

Rapid Health Needs Assessment: The Health Care Needs of Asylum Seekers in Leicester

V13

June 2016

This Rapid Health Needs Assessment has been undertaken to assist the considerations of Leicester City Clinical Commissioning Group regarding its intentions for primary health care services for asylum seekers. While there has been some data collection for this needs assessment, a rapid needs assessment does not generate primary data and concentrates on collating information that already exists.

Acknowledgements:

Dr David Shepherd for analysis of ASSIST and Inclusion service data in Appendix B

Jo Ryder for service user engagement input, Appendix D

Specialist APMS Group for information, advice and guidance.

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Summary

- Asylum seekers are part of the wider group of people applying for refugee protection in the UK. A refugee has an accepted claim as being unable to return to his or her own country for fear of persecution because of race, religion, nationality, sexual orientation or political opinion.
- The Home Office provides accommodation and support for individuals and families seeking asylum who are at risk of destitution. In the East Midlands accommodation is provided by G4S.
- According to G4S the number of asylum seekers resident in Leicester in May 2016 was 1,050 people. Over the last year 504 moved in and 286 moved out, a net increase of 214. Current main countries of origin are broadly in line with the national picture, namely from Pakistan, China, Sri Lanka, Iran, Iraq, Eritrea, Nigeria, Albania, Syria, Sudan and Afghanistan.
- Asylum seekers are currently housed in 305 properties around the city with most properties in the North and West, followed by North and East and Central and South Health Need Neighbourhoods.
- It is anticipated that numbers of asylum seekers will increase until they meet the Home Office formula of one asylum seeker for per 200 people resident, or for Leicester about 1,650 people, over an as yet unknown period.
- Healthcare for asylum seekers in Leicester is provided primarily through ASSIST and to an extent by mainstream GP practices. The service has evolved over a number of years. ASSIST was established in the early 2000s, when asylum dispersal was at its highest, to act as a gateway to primary care services.
- ASSIST has between 1,400 and 1,500 registered patients each year. Slightly more than the G4S population, but probably indicative of churn in the practice. Consistent with the national picture, the practice has higher rates of younger males, aged between 20 and 44 years, and fewer females. The proportion of children aged 0 to 4 years is higher than the local and national averages. The ASSIST population is more deprived than the CCG or England averages.
- The health needs of Asylum Seekers are not homogeneous but they are substantial. The analysis of practice data shows a young, mainly male, population with a disease profile reflecting this, with indicators of social distress in psychological and neurological disease profiles. A number of factors compound health need related to their asylum seeker status and experience in the UK including poor living conditions, lack of meaningful activity and poverty.

- Barriers to health care include language skills, knowledge of health system and regulations regarding access a lack of health screening on arrival, difficulties accessing GP services an increased reliance on A&E, and access to mental health services.
- The challenges to health care provision include: ensuring adequate language support; continuity of care; advocacy; the need for non-clinical support to avoid 'medicalisation' and dependence; significant workload issues in relation to health needs and the asylum system derived turn-over of patients.
- Primary health care provision for asylum seekers needs to engage and relate to the network of other services, groups and organisations established to provide support to asylum seekers.
- The views of service users, GPs and organisations which provide wider support were sought covering access, complexity of health need, the need for advocacy, issues to do with practice registration, views about whether services should primarily be provided by a specialist service or mainstream primary care.
- Information from the CCG's comparator areas indicates overall that there is no settled or established model for the delivery of primary health care services to asylum seekers and CCGs vary in both their 'core' and 'gateway' services.
- Assessment of the available evidence shows that ultimately the choice of interventions comes down to the discussions and considerations of local commissioners and practitioners, partners and stakeholders. This underscores the importance of having a clear purpose, principles and quality standards behind what is commissioned, and a commitment to evaluate against these the services commissioned.

The CCG is recommended to:

- Adopt a strategic longer-term view of its approach to addressing the health care needs of asylum seekers and agree a clear set of aims, principles and quality standards to inform commissioning of appropriate services.
- Consider, adopt and apply a set of quality standards for the commissioning and provision of health care for asylum seekers.
- Monitor access, take up and outcomes of primary health care for asylum seekers.
- Maintain a specialist primary health care service for asylum seekers.

- Take into account when considering the basis of funding that the purpose of ASSIST is to register and assess the health of new asylum seekers, provide appropriate care before referring or supporting them into mainstream primary care, rather than the provision of long term continuing primary care.
- Draw up a protocol describing the basis on which the specialist service can hold on to patients for longer than the period to be defined.
- Agree a more structured approach to the handover of patients from the specialist service to mainstream primary care.
- Recognise and reconcile the conflict of policy in having both a specialist service and requiring the registration by GP practices of individuals within the catchment area of a practice.
- Consider including in the role of the specialist service the provision of training and consultation to mainstream primary care, in support of their work with asylum seekers.
- Ensure that arrangements for the provision of mental health services (IAPT) in support of asylum seekers in primary care are strengthened.

Please see page 35 for the full recommendations.

1. Asylum seekers

- 1.1 While this rapid needs assessment is focused on the health care needs of asylum seekers, part of the context of the issue is that asylum seekers are part of a larger group of vulnerable and marginalised migrants. This includes asylum seekers themselves who are actively applying for refugee protection in the UK; refugees, who have been given leave to stay in the UK; and over-stayers, those who have exhausted their application rights and having been refused leave to stay, remain illegally in the UK. A refugee has an accepted claim as being unable to return to his or her own country for fear of persecution because of race, religion, nationality, sexual orientation or political opinion.
- 1.2 There is a large gap in the UK between numbers seeking asylum, the numbers given asylum, and the numbers of asylum seekers who leave the UK either voluntarily or through deportation. This is known by the government as the 'deportation gap.' The Red Cross estimates that as most asylum applications are refused as many 4,000 destitute asylum seekers without leave to stay may be living in Leicester¹.
- 1.3 An asylum seeker for support purposes is someone aged over 18 who has claimed asylum. They may have dependents entitled to support regardless of their own immigration status. Dependents can be a spouse or partner, anyone under 18 or a disabled person.
- 1.4 Unaccompanied children can apply for asylum and local authorities have a duty to support and safeguard them, promote their welfare and to accommodate them. This is necessary to ensure the UK upholds domestic and international obligations to children. If they are considered older than 18 they will be treated as an adult during the asylum application. In disputed cases children are referred to social services for age assessment.
- 1.5 Nationally age is disputed in about 30% of asylum cases, and at least one local mainstream general practice had experience of this issue.
- 1.6 Although some asylum seekers enter the UK illegally, once they have applied for asylum they are entitled to stay until a decision is made on their claim. People at risk of absconding or facing removal from the UK can be held in detention centres.

2. Home Office Support for Asylum Seekers

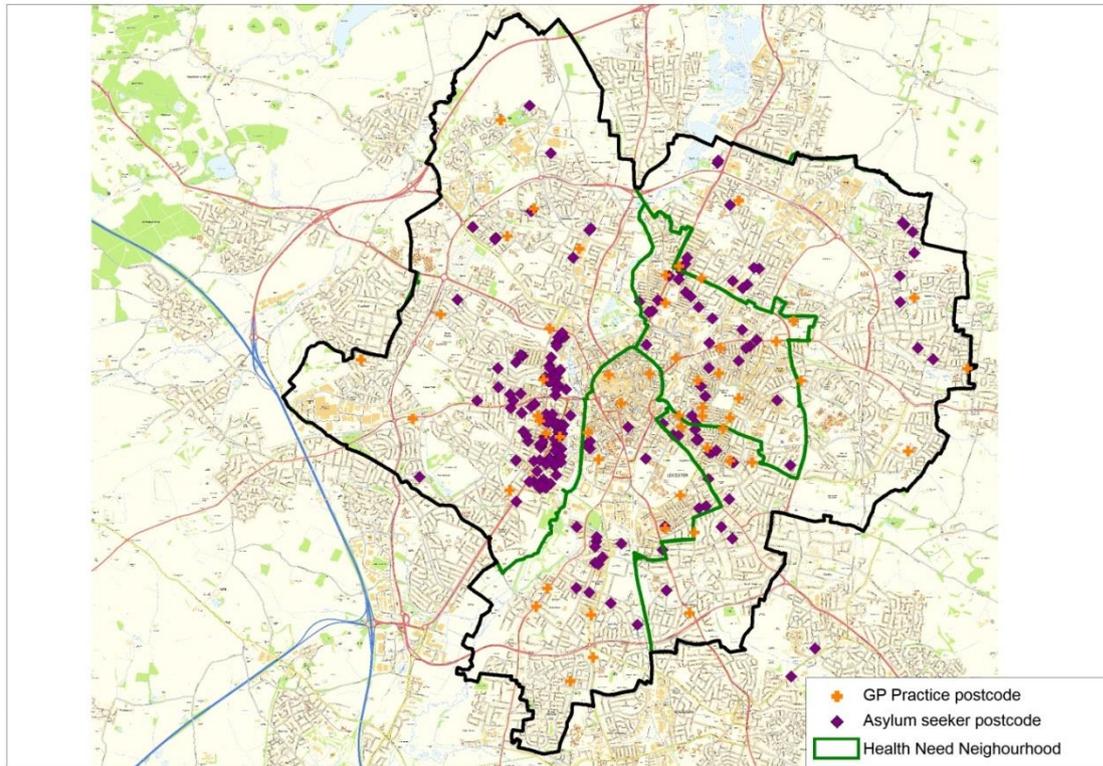
- 2.1 The Home Office provides accommodation and support for individuals and families seeking asylum who are at risk of destitution.
- 2.2 **Section 95** asylum seekers are housed, though they cannot choose where to live. They are entitled to payments of £36.95 per person per week for food, clothing and toiletries. There are additional benefits for pregnant women and

¹ Roberts-Thompson, T., 2014, British Red Cross, Leicester Needs Assessment Report 2014

children aged below 3 years. Children aged 5 to 17 years must attend school, and they may be able to get free school meals. The asylum seeker and their dependents may get free NHS health care, prescriptions and dental care, free eyesight tests and help paying for glasses.

- 2.3 **Section 4** support is for asylum seekers who have exhausted their appeal rights but are unable to return home. It allows for short-term housing; help with prescriptions for medicine, dental care, eyesight tests and glasses. Section 4 asylum seekers are entitled to a payment card for food and toiletries (£35.39 weekly). This can be used with specified retailers and cannot be used to access cash.
- 2.4 The accommodation and transport of destitute asylum applicants is contracted by the UK Border Agency (UKBA) through Commercial and Operational Managers Procuring of Asylum Support Services (COMPASS). Three types of accommodation are provided for asylum seekers under COMPASS:
- Initial (hostel type/full board). Initial housing in the Midlands is at Stone Road Hostel, Birmingham.
 - Dispersed (flats or houses/self-catering)
 - Accommodation for Section 4 asylum seekers ahead of deportation.
- 2.5 Accommodation for dispersal in the East Midlands is provided by G4S. G4S data indicates that currently there are about 1,000 asylum seekers in Leicester. They are housed in 305 properties around the city, which are shown in Figure 1 below.

Figure 1: G4S accommodation for asylum seekers in Leicester, General Practice location and Health Need Neighbourhood



(Data source: G4S and Leicester City CCG)

2.6 G4S housing for asylum seekers in Leicester is highest in the North and West Health Need Neighbourhoods (HNN), 170 properties(56%), followed by North and east HNN 71 properties (23%) and Central (32 properties, 10%) and South (31 properties, 10%); 304 G4S properties in Leicester yield 792 bedrooms, nearly two thirds (62%) are concentrated in the North and West and fewest are in South (9.6%) and Central (9.7%) HNNs.

2.7 Asylum seekers cannot work while their application is being considered, unless it has taken longer than 12 months. Eligible asylum seekers may be allowed to work in a listed occupation.² Permission to work, undertake voluntary activity or vocational training, can be gained from caseworkers.

3. Asylum seekers in the UK, East Midlands and Leicester

3.1 Figure 2 below shows that nationally asylum applications increased from the mid-1980s to a high point in the mid-2000s. While net migration has increased, since 2004 it has generally declined.³ The number of asylum seekers nationally is expected to increase to 1 for every 200 people in the general population in dispersal centres.

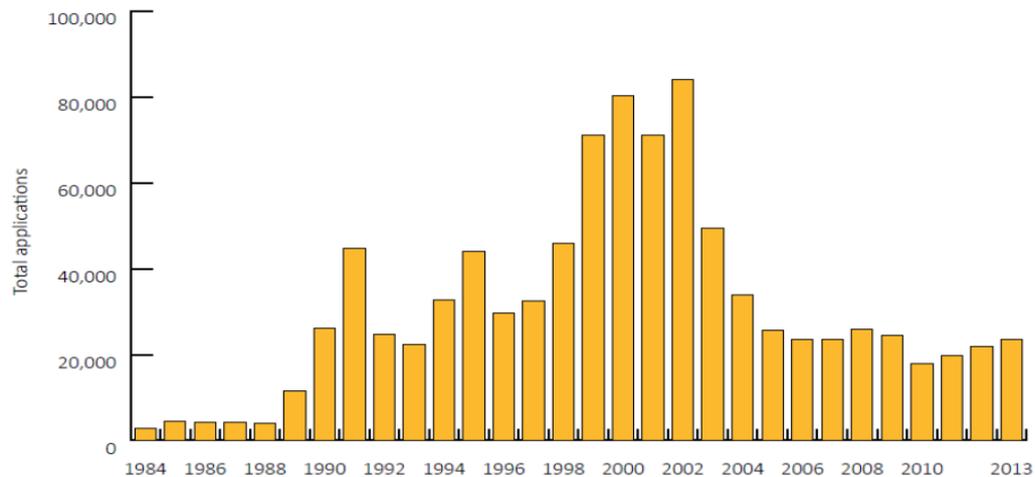
² Published by UK Visas and Immigration.

³ Blinder, S., 2015, Briefing on Migration to the UK: Asylum. The Migration Observatory, University of Oxford at www.migrationobservatory.ox.ac.uk

- 3.2 At the end of 2015, 34,363 asylum seekers and their dependents were being supported in the UK under Section 95, compared with 29,753 at the end of 2014.
- 3.3 Asylum seeker nationality changes with international crises.⁴ In the early 2000s a large proportion came from Europe, Africa and the Middle East, escaping conflicts in Kosovo, Serbia and Montenegro, Iraq and Somalia. Recent leading sources of asylum applicants have been Pakistan, Iran, Sri Lanka, Syria, Eritrea, Albania, Bangladesh and Afghanistan.

Figure 2: UK Asylum Numbers 1984-2013

Chart 1: Asylum numbers over time



Source: Home Office

- 1 S Spencer, 'The Migration Debate', Policy Press, 2011.
- 2 O Hawkins, 'Asylum Statistics', House of Commons, 6 May 2014.

Source: Home Office

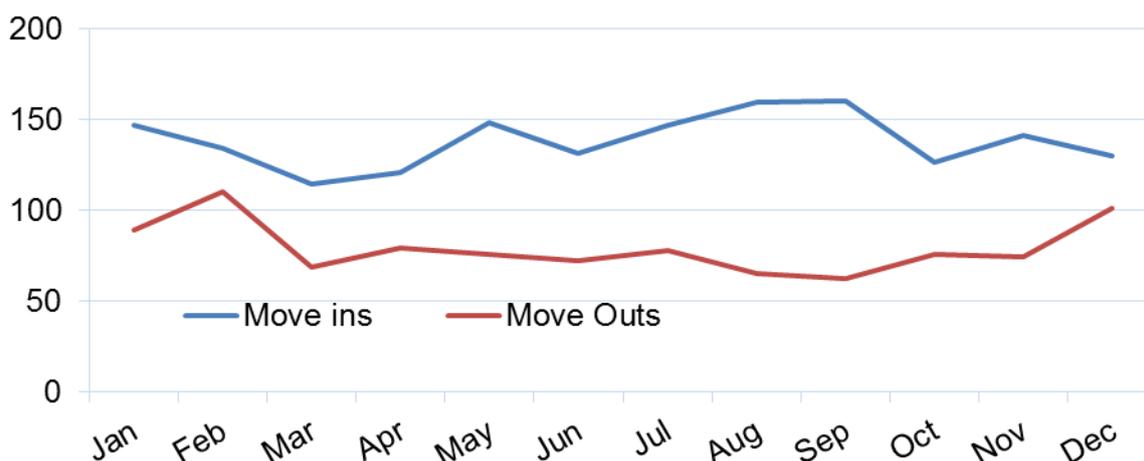
- 3.4 Asylum seekers allocated to the Midlands should be accommodated at the Stone Road Hostel in Birmingham, awaiting further dispersal. There are 6 East Midlands dispersal centres; Leicester, Nottingham, Derby, Oadby (new), Broxtowe and Gedling.
- 3.5 There were just over 2,500 asylum seekers living in the *East Midlands* in 2014, mainly dispersed between the city areas (see Figure 3 below).
- 3.6 In the East Midlands the migrant population from the Middle East and Asia is largely from economically active age groups (aged 20-65); almost half are in their 20s and 30s. The African migrant group are in the slightly older economically active group aged 30-59.⁵
- 3.7 The number of asylum seekers dispersed to the East Midlands is subject to a great deal of churn, as shown in Figure 3, below.

⁴ Crawley, H., 2010, Chance or Choice? Understanding why asylum seekers come to the UK. Refugee Council Report, Refugee Council, London.

⁵ Public Health England, Profile of migrant health data in the East Midlands, Final Draft version 6, September 2015.

3.8 While there may be some stability in the number of asylum seekers, at the individual level there is constant change. Individual asylum seekers are subject to required movements at short notice. Asylum seekers dispersed to Leicester are sometimes required, for different reasons, to move anywhere in Leicester, the Midlands or even Yorkshire.

Figure 3: The number of asylum seekers moving in and out of authorised accommodation in the East Midland, 2014



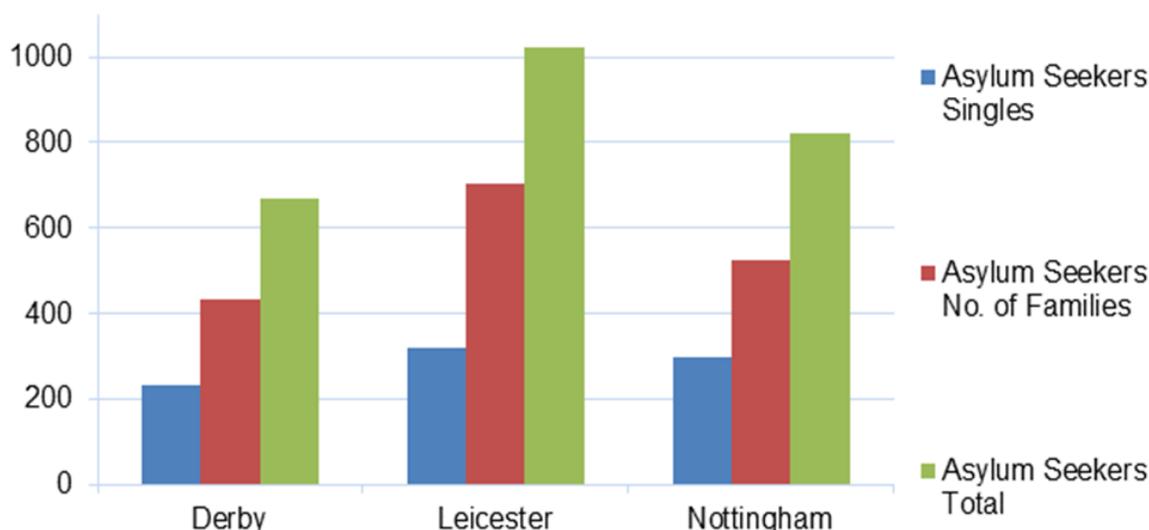
Source: Compass service users (G4S)⁴

3.9 According to G4S the actual number of asylum seekers resident in *Leicester* in May 2016 was 1,050 people. Over the last year 504 moved in and 286 moved out, a net increase of 214. Current main countries of origin are broadly in line with the national picture, namely from Pakistan, China, Sri Lanka, Iran, Iraq, Eritrea, Nigeria, Albania, Syria, Sudan and Afghanistan.⁶

3.10 The relationship of single asylum seekers to family groups can be seen in Figure 4, below (which also shows the pattern of distribution of dispersed asylum seekers between Leicester, Nottingham and Derby).

⁶ G4S data for Leicester LA, May 2016.

Figure 4: Asylum seekers: the number of singles and family groups in East Midlands Cities, 2014.



Source: Public Health England, Profile of migrant health data in the East Midlands, Final Draft version 6, September 2015.

- 3.11 Those claiming Section 4, whose original applications have been rejected, may be moved while awaiting departure. They are more likely than Section 95 applicants to abscond to remain illegally in the UK, out of contact with immigration control.
- 3.12 Once people have gained refugee status they are also vulnerable to homelessness as they are given 28 or, in some cases, 14 days' notice to quit their accommodation.
- 3.13 Given that this population is so mobile, important documents are sometimes delivered to different addresses. This contributes to the already complicated picture. Asylum seekers require different documents to prove their status, When these do not arrive together they can prevent timely access to services, for instance, an address is important in getting medication through a HC2 Certificate.⁷

4. Likely future numbers of asylum seekers

- 4.1 Leicester is a dispersal area for asylum seekers new to the UK. It is anticipated that in future local authorities which are currently non-dispersal areas will be expected to accommodate some asylum seekers, and dispersal areas will have a threshold beyond their present numbers. The best estimate from the East Midlands Strategic Migration Partnership is that asylum seeker numbers will increase until they meet the Home Office formula of one asylum seeker for per 200 people resident, or for Leicester about 1,650 people, over an as yet unknown period. This is about 600 more asylum seekers than presently resident in Leicester, a potential increase of 57%.

⁷ For this process see <http://www.nrpfnetwork.org.uk/Documents/NHS-healthcare.pdf>

5. Background to current health care provision for asylum seekers in Leicester

- 5.1 Healthcare for asylum seekers in Leicester is provided through ASSIST and to an extent by mainstream GP practices.
- 5.2 Currently it is not possible accurately to gauge registration by mainstream GPs. Asylum seekers are not routinely identified on GP data systems, so a key source of local data is missing. We have made enquiries of all Practice Managers regarding an estimated number of asylum seekers registered and received only eleven responses. While two practices made informed estimates there appeared to be no shared working practice regarding recording of asylum seeker or refugee status.
- 5.3 Services in Leicester evolved over a number of years. ASSIST was established in the early 2000s, when asylum dispersal was at its highest (see Figure 2 for the overall trend in asylum seekers coming to the UK).
- 5.4 At that time Leicester had too few GPs and primary care was under pressure. Unregistered asylum seekers were allocated to practices. According to a contemporary non-executive Primary Care Trust (PCT) Board member there were many examples of asylum seekers being moved on after the minimum registration period.
- 5.5 ASSIST was the service response to complex asylum seeker health needs, confused patient histories, communication, housing, destitution and the asylum application process.
- 5.6 One functions of ASSIST is to act as a gateway to primary care services, with the rationale of registering patients, introducing them to the UK health system and resolve complex care issues. When a person becomes a refugee, or their health care needs are stabilised or routinised, they should be assisted to register with mainstream primary health care services.
- 5.7 In the 2000s all local supported asylum seekers lived in the International Hotel. ASSIST developed in close proximity to the hotel, being based at St Peters, then Prince Philip House, before moving to the current Clyde Street premises.
- 5.8 The service made a significant difference and attracted both national and international recognition. There were strong links between ASSIST, other partners in the health community, the local authority and the voluntary sector.
- 5.9 Since its origins as a nurse led pilot, with medical cover, ASSIST has been managed by the then Primary Care Trust and provided by Assura/Virgin Health Care. A significant driver of change in delivery was the Transforming Community Services agenda (2010/11).
- 5.10 In 2015 Leicester City Clinical Commissioning Group (CCG) invited all primary care practices in Leicester, Leicestershire and Rutland to apply to take

responsibility for the service on a caretaker basis while longer term arrangements were made - Inclusion Healthcare were appointed.

- 5.11 Figure 1 above shows asylum seeker accommodation in Leicester is now more varied, with a high concentration particularly in the Narborough Road and Hinckley Road areas.

6. Asylum Seeker health need

- 6.1 This section draws on wider literature regarding the health needs of Asylum Seekers. Due to the lack of availability of mainstream primary care data, the local source is data provided by the specialist service, ASSIST. Comments from stakeholders have been added where relevant.

Demography

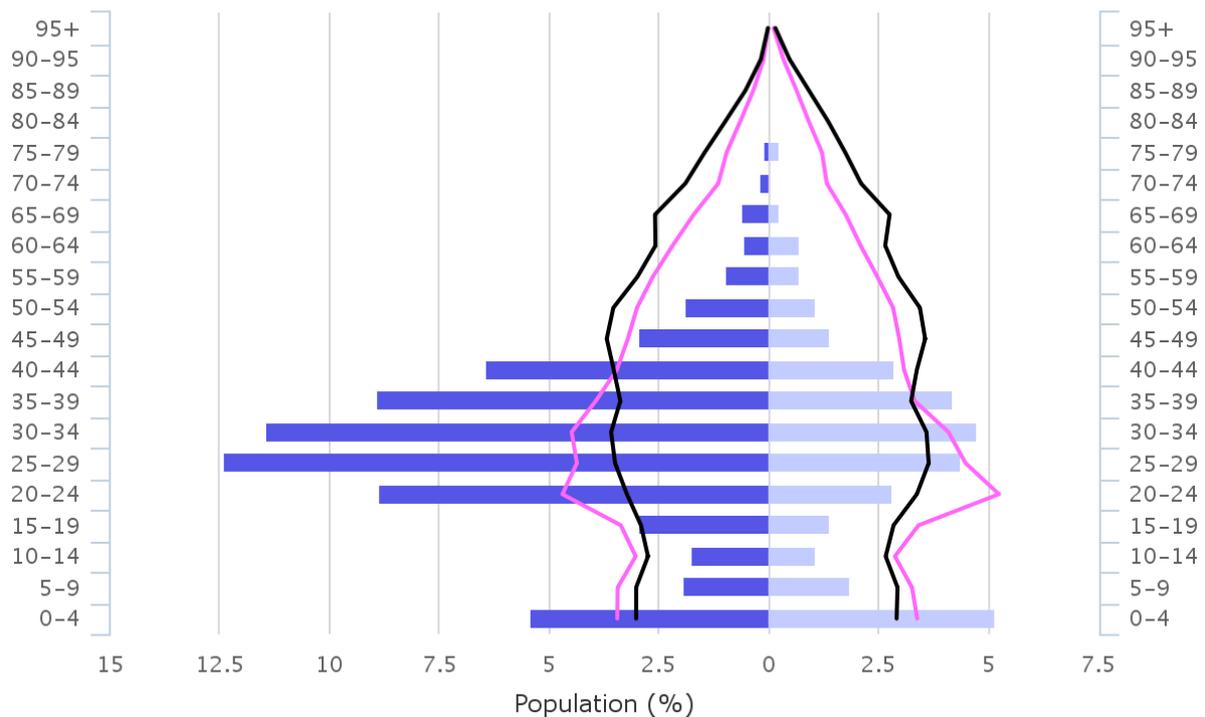
- 6.2 ASSIST has between 1,400 and 1,500 registered patients each year. Slightly more than the G4S population, but probably indicative of churn in the practice. Latest SystemOne data, accessed through an Aggregated Clinical Groups (ACG) report (see Appendix B), gives a registered population of 1,493 patients. In April 2016 the ASSIST registered population was 1,422 patients.⁸
- 6.3 ASSIST has a very young population (see figure 5). The proportion of young people aged 0 to 4 years is higher than the local and national averages. Consistent with the national picture, the practice has higher rates of younger males, aged between 20 and 44 years, and fewer females. According to Migration Observatory⁹ men made up nearly 3 out of 4 (73%) of main applicants for asylum in 2014.
- 6.4 Most HNNs had practices with registered asylum seekers, although it is difficult to quantify them. They have complex needs, including support for post-traumatic stress disorder, physical trauma, advocacy, social rights, lack of knowledge of services available and language barriers. There were mental health problems, absence of vaccination records or vaccinations, responses to adverse life events, and the need for social and psychological support.
- 6.5 The National General Practice Profile shows the ASSIST population is more deprived than the CCG or England averages, with rates of unemployment close to the highest in England.

⁸The National General Practice Profile for the Leicester City ASSIST practice shows that ASSIST has 1,622 patients. <http://fingertipsreports.phe.org.uk/gpp/index.php?CCG=E38000097&PracCode=Y00344>

⁹ <http://migrationobservatory.ox.ac.uk/briefings/migration-uk-asylum>

Figure 5: Age distribution for ASSIST practice population

Age Distribution 2015 for NHS Leicester City CCG (Y00344 – LEICESTER CITY ASSIST PRACTICE)



Source: The National General Practice Profile for the Leicester City ASSIST practice

Health need

- 6.6 The Survey of New Refugees in the UK reported that refugees had poorer health than the general population in England and Scotland. Those described as being in good health being more likely to be employed than other refugees. Poor health was also associated with slow improvement in English language skills over time. According to the Survey of Refugees Living in London, refugees were more likely to say that their health is poor (12% compared with 5% in the general London population).¹⁰
- 6.7 Although patients are entitled to a health screen before coming to Leicester, the reality is that many have no recorded medical history before registration at ASSIST (a point confirmed by mainstream GPs who have registered asylum seekers). Lack of vaccination and medication history only adds to caseload complexity. The self-reported health needs which asylum seekers highlighted included access to dental services and mental health. Wider stakeholders felt that mental health was adversely affected by trauma of the journey to the UK, shame and stigma not being allowed to stay.

¹⁰ in Data Collections: Vulnerable Migrants, Gypsies and Travellers, Homeless People, and Sex Workers Peter J Aspinall Centre for Health Services Studies, University of Kent 2014
<https://www.gov.uk/government/publications/effective-health-care-for-vulnerable-groups-prevented-by-data-gaps>

Communicable disease

- 6.8 A wide range of communicable disease have been reported among asylum seekers and there are anxieties about low rates of vaccination among children and adults and the spread of multi-resistant TB. On the whole TB infection in the population depends where asylum seekers come from in a sample of 397 newly arrived asylum seekers in Sunderland and North Tyneside,¹¹ around 16% of the sample had been vaccinated for measles, mumps, or rubella. Those vaccinated for TB were below that required to provide adequate population immunity.
- 6.9 Migrants from sub-Saharan Africa are at increased risk of HIV/AIDS though no data has been found of prevalence of HIV/AIDS in asylum-seekers and refugees from this region. Several studies report that the policy of dispersal of asylum seekers has impacted adversely on those with HIV/AIDS.
- 6.10 Many asylum seekers come from countries where antibacterial resistance is a serious public health problem, as it is here. Migration is accompanied by migration of resistance through carriage of resistance genes in bowel and skin microbiota. In Leicester there are infections, in both recent and established migrants, caused by bacteria which are susceptible to few or no antibiotics. Treating these infections is an immediate challenge
- 6.11 Immunisation coverage level may be poor for asylum seekers from countries lacking health care facilities.^{12 13} Studies demonstrate lower uptake of immunisations and screening by non-UK born populations compared to those who are UK-born, although socio-demographic factors have also been found to be important.¹⁴ The latest QED data shows that childhood immunisation uptake for ASSIST has increased from 79.1% in 2013-14 to 96.5% in 2014-14. Cervical screening and chlamydia testing are also higher for ASSIST than the CCG average.
- 6.12 Registers of infectious diseases, such as TB and HIV, show higher rates among South Asian, particularly Indian and Pakistani, and Black African non-UK born populations compared to UK-born people from similar ethnic backgrounds.¹⁵ The highest rates of TB among migrants occur among recent arrivals to the UK. Whilst this reflects prevalence rates in countries of origin,¹⁶ it also highlights the possible importance of contributory factors in the UK, such as low income and poor living conditions, given that new migrants are

¹¹ Blackwell et al, 2003 in Hidden Needs Identifying Key Vulnerable Groups

¹² British Medical Association ibid

¹³ Health Protection Agency, 2006, Migrant Health: Infectious disease in non-UK born populations in England, Wales and Northern Ireland; A baseline report. London, Health Protection Agency

¹⁴ Jayaweera, H. and Quigley, M., Health Status, Health Behaviour and Healthcare Use among Migrants in the UK: Evidence from Mothers in the Millennium cohort Study. *Social Science and Medicine* 71(2010) pp 1002-10; Webb, R., et al., Uptake for cervical screening by ethnicity and place of birth: a population-based cross-sectional study. *Journal of Public Health* 26(2004); pp 293-6.

¹⁵ Health Protection Services, 2011, Migrant health: Infectious Diseases in non-UK born populations in the United Kingdom. An update to the baseline report – 2011. HPA, London

¹⁶ Public Health England, 2013, Tuberculosis in the UK: Annual Report of tuberculosis surveillance in the UK, 2013, PHE, London

often accommodated in over-crowded conditions in more deprived areas.¹⁷ ACG data shows higher rates of infections for ASSIST.

Mental health

- 6.13 Mental health problems include post-traumatic stress disorder (PTSD), anxiety, depression and phobias, with rates up to 5 times higher than in the general population. Research by Silvone et al on destitute asylum seekers in SE England found that more than half were receiving medication for depression. Children, victims of torture, women, and LGBT asylum seekers may be particularly affected.¹⁸
- 6.14 UK studies and systematic reviews of European studies point to higher rates of depression and anxiety in asylum seekers and refugees compared to the national population or other migrants.¹⁹ Particularly vulnerable are children, and women who have suffered sexual and physical abuse. The National General Practice Profile for ASSIST shows that the QOF incidence of depression is 5 times and the prevalence rate 3 times, the CCG and national averages.
- 6.15 ACG data shows ASSIST has a higher level of mental illness than the HNN and CCG averages, but somewhat lower than expected for the asylum seeker population. This increased psychosocial morbidity is reflected in tobacco use, anxiety and depression and family and social problems.

Women's Health

- 6.16 While there is a higher rate of 0-4 year olds registered with ASSIST, ACG data shows a lower rate of service use by women. Suggesting that females registered with ASSIST are not in contact with the NHS beyond issues of childbirth. This may be different to the national picture for asylum seekers and refugees, where there is evidence of poor antenatal care and pregnancy outcomes,²⁰ and probably underscores the value of specialist ante-natal and perinatal care which has previously been delivered through ASSIST.
- 6.17 Nationally, pregnant asylum seekers are seven times more likely to develop complications during childbirth than the general population.²¹ Key risk factors for maternal mortality include lack of antenatal care and late booking, little or no English fluency and inadequate interpretation support from maternity services. An analysis of migrant mothers in the first wave of the Millennium

¹⁷ Robinson, D. and Reeve, K., 2006, Neighbourhood experiences of New Immigration: Reflections from the evidence base. Joseph Rowntree Foundation, York

¹⁸ See Hidden Needs Identifying Key Vulnerable Groups in Data Collections

¹⁹ Raphaely, N. and O'Moore, E., 2010, Understanding the Health Needs of Migrants in the south East Region. Health Protection Agency and Department of Health, London

²⁰ McLeish, J., 2002, Mothers in exile: Maternity experiences of asylum seekers in England. London, the Maternity Alliance

²¹ Confidential Enquiry in Maternal and Child Health, 2004. Why mothers die 2000-2002. The Sixth Report of the Confidential Enquiry into maternal deaths in the UK. London, Royal College of Obstetricians and Gynaecologists.

Cohort Study showed that 7.1% of mothers born abroad giving birth in the UK had no antenatal care at all, compared to 2.4% of mothers born in the UK.

- 6.18 A survey of women trafficked for sex or domestic service in European countries found 70% had experienced physical and sexual abuse during trafficking. The majority exhibited physical and mental health symptoms such as back and abdominal pain, headaches, dizziness, gynaecological infections, depression and anxiety.²² However, uptake rates for cervical and breast cancer screening in this group are typically very poor. Other concerns include female genital mutilation and domestic violence.

Long term conditions

- 6.19 ASSIST report high rates of diabetes. These may not have been diagnosed in the country of origin possibly because of lack of health care.²³ However, reflecting its younger population, ACG data shows that ASSIST has a higher proportion of patients with no identified Long Term Conditions when compared with practices in the South Health Need Neighbourhood (to which the ASSIST practice belongs), and a smaller proportion with multiple long term co-morbidity.

Compounding factors

- 6.20 There are detrimental health impacts which reinforce the stress and social isolation of leaving one's country of origin. Many asylum seeker journeys start from areas where health care has collapsed and may include stays in camps with risks of poor nutrition and sanitation which result in malnourishment and communicable disease.
- 6.21 These health needs and mental health issues may be compounded by loss of status, language barriers, uncertainty, racism, hostility, housing difficulties, poverty and loss of choice and control. These factors include inadequate information, particularly for people unfamiliar with the UK health care system, insufficient interpreting and translating support, lack of reliable transport due to their poverty and poor services in deprived areas. There is confusion around entitlement to services among migrants with insecure immigration status and service providers, and cultural insensitivity of some front line health care providers.²⁴ Some barriers, such as information, language and transport, appear to cut across length of asylum seeker residence.

²² Zimmerman, C. et al. 2008, The Health of Trafficked women: A survey of women entering post-trafficking services in Europe. *American Journal of Public Health* 98(2008); 55-9

²³ Health Protection Agency 2006, Migrant Health: infectious disease in non-UK born populations in England, Wales and Northern Ireland. A baseline report. London, HPA

²⁴ Phillimore, J., et al., 2010, Delivering in an Age of Super-Diversity: West Midlands Review of Maternity Services for Migrant women. Department of Health and University of Birmingham;

Johnson, M., 2006, Integration of new migrants. In Spence, S., (ed) Refugees and other new migrants: A review of the evidence on successful approaches to integration COMPAS, University of Oxford

- 6.22 Some people therefore experience deteriorating health while they are in the UK.²⁵ Most asylum seekers have time but no money. If they are on Section 4 they will have so little cash that they may not be able afford daily necessities or access public transport to attend required meetings. For some the proportion spent of transport can have a big impact on their lives. They may have to walk to appointments. When they can access courses they may not support progression or provide accreditation and there are frequent shortages of places.
- 6.23 ASSIST staff have identified, as have those in the voluntary sector groups and organisations working to support asylum seekers, that there is a huge need for things for asylum seekers to do - social groups, classes, physical activity, cultural activity. In this context for example, City of Sanctuary has identified the need of the high number of younger single males in the asylum seekers population for help in looking after themselves, including physical activity, personal health and food purchasing and preparation, among other things.
- 6.24 ASSIST staff have found that asylum seekers are so limited in what they are allowed to do while waiting for a decision on their longer term status, they become dependent on services designed to help and support them, depression is compounded and the danger is that the response to their circumstances is increasingly medicalised. Thus the importance of health care providers having a strong knowledge of a range of services and groups, and active engagement with their networks.

Barriers to care

- 6.25 New asylum seekers are offered non-mandatory health screening at the Stone Road Hostel in Birmingham, however the reality is that some people are not screened. This may be because of numbers or speed of dispersal. On arrival in Leicester ASSIST GPs or local specialist health visitors are often the first person to carry out a health assessment. The first consultation is often the main health assessment. In many cases there is no handover or documentation if the person has not attended prior screening. Mainstream GPs who have registered new asylum seekers have had the same experience.
- 6.26 Difficulties in accessing GP services and an increased reliance on A & E services. Though 98% of refugees in the Survey of Refugees Living in London were registered with a GP and 88% chose GPs as the most preferred service for treatment of illness; uncertainty and lack of clarity among service providers about asylum seekers' eligibility for secondary healthcare services; and low uptake of preventative healthcare measures (breast and cervical screening) have all been reported. Provision of mental health services for the survivors of torture and organised violence are widely regarded as patchy and inadequate. The Survey of Refugees Living in London found that of those who

²⁵ British Medical Association, 2002, Asylum Seekers: meeting their healthcare needs. London, BMA

experienced mental or emotional health problems, 40% reported that they had not received treatment.

- 6.27 The Doctors of the World Impact Report 2009-2010 identified barriers to care such as language, inhospitable and sometimes hostile GP surgery staff, lack of knowledge and understanding of regulations regarding entitlements among surgery staff, poor living conditions of migrants and stress caused by the effects of uncertain immigration status..
- 6.28 Doctors of the World found that biggest barrier to GP registration was the inability to provide paperwork; 39% of registration refusals were because of lack of identification documentation, 36% because of lack of proof of address and 13% because of immigration status.²⁶

Challenges to health care provision

- 6.29 A lack of adequate English is a particular issue. In ASSIST some 45 languages are spoken among people registered. Some asylum seekers have enough English to register, but many have none at all, and no one suitable or available to support and interpret. For many consultations there is no communication without an interpreter. The ASSIST service has speaker phones in each surgery and 40% of consultations are via telephone interpretation. There is a skill in understanding the nuance of non-verbal cues, when someone is speaking an unknown language. All this means that an accurate history takes time to collect. Using the telephone in this way and so consistently is difficult. Many appointments are taken up by understanding patients' needs. ASSIST sometimes allows 30 minutes for an appointment, on occasion appointments can take longer.
- 6.30 Continuity of care for asylum seekers is essential. Without it health needs are both difficult to manage and can have an attritional impact on clinical staff, and increases the need for reassessment. In ASSIST three GPs do planned regular sessions, tracking patients to ensure continuity and minimising locum use.
- 6.31 Advocacy. Asylum seekers need letters to help with the requirement to sign in, accommodation, schools and Section 4 claims which require medical input. There is a skill in knowing the content required when writing such letters.
- 6.32 Recognising the need for non-clinical support. Asylum seekers can lack the independence and resources to take responsibility for their own health and wellbeing, they can quickly become reliant on medicalised responses to their health needs.
- 6.33 Significant workload issues. As indicated above, the asylum seeker population is not a static one. G4S regularly moves out resident asylum seekers and moves in new arrivals to the city (see figure 3 which shows movement on a monthly basis in 2014). Generally areas with higher list

²⁶ Doctors of the World, Registration Refused: A study on access to GP registration in England, 2015

turnover have a higher workload, and patients in the first year of registration tend to have more consultations than other patients with similar characteristics.

- 6.34 The impact of list turnover has been analysed in support of the Carr-Hill resource allocation formula using the General Practice Research Database, which contains data on patient registration. The results of this analysis indicate that the average time in 'consultation' is some 40 to 50 per cent higher for patients in their first year of registration in the practice compared with other patients. The rate varies across age and sex bands, with young males having the strongest additional effect²⁷. It is likely that consultation times for new asylum seekers and the complexity they present may mean that the consultation time is significantly higher. For example ASSIST offers 15 minute appointments, and if an interpreter is used a 30 minute appointment. It is reported that clinics run 45 minutes late, adding an average of 5 minutes to patient consultations.
- 6.35 As expected there is a higher than average turnover of patients registered with ASSIST. This reflects the rationale of moving people to mainstream care and churn in the wider asylum seeker population. The average time which a person is registered with ASSIST is 2.7 years.
- 6.34 The basis for handover to mainstream primary care by the current caretaker provider is clinical judgement and therapeutic relationship. In some cases the development of a therapeutic relationship is hard fought and Inclusion may not hand over such cases to mainstream primary care until the person has some sense of stability.

7 Wider support for asylum seekers

- 7.2 Wider support is funded by the local authority (legal advice, children's social services) or central government (COMPASS) with some specific projects financed by the Big Lottery Fund or similar organisations as well as by voluntary groups drawing on their own funds.
- 7.3 These have either a generic approach to supporting the daily needs of asylum seekers or a specific remit, such as caring for vulnerable young people and asylum seekers with protected characteristics.

Young People

- 7.4 Support for young people focuses on accessing education, legal advice and family tracking. Following social service assessment young people are placed either in foster care or hostel accommodation. They are registered in schools. Unaccompanied young asylum seekers are supported by the Refugee Council Children's Panel Advice Service, the Red Cross family tracking service and

²⁷ Carr-Hill resource allocation formula

<http://www.nhsemployers.org/~media/Employers/Documents/Primary%20care%20contracts/QOF/QOF%20004/Annex%20D%20-%20Carr-Hill%20resource%20allocation%20formula.pdf>

the After 18 project. Eligible unaccompanied young asylum seekers are entitled to financial assistance. Travel cards or warrants are issued to young unaccompanied asylum seekers to enable them to keep Home Office appointments.

Legal Advice

- 7.5 Asylum seekers are eligible for legal aid to assist their application. To do this they are recommended to use a regulated immigration adviser, which can be found through the Gov.UK website, national helpline or by contact with asylum seeker support groups. Regulated advisers in Leicester are Leicestershire Citizens Advice Bureau, Highfields Centre and Community Logg Sewa. There is a Leicester based Immigration Advisory Service, which advises on immigration issues.

Protected characteristics

- 7.6 Voluntary and community sector groups which support asylum seekers with assistance based on protected characteristics include the Race Equality Centre (TREC) and the LGBT Centre.

Social Support

- 7.7 Wider support helps asylum seekers with their daily needs (food, and furniture), new skills, legal support, employment and language are provided by organisations such as the Red Cross, City of Sanctuary, the Welcome Project and the Open Hands Trust.

Language support

- 7.8 Language and communication is a common problem. Theoretically, asylum seekers can access courses for English for Speakers of Other Languages (ESOL) after they have been in the UK for 6 months. However, these classes are not free and are considered to be unaffordable. ESOL provision at Leicester College has been affected by Skills Funding Agency reductions and Job Centre ESOL+ classes are no longer provided. Many asylum seekers rely on community ESOL classes provided through voluntary and community sector organisations such as City of Sanctuary.

8 Consultation

- 8.1 ASSIST service users, GPs at Health Needs neighbourhoods and organisations which provide wider support were consulted for views on ASSIST and asylum seeker health care. See Appendices for full details.²⁸

Access

- 8.2 Transport costs means that many service users walk between 1 and 5 miles for ASSIST appointments. However most were prepared to do this because they were satisfied with the service and liked the central location. Phone contact is the best way to book appointments but is a problem because of cost and language. Patients preferred pre-booked times, though they suggested there could be a drop-in clinic with translators.

²⁸ See Appendix C for list of attendees, D for User Consultation, F for other service stakeholders, G for GPHNN.

Specialist approach

- 8.3 Wider stakeholders perceive that mainstream general practices are not geared up to meet asylum seeker needs. ASSIST has knowledge of relevant paperwork, housing, education, destitution, and the difference between migrants. An ASSIST GP has knowledge about asylum seeker health which is constantly in use. It is possible that some asylum seekers would never disclose their background in mainstream general practice and that practices may not have the resources to match additional needs of asylum seekers, including translation and knowledge of the application process.
- 8.4 The words ‘complex’ and ‘time-consuming’ were frequently encountered. In all city HNN meetings and communications, GPs felt they had the expertise to meet the needs of asylum seekers, but that they do not have the capacity in terms of time to assess complex histories, health needs and translation resources. Some felt that the necessary expertise is impossible to maintain in general practice. Keeping up to date and training in asylum seeker health care is difficult to justify because most GPs will not use skills on a daily basis. The specialist approach enables better contact with different relevant agencies and is a way of keeping up with a shifting scene.
- 8.5 Issues of complex care would be easier to manage with better access to specialist support. However there are reported inadequacies in services, such as IAPT, in terms of timeliness of access and sometimes expertise. GPs have the right skill set and would be willing to assimilate asylum seekers if they had the time and money. Some agreed, with further caveats, such as appropriate secondary care support to deal with the complex health care problems, and fast track IAPT referral and response. These might have to be commissioned, although it was felt that ASSIST had strengths in post-traumatic care.

Advocacy

- 8.6 There is high regard for the level of competence in advocacy skills at ASSIST among wider stakeholders, service users and other GPs.
- 8.7 Service users said ASSIST supported them in response to non-health related issues like housing, Home Office paperwork and dealing with the trauma from losing family members. One said “ASSIST wrote me a report about my homelessness which helped me. Without this I would have struggled”
- 8.8 Support groups felt ASSIST expertise helps people who have experienced rape, torture and other trauma. They suggested that it takes courage to ask questions about torture and rape or to ask about FGM. The asylum seekers may not be believed or given the appropriate support. The experience of a GP in north-west HNN suggested that asylum seekers are frequent attenders in general practice; some had experienced bombing, torture and abuse. Sometimes the consultations took 30 – 40 minutes, but the rate of high practice attendance is for a limited time. Overall it was recognised that

asylum seekers require more time and pose challenges to mainstream practices. They require longer appointments, a multi-language perspective and staff with clinical experience.

- 8.9 There were mixed responses to GP awareness of services for asylum seekers; not all were able to say they are aware of the arrangements. One GP with experience of looking after asylum seekers also recognised the demands of advocacy and letter writing. There were different views about the length of time it took for asylum seekers to settle. These ranged from 2-4 weeks through to 'far longer.'
- 8.10 One GP said his practice found problems with trust, where asylum seekers are not open, and that it takes a few consultations properly to understand needs. Additional issues include poor documentation and limited communication, with language being a particular challenge. At least one GP observed that residents sometimes preferred local services rather than specialist service and that they would be likely to complain if they had to go out of their area for primary care.

Registration

- 8.11 There is possibly some confusion regarding registration of asylum seekers, including the difference between an asylum seeker and a refugee. Some GPs thought that they could not register a patient unless they had documentary proof of residence, some combination of national requirements regarding anti-terror legislation, and proof that the prospective patient is resident within the practice catchment area.
- 8.12 Many GPs were aware of the health care arrangements for asylum seekers in Leicester. Not all, however, had a protocol of advice that they could give to those seeking help who they were unable to register. The CCG representative at one meeting clarified that practices can't refuse to register asylum seekers who are resident in their catchment area, even though there is a specialist practice to meet their needs.

Mainstream practice experience

- 8.13 There were a range of views on whether or not services for asylum seekers should be provided by mainstream rather than a specialist primary care services. Areas that need further consideration are guidelines on the period of time for the specialist service users to make the transition to mainstream practices, and the process by which this would happen.
- 8.14 In one HNN there appeared to be an appetite for registering asylum seekers in mainstream general practice. Some GPs felt they were doing this anyway, though it has been impossible to gauge the scale of such registrations. In another HNN all practitioners believed that they had the skills to deliver the appropriate care. The chair of one HNN said that practices could register asylum seekers with strong support with mental health issues.

- 8.15 Others had doubts. One GP said that asylum seeker needs will get lost in normal primary care, where access to services may be difficult. Integrating asylum seekers in mainstream primary care will be complicated. They may not know how to use the service. It will be a backward step. A different HNN responded that specialist practice gives flexibility to meet asylum seeker needs as they are dispersed. There was a feeling that some mainstream practices would not want to put in the effort. Some concerns were practical, such as concerns over the technical aspects of seeking asylum. The chair of central HNN indicated that the amount to be paid per patient may, should there be a change in the way the service is delivered, may not be the current rate.
- 8.16 One GP in the north east HNN observed that if the specialist APMS practice did not exist there was no guarantee that funding would go to mainstream general practice at the same rate. Once budgets are broken down they may no longer be protected.
- 8.17 Not every asylum seeker makes the same demands upon practices. One gave the example of an asylum seeker who was relatively healthy and ready to work who was different to one who had health problems resulting from traumatic experiences, and is not so settled. Health care problems are different for each individual. There is a need for clinical judgement. When looked at only in terms of value for money one could argue in this case that the higher cost per patient is relevant and could be applied to the latter but not necessarily to the former.

9 Asylum Seeker healthcare in comparator areas

- 9.1 Ten of Leicester's 13 comparator CCGs were contacted to identify the main approaches taken in responding to the health care needs of asylum seekers. The main findings are presented below, with further details in Appendix 1.

Table 4: Approach to commissioning services for asylum seekers in ten Leicester comparator CCGs.

	Rate of Section 95 per 1,000 population (Leicester= 2.72)	Mainstream GMS /PMS only	Enhanced service	APMS for asylum seekers	APMS for vulnerable groups (including asylum seekers)	Works with local gateway advocacy and support for asylum seekers	Funds local gateway advocacy and support for asylum seekers	Reviewing/reconsidering approach to provision
nk=not known								
Oldham	2.98	no	no	no	yes	nk	no	Nk
Derby	2.84	yes	no	no	no	nk	no	Yes
Nottingham	2.77	no	yes	no	no	yes	no	No
Blackburn with Darwen	2.28	yes	no	no	no	no	no	Yes
Manchester	2.12	yes	no	no	no	no	yes	Yes
Coventry	1.63	no	no	yes	no	no	no	Yes
Birmingham	1.61	yes	no	no	no	yes	yes	Yes
Bradford	1.33	no	no	no	yes	yes	nk	No
Hillingdon	0.51	yes	no	no	no	yes	no	No
Ealing	0.39	yes	no	no	no	nk	no	No

- 9.1.1 Overall these findings indicate that there is no settled or established model for the delivery of primary health care services to asylum seekers and CCGs vary in both their 'core' and 'gateway' services.²⁹

Core services

(provide full registration and may be provided by dedicated practices or by mainstream practices, with or without additional support)

- 9.1.2 Six out of the ten CCGs base their core provision on mainstream PMS and GMS practices registering and providing primary care services to asylum seekers.
- 9.1.3 One of the ten CCGs has commissioned an enhanced service from primary care.
- 9.1.4 One CCG has commissioned a specialist service specifically for asylum seekers under APMS.
- 9.1.5 Two CCGs have commissioned a specialist service for a wider patient group of vulnerable people, including asylum seekers, under APMS.

²⁹ Peter J Aspinall, 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, Inclusion Health, 2014, p30.

Gateway services

(Gateway services facilitate entry into primary care by identifying unregistered patients and carrying out health assessments.)

- 9.1.6 Four CCGs are working with local advocacy and support groups for asylum seeker to facilitate access to primary care by identifying unregistered patients.
- 9.1.7 Two CCGs are funding local advocacy and support for asylum seekers.
- 9.1.8 APMS specialist services are more likely to be connected to networks that seek to register asylum seekers and other migrants for primary care services.
- 9.1.9 Across all comparators there is the presence of non-funded (at least by the health system), voluntary and charitable sector care and advocacy organisations and groups which also act to provide a gateway to registration for asylum seekers.
- 9.2 A number of comparator CCGs mentioned the relevance of TB new entrant screening, Urgent Care Centres, nurse-led clinics to asylum seeker registration.

Ancillary services

(services that supplement and support core services' ability to meet the additional health needs of this group)

- 9.3 One CCG particularly mentioned that they commissioned interpreting / translation services to support GP work with asylum seekers – this was not part of an enhanced service.

10 Evidence of what works

Health care intervention models

- 10.1 Evidence of effectiveness was sought through a search for systematic reviews and appraisals using asylum seekers, vulnerable migrants, health care, primary health care, models of delivery on PubMed, general Google searches and grey literature.
- 10.2 The Faculty of Public Health, summarising Feldman and others, identified a range of promising and possibly effective interventions for asylum seekers (see footnote)³⁰. However systematic evaluation of these approaches has

³⁰The health needs of asylum seekers: Briefing statement (undated) http://www.fph.org.uk/uploads/bs_asylum_seeker_health.pdf
The briefing identifies a range of "innovative and pragmatic approaches" to providing primary care including:

- specialist centres for asylum seekers, such as specifically designated GP practices;
- salaried GPs within a practice working only with asylum seekers;
- specific projects to help asylum seekers register with a GP;
- adapting the incentive scheme for GPs (Quality & Outcomes Framework) to include the healthcare needs of asylum seekers, enabling good quality service delivery and ensuring appropriate remittance to GP practices;
- health support teams to ease the burdens on GPs. (The initial assessment of the health needs of asylum seekers by specialist practices can make it easier for 'ordinary' practices to register patients subsequently).

More specialist interventions include:

- 'one-stop shops' for recent asylum seeker arrivals at initial accommodation centres which serve to co-ordinate a multidisciplinary / multiagency approach to asylum seekers' care;

been low. Feldman herself concluded that “a lack of published evaluations and reports about interventions for refugees and asylum seekers constrains further policy development that could build on the strength of interventions.”³¹

- 10.3 Some impetus has been given to evaluation through the establishment of the National Inclusion Health Board set up at the time of the NHS Future Forum which was associated with the Lansley reforms of the NHS. This focused on action to improve the health of the most vulnerable (meaning homeless, vulnerable migrants, Gypsies and Travellers and sex workers). Though there is better evidence of service models for homeless people, and there is some read across, a 2014 review of the available evidence suggested that there is insufficient high quality evidence to draw conclusions as to what works for asylum seeker services³². This review, for example, identified one evaluation at the assessor’s ‘Grade 2’ which incorporates some assessment of process and user assessed final outcomes but no cost data, and eight at ‘Grade 4’, which are general descriptive accounts of interventions.
- 10.4 Published lists of interventions can stimulate, though ultimately the choice of interventions comes down to the discussions and considerations of local commissioners and practitioners, partners and stakeholders. This underscores the importance of having a clear purpose, principles and quality standards behind what is commissioned, and a commitment to evaluate against these the services commissioned.

Quality and clinical standards

- 10.5 While there may have been little or no hard-edged evaluation of models of organising delivery of health care there has been a focus on evidenced based assessments of the key features of the clinical approach to providing effective care appropriate to the needs of vulnerable groups, including migrants. One message that shines through the assessments which have been made has been that quality and clinical quality is of the utmost importance and there appears to be a consensus that high quality treatment for asylum seekers is essential and that, in approach, the foundation of this is the relationship between a service user and a care giver.
- 10.6 Working under the general rubric of the Inclusion Health Board, the Faculty of Inclusion Health, with the College of Medicine, has issued Standards for

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- specific genitourinary medicine sessions for asylum seekers for dealing with the issues of sexual violence, female genital mutilation and HIV/AIDS;
 - culturally appropriate interventions for HIV/AIDS;
 - training of healthcare professionals in managing the health needs of asylum seekers;
 - specialist health workers, mental health services and services for survivors of torture;
 - special school-based mental health projects for children who are emotionally vulnerable;
 - community advocacy projects led by refugee community organisations;
 - specific support projects for young, separated refugees and asylum seekers;
 - specific surveillance schemes whereby regular notifications of new asylum seeker arrivals are sent to the relevant primary care organisation from the regional Home Offices;
 - specific contracts for interpretation services;
 - early, proactive, positive media strategies.

³¹ 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 809-16

³² Aspinall, P *ibid*

commissioners and service providers (2013) which details a set of clear minimum standards for planning, commissioning and providing health care for a number of vulnerable groups (as defined by the National Inclusion Health Board, see above section 10.3), and in different specialities and situations. This is a consensus statement of clinical standards which draws on the clinical experience of health care practitioners actively involved with the provision of effective health care to such groups. This guidance does not apply only to commissioners and primary care. The guidance covers specific standards for 18 health care settings including psychiatric services, dentistry, podiatry, secondary care, physiotherapy services, palliative care and medical respite care.

Learning needs of health professionals

10.7 A separate review of evidence relating to the training and learning needs of health professionals³³ for work with vulnerable groups (undertaken again for the National Inclusion Health Board) found that:

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

10.8 The review identified from the literature a number of areas for inclusion in the curricula for initial and continuing training:

- Staff attitudes to the socially excluded
- Current legislation
- Domains of exclusion
- Non-judgemental and flexible approach to care
- Cultural awareness
- Trust between service user and healthcare professionals
- Substance misuse and mental health.

³³ Inclusion Health: Education and Training for Health Professionals https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/490851/NIHB_-_Inclusion_Health_education_Executive_Summary_accs.pdf and Inclusion Health: Education and Training for Health Professionals END of STUDY REPORT https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/490870/NIHB_-_Inclusion_Health_education_Report.pdf

Specialist and mainstream primary care

10.9 As noted above, there is no settled approach to service delivery models by comparator CCGs, and the extent of formal systematic evaluation is slight. This has led to a locally determined pragmatic approach to service delivery. There are however two basic models of delivery of 'core' primary care services: the *mainstream model with or without supplementary provision* and the *specialist model*. Peter Aspinall, in his review of inclusive practice for the National Inclusion Health Board has compiled a useful list of the advantages and disadvantages of both these approaches, much of which have been reflected in the comments and observations of local stakeholders. This list is provided in figure 6.

Figure 6 : Advantages and disadvantages of the specialist vs. mainstream model

The mainstream model with or without supplementary provision

Advantages

- All practices gain experience from having asylum seekers and refugees as their patients
- When registered with mainstream practices, the impact of fluctuations in the size of the migrant population is spread
- If the migrant population is widely dispersed geographically or small in numbers, mainstream practices may be a more cost-effective option
- Feasibility can be added to the mainstream service model by having dedicated additional services outside scheduled clinical sessions, run jointly with other practices if needed and linked to refugee community organisations

Disadvantages

- Mainstream practices may not find it affordable to provide practice-based specialist services
- Staff in mainstream practices may not be as sensitive to vulnerable migrants' needs as staff in specialist practices

The specialist model

Advantages

- This service model alleviates the problem of registering asylum seekers with mainstream GP practices.
- It thereby relieves pressure on mainstream practices of large numbers of asylum seekers, refugees, and other migrants
- Avoids risk of temporary registration by mainstream practices
- Assists vulnerable persons who experience most access barriers and offers those with complex needs more services
- Staff have specialist interest and knowledge of issues that are particular to asylum seekers and refugees
- Such practices typically offer holistic multi-disciplinary service and are adequately resourced in terms of appointment times;
- They are able to conduct thorough initial assessments & have good interpreting arrangements
- Staff have knowledge/interest/empathy for vulnerable migrants. Greater knowledge of other services to which migrant patients can be referred, and offer better continuity of care

Disadvantages

- Practices may be penalised in QOF (Quality & Outcomes Framework) remuneration because they cannot meet the standard targets, though some (former) PCTs have developed specific QOFs.
- Some specialist practices provide time-limited services, requiring the eventual passing on of patients to mainstream services.
- Another concern is that separate services may marginalise refugees.
- Mainstream practices do not gain knowledge about migrant populations which may sustain prejudice.
- There has also been debate over whether specialist practices that serve vulnerable population groups simultaneously (e.g. asylum seekers and homeless people) cater to the needs of either group adequately.

11 Conclusions

Asylum Seekers

- 11.1 The presence of Asylum Seekers has been a feature of the UK and of Leicester since at least the mid 1980's (see figure 2). The best estimate at the moment is that the number of asylum seekers will increase until they meet the Home Office formula of one asylum seeker for every 200 people, or about 1,650 people, about 600 more than presently accommodated in Leicester, an increase of 57%.

Health need

- 11.2 The health needs of Asylum Seekers are not homogeneous but they are substantial, as described in section 6 above. The analysis of practice data (appendix B) shows a young, mainly male, population with a disease profile reflecting this, with indicators of social distress in psychological and neurological disease profiles.

Data gaps

- 11.3 Understanding the total primary health care response to the needs of asylum seekers in Leicester has been impeded by the lack of data and information from mainstream primary care. The only adequate data source comes from ASSIST.

Change in asylum seeker residence in the city

- 11.4 When the specialist primary care model was originally commissioned asylum seekers were accommodated in one central location, and the specialist service was established nearby in Clyde Street, where the service is still located. Today, however, asylum seekers new to the city are placed in accommodation across Leicester (see section 2 and figure 1). This means that in line with choice requirements they could potentially register with any local general practice and some do, though the extent of this is unknown due to the apparent low level of recording of asylum seekers or refugee status. We have not got the impression from GPs in HNN's that we are talking here about many hundreds of asylum seekers registered and, unfortunately, we have received too few and inconclusive responses to our enquiries of practice managers to come to any view about this (see appendix E). ASSIST does register between 1400 and 1500 patients, a portion of whom would be refugees. Forty-four percent of service users consulted liked the practice at Clyde Street and would like to access primary health care from that location, or a similar city centre venue (see section 8). A large proportion of service users said they walked to appointments, anywhere from 1 to 5 miles, because they lacked funds for buses or other transport.

Complexity of need and capacity and capability of primary care

- 11.5 All consulted in the course of this needs assessment agree that the needs of many asylum seekers are complex and demanding compared with mainstream patients, most of whom, though not without complexity, are likely to speak at least basic English, have a shared understanding of health care and the system, and be far less likely to be distressed by their experiences and by having to deal with a bureaucracy which is new to them. Some GPs believe they have the capability and experience to care for asylum seekers. However, other GPs believe that they do not have the capacity, particularly time, and the cultural awareness, communication skills, timely access to specialist services, advocacy skills and insight into the asylum process.
- 11.6 The picture of additionality through having a specialist service which has emerged has been in leadership, relationships, responsiveness, a focus on clinical quality, engagement with network of wider services and groups, in the interest of the best care for asylum seekers.
- 11.7 The stakeholder consultation with organisations which provide wider support did not feel confident that all mainstream primary care has the capacity, or necessarily the capability, to adequately address the needs of asylum seekers (see section 8). The research undertaken for the National Inclusion Health Board found that healthcare professionals often lack the awareness, knowledge and skills to support vulnerable groups, such as asylum seekers (see section 10.7).
- 11.8 While we found that six of the ten CCG comparator areas leave asylum seeker care to mainstream primary care without enhancement (see section 9), there has been no high quality research focused on the practical organisation of delivery of effective health care for asylum seekers which is culturally appropriate, nuanced and cost effective (see section 12).

High list turnover and consultation time

- 11.9 As indicated above the personnel within the asylum seeker population is subject to constant change. Generally areas with higher list turnover have a higher workload, and patients in the first year of registration tend to have more consultations than other patients with similar characteristics and it has been found that the average time in 'consultation' is some 40 to 50 per cent higher for patients in their first year of registration in a practice compared with other patients. The rate varies across age and sex bands, with young males having the strongest additional effect. It is likely that consultation times for new asylum seekers and the complexity they present may mean that the consultation time is significantly higher.

Handover to mainstream primary care

- 11.10 The purpose of ASSIST is to register and assess the health of new asylum seekers, provide appropriate care before referring, or supporting them in to, mainstream primary care. This has been only partially effective for at least

three reasons. There has never been a proper process for moving people on from ASSIST to mainstream general practice; such as a defined accepted point in time or criteria for therapeutic stability. Second, patients who are satisfied with their care are reluctant to change practices. Third, though it is not the case with the current provider of the ASSIST service, payment via capitation may incentivise providers not to move patients in to mainstream primary care.

Funding

11.11 This rapid health needs assessment has not been able to consider funding, and no local funding data has been made available to us. However, discussion at the Specialist APMS Group has suggested the basis of funding should take in to account that the purpose of ASSIST is to register and assess the health of new asylum seekers, provide appropriate care before referring, or supporting, them in to mainstream primary care, rather than the provision of long term continuing primary care, and in this recognising the increased workload in the first year of registration. Consideration of a different way of measuring activity e.g., the number of new patients seen each year or fixed price contract may also be relevant.

Registration

11.12 Some GPs were concerned that they may not be able to recommend asylum seekers resident in their area to a specialist general practice. Stakeholders were concerned that some practices did not always register asylum seekers who were resident in their areas. Many GPs were aware of the health care arrangements for asylum seekers in Leicester. Not all, however, had a protocol of advice that they could give to those seeking help who they were unable to register (for whatever reason). It appears there has been no coherent policy on registration which reconciles having both the specialist and mainstream primary care services.

Evidence for particular models of delivery

11.12 Academic evidence does not particularly help define the best model of healthcare delivery to this population. There is insufficient research regarding effective and cost effective ways of organising and delivering such care (see section 12), and what Leicester's comparators do with regard to services for asylum seekers indicates that there is no settled or established model for the delivery of primary health care services to asylum seekers (see section 10). Leicester's comparators are drawing on all three of the established models for providing health care to vulnerable groups - *mainstream* (embedded within existing primary care provision), *enhanced* (added on to existing primary care provision) and *specialist* (separate from, but ideally integrated with existing primary care provision).

11.13 The lack of research combined with the variation in delivery models means that the choice of interventions and models comes down to the pragmatic

discussions and considerations of local commissioners, practitioners, partners and stakeholders informed by what evidence there is. This underscores the importance of having a clear purpose, principles and quality standards behind what is commissioned, and a commitment to evaluate the services commissioned against these. Aspinal has provided guidance on the strengths and weaknesses of the main models of delivering health care (see section 10, figure 6).

Clinical quality

- 11.14 As we have discussed with stakeholders provision for asylum seekers, and the complexity they present, what has stood out has been the importance given to quality and clinical quality. The foundation of this is the relationship between a service user and a care giver, but it also embraces the work of wider practice staff, the links and support built up with voluntary and community services and other services (see section 8) and with specialist and secondary services upon which primary care may call. Adoption of clear clinical quality standards will help with definition of service specifications, audit and evaluation of the service approach commissioned and provide a framework to address the training needs of healthcare professionals identified in the national research referred to above (and section 10.7).
- 11.15 The Faculty of Inclusion Health, with the College of Medicine, has issued Standards for commissioners and service providers (2013) (see section 10.6). These detail a set of clear minimum standards for planning, commissioning and providing health care for a number of vulnerable groups (as defined by the National Inclusion Health Board). Such standards do not apply only to primary care. The guidance covers specific standards for 18 health care settings including psychiatric services, dentistry, podiatry, secondary care, physiotherapy services, palliative care and medical respite care.

Service scope

- 11.16 The current service is commissioned for Asylum Seekers and not for refugees. The focus on asylum seekers is, in line with the historic purpose of ASSIST, to assess and stabilise individual asylum seeker health needs, before referring them to mainstream primary care for the longer term. It is recognised that the context of this is a range of vulnerable migrants, including refugees.
- 11.17 Wider than vulnerable migrants is the issue of whether there should be a combined service with other vulnerable groups, particularly the homeless. Two of the ten Leicester comparators commission currently such wider services (though note that the services in Coventry, though commissioned by a single contract, is provided as two separate services, one for asylum seekers, the other for homeless people, working from separate buildings (see Appendix A)). The view of stakeholders consulted is that a single service for both groups would be detrimental, probably to both groups as needs and lifestyles are divergent. There is no appetite from GPs to take on the provision beyond what they do now of services for homeless (or potentially homeless)

people. As far as we are aware there has been no evaluation of such combined services.

12 Recommendations

The CCG is recommended to:

- 12.1 Adopt a strategic longer-term view of its approach to addressing the health care needs of asylum seekers and agree a clear set of aims, principles and quality standards to inform commissioning of appropriate services.** An initial set of aims and principles are set out for discussion and agreement in figure 6. This would give a more structured approach to the commissioning of services for asylum seekers and improve the data available for informing future commissioning decisions, including potential cost effectiveness

Figure 6 Initial set of aims and principles to guide primary health care provision for Asylum Seekers in Leicester – for discussion

Strategic aims:

- To register all asylum seekers new to the city with the primary health care system;
- To ensure that asylum seekers receive high quality primary health care.

Principles:

The CCG recognises the importance:

- given by the CCG and partners locally, and nationally by NHS England and other bodies, to reducing health inequalities;
- of engaging with the complexity of the health and support needs presented by asylum seekers and the need for thorough assessment, longer appointments where necessary, good interpreting arrangements, a stress on continuity of care and, where required, advocacy for patients;
- of the likely increase in the number of asylum seekers allocated to the city;
- of health care staff providing health care, or otherwise interacting with asylum seekers in its provision, to have knowledge, interest and empathy towards vulnerable migrants;
- of primary care services linking and supporting public, community and voluntary organisations active in supporting asylum seekers and refugees;
- of monitoring the access, take up and outcomes of primary health care for asylum seekers, including the quality of their experience;
- of laying out the above principles in a practical set of quality standards to inform provision of primary health care in Leicester for asylum seekers.

- 12.1 **Consider, adopt and apply a set of quality standards for the commissioning and provision of health care for asylum seekers.** Ensure that these are an essential element of contracts, specifications and contract monitoring with primary care services, and in the longer term with all health care commissioned by the CCG.
- 12.2 **Monitor access, take up and outcomes of primary health care for asylum seekers.** Clarify the use of read codes (or otherwise a robust mechanism) for identifying asylum seekers and refugees on all primary care data sets so that trends, effectiveness and appropriateness of the health care arrangements in place can be understood.
- 12.3 **Maintain a specialist primary health care service for asylum seekers.** The advantages and disadvantages of specialist and mainstream primary care delivery have been described in figure 6. This assessment has found that currently:
- most asylum seekers are registered with the specialist provider and there is a lack of clarity about the numbers of asylum seekers actually seen by mainstream primary care and of the services they receive;
 - there is concern from stakeholders, both GP's and others, that the capacity and capability of mainstream primary care to respond effectively to the health care needs and presentation of asylum seekers is by no means evenly spread across practices and that cessation of a good service would inevitably lead to a poorer service overall;
 - there is a high regard held by stakeholders, once again both GPs and others, for the current specialist service provider.
 - the infrastructure of standards, training, engagement with supporting voluntary organisations and groups, and monitoring of asylum seeker experience in mainstream primary care is not in place to allow the dispersal of asylum seekers to general practice;

The longer term view could be that there is a shift in provision towards mainstream primary care. However giving time for better monitoring of services to asylum seekers in primary care to be established and for the CCG and partners to have a clear and accurate understanding of how primary care, as a system, is working to provide asylum seekers with high quality primary health care is essential.

- 12.4 **Take into account when considering the basis of funding that the purpose of ASSIST is to register and assess the health of new asylum seekers, provide appropriate care before referring or supporting them into mainstream primary care, rather than the provision of long term continuing primary care.**
- 12.5 **Draw up a protocol describing the basis on which the specialist service can hold on to patients for longer than the period to be defined.** The current caretaker service provider considers this to be based on therapeutic need and clinical judgement. An agreed protocol would provide clarity.

- 12.6 Agree a more structured approach to the handover of patients from the specialist service to mainstream primary care.**

- 12.7 Recognise and reconcile the conflict of policy in having both a specialist service and requiring the registration by GP practices of individuals within the catchment area of a practice.**

- 12.8 Consider including the provision of training and consultation to mainstream primary care, in support of their work with asylum seekers, in the role of the specialist service.**

- 12.9 Ensure that arrangements for the provision of mental health services (IAPT) in support of asylum seekers in primary care are strengthened.**

APPENDIX A

APPENDIX A

Comparators

To ensure a systematic approach to understanding current commissioning practice, comparator areas to Leicester have been identified by combining the list of Local Authority ONS peer comparators and the RightCare CCGs most similar to Leicester City CCG. The associations are shown in table 3, below, which provides information on the numbers of asylum seekers supported under Section 95 present in each comparator at the end of quarter 4 (December 2015), the resident population and the rate of asylum seekers per 1,000 population. The right-hand column, headed the “number in dispersed accommodation”, shows that all but one of the comparators is, like Leicester, a dispersal area. Please note Derby has been added to the list of Leicester comparators on the basis that it is the third East Midland city (see figure 4) with a similar rate of asylum seekers in receipt of section 95 support to Leicester (2.84 v 2.72 per 1,000 population) and is also a dispersal area.

Table 3: Asylum seekers in receipt of Section 95 support, by Leicester peers as at end of quarter 4, 2015

Peer	resident population	total supported under Section 95	rate of supported under Section 95 per 1,000 population	number in dispersed accommodation
Oldham	228,765	682	2.98	645
Derby	252,500	718	2.84	705
Nottingham	314,268	870	2.77	837
Leicester	337,653	918	2.72	875
Blackburn with Darwen	146,743	334	2.28	323
Manchester	520,215	1,103	2.12	954
Coventry	337,428	551	1.63	511
Birmingham	1,101,360	1,775	1.61	1,674
Bradford	528,155	700	1.33	687
Hillingdon	292,690	149	0.51	75
Ealing	342,118	135	0.39	25
Luton	210,962	75	0.36	39

Hounslow	265,568	82	0.31	18
Reading	160,825	10	0.06	0

CCG associated peer	Both CCG and LA
LA associated peer	Additional comparator
Comparators not included in telephone interviews (see text)	

Source Immigration Statistics, Asylum tables, 25 February 2016³⁴, ONS mid-year estimates 2014

- a. Information has been collected via telephone interviews with CCG commissioners in the relevant CCG's over a six week period. For reasons of capacity and relevance CCGs with a total of less than 100 individuals supported under section 95 were not contacted, and thus Luton, Hounslow and Reading were not included.
- b. The aim of the interviews was to identify the main approaches that comparator CCGs have taken in responding to the health care needs of asylum seekers and focused on what is termed 'Gateway' and 'Core' services and less so on 'ancillary' services.
- c. *Gateway services* facilitate entry into primary care by identifying unregistered patients and carrying out health assessments. *Core services* provide full registration and may be provided by dedicated practices or by mainstream practices, with or without additional support. *Ancillary services* are those that supplement and support core services' ability to meet the additional health needs of this group³⁵.

³⁴ Immigration Statistics, Asylum tables - as_14 to as_19 25 February 2016. See also House of Commons, Home Affairs Committee, The work of the Immigration Directorates (Q3 2015) Sixth Report of Session 2015–16. <http://www.publications.parliament.uk/pa/cm201516/cmselect/cmhaff/772/772.pdf>

³⁵ This summary is drawn from Peter J Aspinall, 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, Inclusion Health, 2014, p30.

Summary table of responses from comparator CCGs

nk=not known	Rate of Section 95 per 1,000 population (Leicester= 2.72)	Mainstream GMS only	Enhanced service	APMS for asylum seekers	APMS for vulnerable groups (including asylum seekers)	Works with local gateway advocacy and support for asylum seekers	Funds local gateway advocacy and support for asylum seekers	Reviewing/reconsidering approach	Service model summary	Cost (where known)
Oldham	2.98	no	no	no	yes	nk	no	nk	<p>Open access APMS practice based in the centre of Oldham, the most deprived area in the city, will register people from any vulnerable group.</p> <p>GP practices also register asylum seekers as per regulations. There is no enhanced service. Commissioner is aware of pressure on primary care and the need to increase IAPT access and uptake. For GPs there is a familiar background of deprived white British population in Oldham and a diversifying BME population is posing challenges e.g., languages., culture etc.</p> <p>Separately from the Asylum Seekers allocated to Oldham by the Border Agency the area is part of the UN/DH Gateway Programme for Syrian refugees. The CCG receives outline health information about the refugee, which includes an anonymised summary assessment of likely secondary care costs. The CCG receives £600 per refugee for the first year only and gives £400 to the practice and retains £200 to offset secondary care costs. Refugee Action (a national voluntary organisation with a local/regional focus) is involved in provision of support to the refugees. There is a separate agreement with the practices who receive allocated refugees.</p>	

Derby	2.84	yes	no	no	no	nk	no	yes	Mainstream primary care services (GMS) available to asylum seekers. Derby City and Southern Derbyshire CCGs have recently set up a small group to consider the issues and possible provision for <i>migrant health</i> (not only asylum seekers). The LMC are involved in the group. The stimulus for this has been the request to the county council to take 50 Syrian refugees. The City Council Public Health Team and LMC is involved in this group. The City Council and CCG have recently put on a migrant health awareness session, but received poor support from primary care.	
Nottingham	2.77	no	yes	no	no	yes	no	no	<p>Asylum Seekers enhanced service has been long established. It is taken up by most practices but a minority actively see patients These tend to be practices in the areas of the city to which asylum seekers gravitate and/or there is a particular commitment by a GP or practice. Out of 40 practices currently 13 are active. Because of the relative rarity of practices seeing asylum seekers the CCG has run (with Into the Mainstream – see below) awareness training sessions for practice staff. Under the enhanced service practices receive £200 per registration including initial health assessment. Around 125 claims have been made in 15/16, thus the cost of £25k per annum.</p> <p>The CCG works with, but does not fund (though they have recently been asked to contribute) a local charity called Into the mainstream (ITM) - previously the local refugee council. ITM provides a contact point and navigation to primary health care (and may do more). The CCG has worked with ITM to inform them about the primary health care system: (1) through providing a route map showing the various ways to registration with a practice and (2) through the development of a template form which makes it easier for practices to register asylum seekers when they initially come to the practice. The CCG observes that there is a difference between the number of asylum seekers ITM are referring / signposting/ supporting into primary care registration, and the number that practices report and claim for under the enhanced service arrangement. ITM is significantly funded by the local authority currently.</p>	£25k
Blackburn with Darwen	2.28	yes	no	no	no	no	no	yes	No enhanced service in 2016/17 and no specialist primary care provision. There is a Health Outreach Team funded currently by the local authority (but currently under review) which facilitates access to primary care (among other things).	

									There are also voluntary sector/civil society groups advocating for and supporting through signposting etc to primary care. The CCG is implementing latent TB screening which they view as relevant to this group. Blackburn with Darwen has a rate of asylum seekers comparable with Leicester but a smaller resident population and smaller number of asylum seekers in receipt of Section 95 support.	
Manchester	2.12	yes	no	no	no	no	yes	yes	<p>There are no primary care services for asylum seekers except mainstream PMS/GMS services, commissioned by the three CCGs that make up Greater Manchester. NHS England, Greater Manchester and Lancashire has drawn this to the attention of the CCGs. Some work is now underway to define what is needed both in terms of responding to asylum seeker health needs and also to understanding and relating to advocacy and support groups already part of the Manchester scene.</p> <p>NHS England, Greater Manchester and Lancashire has funded a project, started earlier in 2016, to develop support for asylum seekers based on co-production. Plans include: developing a directory of services to assist both healthcare professionals and asylum seekers in navigating the healthcare system; improving knowledge and raising awareness of the healthcare system in the UK, by providing timely access to clear information and support for those in need; and using the project to improve policy and practice both within Manchester and nationally.</p>	
Coventry	1.63	no	no	yes	no	no	no	yes	APMS service commissioned five years ago and taken on by NHS England. Known as the Meridian Practice it has around 1,000 contacts per month (12,000 contacts per annum). The current list (April 2016) is 2,268 registered patients. The commissioner felt that they would not re-commission this service in the same way as previously, which has been marked by complex KPIs and focussed on activity rather than outcomes. There is a separate service for homeless patients (£166k p.a). Both services form a single contract with the provider.	£670k

Birmingham	1.61	yes	no	no	no	yes	yes	yes	<p>This summary focusses on the arrangements for asylum seekers dispersed to Birmingham³⁶. NHS Sandwell and West Birmingham CCG takes the view that asylum seekers should be able to use ordinary mainstream GP services. Previously the CCG had a hub and spoke specialist service (GPSI) which was established when there were high numbers of asylum seekers (some 8 or 9 years ago). As numbers declined, the CCG moved to a position of supporting registration with GPs. Awareness of asylum seekers having little money made it difficult to justify them having to travel distances across Birmingham to get a service.</p> <p>There is no enhanced service but the CCG funds interpretation and translation for asylum seekers and an enhanced health check for asylum seekers as part of the new patient health check. The CCG Has invested in training for GPs and mental health pathways are in place for primary care. The CCG commissions the voluntary sector to support registration and to provide support to GP practices that need it and to promote a health and care literacy among asylum seekers. Over a number of years the CCG has promoted training, which for GPs has been co-designed by health care providers and the voluntary sector – working through cases and simulations. Training for practice managers has focussed on rights and entitlements to do with choice and registration. Further training is planned.</p>
Bradford	1.33	no	no	no	yes	yes	nk	no	<p>Primary care services for all hard to reach groups are commissioned under an APMS contract from a single provider, Bevan Healthcare, a Social Enterprise (with an 'outstanding' CQC assessment) which provides responsive NHS general practice services designed to meet the needs of: people who are homeless or in unstable accommodation; those who have come to Bradford as refugees or to seek asylum; and others who find it hard to access health care. GPs also register patients from such groups. The provider engages with community and advocacy groups as part of its mission.</p>
Hillingdon	0.51	yes	no	no	no	yes	no	no	<p>Mainstream primary care. No enhanced Services or APMS specialist services are in place. Borough very close to Harmonsworth (London Airport) where NHS</p>

³⁶ As Birmingham is a national dispersal centre, NHS Sandwell and West Birmingham CCG also commission, on behalf of the Home Office, the health screening service for newly arrived asylum seekers who are awaiting allocation to a dispersal area.

									England has a specialist service for asylum seekers and refugees. Has contact with voluntary groups etc. through LA public health which signposts the availability of primary care services from GPs. Does not fund signposting or support for asylum seekers or homeless. There is some interest at the pan-London level in health care services for asylum seekers.	
Ealing	0.39	yes	no	no	no	nk	no	no	Mainstream GMS provision. Ealing CCG augments provision for asylum seekers and others by commission a gateway nurse led clinic for a drop in - provides minor care and vaccinations for those not entitled to healthcare etc. and encourages registration. GPs also register asylum seeker patients. The Borough has an urgent care centre and one of its objectives is to help people who are not registered to become registered.	

The telephone interviews were conducted between 14 April and 24 May 2016.

Specialist APMS Group Leicester City CCG

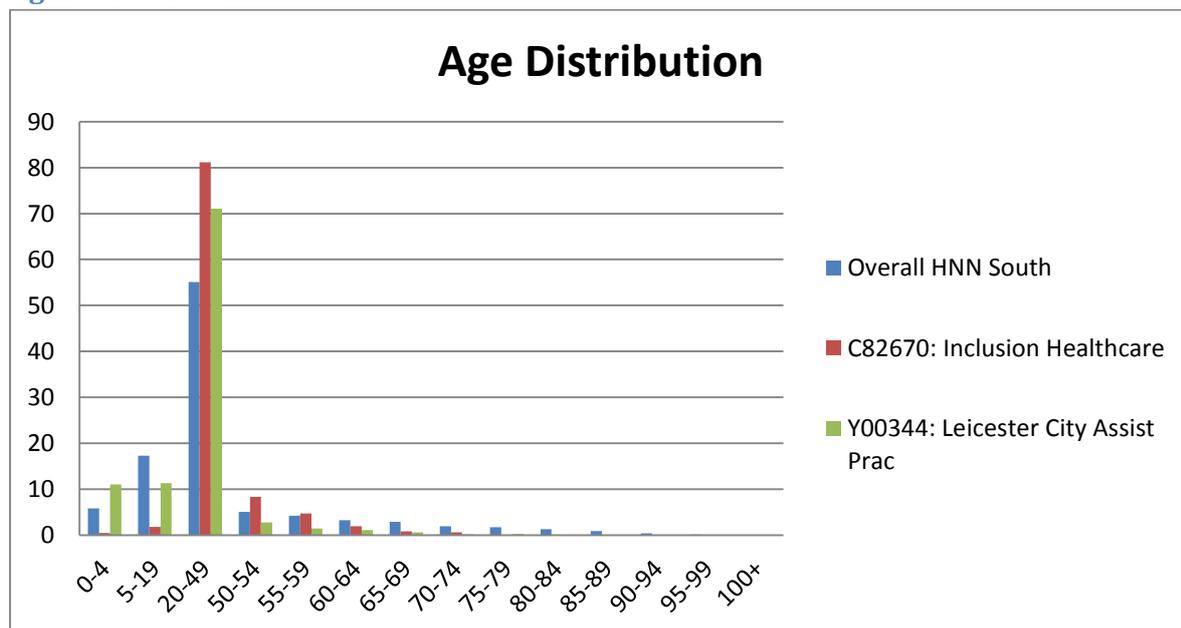
Needs assessment for current population and health needs of Homeless and Asylum Services

Method: data was taken from Gemima 26/4/16 for HNN South which serves as the comparison group for this analysis.

Registered population

Practice	List
C82670: Inclusion Healthcare	1352
Y00344: Leicester City Assist Prac	1493

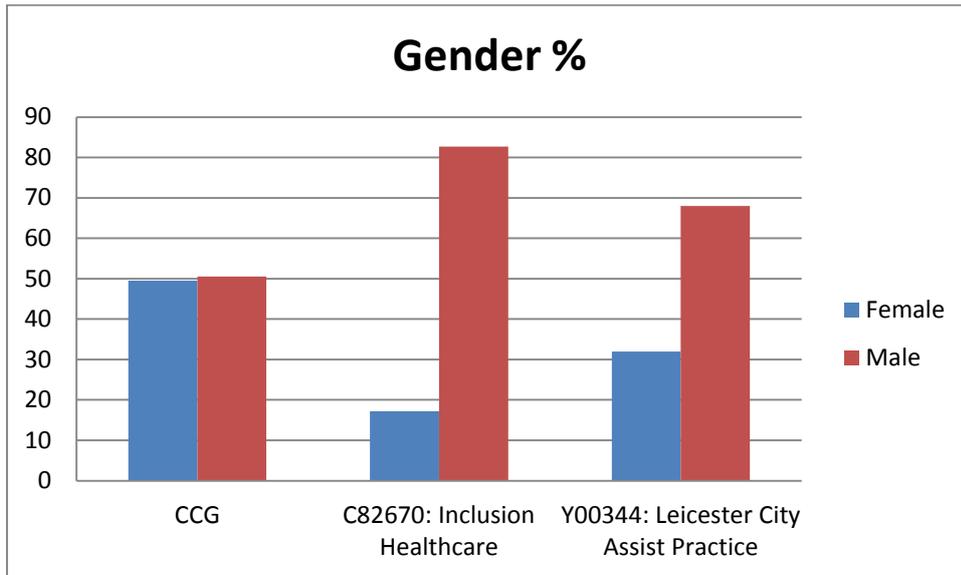
Age breakdown



Assist has a very young population 93% being under 50 (78% for HNN South)

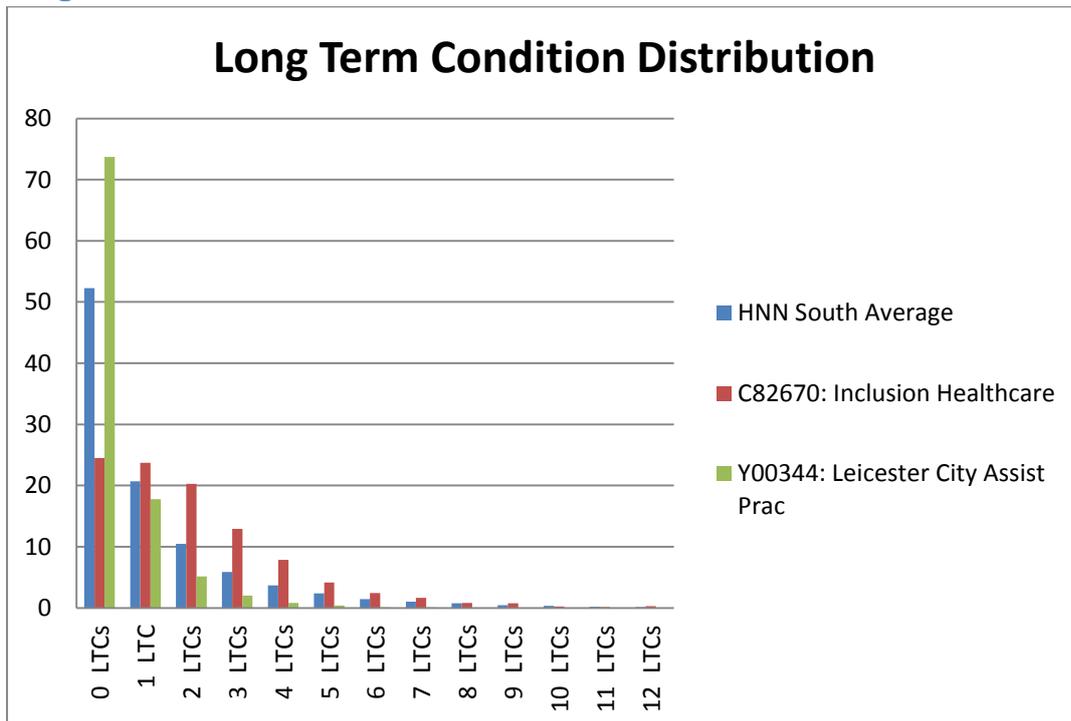
Inclusion too has a young population but heavily concentrated in the 20-59 age group (94% of its population in this age range compared with 64% for HNN South)

Gender



Both practices have a predominantly male population

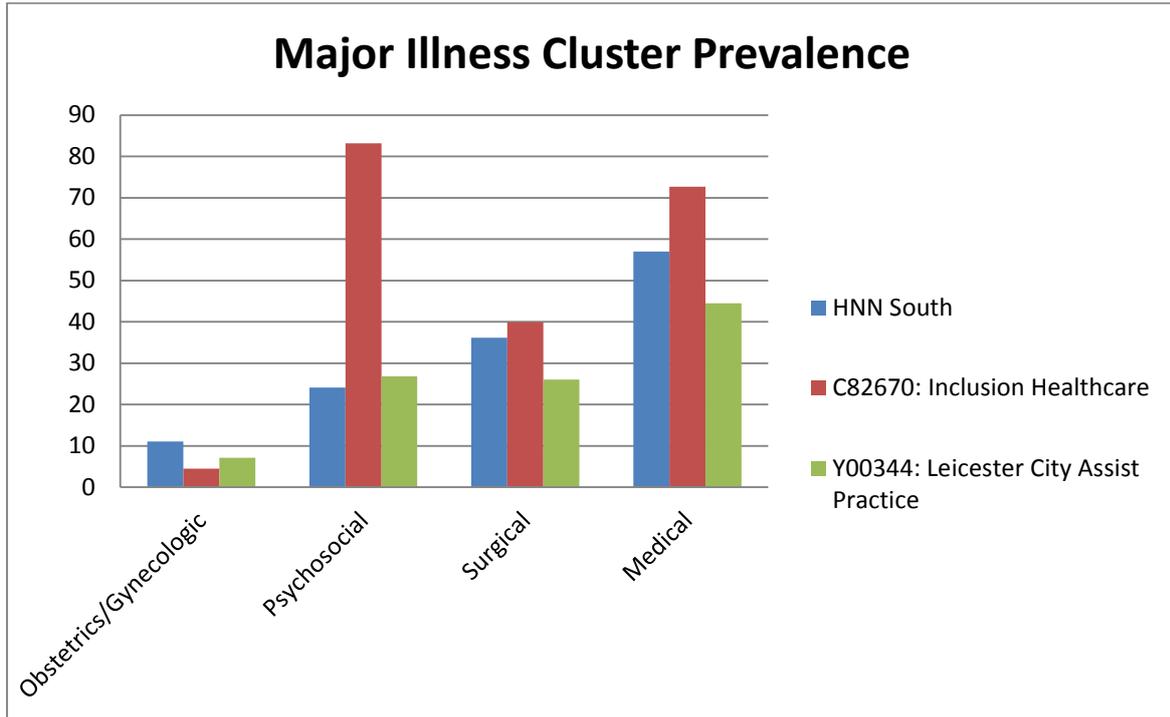
Long Term Conditions



As expected for a younger population Assist has a higher proportion of patients with no identified Long Term Conditions than HNN South and a lower proportion with multiple long term co-morbidity.

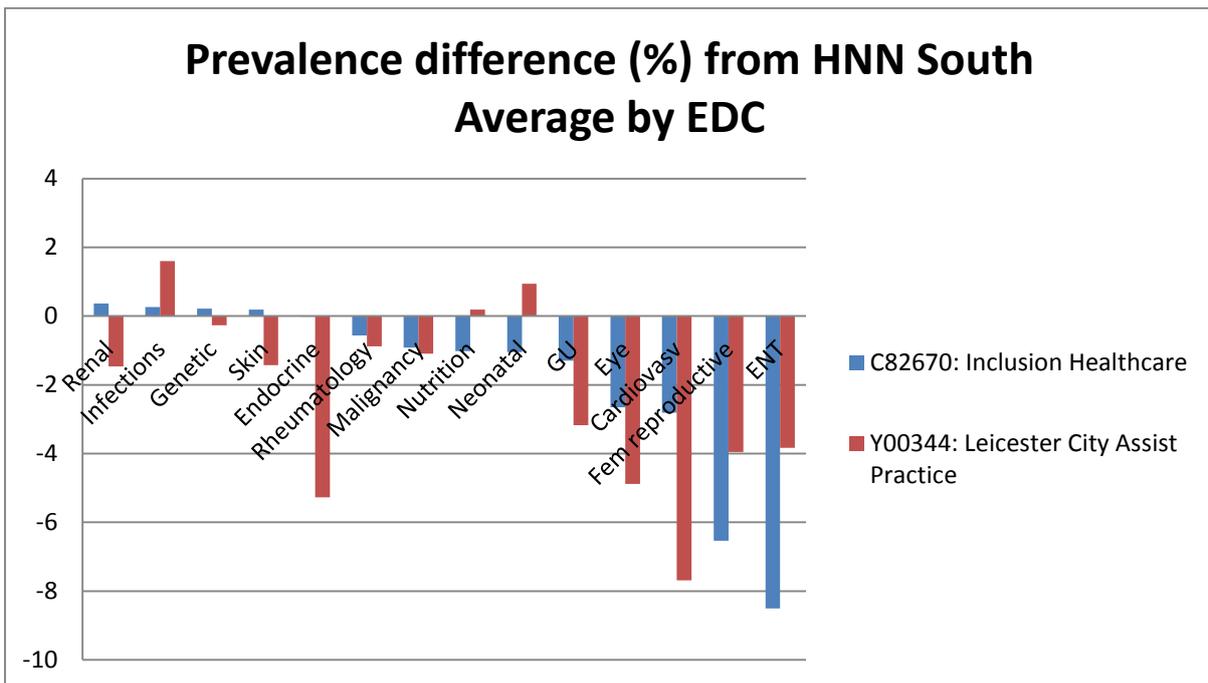
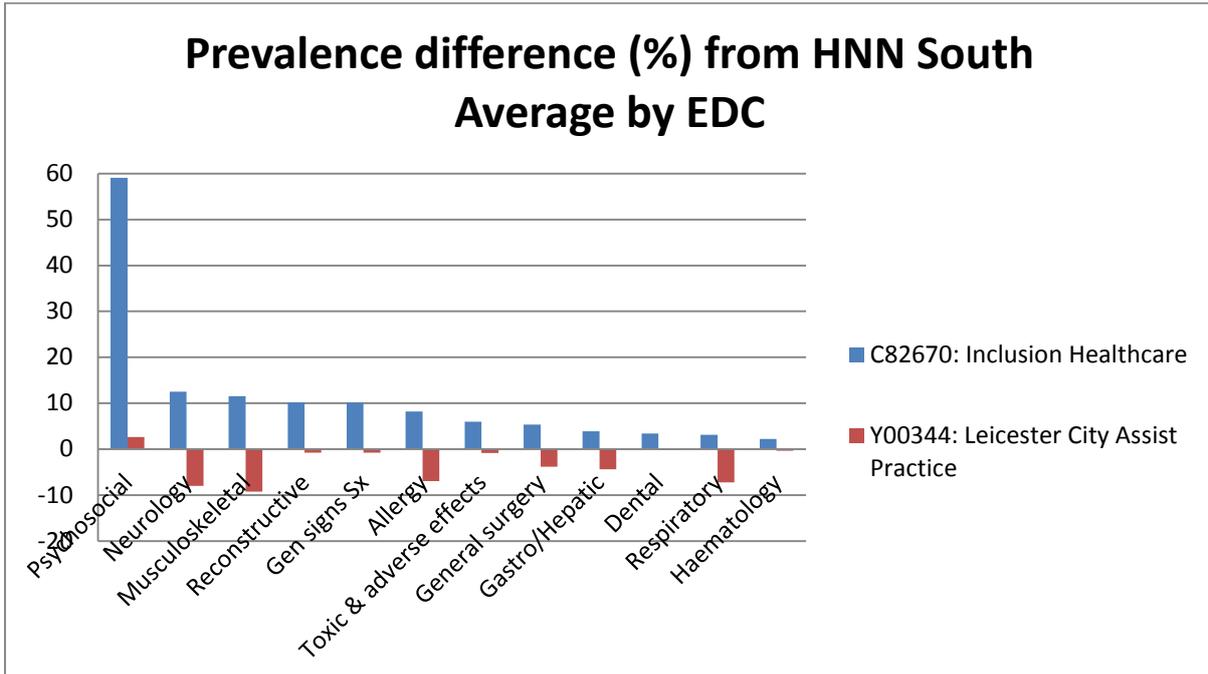
Inclusion clearly has a more multi-morbid population than HNN South, with a higher than average proportion of its population having LTCs. 52% of its patients have 2 or more LTCs, compared with 8.5% for assist and 27% for HNN South overall.

Major Expanded Diagnostic Clusters (MEDC)

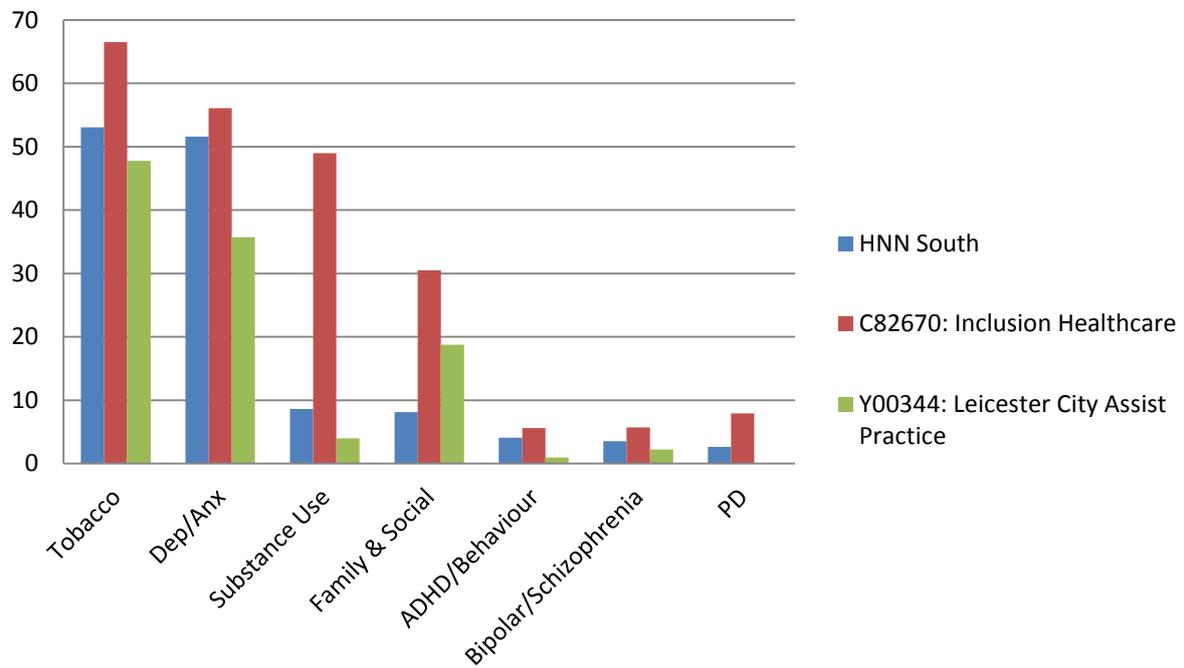


Despite having a young population the prevalence of obstetric and gynaecological illness is low at both practices compared with HNN South reflecting the gender split. However Inclusion has very markedly more recorded psychosocial problems compared with HNN South as well as generally more medical and surgical problems. The lower levels of illness at Assist reflect its young population. The origin of its population is probably reflected in its higher than HNN South prevalence of psychosocial problems (HNN South itself is higher than England average)

EDC Prevalence Differences from HNN South Average

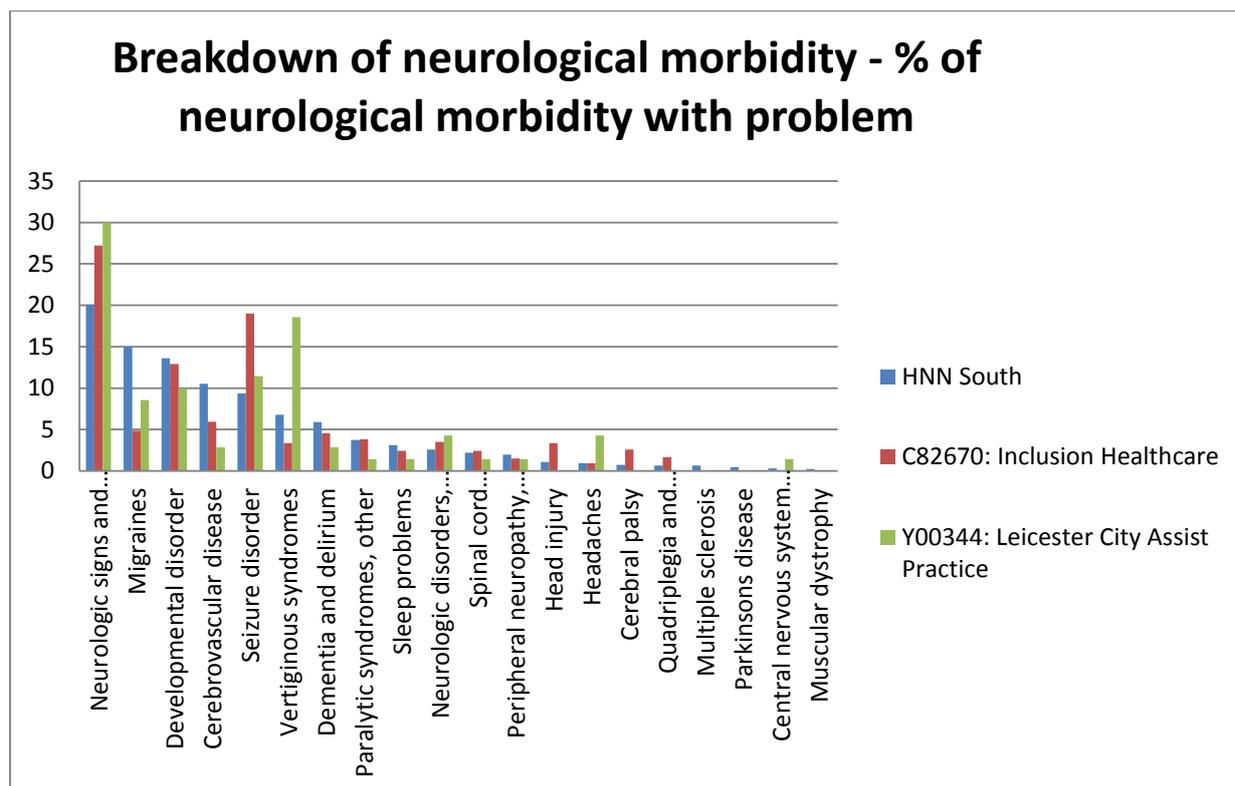


Breakdown of psychosocial morbidity - % of psychosocial morbidity with problem



Of patients with psychosocial morbidity it is notable that Inclusion has a higher proportion across all sub-areas than HNN South, with many of these patients having more than one problem in the psychosocial category.

The increased psychosocial morbidity seen in Assist is confined to tobacco, anxiety and depression and family and social problems, with a lower proportion from major psychiatric illness.



Amongst Inclusion patients seizure disorder and head injury stand out which probably reflects the high rate of alcohol problems in this group.

From Assist the predominance of non-specific neurologic signs, vertiginous syndromes and headache probably reflect high levels of stress in this population.

Summary

Inclusion: a young to middle aged predominantly male population with very high levels of psychosocial multi-morbidity and concomitant physical illness.

Assist: a young mainly male population with a disease profile reflecting this with indicators of social distress in psychological and neurological disease profiles.

Please note this analysis has not been able to look at ethnicity, country of origin or communication issues.

DJS April 2016

APPENDIX C

North and East Leicester HNN Meeting Wednesday 27th April 2016 - 6.30pm - 8.30pm

Practice Name	Attendees Name	Initial		Practice Name	Attendees Name	Initial
Ar Razi Medical	Dr AK Vania	AKV		Willowbrook Medical Centre	Dr N Joshi	NJ
Asquith Surgery	Dr G Sharma	GS		The Willows	Dr P Pathak	PP
Downing Drive	Dr A Bentley (Chair)	TB		Senior Strategy & Implementation Manager LC CCG	Clare Sherman	CS
Johnson Medical Practice	Dr B Patel	BP		Head of Governance LC CCG	Jo Grizzell	JG
Humberstone Medical	Dr D Salkin	DS		Locality Pharmacist LC CCG	Mini Satheesh	MS
Sayeed Medical Centre/Rushey Mead (The Practice PLC)	A Balakrishnan	AB		Leicester City Council Public Health	Mark Wheatley	MW
St Elizabeth's Medical Centre	Dr T Cheesman	TC				

South HNN Meeting Wednesday 27th April from 7.00–9.00pm

Practice name	Attendees name	Initial		Practice name	Attendees name	Initial
Aylestone Health Centre	Dr Minhas Bhavna Maru	HM BM		The Surgery @ Aylestone	Dr Sahdev	RS
Clarendon Park Surgery	Dr Prasad	AP		Victoria Park Health Centre	Dr Browne	LB
De Montfort Surgery	Dr Heaton Paul Houseman	JH PH		Walnut Street Surgery	Dr Panacer	DP
Inclusion Healthcare	Dr Dibdin	ED		CCG : Medicines Optimisation	Kerry Clay	KC
Leicester City Assist Practice	Dr Hiley	AH		CCG : Strategy & Implementation	Hema Jesa Mark Pierce	HJ MP
Pasley Road Health Centre	Dr G Singh	GS		CCG : Nursing & Quality	Wendy Hope	WH
Saffron Health	Dr Shepherd Philippa Guy	DS PG			Sarah Prema	SP
The Hedges Medical Centre	Dr Henwood Carole Jasilek	NH CJ				

Central Leicester HNN Meeting Thursday 28th April 2016 from 6.30-8.30pm

Practice name	Attendees Name	Initials	Practice name	Attendees Name	Initials
Al-Waqs Medical Centre	Dr K Choudhry	KC	SSAFA Care CIC	Dr O Uprichard	OU
Belgrave Health Centre	Dr N Lawrence	NL	Shefa Medical Practice	Dr F Docrat	FD
Broadhurst Street Surgery	Dr KS Morjaria	KM	Spinney Hill Medical Centre	Dr P Pancholi	PP
Canon Street Surgery	Dr B Modi	BM	St. Peter's Health Centre	Dr S Mansingh	SM
East Leicester Medical Practice	Dr Farooqui	AF	HNN Pharmacist	Hitesh Parmar	HP
Evington Medical Centre	Paul Houseman Dr C Kumar	PH CK	The Charnwood Practice	Paul Houseman	PH
Highfields Medical Centre	Dr F Patel	FP	CCG: Strategy & Implementation	Mark Pierce	MPi
Highfields Medical Centre	T Masani, Practice Manager	TM	NHS England	Mayur Patel	MPa
The Melbourne Centre	Dr K Hoque	KH	CCG: Senior Strategy & Implementation	Clare Sherman	CS
East Park Medical Centre	Dr S Shah	SS	CCG IM&T Facilitator	Nisha Mistry	NM
St Matthews Health & Community Centre	Dr S D'Souza	SD'S	CCG: Lead Nurse	Wendy Hope	WH

North and West Leicester HNN Meeting Thursday 28th April 2016 from 7.00-9.00pm

Practice name	Attendees name	Initial		Practice name	Attendees name	Initial
Dr Arolker & Partners	Dr D Jawahar	DJ		Westcotes Medical Practice & Brandon Street Surgery	Dr G Boora	GB
Beaumont Lodge Medical Practice	Dr Virdee	MB		Public Health	Mark Wheatley	MW
Fosse Medical Centre	Dr H Mukadam	HM		Westcotes Health Centre	Dr KM Taylor	KT
Groby Road Medical Centre	Dr C Rabbitt	CM		Oakmeadow Surgery	Dr P Jones	PJ
The Parks Medical Centre	Dr B Hainsworth	BH		The Practice – Beaumont Leys	Dr G Alagesan	GA
Hockley Farm Medical Practice	Dr A Bayford Cheryl Wright	AB CW		Leicester City CCG Independent Lay Member	Nick Carter	NC
Merridale Medical Centre	Dr R Tew Vicky Kershaw	RT VK		Leicester City CCG	Hannah Hutchinson / Ali Brooks	HH AB
Heatherbrook Surgery	Dr T Kapasi	TK		Medicines Optimisation – Leicester City CCG	Amit Sammi	AS
Fosse Family Practice	Dr U Roy	UR				

Needs Assessment: Asylum Seekers Wednesday 4th May 2016

Name	Job Title	Organisation
Mark Roberts	Head of Service	LPT
Nigel Hewett	Medical Director	PATHWAY
Anna Hiley	GP Inclusion	Inclusion
Nalini Patel	Specialist Health Visitor	LPT
Maxine Jenkins	Specialist Health Visitor	LPT
Tirathpal Nante	Development Worker	EQSD/PCEG
Tahera Khan	Snr Race Equality Officer	TREC
Matt Davis	GP	HFMP
Priya Chavda	Primary Care Contract Support Manager	LC CCG
Lee Keeling	Contracts and Assurance Manager	Leicester City Council
Benadetta Balmaverde	RS Co-ordinator	Red Cross
James Atkinson	Service Manager Rough Sleepers	Turning Point
Vinod Chudasama	Snr Race Equality Officer	The Race Equality Centre
Sarah Short	Lead Officer	East Midlands Councils EMSMP
Sadiya Mohamed	Support & Wellbeing worker	LASS
W.F (Bill) Myers	Vice-Chair	Support Group for Asylum Seekers and Refugees
Colleen Molloy	National Development Officer	City of Sanctuary

ASSIST Engagement summary (phases 1 and 2)

Summary of findings

The below bullet points highlight the combined key themes from all qualitative and quantitative data collected from patients during the **first and second** phase of engagement:

Summary from first engagement phase

- The majority of patients who gave their views were registered patients at ASSIST (88%)
- 104 people completed the first survey
- The majority of respondents who completed the survey were male (79%)
- The majority of respondents who completed the survey were African (27%) and 22% were from Arab countries
- The majority of respondents (41%) stated that they were between 25 and 34 years old.
- Most of the respondents stated they were married or in a civil partnership (56%).
- Of the 18% who said they had a disability, the main type stated was physical (42%), 28% said they had a mental health illness or condition
- Workshop attendees were from Iraq, Iran, Etrean, African, Arab (Sudan)
- A large proportion of respondents to our engagement stated they walked to appointments which can be anywhere from 1-5 miles (and stated a lack of funds for bus or transport)
- Patients generally prefer to make appointments on the phone, but resort to walking the distance due to language barriers
- A large number asked for urgent appointments within 4 hours
- 79% asked for an interpreter or someone speaking their language
- Preferred appointments Tuesday, Friday and Monday, 8am-12pm and 12pm-4pm
- Asked for dental services
 - Communicate local dental services and access

Feedback on the option to merge contracts was favourable for the Homeless Service and ASSIST service

Summary from second engagement phase

- The majority of patients who gave their views were registered patients at ASSIST
- 68 people completed the first survey
- The majority of respondents who completed the survey were male (54%)
- The majority of respondents who completed the survey were African and Muslim was the most stated religion
- The majority of respondents stated that they were between 25 and 34 years old.
- Most of the respondents stated they were single (44%).
- Of the 22% who said they had a disability, the main types stated were mental health condition or illness and physical.
- From the survey findings, 44% liked the practice at Clyde Street and would like to access it from that location (or a similar city centre venue)

- A number of patients who had tried to register elsewhere were either refused the service or were unhappy with their experience of trying to register
- Getting an appointment to be seen quickly was highlighted as the most important area for ASSIST services (50%)
- Specialist knowledge of asylum seeker/refugee needs was highlighted as the most important thing when choosing a doctor or nurse (53%)
- A number of patients said they were able to talk about all of their issues (non-health related) which relate to seeking asylum such as housing, Home Office paperwork and dealing with the trauma from losing family members.
- A pre-booked appointment was the preferred type of appointment from all of the patient feedback we received. Other asked for both pre-bookables and a sit and wait service with a suggestion for a drop in clinic with translators.
- A suggestion was made to be offered a sit and wait service, with an allocated time slot not too far ahead
- The cost of making a call to make an appointment was the key issue concerning appointment bookings facing respondents (60%)
- There were a number of suggestions made in the survey and the workshop to extend the phone booking time by half an hour.
- A large proportion of patients who responded to the survey said they would go to A&E or the Urgent Care Centre if they needed help that wasn't urgent (36%)
- Patients in the survey felt that seeing a GP of your choice was very important due to the number of issues they faced.
- Patients at the workshop asked for literature in English and were happy to get this translated themselves
- The majority of people we heard from were walking to make appointments and even though in some cases this was a fair distance, the majority were happy to walk to the service.
- Dentists were highlighted at the workshop as the key health issue facing patients.

Quotes

"When I was worried about my friend there was someone to speak to at the practice and to reassure me. I felt reassured because I knew they understood the asylum seeker process and the effect of trauma on a person"

"Hostile to asylum seekers" (When talking about their experience of registering with another GP practice)

"Don't have a phone. Cost of coming here is expensive. Just feel stressed all the time"

"Remember, the asylum seekers are on PAYG (Pay As You Go) and a 'hold' can use up all their allowance"

"First come first served" approach means some very sick patients with poor communication skills or where English is not the first language may not get seen."

"I know my friend and his friends would not see the difference between casualty and walk in centre"

"I walk a long way then can't get an appointment for days and have to come back"

“You need to extend the booking time by half an hour”

“We like getting letters. Friends and family translate them for us or we take them to TREC or the Red Cross”

“ASSIST wrote me a report about my homelessness which helped me. Without this I would have struggled”

“Very bad service with Dentists. No appointment till 2 months”

Appendix E

Responses were from: De Montfort Surgery; East Leicester Medical Practice; Saffron Health; East Park Medical Centre; Heatherbrook Surgery; Dr Osama & Partners; Dr Pratima Khunti & Partners; The Parks Medical Centre; Johnson Medical Practice; Aylestone Health Centre; Manor Park Medical Practices (Dr S M Arolker & Ptns)

Practices were given the opportunity to discuss further the issues raised in the HNN meetings. 11 Practices responded to the Practice Managers' questionnaire.

Two practices were able to enumerate registered asylum seekers, three others gave informed estimates and others do not know how many are on their lists. Where numbers were known there were 20 and 11 asylum seekers. Other estimates ranged between 0 and 11. One practice had an estimated 10 registered asylum seekers, with additional refugees. Most registered asylum seekers are single, though one practice had an even split between single people and families.

Practices with registered asylum seekers found that they required longer appointments, more detailed questioning, and had greater clinical uncertainty and risk. There was difficulty in contacting previous GPs, chasing patient records, being the first UK GP registering the patient or registering any patients born outside the UK. A practice had difficulty in inviting asylum seekers to the new patient health check.

Seven practices responded to the question on whether they had written letters or made telephone calls in connection with a person's asylum application. Two replied that this was not applicable, others had provided a letter, but this was not a frequent request and one provides a letter 'where appropriate.' Another 'would not know what to do with this,' whilst other practices appeared to conflated the advocacy issue with contacting the patient suggesting they 'use SMS as letters and telephone calls tend to not get replies' and 'try to get their most up to date details when we register the patient.'

The responses to the issue about wrong or misleading information, regarding age or other circumstances, suggested that this had not been a problem recently, although one practice found that date of birth and names used by some patients is different to the names on their passports.

With regard to confusion about registration rules this had not been an issue for one practice, one reply was this is the same for all none UK registrations and another that the administrative staff are aware they cannot refuse registration. Others had internal administrative processes to deal with the issue.

Asylum seeking patients not attending appointments were a problem for some practices. One practice texted confirmations and reminders to try and mitigate the issue but still had a higher DNA rate; others sent out DNA SMS text messages or contacted patients by telephone. Another practice found many asylum seekers do not attend appointments but this issue isn't unmanageable.

Where practices did have registered asylum seekers they used different ways of helping patients to communicate. Four used language line; three used or tried to book external translation and interpreting services; other ways of supporting patients who had difficulty in communicating in

English included longer appointments, family, friends, and other staff if appropriate and google translate.

Appendix F

Asylum Seekers: Stakeholder meeting 4th May 2016

Purpose of today:

By way of context Leicester City Clinical Commissioning Group is looking again at how it provides services for asylum seekers and homeless people in Leicester. Public Health at Leicester City Council is working on a needs assessment for both populations as a first step in identifying a service model and specification for future service provision.

In order to do this we have arranged these meetings with stakeholders to better understand needs, issues and challenges in providing primary health care to homeless people and asylum seekers in Leicester.

This meeting is only in relation to the needs assessment. There will be further stakeholder engagement and public consultation, as previously, when the CCG has developed proposals for future service provision.

We have a small number of questions to get through today. If you feel that they are not the right questions to ask and if you don't get the chance to say everything you want we will give you the opportunity to follow up, we are already in contact with some of you and we have your contact details.

In attendance	Mark Roberts; Nigel Hewett; Anna Hiley; Nalini Patel; Maxine Jenkins; Tirathpal Nanate; Tahera Khan; Matt Davis; Priya Chavda; Lee Keeling; Bernadette Balmaverde; James Atkinson; Vinod Chudasama; Sarah Short; Sadiya Mohamed; Bill Myers; Colleen Molloy; Vesna Dubaic.
<p>Background information: Thinking about how asylum seekers are dispersed to Leicester by NASS. Asylum seeker needs and how they impact on health and wellbeing. The way in which asylum seekers get in contact with you.</p> <p>We are looking for evidence of the main needs, the problems faced by asylum seekers, including the process of applying for asylum, cultural and language differences, effective multi-agency working and Home office processes.</p>	
<p>What's the story of asylum seekers in Leicester? The number of people, where they are housed, how they move between different areas,</p>	<p>Discussion about dispersal, health screening, destitution, secondary care, different types of asylum seekers.</p> <p>SS said that Stone Road is the dispersal centre, the start of the process. It is where all asylum seekers go in the midlands.</p> <p>Leicester is a dispersal centre, one of 6 in the East Midlands which also includes Nottingham, Derby, Oadby Broxtowe and Gedling.</p> <p>In Leicester G4S runs the asylum seeker accommodation contract. More than 1,000 asylum seekers are in Leicester, but this is a snap shot and not indicative of the rolling total over a period of time. At the meeting VD did not know the total number of people housed during the year, but said that she would find out and let us know.</p>

	<p>G4S send notifications to health and education. There was some discussion about the need for some point of contact, and that this is worth following up with G4S, the CCG and the local authority.</p> <p>Health care: Initially all individual asylums seekers are offered health screening by Virgin Care at the Stone Road Hostel. Currently the accommodation in Birmingham is oversubscribed, with reportedly 400 people in hotels at the moment.</p> <p>Although there is a process of sorts, the reality is that some people are never screened. This may be because they fail to attend a health screening appointment.</p> <p>The specialist health visitors felt this to be the case; some families are not seen and the health visitors may be the first person to have seen them. This is an issue because of complexity of cases and the first visit is the assessment visit. There is often no handover or documentation if the person has not attended screening.</p> <p>The difficulties with health screening include a separate budget for health provision at Stone Road and that the screening itself is not compulsory for new asylum seekers.</p> <p>There are different reasons why asylum seekers are required to move quickly from area to area. Once they have gained refugee status they are given 28 or, in some cases, 14 days' notice to quit their accommodation. People in this position with nowhere to move to are very vulnerable.</p> <p>One of the issues is that asylum seekers and refugees require different documents to prove their status. Often these do not arrive together, and sometimes they may be delivered to different places. The asylum seeker process eats into a person's time. Asylum seekers can't do anything without residence permit.</p> <p>SS said that locally people who are claiming Section 95 and Section 4 support may move anywhere in the Midlands or Yorkshire. Most likely they will be given notice. Cases may be worse for people claiming Section 4 hard case appeal.</p> <p>Risks of destitution are probably highest for people not granted leave to remain. However, there are examples of people who are granted refugee status who become destitute when they lose support.</p> <p>There are cases when people have been refused treatment in secondary care because of the Migrant Cost Recovery Programme. Without a HC2 certificate a migrant will not be able to get medication. Sometimes there are bureaucratic difficulties in getting a HC2 certificate.</p> <p>G4S provide accommodation. Part of the condition of occupancy is</p>
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	<p>that asylum seekers are treated as absconders if they are away for more than 7 days.</p> <p>Subsistence only support is an additional subset of asylum seekers, adding to a picture of complexity. There is a requirement for people to be independent but they do not have the means to support themselves. Leicester has the highest number of subsistence only cases in the East Midlands.</p> <p>Another complicating factor is those who do have independent means, which is presumably a small number of people. In addition there are Syrian students claiming asylum, some have spouses in the UK and may have rights of family reunion, the right to bring family across.</p> <p>The Syrian resettlement programme is separate to the usual asylum seeker process. People claiming refugee status under this programme have 5 years leave to remain. Leicester has agreed to take 45 people a year for the duration of the programme (5 years).</p> <p>The last survey on destitute asylum seekers shows that accurate numbers are not known. The Red Cross estimates that there are about 5,000 destitute asylum seekers. Where there is no recourse to public funds (NRPF) health comes to the fore because people sometimes become acutely ill.</p> <p>NRPF means that there is a problem of hidden homelessness in the asylum group;. There are cases of people sofa surfing in G4S properties, people living in factories, and some people who are given refugee status who have moved to Leicester, but have no support here.</p>
<p>In your experience what are the main needs of asylum seekers above and beyond primary care? Issues of poverty, trauma, language barrier, food banks, red cross for tracing lost family members</p>	<p>The main needs highlighted are housing, language, assessing age, mental health, lack of funds and deskilling aspect of claiming asylum.</p> <p>Housing: When people become homeless, they are given temporary housing. Rehousing can exacerbate stress; adding to issues of trauma, abuse, mental illness etc.. This issue affects families and single people.</p> <p>Assessing age: There is an issue related in particular to an influx of young men. Age assessments are required because people who are aged less than 18 years have automatic leave to remain and a social service duty to meet that need. Age assessments look at life skills. There is a need for local authorities to support Kent, which has so many unaccompanied children that the local infrastructure cannot cope. There is a new scheme by which children will be transferred to other local authorities; this is currently voluntary.</p> <p>Language: City of sanctuary has English classes and drop-in activities. Access to English classes is important because it helps people to</p>

	<p>assimilate and gives them something to do with their time.</p> <p>Mental health: Mental health and wellbeing needs to be protected. This includes the impact on mental health cause by trauma of the journey to the UK, shame and stigma not being allowed to stay. Social aspect not welcomed by the local community.</p> <p>Deskilling: Asylum seekers are so limited in what they are allowed to do there is a feeling that they become infantile. Many asylum seekers have time but no money. If they are on Section 4 they will have so little cash that they may not be able afford daily necessities or access public transport to attend required meetings. For some the proportion spent of transport can have a big impact on their lives. They may have to walk to report. Where there are courses they may not support progression or provide accreditation and there are frequent shortages of places.</p>
<p>How do asylum seekers come into contact with your organisations? What services do you offer them? You can provide us with written materials if you want</p>	<p>People get in touch by word of mouth, and then an organisation will signpost asylum seekers to others with different specialisms. TREC works with people who have leave to stay, before that they would have been seen by Red Cross and City of Sanctuary.</p> <p>Other important organisations at this stage are housing, Department of Work and Pensions and G4S.</p> <p>Some contacts are made through religious organisations and there is signposting at the reporting centre at Loughborough.</p> <p>Reporting is required at least on a 6 monthly basis, although potential absconders may have to report more frequently. There are not criteria for frequency of reporting, for example a largish group of Eritrean people in Leicester have been told that they don't have to report at all.</p>
<p>Description of health care service: Thinking about how well are the health needs of asylum seekers met in primary and secondary care. The role of specialist general practice.</p>	
<p>What is the process by which asylum seekers register with ASSIST?</p>	<p>When asylum seekers come to Leicester they are encouraged to register with a local GP. ASSIST is one of the choices. Some asylum seekers may not want to travel and so will register with a GP in their locality. After gaining refugee status some want to continue with ASSIST and may not wish to register with another local GP.</p>
<p>Do you have views about what happens to asylum seekers in Leicester as time progresses, whether they register with mainstream general practices</p>	<p>Mainstream local GPs are not necessarily geared up to care for asylum seekers; there are issues with language. Care for mental health of asylum seekers is complex too; requires specialist skills, for instance mental illness may be a taboo in certain cultures, and people express things differently.</p> <p>A GP working in ASSIST will have a different starting point, having the knowledge that all patients are asylum seekers. In mainstream general practice it is possible that some asylum seekers never disclose their background. Factors such as expertise, holistic care, continuity of care in one practice makes ASSIST a preference to some people.</p>

<p>and how they come to be with different practices</p>	
<p>Do people register with mainstream general practice when they gain refugee status?</p>	<p>There is a risk that patients will be turned away if they don't have the correct documentation, and some general difficulties with registering with mainstream GPs. When challenged about this, it emerged that this may just be in secondary care. However, the group concurred that the risk remains, and that the existence of an expert General Practice means that people can be reassured that this won't happen in Leicester.</p> <p>There is less knowledge of asylum seeker health and social care needs among mainstream practitioners. They don't have knowledge of paperwork relevant to the asylum seeker process, and how things are organised, housing, education, how little access there is to services, issues about destitution, or the difference between migrants. Some GPs may have knowledge but no time. Reception staff members have an influence, and there is a need to be more patient with asylum seekers because not only are their needs complex, but they also have difficulties communicating them and different expectations.</p> <p>Practices may not have the resources to match additional needs of asylum seekers. They need access to interpretation and translation services. Usually it is difficult to get mainstream GPs to use language line.</p> <p>Some issues were about practice. Some asylum seekers who have experienced domestic violence or sexual abuse may not be able to talk about their experiences; it takes courage to ask questions about torture and rape or to ask about FGM. The asylum seekers may not be believed or given the appropriate support.</p> <p>Looking forward there should be more health education and protection to focus on prevention of illness.</p>
<p>What are the strengths and weaknesses of different service models in looking after asylum seeker health needs?</p> <p>Specialist Services (separate from but ideally integrated with existing provision)</p> <p>Enhanced (added</p>	<p>Initially there is a need for a specialist service to help people to feel settled. Removing the specialist service would result in a crisis. This is because there are resources and skills in the specialist service which are not found in mainstream care. If ASSIST is decommissioned there would be a need to reinvent it. The expertise is required because of the complexity of need of people who have experienced rape, torture, and other trauma.</p> <p>Maternity service care is important; female asylum seekers experience 14% of all maternal deaths vs <1% of pregnancies. The best care will be delivered by people expertise and experience.</p> <p>In those areas where there has been a specialist practice provision asylum seekers have a better healthcare experience.</p> <p>Widening dispersal and new areas accommodating Syrian refugees means that there will be more patients, and by default there will be centres of excellence.</p>

<p>on to existing provision)</p> <p>Mainstream General Practice (Embedded within existing provision)</p>	<p>General Practice Perspective: There are 3 barriers to providing effective health care for asylum seekers in mainstream general practice.</p> <p>Time: 10 min appointments are challenging for normal patients</p> <p>Interpretation and translation: Language line, cultural difficulties</p> <p>Questionable past medical histories: Dealing with this would be difficult in mainstream general practice; trauma, a case of untreated HIV who has night sweats probably has malaria.</p> <p>Training and expertise is impossible to maintain. Keeping up to date and training in asylum seeker health care is difficult to justify because most GPs will not use skills on a daily basis. The specialist approach enables better contact with different relevant agencies and is a way of keeping up with a shifting scene.</p>
<p>Other</p>	<p>Where are the numbers in the city going?</p> <p>Trajectory is for more asylum seekers. There will be more pressure on places that are not yet dispersal areas. The Syrian programme will be important over the next 5 years. There are likely to be more unaccompanied children. Nationwide more local authorities will need to take asylum seekers.</p> <p>There is an expectation that people will come to talk to ASSIST for their expertise in delivering asylum seeker health care.</p> <p>As for Leicester, the numbers will depend on the population of the city, and the impact of asylum seekers in other areas. The numbers will increase, until they hit the Home Office informal estimate of 1:200; that is one asylum seeker for every 200 people.</p>

Appendix G

Draft summary of discussions with HNN 27 and 28 April 2016

1. The perception of existing specialist services.

Overall there is little doubt that the specialist services and their staff are held in high regard by the body of GPs in Leicester. This has been mentioned at all the HNN meetings attended and we have also received individual communications to that effect.

2. Practice experience of asylum seekers, homeless and refugees.

Most HNNs had practices within them that encountered both asylum seekers and homeless patients.

It is difficult to quantify the numbers seen. While a practice in North Evington indicated that they had no asylum seekers, others in the same HNN indicated they did have asylum seekers registered. Probably fair to say that all HNNs had some asylum seekers registered. The picture emerging from the HNNs of registration of homeless people is that on the whole it is rarer for practices to register a homeless person and unlikely to be “street” homeless. What practices seem to encounter is less of focus on the “no fixed abode” type of homeless but more on a process of patients becoming homeless – and who are staying with people, sofa surfing and who are generally insecurely housed.

Regarding the asylum seeker population encountered by practices, there was recognition of complex needs, including support for post traumatic stress disorder, physical trauma, advocacy, social rights, lack of knowledge of services available and language barriers. There were also mental health problems, absence of vaccination records or vaccinations, responses to adverse life events, the need for social and psychological support. One practice had an asylum seeker who had lied about his age.

Regarding homeless people there were issues which included cellulitis, drug and alcohol problems, social and psychological support, co-morbidities. The classification of a homeless person is problematic (someone who is staying at a friend’s house, for instance could be homeless). The complexities of care for homeless people was mentioned. Patients are often concerned about drug pushing in hostels, one mentioned that the capacity at a local hostel is a problem and another that some homeless people live in cars. Generally across practices and across HNNs it appeared that GPs dealt with the insecurely housed, young adults leaving/pushed out of home, or patients who have become homeless through other causes. The impression given was that GPs did not see many of the no fixed abode/street homeless people.

3. Registration issues.

There is possibly some confusion regarding registration of both asylum seekers and homeless people. Many GPs in the south thought that they could not register a patient unless they had some documentary proof of residence, some combination, it was said, of national requirements – “anti-terrorism” – and a need for proof that the prospective patient is within the catchment area of the practice itself. Most or all GPs in the meetings were aware of the healthcare arrangements for homeless and asylum seekers in the city. Not all,

however, had a protocol of advice that they could give to those seeking help who they were unable (for whatever reason) to register. A CCG manager clarified that “practices can’t refuse to register people who are resident in their catchment area, even though there is a specialist practice to meet the needs of those groups”. There was a feeling amongst some of those who spoke at the central HNN that they are obliged to register asylum seeker patients and that they are therefore not able to signpost to another primary care practice (e.g. ASSIST).

4. Demands on GP Practice.

Asylum seekers. One GP reported that his practice does register some asylum seekers and the problems encountered are complex. Another indicated that asylum seekers have complex needs which would be difficult to manage in mainstream primary care. The words complex and time-consuming were frequently encountered. One doctor spoke about the complexity of care of people from different ethnic and language backgrounds, the inadequacies of supporting services (such as IAPT which were described as inadequate in terms of timeliness and sometimes expertise to meet the needs of people who have experienced trauma). One with experience of looking after asylum seekers also recognised the demands of advocacy and letter writing, etc. There were different views about whether asylum seekers needed 2 – 4 weeks to settle and it was said at one HNN at least that the experience of asylum seekers was so complex that they took a long time to recover. The experience of the north west suggested that attendance once registered at practices was high. Sometimes the asylum seekers required 30 – 40 minute appointments. Patients from all over the world, some had experienced bombing, torture and abuse. These require longer appointments. Sometimes the high practice attendance rates is for a limited time only. Overall there was a clear recognition that both groups (and also refugees) require more time and pose challenges to mainstream practices. They require longer appointments, a multi language clinical practice perspective and staff with experience of providing clinical services to these types of groups.

One GP said about how his practice found problems with trust, patients not being open and that it takes a few sessions to establish it. There were also issues such as no clear documentation. There would often be no or limited communication, language being a particular challenge. There was a feeling that residents, including the homeless and refugees, sometimes preferred local services rather than specialist service and that they would be likely to complain if they had to go out of their area for primary care.

5. Transition to mainstream primary care.

Areas that need further consideration are - guidelines on the period of time for the specialist service users to make the transition to mainstream practices, and the process for doing this. With the homeless particularly it was felt it was a bit of a revolving door, linked to the nature of homelessness/insecure housing.

6. Funding cost per patient.

One GP in the north east HNN observed that if the specialist APMS practices did not exist there was no guaranteeing funding would go to mainstream general practice at the same

rate. And once budgets are broken down they may no longer be protected. Not every asylum seeker particularly, made the same demands upon practices. One observed that his experience of looking after a Syrian asylum seeker who was relatively healthy and ready to work was different to that of an Iraqi asylum seeker who had health problems resulting from traumatic experiences, and is not so settled. Healthcare problems are different for each individual. He felt there is a need for clinical judgement. When looked at only in terms of value for money one could argue in this case that the higher cost per patient is relevant and could be applied to the Iraqi but not necessarily to the Syrian asylum seeker.

7. Views on distribution to primary care.

There were a range of views on whether or not services for asylum seekers and the homeless should be provided by mainstream primary care rather than a specialist primary care services.

In one HNN there appeared to be an appetite for taking on the primary care of asylum seekers. Some GPs felt they were doing this anyway. In another HNN all practitioners believed that they had the skills to deliver the appropriate care, if there was secondary care support in place and if they had the time to deal with the complex healthcare problems. GPs, it was felt, have the right skill set and would be willing to assimilate homeless people and asylum seekers if they had the time and money. For some there were caveats connected with this appetite. One practice with experience of registering asylum seekers said a small minority have some sort of trauma. There is a special need for quick mental health rapid access. A fast track specialism from IAPT which would need to be commissioned. The chair of this particular HNN said that practices should register asylum seekers, but with strong support with mental health issues.

There were voices that had doubts about GP practices taking on the primary care of asylum seekers. One GP in the north east HNN said that “patients’ needs will get lost in normal primary care, where access to services may be difficult”. Integrating in mainstream primary care will be complicated. Asylum seekers may not know how to use the service. It will be a backward step. A different HNN said that specialist practice gives some flexibility to meet needs of people as they are dispersed. There was a feeling that care would depend on the general practice and that not all practices would want to put in the effort. And others that if there was a move towards mainstream care it would require more GP time and effort. Some concerns were practical, e.g concern over proving asylum seeker status – the Home Office letter etc.

The chair of central HNN indicated that, were the service to be devolved to practices, the amount to be paid per patient may not be the current rate.

