Paper*. Race Equality Foundation, Communities and Local Government. 2010.

<sup>36</sup> Aspinall, J. (2014). *Inclusive Practice, Vulnerable Migrants, Gypsies and Travellers, People Who Are Homeless, and Sex Workers: A Review and Synthesis of Interventions/Service Models that Improve Access to Primary Care & Reduce Risk of Avoidable Admission to Hospital*. Available at: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/305912/Inclusive\\_Practice.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/305912/Inclusive_Practice.pdf) (Accessed 5th March 2018).

<sup>37</sup> Bhatia, R., Wallace, P. (2007), *Experiences of refugees and asylum seekers in general practice: a qualitative study*, *BMC Family Practice*, 21(8), pp.8-48.

<sup>38</sup> Joshi, C. et al. (2013), *A narrative synthesis of the impact of primary health care delivery models for refugees in resettlement countries on access, quality and coordination*, *International Journal for Equity in Health*, 12(1), p.88.

<sup>39</sup> Pottie, K. et al (2014), *Improving delivery of primary care for vulnerable migrants: Delphi consensus to prioritize innovative practice strategies*, *Canadian Family Physician*, 60(1), pp.32–40.

<sup>40</sup> Feldman, R. (2006), *Primary health care for refugees and asylum seekers: A review of the literature and a framework for services*, *Public Health*, 120(9), pp.809–816.

### Unaccompanied Asylum Seeking Children (UASC)

Unaccompanied Asylum Seeking Children (UASC) face a range of physical, psychological and social challenges and are a particularly vulnerable cohort within the population. Based on the definition adopted by UK Visa and Immigration, UASC are children under the age of 18 who are applying for asylum in their own right, are fleeing persecution from their own country and have no adult relative or guardian in the UK. Their main countries of origin include Eritrea, Afghanistan, Sudan, Syria and Iraq. Most UASC are male and are aged between 14 and 17 years. The majority of female UASC come from Eritrea.

Under the Children Act 1989, support for UASC is the responsibility of the local authority's social services, regardless of the child's immigration status. At present, a small number of local authorities, such as Kent County Council, harbour the majority of UASC living in the UK. In July 2016, the government launched the Interim National Transfer Protocol. This policy is designed to ensure a more equitable distribution of UASC throughout the country and thereby relieve the strain on those authorities currently looking after the highest numbers of children.

Data from the Home Office shows that, in 2017, there were 2,026 asylum applications by UASC – a 33% reduction compared with 2016. The number of asylum applications by UASC currently accounts for around 8% of all asylum applications in the UK.<sup>41</sup>

### THE MANCHESTER PICTURE

Greater Manchester boasts a diverse and dynamic population of refugee and migrant communities from a wide variety of backgrounds. Greater Manchester has the highest concentration of dispersed asylum-seekers outside London, with approximately 25% housed in the city-region. National asylum statistics published 23 February 2017 show that 1,177 people were in receipt of Section 95 (asylum support subsistence and or accommodation) in the Manchester Local Authority area at the end of 2016, with an increasing trend. The [Profile of Migration in Manchester](#) produced by Manchester City Council contains a detailed analysis of migration trends in the city. These figures do not include undocumented migrants and those without recourse to public support.

The Boaz trust estimates the numbers of asylum seekers residing in the city to be 6000, with 2000 destitute.<sup>42 43</sup>

Some of the newer, larger refugee and migrant communities in Manchester include:

- Eritrean community
- Roma community
- Kurdish (Iran & Iraq) community
- Francophone African community
- Anglophone African (Zimbabwean) community
- Syrian community
- Somali community

Overall, local authorities across the North West have had limited experience in working with UASC. In 2017, 50 UASC were transferred to the North West of England as part of

<sup>41</sup> Refugee Council (May 2018) *Children in the Asylum System*.

[https://www.refugeecouncil.org.uk/assets/0004/3368/Children\\_in\\_the\\_Asylum\\_System\\_May\\_2018.pdf](https://www.refugeecouncil.org.uk/assets/0004/3368/Children_in_the_Asylum_System_May_2018.pdf)

<sup>42</sup> Farrington et al, *Proposal*

<sup>43</sup> The Red Cross and Boaz Trust (2013), *A Decade of destitution: time to make a change*.

<http://www.redcross.org.uk/~media/BritishRedCross/Documents/What%20we%20do/UK%20services/Greater%20Manchester%20destitution%20report.pdf> [Accessed 20th Feb 2018]



the National Transfer Scheme. As at July 2018, there were 68 UASC being looked after by Manchester City Council. The number of UASC looked after by Manchester City Council has been increasing gradually since March 2015 when the figure stood at 16.

Scoping work undertaken by NHS England highlighted that access to health and social care services for asylum seekers and migrants in Manchester was an issue. This research revealed that North, Central and South Manchester Clinical Commissioning CCGs (now part of Manchester CCG) were the only CCGs in Greater Manchester without a specific locally commissioned service (LCS) in place for primary care provision for asylum seekers and vulnerable migrants.

The impact of this gap can be seen in the local burden of disease, the lived experience of this population, and the experiences of those working in the third sector and healthcare services. These are discussed in more detail below.

### Health Statistics

There are no published health statistics for this specific population. However, there are measures of infectious disease rates and local-scale unpublished reports.

The [Tuberculosis Strategy Monitoring Indicators tool](#) developed by Public Health England shows that Manchester continued to have the highest TB incidence rate of local authorities in Greater Manchester, at 32.3 per 100,000 population in 2013 because many migrant communities come from countries where the prevalence of TB is high. This is higher than the England incidence rate of 13.5 per 100,000 population. Between 2010 and 2012, there were 831 new HIV diagnoses in Greater Manchester. Of these, 376 (45%) were from people living in Manchester local authority, with a substantial proportion of diagnoses made at a late or very late stage.

A small-scale study at a GP practice with a list size of 20,500 patients showed that of the 63 female patients who identified themselves as Somali ethnic origin, 41.3% did not respond to an invitation to have a smear test for cervical cancer. Another small-scale project in Manchester suggested that children aged over 3 who are asylum seekers have significant gaps or a lack of immunisation history.

### LIVED EXPERIENCE

In October 2016, three reports into the experience of migrant groups in the city were undertaken by TS4SE. These are entitled the [‘Moving Lives’ reports](#), which looked at specific migrant communities in Manchester, and their health priorities. There were some specific community issues across groups:

- Support for refugees to identify and register with a GP- “When we first come here we do not understand the system and we are not well”
- The quality and lack of interpreting at healthcare appointments - “My interpreter couldn’t understand the doctor, he just pointed to his body and said here”
- Gender specific interpreting and consultations - “This is important, a man cannot touch my skin or see me without clothes”
- Mental health support and wellbeing - “The NHS should work with organisations such as WAST [Women Asylum Seekers Together] and support them, because this helps us more than antidepressants”
- Lack of staff education - “My doctor said I do not know how to help you, she seemed very sorry”

TS4SE were also commissioned to undertake some further engagement with migrant communities in Manchester to provide additional evidence for the JSNA. The findings from this work are provided in a separate report accompanying this topic report.

### Third Sector experiences in Manchester

As part of the work to develop a locally enhanced service for new migrants in primary care, a questionnaire was sent to key third sector organisations in Manchester working in the field. They were asked “In your experience, what barriers do new entrants face when trying to access services?”

- GP registration due to a lack of proof of address documentation.
- Knowledge of what services are available and how these can be accessed, in the language of the individual
- Little knowledge of rights to healthcare, including primary and maternity care, and the preventative approach to healthcare in this country
- Undiagnosed physical and mental health problems, including alcohol and drug misuse
- Staff lacking awareness of asylum seeker and refugee experiences and rights
- Fear of accessing services due to immigration status
- Language and access to English for Speakers of Other Languages (ESOL) courses
- Access to benefits and housing support

The [results of the questionnaire](#) are consistent with many of the lived experiences described elsewhere in this paper.

### Experiences of Health Professionals

In 2017 Medact Manchester (a not-for-profit organisation run by health professionals) carried out some research into [healthcare professionals' views and experiences of dealing with refugees and asylum seekers](#). They found that only 21% of healthcare professionals in the North West of England were confident about their knowledge of the difference between an asylum seeker, a refugee and a “failed” asylum seeker and only 26% of respondents were aware that all three groups are entitled to free emergency and primary care. This is despite the fact that 55% of respondents reported having cared for someone who they were aware had experienced torture. Only 12 % said they felt fully confident to asking that patient questions about their torture. The vast majority (88%) of health professionals said they would benefit from further training on issues surrounding asylum seekers and refugees.

## WHAT WOULD WE LIKE TO ACHIEVE?

As the population of Manchester is growing and becoming increasingly diverse, it is vital that we recognise the needs of differing groups, and how they could be assisted to access health and social care services appropriately. There is no ‘one size fits all’ solution, however, there are evidence-based strategies to increase access for vulnerable and hard-to-reach populations. <sup>44,45,46</sup>

To facilitate the planning of health services and interventions and to ensure they are patient centred, it is necessary to gather more information about the experiences of this population group is required. This information could be captured in terms of data, and more importantly by giving this disadvantaged population a strong “voice”.

<sup>44</sup> Joshi et al. *A narrative synthesis*, p. 88

<sup>45</sup> Pottie et al. *Improving delivery*, pp. 32 - 40

<sup>46</sup> Feldman, *Primary health care*, pp. 809 - 816.

Health services commissioned must be flexible and respond to the voices of this population to adequately address the complex health needs. Continuity of care is vital and Staff working in healthcare need to be aware of the population's entitlement to healthcare, and common health issues faced.

Well-being needs cannot wholly be met by general practice. The identification and plugging of gaps in services, and innovation in service design could enhance collaborative work between different services to encompass wider determinants of health. Evaluation of services is vital to drive improvement and build an evidence base about what works.

Manchester should aim to empower refugees and asylum seekers to engage with and access healthcare, building capacity for individuals to take control of their lives. Empowered individuals augment social capital and reduce demand on services. These overlapping factors are discussed in greater detail below.

Ensuring appropriate access to primary healthcare for new entrants to Manchester will address a number of the strategic priorities of the Health and Wellbeing Board including:

- Strategy 2: Educating, informing and involving the community in improving their own health and wellbeing
- Strategy 3: Moving more health provision into the community
- Strategy 4: Providing the best treatment we can to people in the right place and at the right time
- Strategy 6: Improving people's mental health and wellbeing

The sections that follow have been co-produced in partnership with community representatives, voluntary and community sector organisations and statutory partners including Manchester Congolese Organisation; EURoma; Manchester Eritrean Community Association; Freedom From Torture; Zimden; British Red Cross; Rainbow Haven; Manchester Alliance for Community Care; Revive; WAST; Manchester Refugee Support Network; Boaz Trust; Doctors of the World and Refugee Action.

### Increased access

The barriers to accessing healthcare for this vulnerable population need to be broken down. Primary care staff need to be aware that this population is entitled to free primary care, and that proof of address is not a necessity to access primary care. GP registration should be an interpreted event, and patients should be registered as permanent to ensure enrolment onto national screening programmes.

This population needs to be empowered to access healthcare, by education and advocacy. The third sector has been providing this support for decades, and their experience is invaluable. Increased collaborative working between the health services and the third sector would strengthen this further.

Universal services which recognise migrants' needs are more likely to reach this population. For that reason, mainstream primary care is the most appropriate place to manage general assessment and clinical needs for this population, provide continuity and co-ordination of care and preventative services. An enhanced service within general practice is required in order to recognise the complexity of this population and provide holistic care.

However, some people's needs may not be met by mainstream interventions and will require specialist or culturally specific services. For example, survivors of torture with complex mental health needs may require specialist help.

## Patient-centred service

The flexibility of services is crucial, as socially excluded clients may lack the capability to effectively access and navigate the care to which they are entitled. By their nature, migrant populations are extremely diverse, less visible and transient. For that reason, they are poorly captured by national data sets, which can present challenges to local commissioners in terms of identifying and quantifying the scale of need. Thus, it is easy for such clients to fall between the gaps of different services, leading to expensive unplanned care and clients 'revolving' through the system. Often, third sector providers are the link which brings vulnerable groups into contact with services.

There are some guides to commissioning for this population which are helpful.<sup>47,48,49,50</sup>

The community project carried out by TS4SE gave a valuable voice to this population, and demonstrated the wide variety of experience and need, with no "one size fits all" solution. The research findings could be used by commissioners to personalise services.

Greater co-ordination of care between providers and continuity of care within providers would help bridge the artificial divide between clinical and social models of care and allow more comprehensive and person-centred identification of need and subsequent service provision.

## Staff Education

Experience shows that It takes time to establish trust and confidence, to communicate across cultures, to assess and manage complex issues and to coordinate care and signpost.<sup>51</sup> Yet doing so has sustainable benefits for individuals and society.

The TS4SE survey and Medact research demonstrates there is a clear knowledge gap for many health professionals in terms of vulnerable migrant health. Staff uncertainty regarding registration and charging can cause confusion and dissuade this population from accessing care. Increased access to relevant, high quality training for health and social care professionals in the city, including frontline healthcare and reception staff, managers and commissioners, would help to resolve this, empowering staff by giving them the confidence to address the needs of this population.

Working with this population can be rewarding, but there can be an emotional cost to the practitioner of working with traumatised patients, for example, vicarious traumatisation. Clinical supervision is essential to protect the mental health of staff.

## Working in collaboration with the third sector

The voluntary sector has worked with this population for decades and is therefore an extremely valuable resource in terms of lived experience, the resources they can offer, and the trust of the population they have earned.

The voluntary sector often has a shorter chain of command than the NHS, allowing greater innovation. They can access hidden populations more easily and may be the only link between an individual and healthcare services. They are effective at prevention and early intervention, and can provide support, education, signposting and advocacy.

<sup>47</sup> Rose et al, *Including Migrant Populations*

<sup>48</sup> NHS East of England, (2001) *Commissioning framework for language support*, [www.eelga.gov.uk/documents/publications/commissioning\\_framework\\_for\\_language\\_support\\_final\\_print\\_version.pdf](http://www.eelga.gov.uk/documents/publications/commissioning_framework_for_language_support_final_print_version.pdf) [Accessed 19th Feb 2018]

<sup>49</sup> MIND, (2017) *Mental Health commissioning with Migrant communities*, <https://www.mind.org.uk/media/14259589/mental-health-commissioning-with-migrant-communities.pdf> [Accessed 20th Feb 2018]

<sup>50</sup> TS4SE (2011) *Including Migrant populations in Joint Strategic Needs Assessment, A guide*, <http://ts4se.org.uk/resources.html> [Accessed 20th Feb 2018]

<sup>51</sup> Farrington, R., Ricketts, A. (2013) '*Primary Care access and Provision for Vulnerable Migrants*'. Written for the North West Health and Migration Programme.

There is a clear need for investment in thematic infrastructure within the voluntary sector to enable collaborative work between the voluntary sector and health and social care organisations. This was identified as a key issue in the survey with key third sector organisations in Manchester.

### **Community education and capacity building**

There is benefit in adopting a 'co-production' approach to needs assessment that involves migrant service users and community members at the earliest point in the commissioning process. Acknowledging the expertise, experience and networks that exist within migrant communities will enable commissioners to identify population needs, highlight gaps in service provision and design more culturally appropriate and effective services.

Community development is about building active and sustainable communities based on equality, participation, learning and cooperation. It involves changing power structures to remove the barriers that prevent people from participating in the issues that affect their lives. True empowerment enables populations to gain knowledge, skills and the confidence to engage more widely.

It is also important to recognise that investing time and effort in engaging with specific communities that have previously had limited contact is challenging yet pays dividends in terms of tackling health inequalities.

### **Interpretation**

Effective communication between service providers and refugees and people seeking asylum has long term benefits. Although interpretation requires longer appointment times, appropriate and independent professional interpretation available at the earliest opportunity optimises care, prevents missed appointments, misdiagnosis, prescribing errors, inadequate consent and complicity in abuse and neglect. Interpretation maintains dignity and confidentiality, increases the likelihood of compliance, improves awareness of support services and ultimately helps to reduce the re-consultation rate and associated costs in the long run. Registration should also be interpreted.

Cultural and gender alignment may need to be considered. Family members should not be used for interpretation. Providers of interpreting services should also be held accountable to quality assurance standards.

### **Mental wellbeing**

The same barriers to accessing physical health exist for accessing mental health services. Stigma surrounding mental illness may be particularly marked in some migrant communities and may further inhibit some people from accessing services. Community-based culturally appropriate health awareness programmes can reduce this stigma. Such programmes should be designed in partnership with migrants, community organisations and service providers.

Migrants may benefit from a range of creative therapies such as music, art or gardening as an alternative to traditional talking therapies, which can be perceived as less stigmatising, more appropriate and easily accessible. Such projects also have the benefit of building community and individual resilience and reduce cultural bereavement. Religious and spiritual support can play a significant role in the lives of migrants.

Involvement of the voluntary sector is crucial, as these groups provide the social support many in this population have lost. Social support is a known protective factor in mental health problems.

Mental health services should be staffed by professionals with an awareness of the impact of immigration, torture, detention and the asylum determination process on mental health. Importantly, accessible, face-to-face interpretation is required in cases of mental distress.

### **Advocacy**

While there are examples of local champions making their voices heard against the odds, socially excluded populations and the professionals who work with them can lack influence at both national and local levels. Particularly strong leadership is required at a community level in deprived areas where there are significant concentrations of socially excluded clients. Leadership in this field needs greater attention, and professional excellence should be adequately recognised and rewarded.

Strong national and local leadership with an inclusion health agenda would provide the platform to drive change.

### **Health Promotion**

Investment in prevention and early intervention reaps benefits over the medium and longer-term. This relies on partnerships between the NHS and other organisations and maximisation of the skills of those who are 'at the front door' of prevention, such as medical professionals, pharmacists or those working in the voluntary sector and social services.

Addressing health promotion for refugees and people seeking asylum and other minority groups cannot be achieved without provision of language support and a workforce that is culturally sensitive.

### **Innovation**

The neighbourhood health and care model provides an opportunity to develop innovative partnerships between service providers that support this population by providing fluid and holistic care and reducing duplication. To achieve this ideal, many of these service providers will require support in terms of funding, interpretation and staff education.

## **WHAT DO WE NEED TO DO TO ACHIEVE THIS?**

### **Increased Access**

Primary care services should be supported to uptake the new locally enhanced service for vulnerable migrants and given access to ongoing further education.

Clear guidance should be communicated to health services on eligibility, charging regulations and best practice, including interpreted registration.

For the homeless, a secure postal address to receive medical mail can be agreed. This could be the GP practice or a recognised support agency.

Greater collaboration with the third sector to assist patients to access health services by increasing thematic infrastructure is needed.

Increasing the capacity of existing specialist services or commissioning new supplementary specialist services for complex needs would be beneficial. Improved signposting and advertising of available services would enhance access to these services.

Health care practitioners should consider infectious conditions in at-risk migrants. Some diseases may not present clinically for a long time after arrival in the UK. Once

registered with a GP, screening for infectious diseases and required immunisation is essential to protect the individual and the wider society.

### **Patient-centred Service**

A 'co-production' approach to needs assessment allows commissioners to identify population profiles and needs, highlight gaps in service provision and design culturally appropriate and effective services. There should also be a co-production approach to service evaluation, to improve future services. Currently there is a limited evidence base on what service model is most successful for this population, and thus evaluation of the new service is vital.

Better co-ordination of services would allow patients to transition through services smoothly i.e. between primary care and secondary care, between health systems and the third sector, and between health and social care. A greater focus on commissioning innovative, horizontal patient-centred integration (care planning and continuity across community settings and service provider boundaries) would ensure patients can receive continuity of care even if they are moved from the address that originally gave them access to that care.

The effective use of new digital technologies and tools such as practical, portable health records for those with transient lifestyles, could better connect different parts of the service together around the patient. This would help empower both patients and staff.

### **Staff Education**

To have meaningful and therapeutic contact with this population, all health and social care professionals require training on a diverse range of topics.<sup>52</sup> These topics include:

- cultural awareness, the effects of cultural bereavement and social loss
- communication barriers and working with interpreters
- guidelines for registering patients
- guidelines on charging regulations
- the complexity and chronicity of asylum seekers' health problems contributing to morbidity and health risks
- the psychological and mental health problems faced by this population and the complex psychosocial and medico-legal context of seeking sanctuary
- appropriate referral pathways and support
- the asylum system and its frequent re-organisations and limited social care resources
- the impact of poverty, destruction, hate crime and social exclusion on health
- help seeking behaviours of people with complex psychological trauma
- their own risk of vicarious traumatisation as professionals in this field
- the benefits and limitations of voluntary sector involvement

Employer organisation should take advantage of the training opportunities that are already available from local statutory or voluntary sector organisations in Manchester or Greater Manchester, who have the experience and expertise in this field. This would also enhance social value by ensuring that spend on education and training is kept within the local economy.

In addition, there needs to be clear professional development pathways and recognition of the achievements of professionals working in this demanding specialist field.

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<sup>52</sup> Farrington et al. *Proposal*

### **Working in collaboration with the third sector**

Funding for the development of thematic infrastructure is required. The development of a Manchester coalition, rooted in the voluntary sector that could lead on thematic infrastructure, capacity building and strategic co-ordination would present an opportunity to engage organisations in a real and meaningful co-design process, whilst additionally increasing the visibility of the sector and reducing pressures on the NHS.

With funding, there would be potential to increase and expand the range of volunteering opportunities across the sector, which could significantly increase capacity and effectiveness. The additional funding could be used to plan, recruit, train, develop and manage additional volunteer roles.

### **Community Education and Capacity Building**

Migrant community organisations and service user groups are often able to inform commissioners about good practice and gaps in the system, and to improve mental health services. However these groups are reliant on volunteers and often poorly resourced. Community engagement and consultation require infrastructure development and sustainable funding.

It is recognised that migrant communities may become disenchanted and disengaged if they are repeatedly consulted without experiencing any apparent change or benefit. There are good examples of work in Manchester that has involved migrant community leaders and service users directly in the decision making process (e.g. by inviting them to participate in management committees, steering groups and client feedback groups etc.) However, in order to make this more sustainable and part of 'business as usual', some development funding is needed in order to allow migrant groups and organisations to receive training, development and direct payment to free them up and allow them to speak for themselves.

In order to engage and consult effectively with migrant communities, it is necessary to draw on the talents of those people who have the necessary lived experience, skills, language, confidence, interest and motivation. These people already exist within the local population and are thus ideally placed to facilitate engagement in consultation exercises, gather information about needs and experiences and build capacity etc. Making this happen requires commissioners need to find ways of helping local community groups and organisations to 'level the playing field' and enable them to get involved in and influence spend and investment decisions in a more effective manner.

Other approaches to empowerment could include neighbourhood committees and community champions who act as links between community and commissioners. However, these roles are often unpaid and tend to draw on a relatively small pool of people who have the necessary time, skills, commitment and motivation to participate in these activities. Additional investment is needed to make these approaches sustainable and ensure that people are adequately recompensed for their work.

Increasing volunteering opportunities might address some issues of social isolation and cultural bereavement amongst migrant populations. There are many assets in this population which commissioners should map and include in service planning. Investment in patient education and orientation in how to navigate the NHS would empower patients to use services more appropriately.

For example, there are Doctors of the World clinics run in both London's Bethnal Green and in Brighton, which offer primary care and health and social advice from volunteer doctors, nurses and support workers for excluded people including asylum seekers, and



also provide clinical advocacy, negotiating with GP practices on behalf of patients who have been unable to register.

### **Interpretation**

Healthcare workers must be appropriately trained to be confident and competent in working with interpreters. This requires education and guidance for staff.

### **Mental Health and Wellbeing**

Access to mental health and wellbeing services for asylum seekers needs to be increased, possibly through self-referral or voluntary sector referral. Access to well-supported community organisation and volunteering opportunities and the development of peer support programmes should also be facilitated.

Resources and expertise within migrant communities should be used to raise the awareness of health professionals of wellbeing needs of migrant communities.

### **Advocacy**

Leadership capacity both nationally and locally needs to be developed. Creating a network for leaders would provide support and drive continued improvements in outcomes. The education of healthcare staff will increase their confidence to advocate for this population.

### **Health Promotion**

Low cost, high impact and culturally appropriate and interpreted health promotion interventions need to be developed by working with established community organisations.

The voluntary sector is ideally placed to deliver health promotion messages, but this required greater collaboration and the strengthening of thematic infrastructure.

### **Innovation**

The integration of health and social care in Manchester provides greater possibilities for collaboration between services for the benefit of users. Possible examples of new collaborative ways of working include:

- Supporting pharmacies to undertake basic screening through an additional contractual offer, bringing preventative services even closer to people's homes.
- Working with education providers and housing associations through the One Team agenda to identify new entrants who are not accessing health and social care support.
- In line with the One Team model, improve partnership working with Greater Manchester Police and Greater Manchester Fire and Rescue Service to help identify new entrants who may need additional support.

There are a number of other examples from across the UK of areas that have developed innovative approaches to the joined up delivery of services for migrant populations. For example, the York Street Health Practice in Leeds is notified by the Home Office of asylum seekers housed in the local area. The practice sends out a letter to them inviting them to register and with information about services provided. There are drop in sessions at the practice from nurses, case workers, solicitors and benefits advisors. The Mulberry Practice in Sheffield has weekly new arrival clinics, where the local housing provider funds a mini bus that takes new arrivals to the practice, inviting them to register on that day. In addition to having drop in sessions with a range of primary care

staff, they have a collaborative relationship with secondary care services to provide an onsite infectious disease clinic and links with specialist midwives.

## WHAT ARE WE CURRENTLY DOING?

### Increased Access

Information regarding eligibility and charging regulations has been circulated by the CCG to practice managers in Manchester. Here is a link to the [Government Fact Sheet, Doctors of the world safe surgeries toolkit](#), and information about [charging regulations](#) by the Freedom Matters charity.

Manchester CCG has commissioned a “locally enhanced service” pilot within general practice, entitled the ‘new entrants’ project. After consultation with third sector agents in the field, the decision was made to make the service core rather than specialised, hoping this will be more sustainable, cost effective and distribute the patients equitably, with resultant widespread experiences of caring for refugees. The service has been designed by The New Entrants Project Group, comprised of representatives from Manchester CCG, key third sector contacts, public health specialists, data analysts and a refugee with lived experience.

The proposed scheme will be offered to all practices via the Locally Commissioned Services model and support the delivery of a nurse led enhanced primary care registration, assessment and navigation service. This will take the form of an extended initial appointment to establish and record a full history using the newly developed EMIS template, with interpreters present if needed. The assessment will determine clinical and non-clinical needs, treatment options, enhanced screening requirements in line with national guidance and specialist support (specifically mental health). Practice staff (both clinical and admin) will undertake bespoke training and will develop the links/referral pathways between health, social care, voluntary and community specialist services.

The aims of the service are to:

- ensure the most vulnerable new entrants receive appropriate and timely access to health and social care services
- empower primary care services to meet the health needs of vulnerable migrants holistically, by working in an integrated way with relevant services
- support capacity building in primary care to reduce inappropriate variation and increase quality
- promote inclusion health, neighbourhood partnership working and pathways to specialist services
- reduce inappropriate impact on urgent and emergency services
- generate an evidence base to support a full business case for recurrent funding.

Ideally, additional specialist NHS health services would be commissioned, with a focus on meeting specific complex additional needs (e.g. relating to torture), and providing advice, expertise and training to support mainstream services. There is evidence behind a specialist MDT approach to migrant health (Feldman), and this service has been called for by many of the third sector workers (see questionnaire).

There are currently some specialist voluntary sector providing such services in Manchester. For example, Freedom from Torture is a voluntary organisation providing therapeutic mental health services for survivors of torture and their families. It also

supports and trains other organisations in both the statutory and voluntary sectors, increasing their capacity to provide care for torture survivors.

### **Patient-centred Services**

It is vital that migrant groups become more visible to enable commissioners to tailor services accordingly. To that end, TS4SE was commissioned to carry out research into the experiences of several migrant groups in Manchester. The report gives a richer picture of the difficulties faced by this population and can be used by commissioners to shape services.

The “new entrants” in-depth registration template should allow tailoring of primary care to meet that individual’s needs, and prompt referral to relevant support networks. Current and ongoing data will be extracted from the template and used to glean a richer representation of the distribution and needs of this complex and dynamic population.

Quantitative and qualitative evaluation will be co-produced with the population following the pilot, to refine the service and secure future funding. In particular information on the accessibility, cultural sensitivity, patient outcomes and effectiveness of services should be gathered. An equality impact assessment should also be undertaken.

Through the new “Single Hospital Service” in Manchester, A&E services should be able to identify new entrants and register them with a local GP at the time they present at A&E. The GP would then follow up with the patient, hopefully preventing illness and inappropriate A&E attendances in the future. The new Summary Care Record Service and Electronic Prescription Service have the potential to improve links between providers, enhancing continuity of care for the socially excluded.

### **Staff Education**

Manchester CCG held the first training day for primary care staff in February 2018. The [Doctors of the World “Safe Surgeries” toolkit](#) has been distributed to primary care staff, which gives clear guidance on the registration process. NHS Guidance on the [new charging regulation](#) has been distributed.

T4SE have developed a [healthcare professionals training resource](#) on issues faced by migrant populations.<sup>53</sup> This can be used in health settings to support staff in treating new entrants.

There are a number of other advice and support websites that health and care staff can access (see box below)

#### **Advice and support websites for staff**

Asylum Aid

<https://www.asylumaid.org.uk>

Asylum Help UK

<http://asylumhelpuk.org>

The British Red Cross

<http://www.redcross.org.uk>

Freedom from Torture

<https://www.freedomfromtorture.org/about-freedom-from-torture>

Manchester Refugee Support Network

<http://mrsn.org.uk>

NHS England: Patient Registration Guidelines for Primary Care

<https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/11/pat-reg-sop-pmc-gp.pdf>

<sup>53</sup> TS4SE, *Improving Access*

No Recourse to Public Funds (NRPF) Network factsheet on NHS healthcare for migrants with NRPF (England)

<http://www.nrpfnetwork.org.uk/Documents/NHS-healthcare.pdf>

Refugee Mental Health and Wellbeing Portal

<https://www.uel.ac.uk/Schools/Psychology/Research/Refugee-Mental-Health-and-Wellbeing-Portal>

Refugee UK

<http://www.refugee-action.org.uk>

Royal Medical Benevolent Fund

<http://www.rmbf.org/get-help/help-for-refugee-doctors>

UK Government Migrant Health Guide: NHS Entitlements

<https://www.gov.uk/topic/health-protection/migrant-health-guide>

World Health Organisation: Migration and Health (Key issues)

[http://www.euro.who.int/\\_data/assets/pdf\\_file/0005/293270/Migration-Health-Key-Issues-.pdf?ua=1](http://www.euro.who.int/_data/assets/pdf_file/0005/293270/Migration-Health-Key-Issues-.pdf?ua=1)

### Working in collaboration with the third sector

There are a number of official partnerships that exist, such as the Regional Strategic Migration Partnership. The third sector is currently represented in the new entrants' task force. However, there is a wealth of third sector charities in Manchester providing vital services for this population with a great potential for collaboration. Appendix 1 contains a list of the larger charities:

### Community Education and Capacity Building

The new entrants' task force included representatives from the patient population and from the third sector, who have contributed to the planning of the project and will be included in the evaluation of the project.

The NHS England Local Area Team for Greater Manchester and Lancashire have commissioned a project to develop a [Directory of Service for Asylum Seekers](#), to signpost patients to services. This project is currently in its early stages and the project team is hosted by Urban Village Medical Practice, supported by Manchester CCG.

The [Choose Well website](#) contains signposting to information about NHS services, specific to Manchester, available in a number of languages.

The NHS have an online guide and videos on how to use the NHS translated into a number of different languages (see box below).

#### NHS online guides to how to use the NHS (2012)

English	<a href="https://youtu.be/7UI4Z8gihQc">https://youtu.be/7UI4Z8gihQc</a>
Arabic	<a href="https://youtu.be/HF9KIM_THXw">https://youtu.be/HF9KIM_THXw</a>
Polish	<a href="https://youtu.be/Xh_Ti-oQwTU">https://youtu.be/Xh_Ti-oQwTU</a>
Kurdish	<a href="https://youtu.be/A-hAZ06xUNQ">https://youtu.be/A-hAZ06xUNQ</a>
Sylheti	<a href="https://youtu.be/UyRoyEJAoC0">https://youtu.be/UyRoyEJAoC0</a>
French	<a href="https://youtu.be/dLztAUcDsXo">https://youtu.be/dLztAUcDsXo</a>
Mandarin	<a href="https://youtu.be/L6ZggPHdu6M">https://youtu.be/L6ZggPHdu6M</a>
Somali	<a href="https://youtu.be/RKEybf5FtXk">https://youtu.be/RKEybf5FtXk</a>
Farsi and Dari	<a href="https://youtu.be/y_qU68nP62A">https://youtu.be/y_qU68nP62A</a>
Cantonese	<a href="https://youtu.be/GT47ydtmRjM">https://youtu.be/GT47ydtmRjM</a>

There are online [educational health leaflets](#) available for refugees, which can be translated into over 100 [different languages](#).

### Interpretation

Manchester Health and Care Commissioning (MHCC) has developed its Interpretation and Translation Policy. The purpose of the policy is to set out the principles which are needed to ensure safe, high quality interpreting and translation service in primary medical health care. It is designed to support staff working for MHCC and member Manchester GP Practices who are commissioned to deliver NHS primary medical care services by providing information about how to access interpretation services for people who experience communication barriers and when interpretation services should be used.

This policy is intended to ensure measures are in place to support communication with non-English speakers, people for whom English is a second language, sign language users, people with hearing or visual impairment and people with learning disabilities. It describes arrangements for telephone based and face-to-face interpreting, and for the translation of written materials. The policy applies to employees, agency staff, volunteers and anyone else contracted to deliver primary medical care services in Manchester. It covers both patients and staff who may require access to interpretation and translation.

The intended outcome of this policy and associated guidance is to make sure that all patients are able to access primary medical care services in a way that ensures their language and communication needs do not prevent them receiving the same quality of healthcare as others.

The interpreted NHS health videos listed in the community empowerment section have been circulated to primary care professionals in Manchester.

### Mental Health and Wellbeing

There are a range of charities based in Manchester who aim to enhance mental wellbeing and who promote community participation. Appendix 1 gives greater detail on these charities.

More specifically, Freedom from Torture is a charity providing counselling and therapy to victims of torture and healthcare workers can refer to the [North West branch](#).

There are several Health and Wellbeing websites that have been translated, including:

- Living with Pain in Manchester (<http://nhs.manchester.paintoolkit.org>)
- Mental Health in Manchester (<http://www.mhim.org.uk>)
- End the Fear (<http://www.endthefear.co.uk>)
- buzz Health and Wellbeing Service (<https://buzzmanchester.co.uk>)
- MCRactive (<https://mcractive.com>)

### Advocacy

The third sector has advocated for this population for many years and has considerable experience in doing so. Asylum Matters is project with the specific aim of advocating for this population. The City of Sanctuary is a grassroots movement to build a culture of hospitality for people seeking sanctuary in the UK. Their goal is to create a network of towns and cities throughout the country which are proud to be places of safety for people seeking sanctuary and helping them integrate into their local communities. The Manchester branch provides a range of workshops, meals and local events.

The [Roma Family Support Project](#), run by the Black Health Agency (BHA), aims to improve the stability and quality of Eastern European Roma families and communities by increasing access to services and other activities that lead to improved health and wellbeing, reduced levels of social and economic exclusion and increased economic independence among young people. The project has also supports Roma families that have young people in high school, including the transition from high school to college. The project delivers short term targeted interventions to meet the needs of families by providing outreach home visits, meeting families in their environment, engagement on 1-2-1 basis and tailoring support appropriate to the family's and young people's needs.

Citywide leadership and championing of the 'new entrants' project will provide ongoing support for the rollout.

### Health Promotion

The new entrant template will include comprehensive screening for disease and risk factors for disease.

The development of a directory for migrants and interpreted NHS videos is method of health promotion in current circulation.

### Innovation

There are examples of successful collaborative work in Manchester. For example, the Urban Village Medical Practice works closely with many community organisations in Manchester as part of their homelessness service. The practice employs staff from the council housing sector and does both street outreach and outreach into Manchester Royal Infirmary, which means that they often have contact with people who have newly arrived in Manchester and have found themselves destitute. This model has been successful in reducing emergency hospital readmission rates for this population and the lessons that this team have learned from working with vulnerable and transient populations could be transferrable to the refugee and asylum seeker population.

The [Romani Well-being project](#) is funded by the Equalities Fund at Manchester City Council. The Project supports Romanian Roma families in Manchester with access to education for children and adults, access to employment, welfare benefits and housing. The Project works in a holistic way by helping identify the needs of the whole family and seek to address these in ways which builds on existing strengths of families.

### Links to Manchester strategies

Improving the health and wellbeing of Manchester's refugee and migrant communities links to the following priorities in the [Joint Health and Wellbeing Strategy](#):

Improving people's mental health and wellbeing

- Bringing people into employment and ensuring good work for all
- Enabling people to keep well and live independently as they grow older
- One health and care system – right care, right place, right time
- Self-care

Improving the health and wellbeing of Manchester's refugee and migrant communities links to the following priorities in the [Manchester Locality plan for Health and Social Care](#):

- Address the causes of ill health
- Spot illnesses earlier
- Provide support earlier
- Manage illness
- Help beat loneliness
- Check your medicines
- Turn up to appointments
- Only use A&E for emergencies
- Live a healthy life
- Look after yourself
- Follow the five ways to wellbeing

## OPPORTUNITIES FOR ACTION

### Increased Access

- All new entrants should be allocated to a GP surgery on arrival.
- Commission a new multi-disciplinary specialist service based on a Hub and spoke model with GP practices enrolled on the locally enhanced service.<sup>54</sup> There are also opportunities to enhance the capacity of pre-existing specialist services.
- Use primary care outreach teams to increase access for particularly hidden populations.
- Consider the use of self-referral for particular services.

### Patient-centred Service

- Provide holistic and integrated services to meet the wider needs of migrant communities and ensure that this population is more closely linked to services. For example, housing or benefits advisors could do outreach in primary care and primary healthcare workers could do outreach with social services.
- Consider undertaking more focused research into specific migrant groups such as health needs of refused asylum seekers or torture survivors.
- Improve data collection on migrant admissions to acute mental health services, accident and emergency departments and third sector involvement in order to provide a better picture of the use of such services by migrant communities. The outcomes and measures of success could also be shared across multiple agencies. Analysing neighbourhood profiles would give a greater understanding of geographical equity of services.

### Staff Education

- Wherever possible, use existing sources of training and development that are already available from local voluntary and community sector groups and actively collaborate with these groups to further develop their capacity to deliver authentic, local and bespoke training from those on the frontline.
- Appoint a migrant health champion in each primary care centre.
- Collaborate with the undergraduate and postgraduate training schools for medical, nursing and social work students, to include migrant health in their curriculum.

### Working in collaboration with the third sector

- There are multiple charities in Manchester who could be mobilised with greater infrastructure support.
- Build on and improve existing channels of communication between the voluntary sector and the NHS in order to better understand and respond to changes in the

<sup>54</sup> Farrington et al, *Proposal*

range and distribution of migrant communities and the support networks or groups that exist in local neighbourhoods.

- Embed health professionals within the voluntary sector, to facilitate contact with primary care. Where NHS staff have volunteering time allocated to their roles, this could be spent in the local voluntary sector.
- Provide additional encouragement and support to small community-based organisations to enable them engage in the commissioning process as potential service providers through partnership bids and sub-contracting and identify opportunities to scale this up wherever possible.

### **Community Education and Capacity Building**

- Make greater use of the large and untapped human resource within in the community, with many people with extensive experience and non-UK professional qualifications who could be highly effective in roles that recognise their skills, experience and strengths.
- Additionally, there is a significant untapped resource within the resident population too, who are seeking volunteering opportunities that do not currently exist.
  - Creation of Community Development Worker role
  - Development of a peer support programmes to develop community capacity.
  - Confidence building courses for service users
  - Increase the number of ESOL classes available
  - Provision of advice regarding the NHS prior to arriving in Manchester, for example during a stay in a detention centre
  - Show interpreted videos on how to use the NHS widely, for example in A&E or primary care waiting rooms

### **Interpretation**

- Make more free translating services available to non-profit organisations to enhance their capacity
- Encourage GP practices to adopt a range of language support strategies, including encouraging and supporting bilingual staff to undertake training with a view to achieving [Level 3 community interpreting certification](#) so they can legitimately act as an interpreter.
- Increasing the range of interpreted resources for those who are not computer proficient.

### **Mental Health and Wellbeing**

- Consider alternative pathways for referral to mental health services, for example from the third sector, self-referral or maternity services.
- Make use of accessible community venues and existing advice drop-ins as ways of disseminating information about mental health and wellbeing.
- Consider incorporating mental health workers into the voluntary sector, as mental health interventions may be more effective in an environment where patients feel comfortable and safe.

### **Advocacy**

- Greater collaboration with the third sector via increased thematic infrastructure.
- Establish channels for reporting any clinical circumstances where the new charging regulations have had negative health impacts for this population to the Asylum matters charity, which is collecting vignettes of such instances.



### Health Promotion

- Innovations such as the Community Development Worker.
- Collaborate with wider primary care services, including pharmaceutical, dental and optical, to support engagement of this population through regular events and outreach work into the community.

### Innovation

- Manchester Health and Care Commissioning should seek to learn from other parts of the UK in terms of developing innovative approaches to joining up the commissioning and delivery of services for migrant populations, such as those adopted by the York Street Health Practice in Leeds and the Mulberry Practice in Sheffield.
- Provision of more integrated multi-agency services including funded posts for liaison and coordination between services.

## APPENDIX 1: SERVICES IN MANCHESTER

**Freedom From Torture** is a national organisation with a centre in Manchester specialising in therapeutic rehabilitation of survivors of torture. It offers a varied programme of group and individual therapy, for adults, children, young people and families, in line with NICE guidelines. It works with the chaotic, unsupported situations in which clients find themselves as asylum seekers, rather than expecting them to conform to structured therapeutic models which only move on through a set formula or use a fixed numbers of sessions.

The service undertakes casework as well as therapy, meeting mental health and social, physical and mental health needs, together with systemic support for children and families, providing a culturally sensitive response, using specially trained interpreters. Freedom from Torture also provides training and supervision to a range of third sector and statutory organisations, as well as documenting and verifying the injuries and experiences for the asylum process.

The centre receives referrals from GPs, IAPT and secondary mental health services, as well as other sources, and supports 250 people per year at its Manchester centre. However, it has to turn away 2 in every 3 appropriate referrals for rehabilitation, because the capacity of this specialised charity-funded service is limited. The service is currently only able to accept the 1 in 3 who have the most complex needs, while the others with only slightly less complex needs are not able to have their needs met. Since up to 30% of asylum seekers and refugees are survivors of torture, there is an immediate opportunity to improve the lives of many asylum seekers and refugees if this service could expand.

**Boaz Trust** provide temporary accommodation and support for destitute asylum seekers (usually, who've had their asylum claims refused) and refugees. They provide this accommodation for up to 12 months through 14 shared houses and a volunteer hosting scheme. They also run the Boaz Night Shelter for 12 asylum seeking and refugee men from October to May every year, which is run by churches and volunteers. Client support workers to offer 1-1 practical and emotional support for those in Boaz accommodation. They also run a programme of wellbeing activities, provide basic living essentials and bus ticket money, and support people to work with a solicitor to look at their legal options and see if any progress can be made on their asylum case. Boaz also works with faith

groups and communities to help equip them with knowledge about the asylum system, and how they can provide support for destitute individuals in their communities.

The **Greater Manchester Refugee Support Partnership project (GMRSP)** is a partnership between Refugee Action, Rainbow Haven, Revive and the British Red Cross. The partnership aims to provide a more welcoming environment for refugees and asylum seekers (RAS); offer support to find durable routes out of destitution; improve skills, employability and emotional wellbeing; support better integration of asylum seekers into their local communities; ensure that community voices are heard by local and national decision makers; work to improve positive attitudes and better understanding in the media and local communities.

Staff and volunteers from the four agencies will work together to meet the needs of refugees and asylum seekers at six local Hubs throughout Greater Manchester, the support will include wellbeing activities, ESOL and IT classes, case working, employability courses, volunteering, legal advice, advocacy and training and support.

**Refugee Action** strategic priorities are Justice and poverty. They run two projects around asylum process early intervention and complex casework (section 95 and section 98). A typical example of this type of casework would be a self-supported asylum seeker who accesses normal community facilities - when their support falls through, they try to access asylum support and are dispersed to emergency accommodation in Liverpool, then moved randomly to temporary accommodation over 4-5 months where services (education, health etc.) lose track of them. Refugee Action also focus on capacity building and mobilising VCS orgs around advocacy & Immigration Act 2016. They also have a psychosocial wellbeing project - the thrive programme - which aims to stabilise & improve resilience.

**Rainbow Haven** runs wellbeing groups for men or women, co-facilitated by a mental health worker and a member of RH staff. Courses include; Living Life to the Full Men's Group for socially isolated men in Salford who want to grow in confidence and address concerns about their mental health; Positive Parenting, addressing issues raised by service-users about parenting in an alien culture, and Improve your Confidence Women's Course, building on previous work with women who wanted to feel less anxious, and more confident about coping with daily life.

They also offer ESOL, IT classes, volunteering opportunities which help people to regain confidence and dignity; empowered people make healthy choices alongside numerous measures to address isolation and its associated health implications.

Rainbow Haven also manages the GMRSP hub in Manchester where a welcoming social space is provided for refugees and asylum seekers, with a range of services and support, including advice and case work; ESOL courses (with a crèche); wellbeing activities (with a crèche); employability courses; computer courses; socialising and a communal lunch and destitution support.

**Women Asylum Seekers Together (WAST)** provide Drop-in sessions, regularly seeing around 60 women at each session. They seek to improve the physical and mental health and wellbeing of socially excluded migrants by relieving isolation; giving an opportunity for purposeful activity; providing an opportunity to volunteer and 'give back'; a hot meal and practical support with problems.

**Revive** is an independent community project which provides free practical and emotional support to refugees and people seeking asylum. Revive provides a range of high quality services: friendly drop-in services offering advice, guidance and support on immigration, housing, health care, education; emergency provisions, specialised casework, advocacy and volunteering support. Revive also manages the GMRSP

service hub in Salford and in addition offers specialist one-to-one OISC level 2 legal advice and social work support by referral, or by appointment at their Manchester offices or by outreach.

The **British Red Cross** helps refugees and asylum seekers in Greater Manchester access essential services and adapt to life in a new country.

Their Refugee orientation service helps vulnerable refugees and asylum seekers adapt to life in a new country by offering short term, one-to-one advice and support; help with accessing health, education, welfare and legal services; information about local facilities such as libraries, pharmacies and post offices; links to local community groups, playgroups and English language classes; details of other services and agencies. They also offer a travel assistance service for refugees who are looking to be reunited with their families.

The **Red Cross Destitution Project** helps asylum seekers unable to obtain support from the state and local authorities because their cases have been rejected) or because they have been granted asylum but are having problems moving onto employment or mainstream benefits. Working in partnership with five projects across Greater Manchester, the Red Cross offers destitute asylum seekers and refugees food parcels, toiletries and money for a daily bus ticket; help in accessing legal advice, support and accommodation; and details of useful health and educational institutions.

The **Routes Project**, run by the BHA, has been supports new arrivals to Manchester, with a focus on supporting new Roma arrivals They support families to access the right health services to improve their quality of life. Each family is allocated an outreach worker following a referral to the routes, and are then part of an ongoing action and case review until their outcomes are met.

## REFERENCES AND LINKS

BHA: Roma Family Support

<https://www.thebha.org.uk/roma-family-support>

BHA: Romani Well-being Project

<https://www.thebha.org.uk/romani-well-being-project>

Doctors of the World: Safe Surgeries Toolkit

<https://www.doctorsoftheworld.org.uk/Pages/Category/safe-surgeries>

Easy Health: Educational health leaflets

<http://www.easyhealth.org.uk/categories/health-leaflets>

Freedom from Torture - North West Branch

[https://www.healthinfotranslations.org/topic/health\\_information\\_translations/39384](https://www.healthinfotranslations.org/topic/health_information_translations/39384)

Health Information Translations

[https://www.healthinfotranslations.org/topic/health\\_information\\_translations/39384](https://www.healthinfotranslations.org/topic/health_information_translations/39384)

Manchester College, The: Level 3 Community Interpreting Certification

<https://www.tmc.ac.uk/courses/community-interpreting>

Manchester City Council: Profile of Migration in Manchester

[http://www.manchester.gov.uk/downloads/download/4220/public\\_intelligence\\_population\\_publications](http://www.manchester.gov.uk/downloads/download/4220/public_intelligence_population_publications)

Manchester City Council: Joint Health & Wellbeing Strategy

[http://www.manchester.gov.uk/downloads/download/5657/joint\\_health\\_and\\_wellbeing\\_strategy](http://www.manchester.gov.uk/downloads/download/5657/joint_health_and_wellbeing_strategy)

Manchester Health & Care Commissioning: Moving Lives Report

<https://www.mhcc.nhs.uk/publications/knowledge-hub/asylum-seekers-migrants-refugees/>

Manchester Health & Care Commissioning: Manchester Locality Plan for Health and Social Care

<https://www.mhcc.nhs.uk/publications/manchester-locality-plan/>

Medact Manchester: Survey on healthcare professionals' views and experiences of dealing with refugees and asylum seekers

<https://medactmanchester.wordpress.com/>

NHS England (Great Manchester and Lancashire): Manchester City of Sanctuary

<https://manchester.cityofsanctuary.org/everything-you-need-to-know>

Public Health England: Tuberculosis Strategy Monitoring Indicators

<https://fingertips.phe.org.uk/profile/tb-monitoring>

Refugee Council: Glossary

<https://www.refugeecouncil.org.uk/glossary>

## OTHER RELATED JSNA TOPICS

- [Adults with Complex Lives](#)
- [Black and minority ethnic \(BAME\) communities](#)
- [Homelessness and Health](#)
- [Suicide Prevention](#)

**Date: July 2018**

It is hoped that you have found this topic paper useful. If you have any comments, suggestions or have found the contents particularly helpful in your work, it would be great to hear from you.

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