Understanding the health needs of migrants in the South East region

A Report by the South East Migrant Health Study Group on behalf of the Department of Health

NHS Berkshire East

www.slough.gov.uk Slough Borough Council

sepho South East Public Health Observatory

University of Oxford

Acknowledgements

The preparation of this report was project-led by Nika Raphaely (NR) and Éamonn O'Moore (EOM) of the Thames Valley Health Protection Unit (TVHPU). The work is the product of the South East Migrant Health Study Group, a multi-agency research collaboration between the Health Protection Agency (HPA), the South East Public Health Observatory (SEPHO), the University of Oxford, NHS Berkshire East Primary Care Trust (BEPCT) and Slough Borough Council. The Department of Health (DH) commissioned the project. The report brings together data on the health needs of migrants in the South East (SE) region of England from a range of publicly available data sources. This is supplemented by original research work conducted with a range of statutory and non-statutory agencies and organisations working with migrants in the SE region.

Interviews were undertaken by NR, Laura Ingle, Ruth Harrison and Vanessa Baugh. Unless otherwise stated, the material was written by NR and EOM, who also edited all the chapters, contributed to the discussion sections and summarised all the public health recommendations.

We gratefully acknowledge all those who contributed to this report, including colleagues from primary care trusts, local authorities, NHS acute and mental health trusts, Immigration Removal Centres, police and prison services, the South East England Development Authority (SEEDA) and non-statutory and voluntary organisations. We also acknowledge the help, support and contributions of colleagues within the HPA, including scientists and administrative staff who contributed in many ways to this report.

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Contact Details	Dr Éamonn O'Moore Thames Valley Health Protection Unit, Health Protection Agency Chilton, Didcot, Oxfordshire OX11 0RU 01235 436720 www.migranhealthse.co.uk.
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Authors and contributors

Main authors of the report	Nika Raphaely, Éamonn O'Moore
Contributor to Chapter One	Ivan Perkovic, Head of Economic Research, SEEDA
Contributor to Chapter Two	Gabriele Price, Senior Public Health Intelligence Analyst, SEPHO
Contributors to Chapter Three	Ruth Gilbert, Migrant Health Lead, Travel & Migrant Health Section, HPA Ettore Severi, Epidemiological Scientist, South East region, HPA Ibrahim Abubakar, Consultant Epidemiologist/Tuberculosis Section Head, Centre for Infections, HPA
Author of Chapter Five	Nika Raphaely, Research Fellow, TVHPU
Contributors to Chapter Five	Mina Fazel, Clinical Lecturer, Child & Adolescent Psychiatry, University of Oxford Gabriele Price, Senior Public Health Intelligence Analyst, SEPHO
Author of Chapter Six	Vanessa Baugh, Health Protection Practitioner, TVHPU
Contributors to Chapter Six	Emma MacLaren, Academic Foundation Trainee, TVHPU Éamonn O'Moore, Interim Director and Consultant in Communicable Disease Control, TVHPU
Author of Chapter Seven, Appendices D and E	Angela Snowling, Consultant in Public Health, NHS Berkshire East
Author of Appendices A and C	Gabriele Price, Senior Public Health Intelligence Analyst, SEPHO
Other contributors	Emma Plugge, Director, MSc Global Health Science, University of Oxford Lauren Watts, Pathways Team Manager, Slough Borough Council Alison Hill, Director, SEPHO Marta Szczepaniak, Public Health Intelligence Analyst, SEPHO Karina Paturel, Health Intelligence Programme Manager, Solutions for Public Health Ken Baker, Foundation Trainee, TVHPU Kakoli Choudhury, Rebecca Cooper, Gracia Fellmeth: Specialty Trainees, TVHPU

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Abbreviations used in the report

A8	Eight accession countries which joined the European Union in 2004
AIDS	Acquired Immune Deficiency Syndrome
BBV	Bloodborne Viruses
BME	Black and Minority Ethnic
CfI	Centre for Infections
DH	Department of Health
DRE	Delivering Race Equality in Mental Healthcare
EEA	European Economic Area
EU	European Union
GDP	Gross Domestic Product
GOSE	Government Office for the South East
GP	General Practitioner
GUM	Genitourinary Medicine
GUMCAD	Genitourinary Medicine Clinical Activity Dataset
GVA	Gross Value Added
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HPA	Health Protection Agency
IAPT	Increasing Access to Psychological Therapies
IDUs	Injecting Drug Users
IPPR	Institute for Public Policy Research
IPS	International Passenger Survey
IRC	Immigration Removal Centre
JSNA	Joint Strategic Needs Assessment
KPI	Key performance indicator
MHMDS	Mental Health Minimum Dataset
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NINO	National Insurance Numbers
NOIDS	Statutory Notifications of Infectious Diseases
ONS	Office for National Statistics
PCT	Primary Care Trust
PROM	Patient-Reported Outcome Measures
PTSD	Post Traumatic Stress Disorder
SARC	Sexual Assault Referral Centre
SE	South East
SEMH	South East Migrant Health Network
SEPHO	South East Public Health Observatory
SESPM	South East Strategic Partnership on Migration
SHA	Strategic Health Authority
SOPHID	Survey of Prevalent HIV Infections Diagnosed
STI	Sexually Transmitted Infection
TB	Tuberculosis
UKBA	UK Border Agency
WHO	World Health Organization
WCC	World Class Commissioning

Definitions

Throughout this report the term 'migrant' rather than 'immigrant' is used, in line with United Nations (UN) definitions since 1998 (1). Four categories of migrants are considered throughout this report:

Economic migrants: people leaving their usual place of residence to improve their quality of life. This may include long-term migrants or short-term seasonal workers.

International students: a large group which includes people of any age moving to another country for the purpose of full-time study.

Asylum seekers: people with a fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinion who enter a country and claim asylum under the 1951 Geneva Convention. Once the fear has been proven to be well-founded, the claimant is granted refugee status.

Irregular migrants (or undocumented or clandestine): migrants without legal status owing to illegal entry or the expiration of their visa. (1, 2)

References

1. Gilbert R, Jones J. Migrant Health: Infectious diseases in non-UK born populations in England, Wales and Northern Ireland: a baseline report: Health Protection Agency, Centre for Infections; 2006.

2. Nygren-Krug, H (Ed). International Migration, Health and Human Rights: World Health Organization; 2003. http://www.who.int/hhr/activities/en/intl_migration_hhr.pdf

Foreword

The ebb and flow of migration has been particularly dynamic over the last ten years due, in part, to increased accession in the European Union and also international upheaval as a result of war and natural disasters. In light of this, an overview of the impact that these flows of people have had on the South East seems both timely and appropriate. To this end, the Department of Health commissioned the Thames Valley Health Protection Unit and its partners to provide details on groups of international migrants, including economic migrants, international students, irregular migrants and, with an awareness of the particular health needs of asylum seekers, refused asylum seekers and refugees. We were especially interested in those migrants who are most vulnerable to social exclusion, and in any sources of information which reveal their health needs and barriers to their accessing services.

The report is designed to be of practical value to health and social care colleagues in terms of needs assessment and commissioning service provision for such vulnerable groups. In producing the report, the needs of professionals working with migrants have been highlighted and have already produced a regional network to provide information and support, the South East Migrant Health Network (SEMH). The South East Strategic Partnership for Migration has identified the importance of addressing migrants' health and access to health services and, alongside the Government Office for the South East, will play a key role in sustaining partnership work to meet the needs of vulnerable groups.

David Sheehan
Development Manager

Public Health Group South East
Department of Health
Government Office in the South East

Executive summary

The Department of Health (DH) commissioned this report to inform health and social care commissioners and providers in the region about the health needs of migrants, and to advise them on ways to meet identified needs. This report has been written by the South East Migrant Health Study Group, a research collaboration led by Thames Valley Health Protection Unit (TVHPU) which includes the South East Public Health Observatory (SEPHO), the University of Oxford, NHS Berkshire East Primary Care Trust (BEPCT), Slough Borough Council and the Health Protection Agency's Centre for Infections. Stakeholders, including those participating in the inaugural meeting of the South East Migrant Health Network (SEMH) in March 2010, have also informed the report. It is being published as an e-publication to facilitate easy and wide dissemination, in order to increase its impact and accessibility to the broadest range of stakeholders.

Migration has always played an important part in the economic, cultural, social and educational life of England generally, and the South East (SE) specifically. Migrants are a diverse and dynamic group and, for this reason, have variable and varying health needs. Migrants can be those seeking employment or education, asylum seekers and refugees, family members coming to join established relatives, or irregular, illegal and undocumented people. By far the most important groups in the SE are economic and educational migrants, and family joiners. Migration is also affected by geopolitical and economic factors. The recent economic recession has led not just to a reduction in migration into the SE region but also an increase in emigration from the area.

The research methodology used to compile this report has included a detailed literature review, identifying and interrogating data sources, and a survey of organisations and individuals involved in working with migrants in the SE. A key finding of this process is how poorly currently available data resources help us identify the population of interest, their experiences of health and disease, or their use of health services. A comprehensive report exploring the strengths and weakness of these data sources is provided as an appendix to this report. The report also provides exemplars of good practice, which we have highlighted throughout the document.

The survey we conducted targeted organisations and individuals in the SE region working with migrants and asked them to then identify others within their professional networks who might be able to contribute positively to the process. The results of the survey are drawn from a range of both statutory and non-statutory agencies across a wide geographical spread. The limitations of both the survey results and other methods used in the report are discussed, but this work should provide a useful 'baseline' of current knowledge against which future work can be measured.

The report provides detailed information on the population of migrants in the SE region, recorded using current data systems. It also provides information on what organisations in these areas know about this population, as evidenced in their JSNAs and other local research reported to us by survey participants. Different migrant groups and what is known about them are described and gaps in knowledge identified. All this data demonstrates the heterogeneous nature of the migrant population and its irregular distribution throughout the SE region. It further identifies areas where migrant numbers are much greater, highlighting localities where health and social care commissioners and providers may be challenged in meeting health needs.

The physical health needs of migrants are affected by the background levels of diseases, health behaviours and health services in countries of origin, as well as the reason for migration. Economic and educational migrants tend to be drawn from healthier and wealthier populations in any country, whereas those arriving as asylum seekers or refugees may have experienced deprivation, disease and disaster, often arriving in the UK with greater and more immediate health needs. Currently available health databases provide only limited information on the physical health needs of migrants to the SE region. This is due both to a failure to capture and a failure to record the migrant status and/or country of origin of individual patients. Infectious disease surveillance systems do provide more detailed information than many health databases in the region. Data provided by the Health Protection Agency identifies a disproportionate number of people infected with tuberculosis (TB) and/or HIV/AIDS among migrant populations than UK-born people and provides evidence of increasing numbers of cases of such infection, nationally and regionally. Port health screening offers only a very limited opportunity to identify TB in new migrants, as most are not diagnosed with the infection until many years after arrival. TB is a

treatable condition, but in the SE region only 73% of identified cases are fully treated, well below the WHO target of 85%. HIV infection in the SE disproportionately affects Black African communities and often presents with TB co-infection. Data from sexual health services (GUMCAD data) provided by the HPA includes both country of origin and ethnicity. However, data recording is currently incomplete, so the true number of migrants accessing services and diagnosed with sexually transmitted infections is not known. Vaccine-preventable diseases represent a specific challenge. Many migrants come from countries where childhood vaccination programmes are poorly administered or differ from UK programmes, and have different experiences of endemic diseases. The most frequent query from primary care teams to VACCSline, a vaccine-advice service provided by the Oxford Vaccine Group at the University of Oxford and TVHPU, concerns non-UK schedules of immunisation. Finally, health behaviours, such as smoking, differ in different countries and migrants import such behaviours. This means that health promotion programmes on smoking cessation should consider migrant groups specifically and how to reach them.

Many migrants experience barriers to accessing healthcare services. This may be due to failure to understand what services are available and how to use them, confusion around entitlement to NHS care, and language and cultural barriers. This can lead to both failure in seeking care and treatment appropriately or at all. For example, migrants may inappropriately use A&E services when their needs would be better served by GPs. But, because they do not register with primary care, they may find walk-in services offering immediate care without the need for such registration more easily available to them. However, this means that only acute needs may be met and they may miss out on more appropriate preventive treatment, vaccination, screening or diagnostic services delivered via primary care.

Mental health needs are frequently identified in both the literature review and among our survey respondents as a key issue among migrants. However, it is important to recognise that different migrant groups have very different experiences of mental health issues. Asylum seekers and refugees are often fleeing persecution, violence, disaster, or disease and therefore have a greater risk of serious mental health problems. The nature of their journey to the UK and the conditions they experience on arrival can exacerbate the risk even further. Women and children among such groups are particularly vulnerable. Current data systems have improved the recording

of ethnicity data, but country of origin is poorly recorded. Ethnicity is not a good proxy for migrant status, as large numbers of ethnic minority populations are UK-born. This issue needs to be addressed in the review of data systems capturing mental health needs in the region. However, such datasets as do exist show a disproportionate number of people from black and minority ethnic communities among those detained under the Mental Health Act. Cultural and language barriers can also prevent access to appropriate care for migrant groups.

The criminal justice system encounters migrants both in detention settings and in the community. The SE region has a large number of prisons and Immigration Removal Centres (IRCs). Prisons increasingly hold foreign-born offenders. For example, HMP Canterbury's population is almost entirely non-national. The research literature shows that diseases such as BBVs and TB are much more prevalent among such incarcerated populations than those in the community. Furthermore, mental health problems are more prevalent and may be exacerbated by the conditions of detention, isolation from family and friends, and social isolation due to cultural and language barriers. Women and children are particularly vulnerable in such settings. Prison healthcare is provided by the NHS, whereas the care in IRCs is provided by a range of different providers. It is recognised that this leads to variation in quality. It is recommended that the provision of healthcare in IRCs is directly commissioned by the NHS, as per the prison model, to improve quality and integration with acute care and community services.

Commissioning and providing effective healthcare to migrant populations is a challenge that both health and local authority commissioners need to meet. To commission effectively you need to know what outcomes you wish to improve, how to maximise resources from a range of partners, which interventions are effective, and how to measure and manage performance to achieve the desired outcomes. Effective commissioner/provider relationships must exist for this to happen. PCTs are bound by law to manage their funds within their allocation and to commission effective services for the whole population they serve, UK-born or migrant. Strategies to improve health outcomes must involve improving access to currently-provided health services for all members of the community, as well as targeting specific migrant groups. Effective coordinated commissioning between health and local authorities is enabled through the process of JSNAs. It is recommended that a

multidisciplinary group reflecting all key stakeholders and the structural and social determinants of health owns this process. Effective commissioning to meet the health needs of migrants requires knowledge of the numbers and the types of migrants, the prevalence of risk factors for disease, cost-effective and appropriate interventions, clear aims, service plans and accessible care pathways, a common dataset for comparing provider performance, SMART key performance indicators (KPIs), clinical quality indicators linked to contract payments and clear health improvement outcomes, which should also include patient-reported outcome measures (PROMs).

In March 2010, the DH held an event to share initial findings from the research into the health needs of migrants. Furthermore, this event was also designed to become the inaugural meeting of the SEMH. The delegates included a broad range of stakeholders from a range of statutory and non-statutory organisations, all of whom have a direct interest, or role, in working with migrants in the SE region. An account of the event's proceedings is provided in this report. The meeting served to triangulate research findings identified by the SEMH Study Group, to highlight any gaps and establish a working network in the SE region to understand and meet the needs of migrants. The meeting also provided a mandate for commissioners to support further work of the network through a facilitated internet-based resource (www.migranthealthse.co.uk), which is being launched at the publication of this report. The internet resource will allow members of the network to interact with each other, provide a forum for discussion, act as a repository of key documents and other materials, and allow more effective sharing of good practice across the region. The SEMH network is supported by the DH, the Government Office for the South East (GOSE) and the South East Strategic Partnership on Migration (SESPM).

The key recommendations from this report include a need for more 'intelligent' data sources, which can map across health and social care databases appropriately to describe this population's experience of health and disease, health service utilisation and access to services. Furthermore, migrants need better information about the range of health services available to them and their appropriate use. Health and social care partners require better training in understanding their roles in meeting the needs of migrants. Joint working across agencies is required to address the range of social problems that may have a negative health impact. Migrants need better

information on the range of healthcare services available in the region and their appropriate use. This process will be aided by improving opportunities to learn English for migrant communities already established and the increased level of understanding of spoken and written English required by new migrants, especially economic migrants. The most effective way to coordinate joined-up multi-agency work across a whole region is to establish a regional network of commissioners, providers, non-statutory and statutory agencies and service users to inform the design and delivery of appropriate healthcare services.

Chapter One: Introduction and context

Key findings:

- Migrants are a diverse group and therefore their health needs will vary significantly.
- Migration is a dynamic process influenced by geopolitical and economic factors.
- The recent economic downturn has substantially impacted on migration into the SE region.
- No single data source can describe in any complete way the experience of health and disease of migrants in the SE region or their use (or not) of health services.
- This project adopted a pragmatic research approach to establish what is known and unknown about migrants in the SE region, and to highlight areas of best practice.
- Research methodology included a literature review, interrogating sources of routinely collected data, an online survey and interviews.

Migration has always been an important factor in the growth and development of the United Kingdom. In recent years, the UK has experienced very substantial increases in migration and, according to multiple data sources, the SE region has attracted the highest number of migrants after London (1). The region's economic strengths, its large number of universities and colleges, its proximity to London and its many ports of entry make it an attractive destination for a broad range of both short- and longer-term migrants.

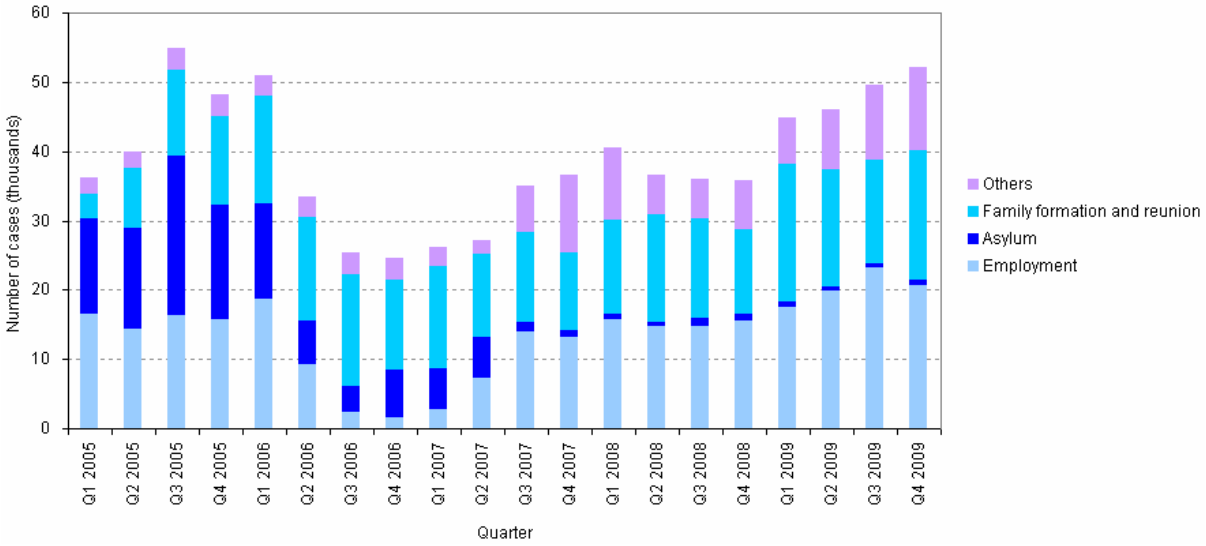
The term 'migrant' is a very loose term which includes at least four distinct groups (2):

- Economic migrants.
- International students.
- Asylum seekers and refugees.
- Irregular migrants, including undocumented people, visa over-stayers and family joiners, among others.

All these groups vary in terms of their size, age/sex structure, economic power, and health and social care needs. It is not helpful to describe 'migrant health needs' too generally, as the needs will vary by group and sub-group. Some groups may

experience high standards of health and have good access to healthcare services, whereas others will have much less favourable health status and access to care. Economic migrants often represent a fit and well- educated section of society in their country of origin and often have relatively better health status than their peers - the so-called 'healthy migrant effect'. Those fleeing persecution and seeking asylum may represent an 'underclass' within their home societies and may experience worse levels of health, either because of this, or due to hazardous conditions during their search for refuge in other countries.

Migration is a dynamic process, with numbers in different migrant groups fluctuating in response to political and economic developments in the UK and internationally. Since the 1990s, numbers of migrants to the UK increased initially among asylum seekers and refugees, but later among economic migrants and others, especially after the European Union enlargement in 2004 (3). Among those migrants monitored by the Office for National Statistics, the relative changes over the past five years among constituent groups of migrants to the UK are demonstrated in Figure 1.1.



Source: Office for National Statistics

Figure 1.1: Grants of settlement in the UK, excluding European Economic Area and Swiss nationals, 2005–2009 (4).

This report, where possible, will describe the health needs of the various different types of migrants to the SE region of England. However, data sources do not provide reliable, consistent or comparable information on the variety of migrants.

Furthermore, no single data source describes all types of migrants, or their experience of health and disease. Therefore, we have flagged up the lack of data on specific groups or their access to healthcare throughout our report.

Economic migrants to the South East region

Economic migrants represent a very significant proportion of all migrants to the SE region and their numbers have increased over the past decade (see Figure 1.2). Although they are often young and fit, the impact of their presence is often more visible to mainstream health services than smaller migrant groups with greater health needs (5).

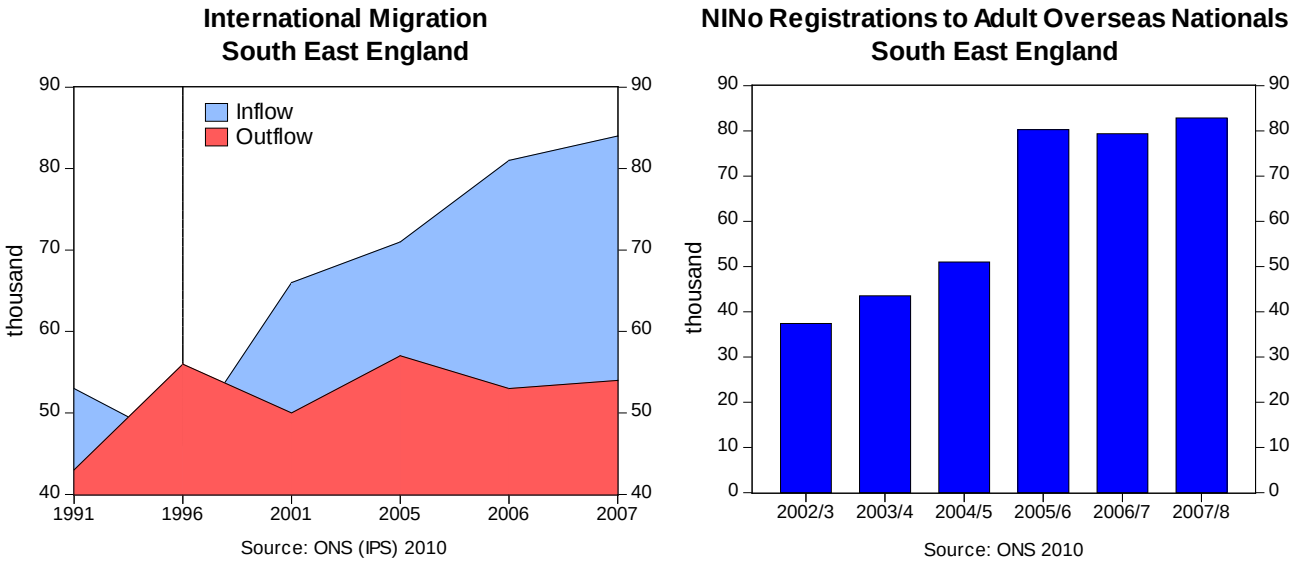


Figure 1.2: Trends in migration into the SE region, from the International Passenger Survey (IPS) and National Insurance Number (NINo) registrations (6).

Economic migrants have been attracted by the employment opportunities here, often in industries and services less favoured by indigenous populations. Figure 1.3 shows the growth in employment in 'migrant dense' sectors of the economy during the first decade of the 21st century.

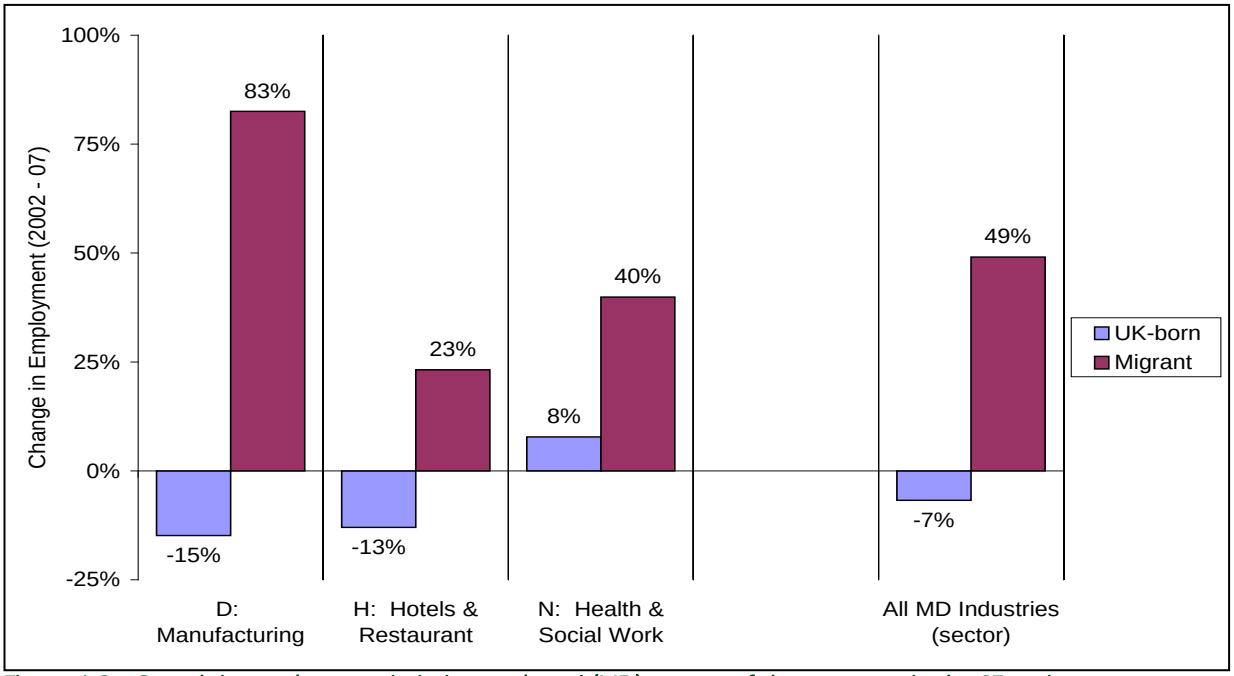


Figure 1.3: Growth in employment in 'migrant dense' (MD) sectors of the economy in the SE region 2002-07 (6).

The contribution of migrants to the SE region's economy has been substantial over these years (see Figure 1.4).

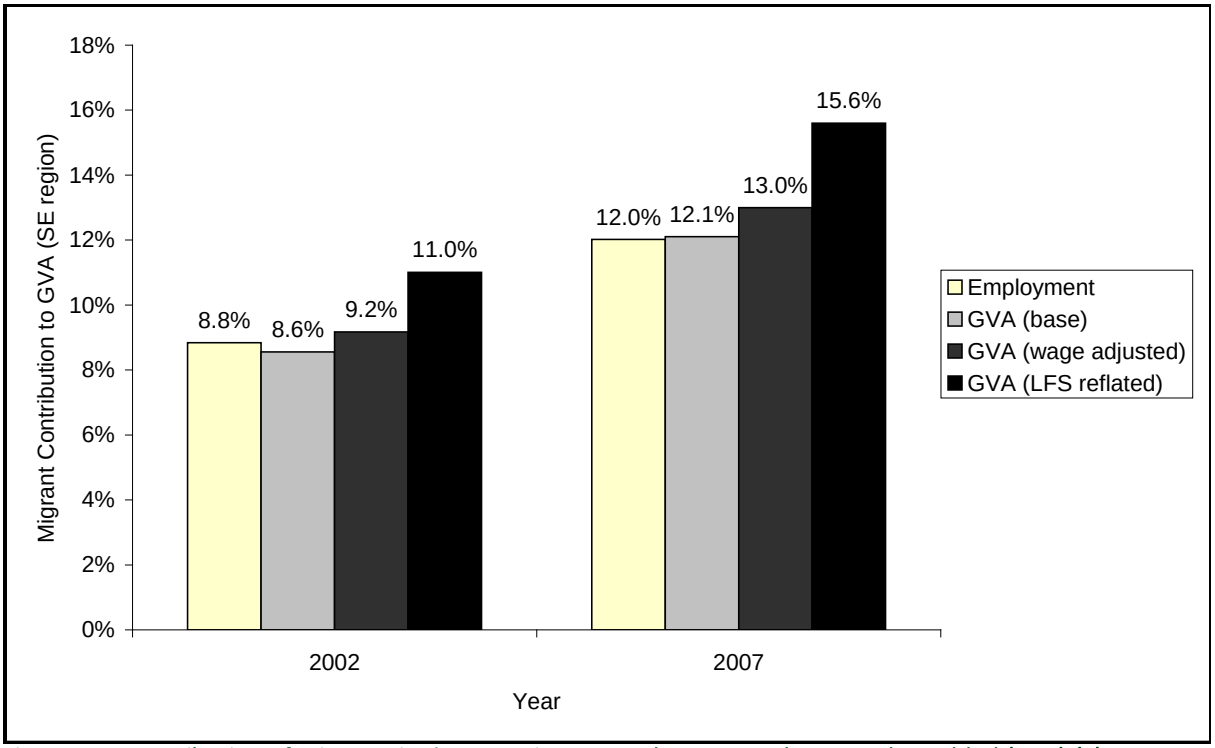


Figure 1.4: Contribution of migrants in the SE region to employment and Gross Value Added (GVA) (6).

However, since 2008, the UK economy has suffered the longest and deepest recession in the post-War era, experiencing six quarters of falling output, but 2.5 years of lost output growth (see Figure 1.5).

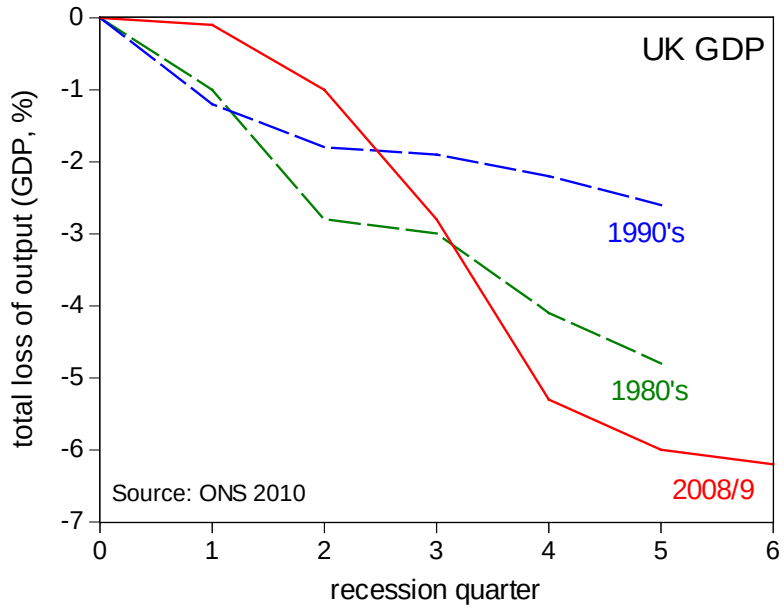


Figure 1.5: Loss of output as a percentage of UK Gross Domestic Product (GDP) during 2008-09 (6).

The impact of the economic downturn has included an impact on migration into the SE region where we have experienced not just a levelling-off of migration inflows, but a considerable increase in migration outflows (see Figure 1.6).

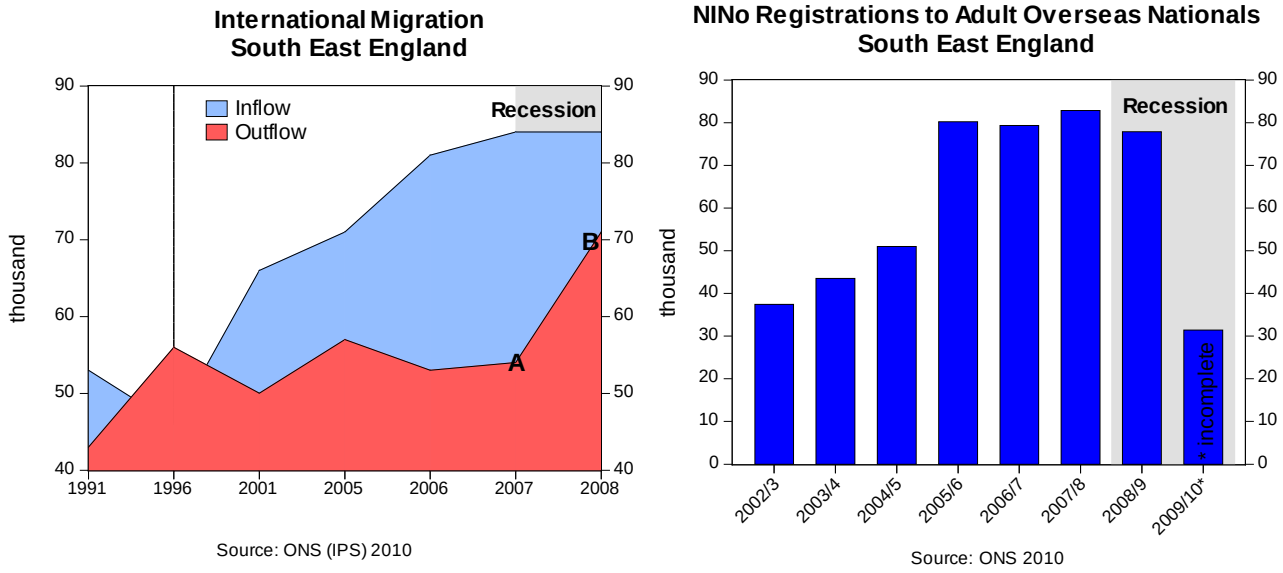


Figure 1.6: The impact of the economic recession on migration into the SE region: migration inflows and outflows from the International Passenger Survey and National Insurance number registrations for overseas workers (6).

This loss of migrant labour has been seen especially in migrant-dense sectors of the economy (see Figure 1.7).

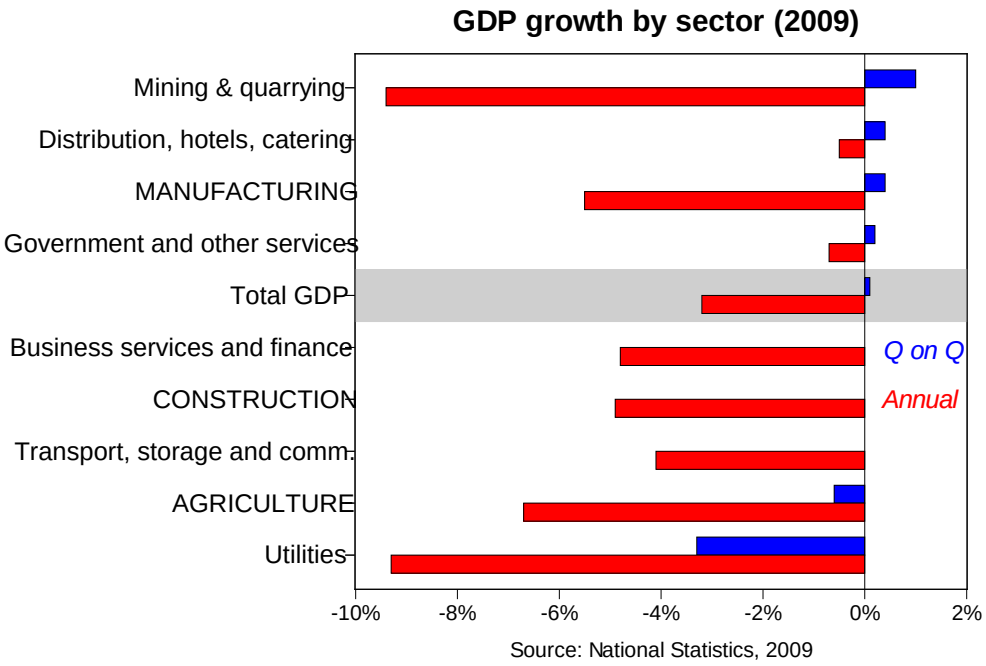


Figure 1.7: The differential impact of loss of migrant labour in different sectors of the economy (6).

This demonstrates clearly the impact of global economic factors on migration in the SE region and the challenges facing health services and other planners in considering the needs of this variable population.

Research methodology

This project faced methodological challenges, due to the SE region's two SHAs, the limitations of available data and time, and the spectrum between localities with better and less well-established local networks. A pragmatic research approach sought to establish both what is known and what is unknown, as well as to highlight areas of best practice across the SE region.

Literature review

An iterative literature review was undertaken of published and 'grey' sources, initially using search terms identified in other published reports, and later in following issues highlighted by survey respondents and interviewees. Searches were undertaken for the four groups of migrants identified above.

Interrogating sources of data

Current routinely collected datasets and data sources are insufficient to describe the migrant population in the UK and/or their experiences of health and disease. However, this project explored those sources of data with greatest potential value in describing migrant populations and their health needs. A full report of the strengths and weaknesses of these sources of data is given in Appendix A.

Survey

An on-line survey tool was developed after the literature review and initial discussions with key informants. The survey questionnaire can be found in Appendix B. Informants giving incomplete answers or providing key additional information were contacted by telephone by the research team to discuss questions and answers more thoroughly, when possible.

Invitations to participate in the survey were distributed throughout the SE region to Directors of Public Health in all PCTs, Chief Executives in all local/county/unitary authorities, and senior managers in all ambulance, acute and mental health trusts. A snowball strategy was employed, by which recipients were asked to disseminate the survey to the most appropriate contacts in their own organisation and to other organisations involved in providing or commissioning health services to migrants in their area.

Sixty responses were received which contained useful levels of detail, from a good geographical and organisational spread across the region (see Figures 1.8 and 1.9).

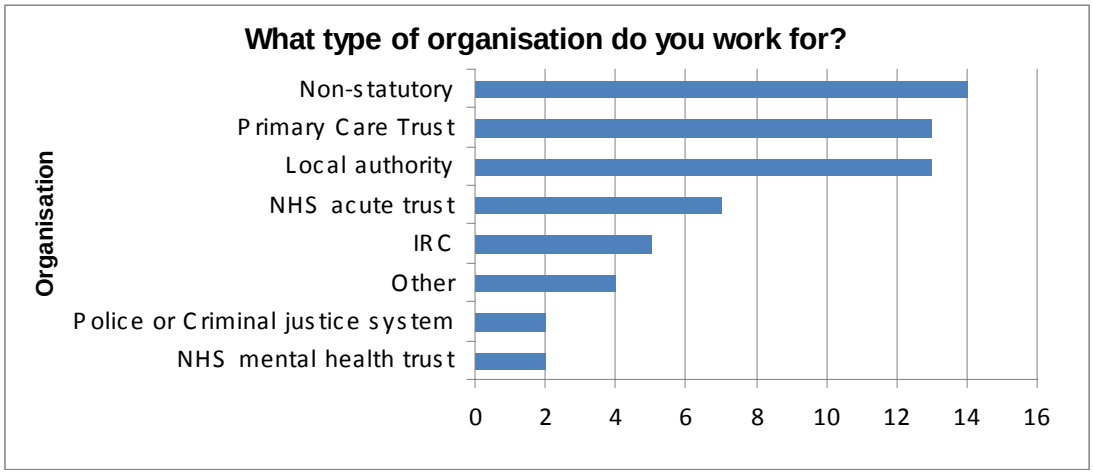


Figure 1.8: Types of organisation providing relatively complete responses to the survey tool used during this research project (n=60).

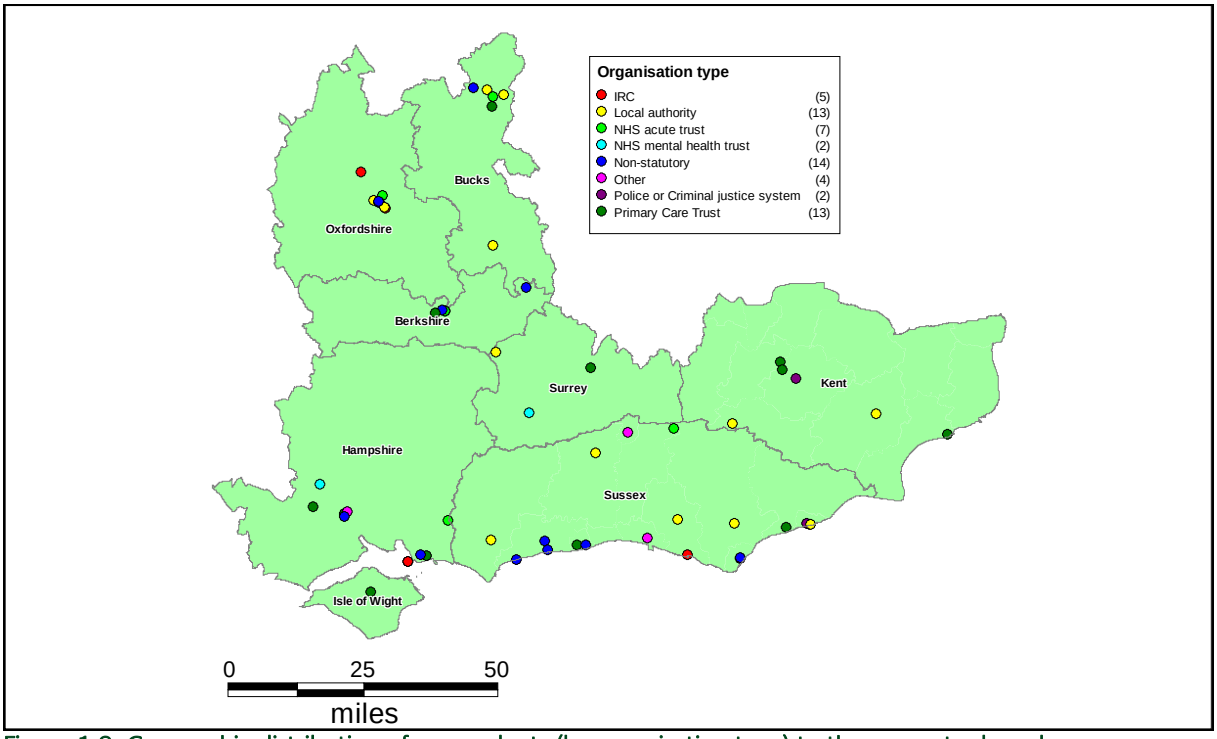


Figure 1.9: Geographic distribution of respondents (by organisation type) to the survey tool used during this research project across the SE region (n=60).

Note: One response from a PCT outside the South East region (Lambeth) was included, due to its particular expertise in targeted work with asylum seekers and refugees.

Interviews

A total of 32 interviews (telephone and face-to-face) were conducted to gain a deeper understanding of complex issues, or further insight into areas of particular importance. The range of organisations included in interviews is shown in Figures 1.10 and 1.11.

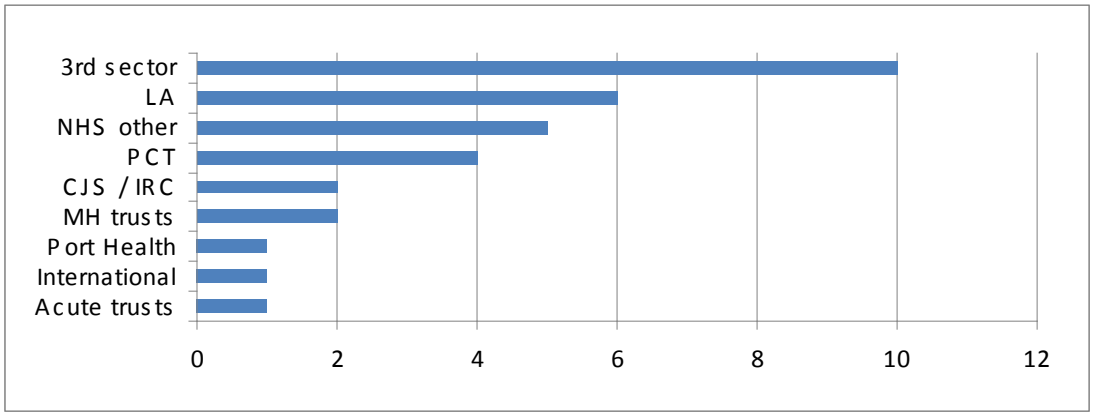


Figure 1.10: Types of organisation represented among interviewees participating in this research project (n=32).

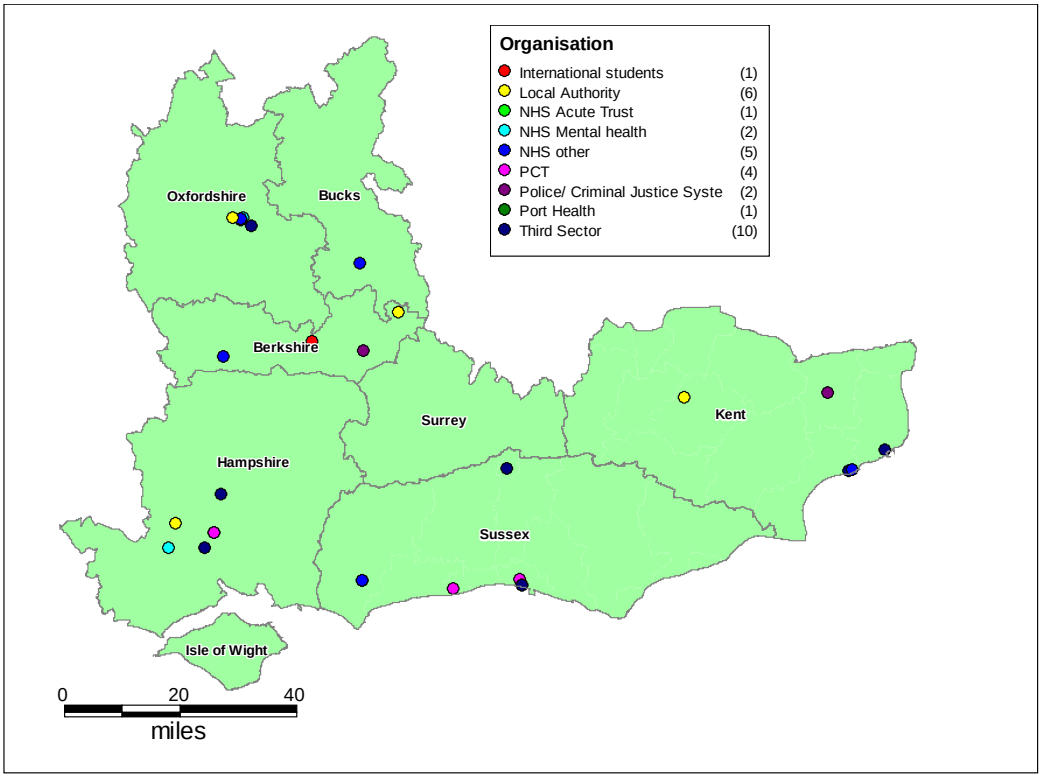


Figure 1.11: Geographical distribution of interviewees (by organisation type) participating in this research project across the SE region (n=32).

Note: Two interviewees from outside the South East region were included; an expert in trafficking at the London School of Hygiene, and the Head of Port Health based at Heathrow (whose Port Health system also covers Gatwick, in the South East region).

The findings from the literature review, the survey and the interviews have informed the structure and content of this report, and allowed us to identify exemplars of good practice. We have included some examples of these in relevant sections throughout this report. The report has also been informed by the proceedings of the inaugural meeting of the SEMH held in March 2010, attended by a broad range of

stakeholders, many of whom had been participants in the study. Details of this meeting are provided in Chapter Eight.

Conclusions and recommendations:

- Commissioners and healthcare providers need to define carefully the specific migrant groups they are referring to when considering the health needs of the population they serve.
- Health planners need to recognise the variability of migrant populations in the South East and that the fluctuations that may be dictated by regional, international, or global events.
- Sources of routinely collected data need to be developed to allow more sophisticated analysis of migrants' health needs.

References for this chapter

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3. Rutter J, Latorre M. Social housing allocation and immigrant communities: Equality and Human Rights Commission, Institute of Public Policy Research: Migration, Equalities and Citizenship Team; 2009.
4. Office for National Statistics. Migration Statistics Quarterly Report; 2010 Feb.
5. Migrant workers from the EU Accession countries: A demographic overview of those living and working in England and Wales and a comparison of infectious disease and immunisation rates in the Accession countries with those in the UK: Travel and Migrant Section, Health Protection Agency; 2008.
6. Perkovic I. Head of Economic Research, SEEDA. 2010.

Chapter Two: What do we know about migrants in the South East region?

Key findings:

- Describing the demography of migrants is challenging.
- Different sources of data reflect different categories of migrants, but no category of migrants is comprehensively described.
- Data sources generally fail to capture outflows of migrants, within and beyond the UK.
- Routinely collected data sources are particularly poor at locating irregular migrants and people granted refugee status.
- Some data sources capture ethnicity, but this is a poor proxy for understanding migrants.
- Local examples of best practice from across the SE region suggest a widespread desire to understand better the demography of migrants, and potential ways to do this.

To understand the health needs of any population we must first try to describe the size, shape and location of that population. There is a widespread consensus that this is a challenging task, not met by any single source of data (1,2). Migrants to the UK are drawn from demographically and culturally heterogeneous populations, with diverse health needs. The problem is compounded by the irregular migrants' desire to avoid being counted, for fear of deportation or criminal prosecution.

Migration is a dynamic process, and the sources of currently available data capture some of the people entering the region, but there is very limited data about people leaving (1,3).

Where migrant status cannot be directly determined, country of birth and nationality are often used as proxy indicators for migration. Country of birth gives a more robust estimate of migration. It is possible that an individual's nationality may change, but the respondent's country of birth remains the same. Although country of birth is a more robust option, it does not represent a precise proxy. The category 'foreign born' will include some UK nationals, for example, those born to UK service people stationed abroad.

Ethnic background is also often used to estimate migration, but it is an even more inaccurate proxy (1,2,3). Any of the ethnic minority groups (for example, Asian or Black Caribbean) will include individuals who were born in the UK, who are British nationals, or who have been living in the UK for many years, who therefore should not be classified as migrants. Figure 2.1 presents 2001 census data comparing ethnicity and region of birth. Although no more recent census data is available, the 2001 census data illustrates the issues associated with the use of ethnicity as proxy for migration.

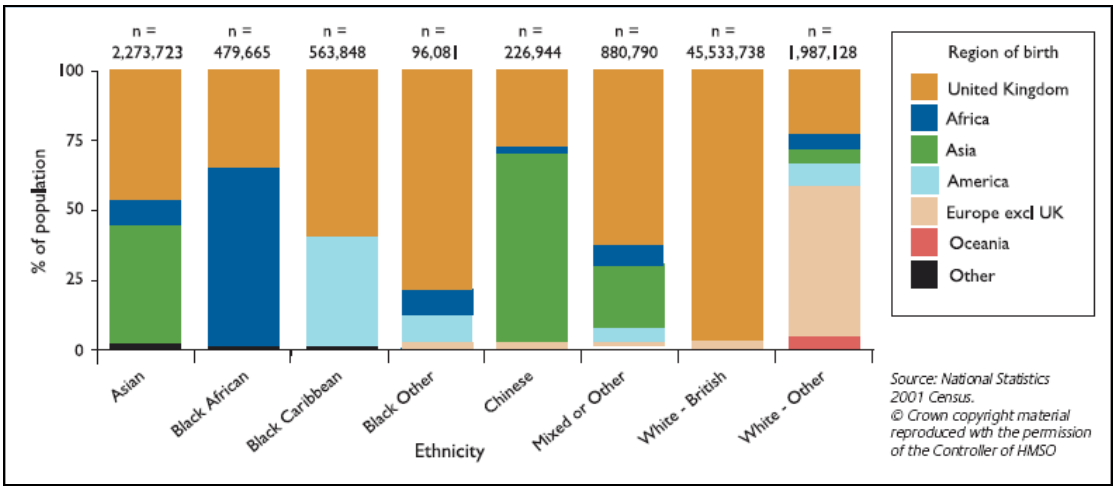

Figure 2.1: Comparison of region of birth and ethnicity, 2001 census data (4).

The Office for National Statistics (ONS) established an Interdepartmental Task Force on Migration Statistics in May 2006, which has made some progress in modelling short-term migration (see below).

This project took two parallel approaches to understanding the distribution of migrant populations across the region:

- A rigorous review of the sources of routinely collected data, led by SEPHO, produced a report on the strengths and weaknesses of the most useful sources (Appendix A) and the results are presented later in this chapter.
- In addition, the demographic understanding of organisations in the region was briefly assessed, through their JSNAs and through the survey and interviews.

What the ONS data tells us

The ONS produces estimates of populations by local authorities and counties, for use by service providers and commissioners. Data on individuals born outside the UK is included in these estimates. As presented in Figure 2.2, in the SE region population estimates for individuals born outside the UK demonstrate considerable geographical differences, with Slough, Reading and Milton Keynes presenting some of the highest proportions of the total population estimates (see Appendix C for more details).

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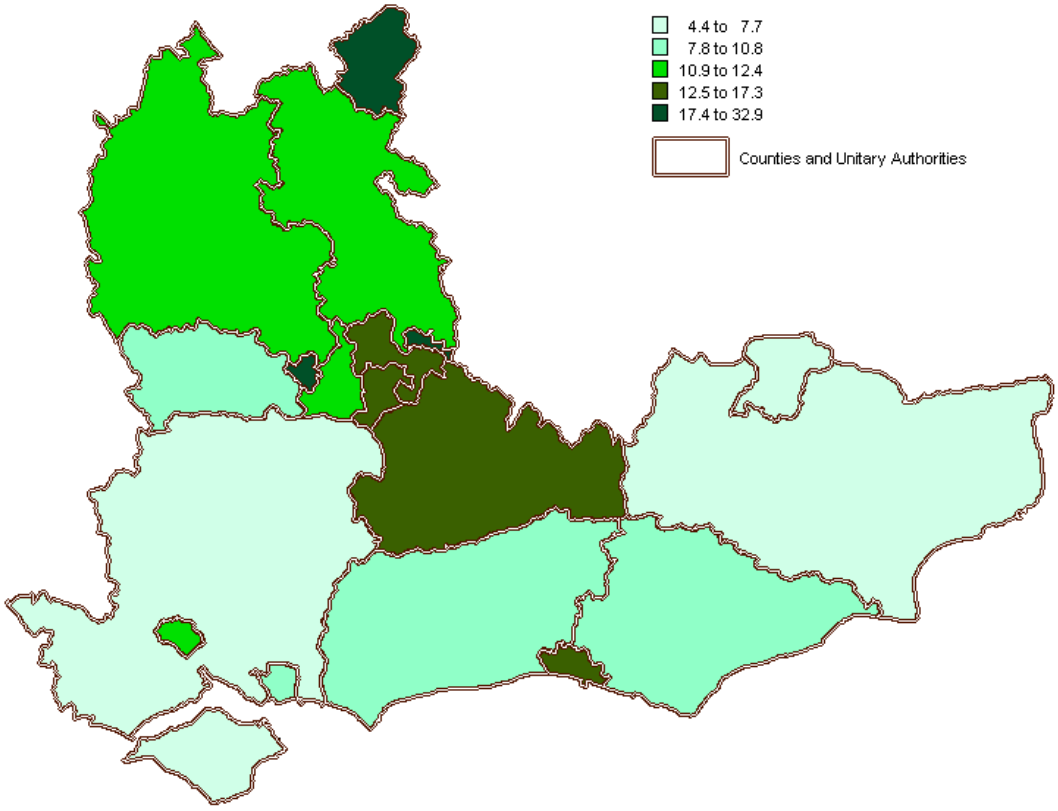


Figure 2.2: Population estimates for individuals born outside the UK, as percentage of total population estimates. Counties and unitary authorities in the South East (April 2008 to March 2009).

Despite some areas of overlap, different areas show the greatest concentrations of non-British nationals (see Figure 2.3). For example, although Slough, Reading and Milton Keynes remain the top three areas, the percentage of non-British nationals living in Oxfordshire and Southampton is now also among some of the highest in the region (see Appendix C for more details).

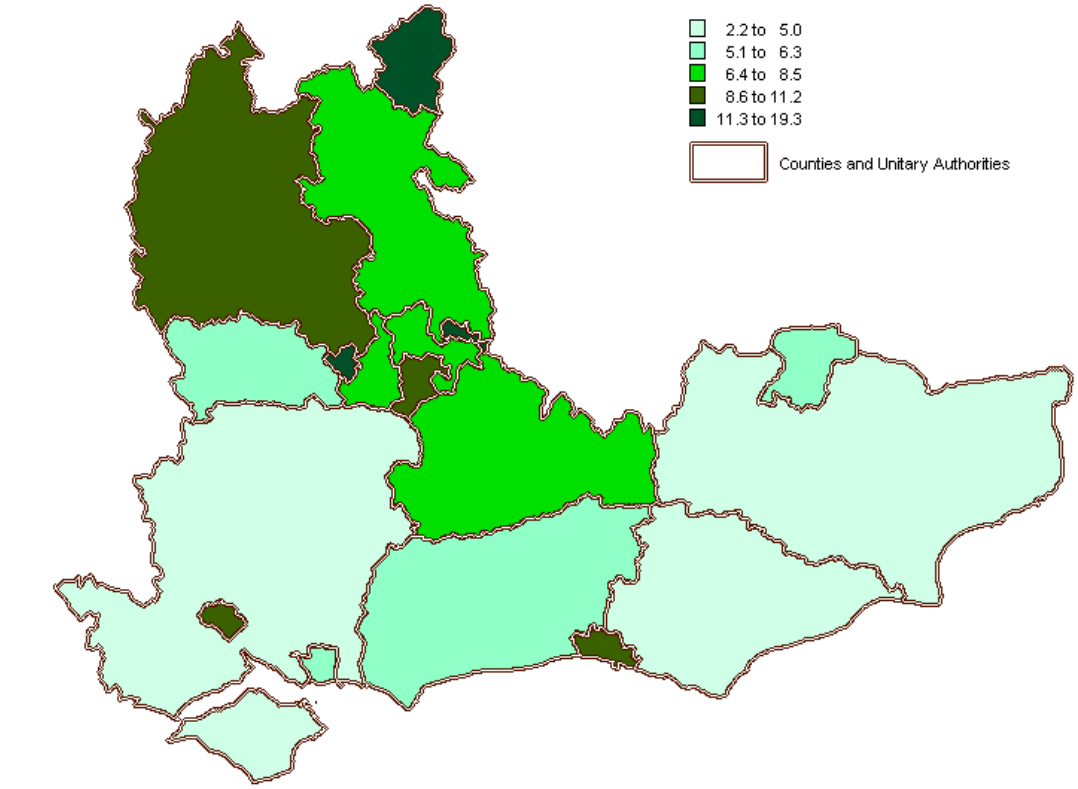


Figure 2.3: Population estimates for non-British nationals, as percentage of total population estimates. Counties and unitary authorities in the South East (April 2008 to March 2009).

Modelling undertaken by ONS combines various data sources in the only attempt to reflect people leaving, as well as entering, the region (Figure 2.4). In addition to counties and unitary authorities, this data is available for local authorities in the region. When compared to the population estimates presented in Figures 2.2 and 2.3, some interesting findings become apparent. Some counties have relatively low overall proportions of their populations born outside the UK, or of non-British nationals, but also have pockets with high volumes of international migration. Good examples of this are Surrey and Kent. These differences may reflect different groups of migrants living within the counties. Oxfordshire is another good example, with Oxford showing the highest population turnover in the SE region, which is likely to be reflected by the large international student population in the area. (See Appendix C for more details.)

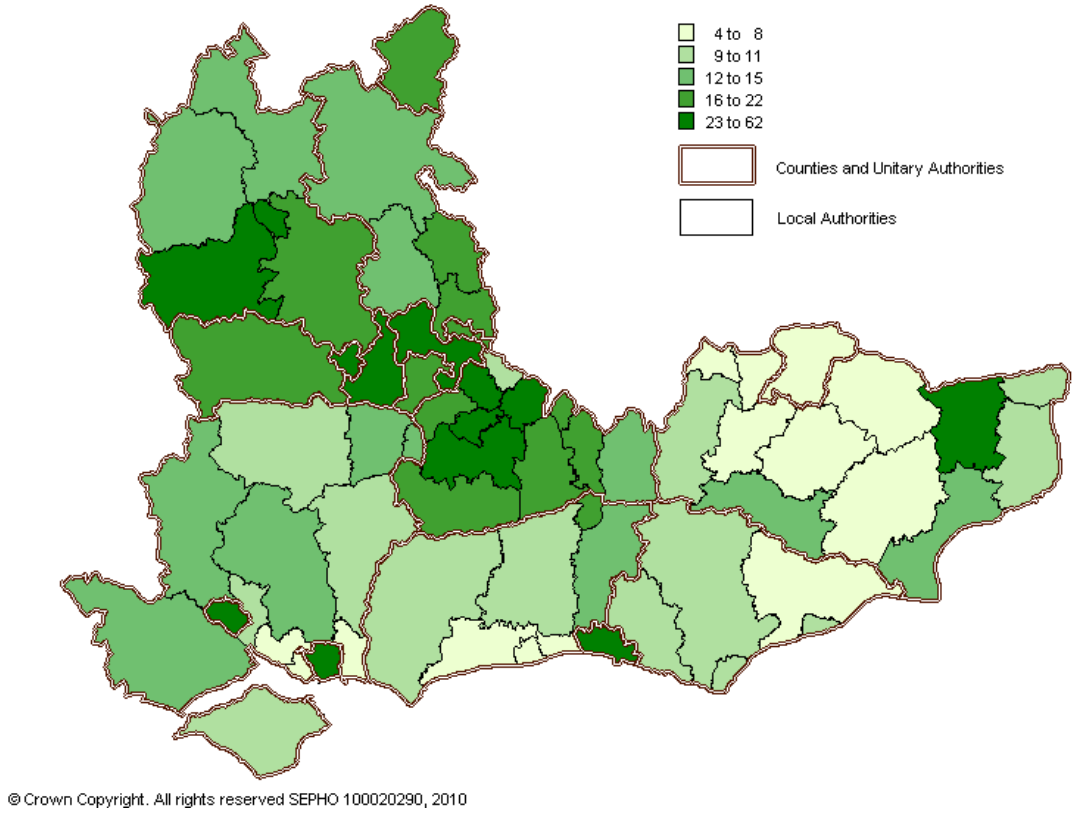


Figure 2.4: Volume of international migration per 1,000 population. Districts and unitary authorities in the South East (Mid-2007 to Mid-2006)

What organisations know about migrants in the SE region

The WCC policy requires all PCTs to collaborate with their local authorities to identify shared strategic needs in a JSNA, and to make this publicly available. The majority of JSNAs from the region discussed ethnic minorities in relation to targets for educational achievement, or occasionally in relation to increased health risks, such as circulatory disease (Surrey, Milton Keynes), sexually transmitted infections and HIV (Buckinghamshire), or mental health problems (Brighton and Hove). Several JSNAs also spoke about travellers as a minority ethnic group with a need for additional support.

References to migrants specifically were less common. People from Poland and Central Europe were mentioned in fewer than half of the JSNAs, and two mentioned Nepalis or Gurkhas. Asylum seekers were discussed in seven JSNAs, in the specific context of an IRC (Hampshire), the need to increase accessibility of primary care services (Slough), or the particular vulnerabilities of unaccompanied asylum-seeking children (Southampton, Surrey, Brighton & Hove). The increased mental health needs

of asylum seekers and refugees were raised by two JSNAs (Southampton, Brighton & Hove). Southampton's JSNA also discussed other health needs of migrants, including maternal and child health, and early identification and treatment of people with TB.

A few JSNAs highlighted the extent to which the 2001 census does not accurately reflect the migrant contribution to local populations. More up-to-date sources of data they mentioned were NINO registrations (Slough, Reading and Buckinghamshire), Workers Registration Scheme (West Sussex) and school census data (Bracknell Forest, Reading, Milton Keynes, Portsmouth City).

The survey asked organisations about sources of data they found helpful to understand the demography and the health needs of migrants in their area. The free text comments for both questions included a proportion saying that they did not know, or could not get access to any data sources. Several commented that the data was not sufficient, and a few gave examples of good local research done by their own organisation (see Figures 2.5 & 2.6).

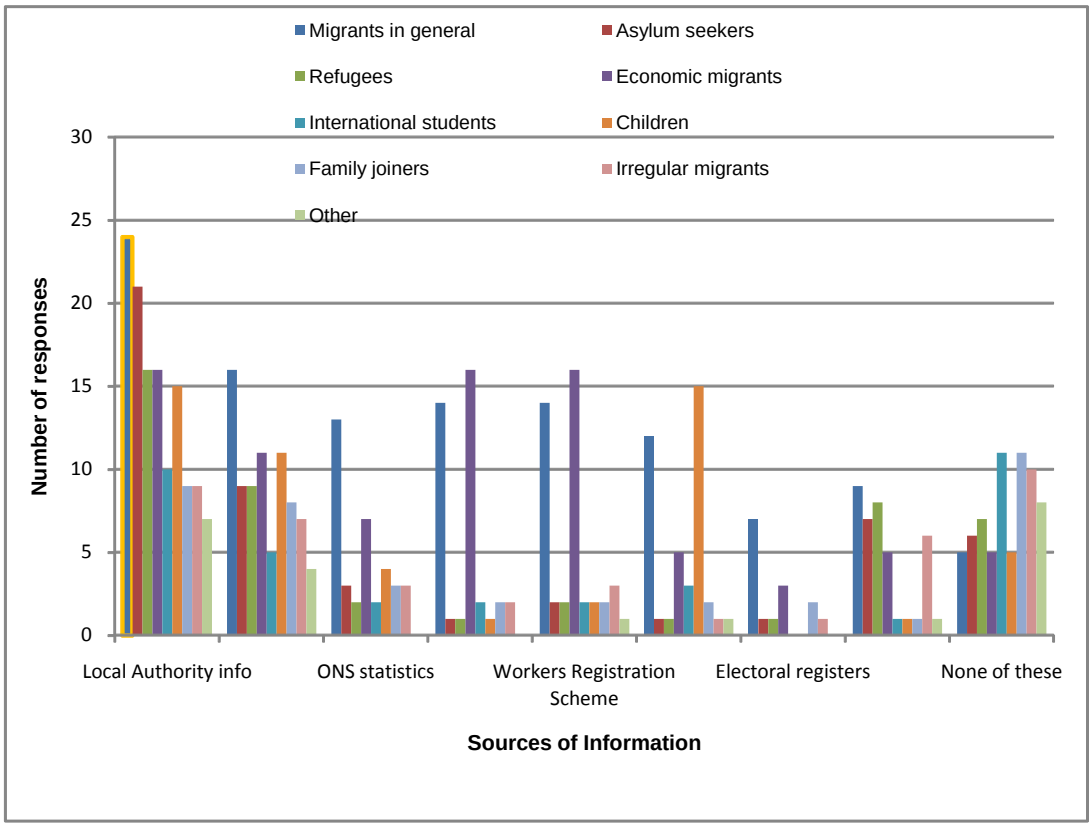


Figure 2.5: Responses to 'What sources of information do you find helpful to understand the numbers of migrants in your area? Please select any which are helpful for each category'.

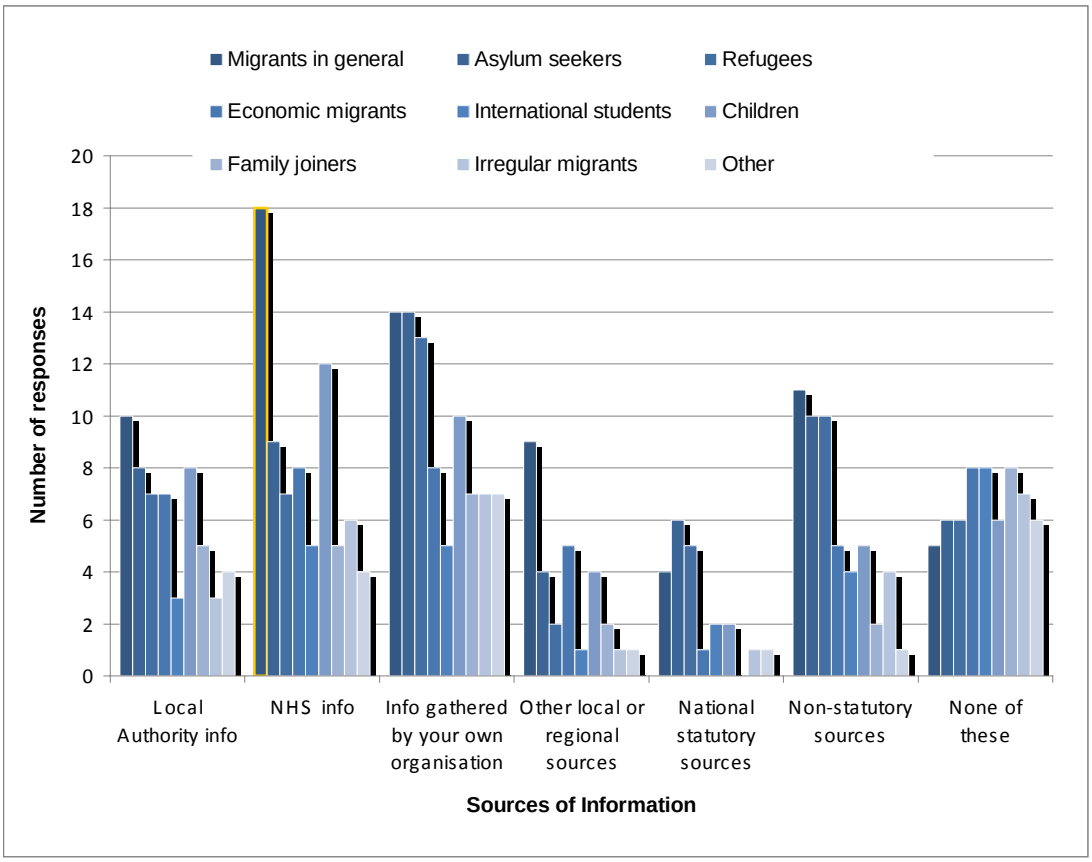


Figure 2.6: Responses to 'What sources of information do you find helpful to understand the health needs of these groups in your area? Please select any which are helpful for each category'.

Best Practice Example

Estimation of Polish population numbers, Banbury:

Oxford County Council (OCC) became concerned by alarmist reports being circulated by local media and one district council that 10,000 Polish people were living and working in Banbury. This figure suggested that they comprised 25% of the town's population and contributed to local tensions between East European migrants and Asian residents.

OCC began with Workers Registration Scheme data, which recorded numbers of dependents for each registered worker. Enquiries to the local Polish association, and the employment agency bringing the majority of Polish workers to Banbury, revealed that most came from a single Polish city. OCC then liaised with churches in that city and with Polish churches around Banbury, extrapolating from the proportions of various groups who attended church in Poland, to attendance figures around Banbury. Similarly, the working population's age structure in Poland was triangulated with WRS dependents figures and the school census numbers of Polish-speaking children attending schools, which is a comprehensive and robust data source.

Using various assumptions for these extrapolations, the size of the Polish population around Banbury was estimated to be 1,000-3,000.

Data sources on economic migrants

Any migrants over the age of 16, intending to work legally in the UK, register for a NINO. The place in which migrants first register is captured, but the system does not capture their subsequent moves within or out of the UK. Figure 2.7 presents NINO registrations for non-British nationals (as a percentage of resident population) in the SE region. Slough, Oxford and Reading show some of the highest percentages. These areas also have some of the highest proportions of their populations born outside the UK (Figure 2.2), or of non-British nationals (Figure 2.3), and the highest population turnover (Figure 2.4) in the SE region. (Further details are available in Appendix C.)

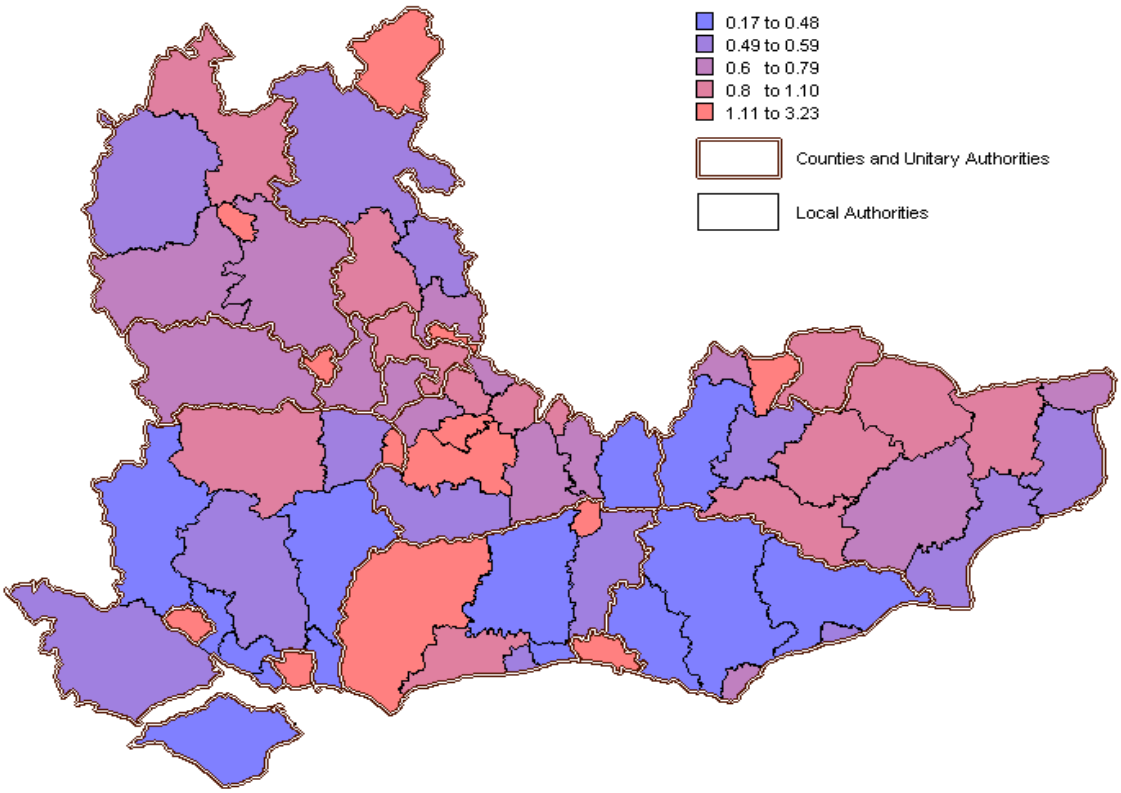


Figure 2.7: National Insurance Number registrations among non-British nationals as percentage of resident population. Unitary and local authorities in the South East (April 2008 to March 2009.

The Workers' Registration Scheme was introduced in 2004 to monitor migrants from European A8 countries working as employees for one month or longer. Workers are registered by their employer's location. Many migrants avoid it as they perceive it as a form of taxation, and it does not capture self-employed migrants (see Figure 2.8).

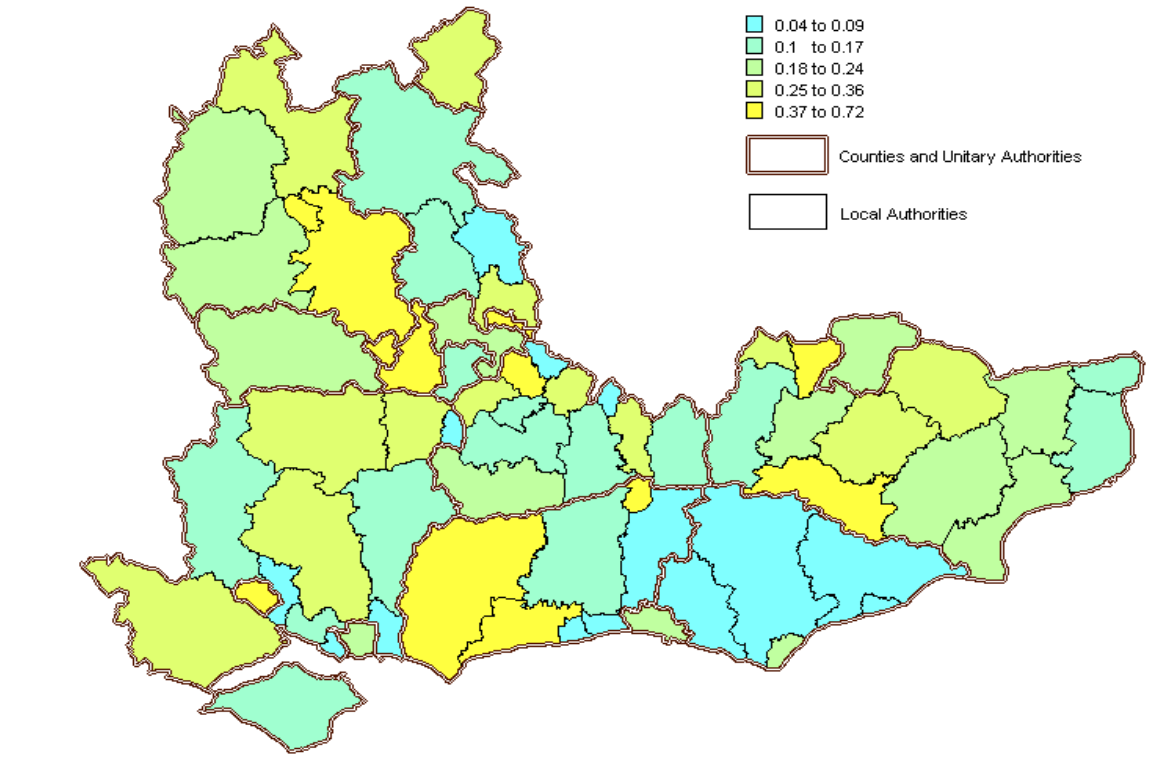


Figure 2.8: Worker registration as percentage of resident population. Unitary and local authorities in South East region.

Data sources on international students

The Higher Education Statistics Agency maintains a record of all students in UK institutions of higher education, including those whose country of usual residence is outside the UK (grouped into Other EU and Non-EU). Students give an estimate of their intended length of stay, so departing students are reflected to some extent, although there is no enforcement to ensure international students leave the UK at the end of their course of study. The South East has numerous institutions of higher education (see Figure 2.9), several of which have above-average proportions of international students (see Figure 2.10).

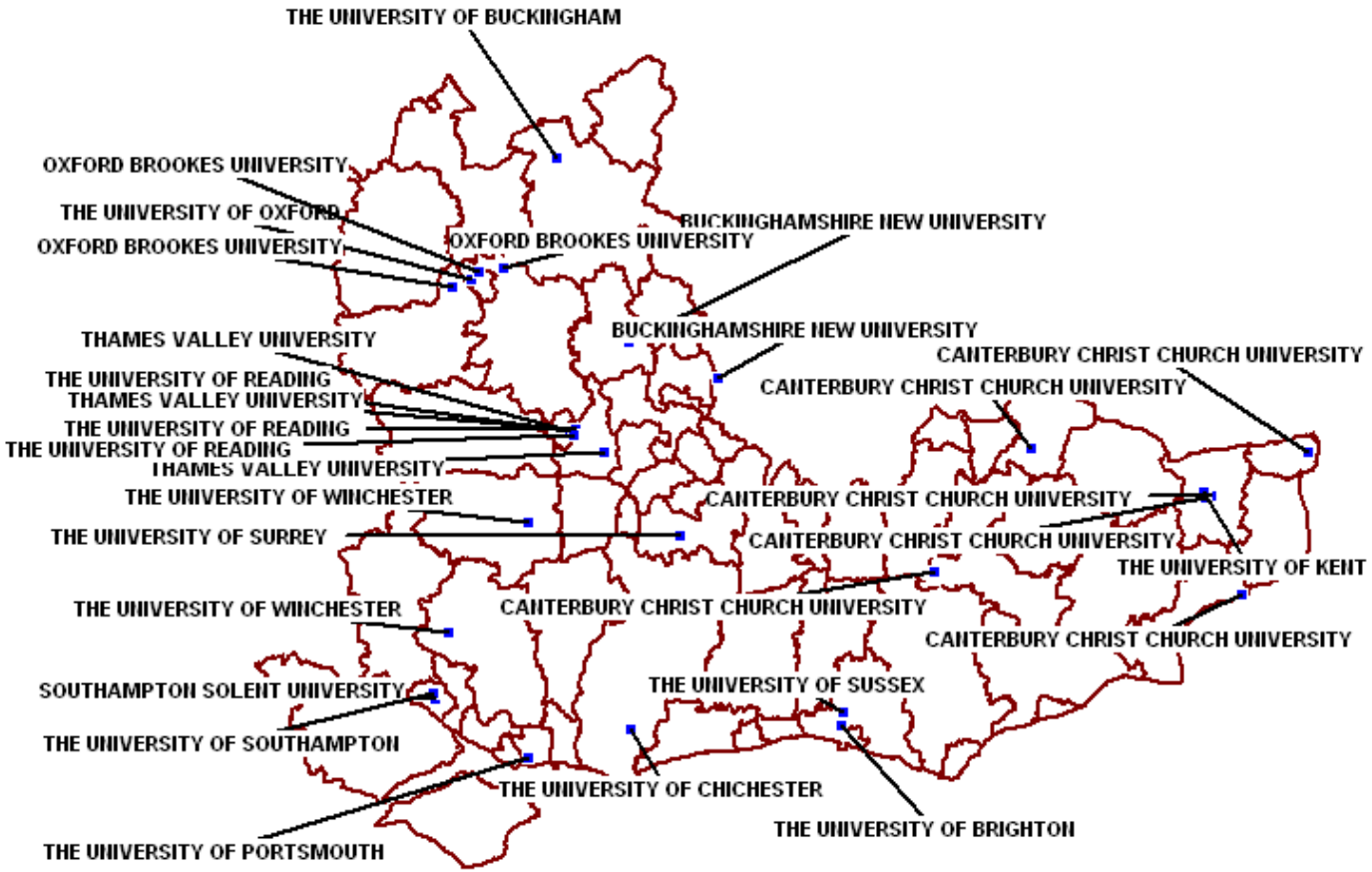


Figure 2.9: Universities (including campuses) in the South East region.

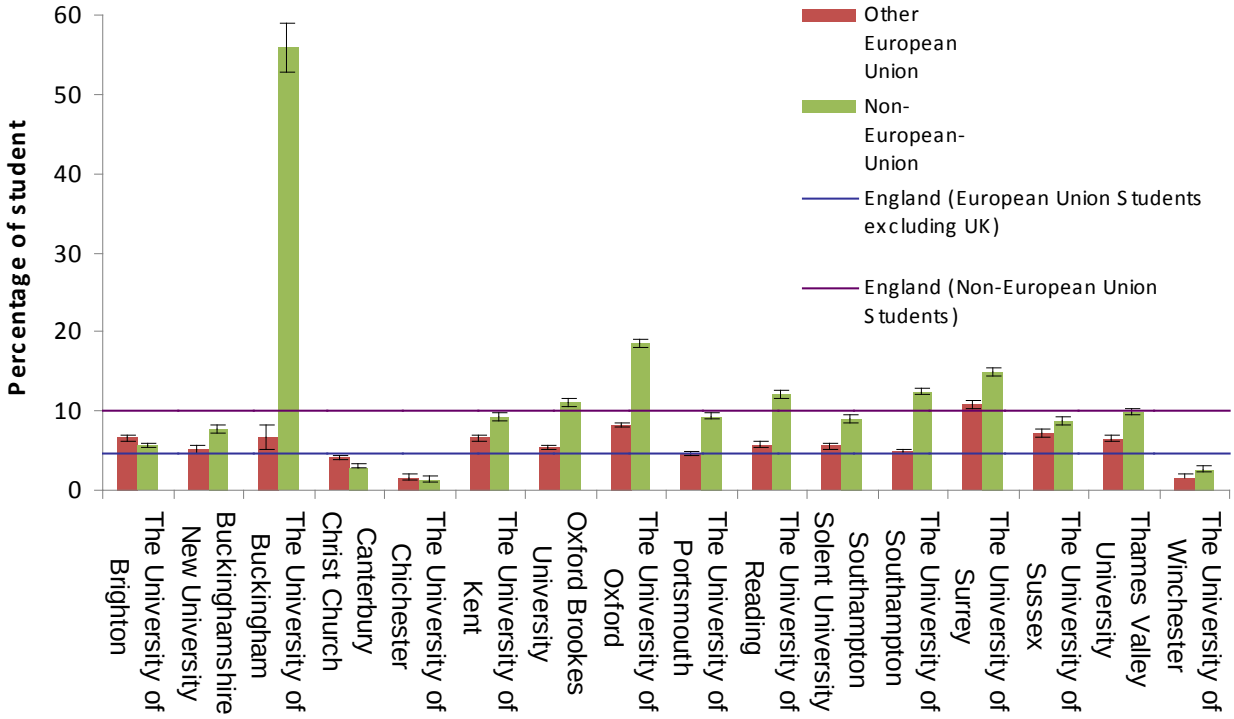


Figure 2.10: Proportion of overseas students across the South East region by institution and country of origin (2007/08).

Data sources on asylum seekers and refugees

Asylum seekers, by definition, are seeking the right to refuge in another country due to a well-founded fear of persecution in their country of origin. If their claim to asylum is successful, they are granted leave to remain in the UK as refugees or under a variety of complex and frequently changing regulations (5).

While their claim is assessed or appealed, the UK Border Agency (UKBA) may require them to be detained in an Immigration Removal Centre (IRC), or may support them with accommodation (requiring them to accept accommodation in a 'dispersal area' away from London). There are not many dispersal areas in the South East, as the intention of dispersal was to distribute asylum-seekers around the UK, reducing their concentration in and around London. Should asylum seekers choose not to accept dispersal accommodation, they may receive 'subsistence only' financial support, while they make their own accommodation arrangements.

Unaccompanied asylum-seeking children are supported by the local authority in which they first claimed asylum, even if they are then placed in another area, so they are not reflected in UKBA data. Asylum seekers in detention will be discussed further in Chapter Six. Failed asylum seekers whose claim has been rejected may be entitled to some support from UKBA, subject to certain conditions, but are not entitled to access NHS care, except in emergencies. If refugee status is granted, asylum seekers become refugees, are entitled to work and access mainstream social security, and are issued with travel documents and entitled to move freely within and beyond the UK. Refugees are therefore not reflected in UKBA data.

Numbers of asylum seekers to the UK have decreased since 2006, but ONS data shows that they have always formed a smaller proportion of migrants than economic migrants and family joiners (see Figure 1.1). It is difficult to map this population accurately across the region, due to their small numbers, changing status and complex regulations. The data available from UKBA does not express their physical and mental health needs, which are often greater than other migrant groups, and these needs are often met by non-statutory organisations which have undertaken research more accurately expressing these needs (6).

Although limited, UKBA figures are published quarterly and reflect the national government's picture of how certain sections of the asylum seeker population are distributed across the region. For example, asylum seekers accepting dispersal accommodation across the UK and South East are shown in Figure 2.11.

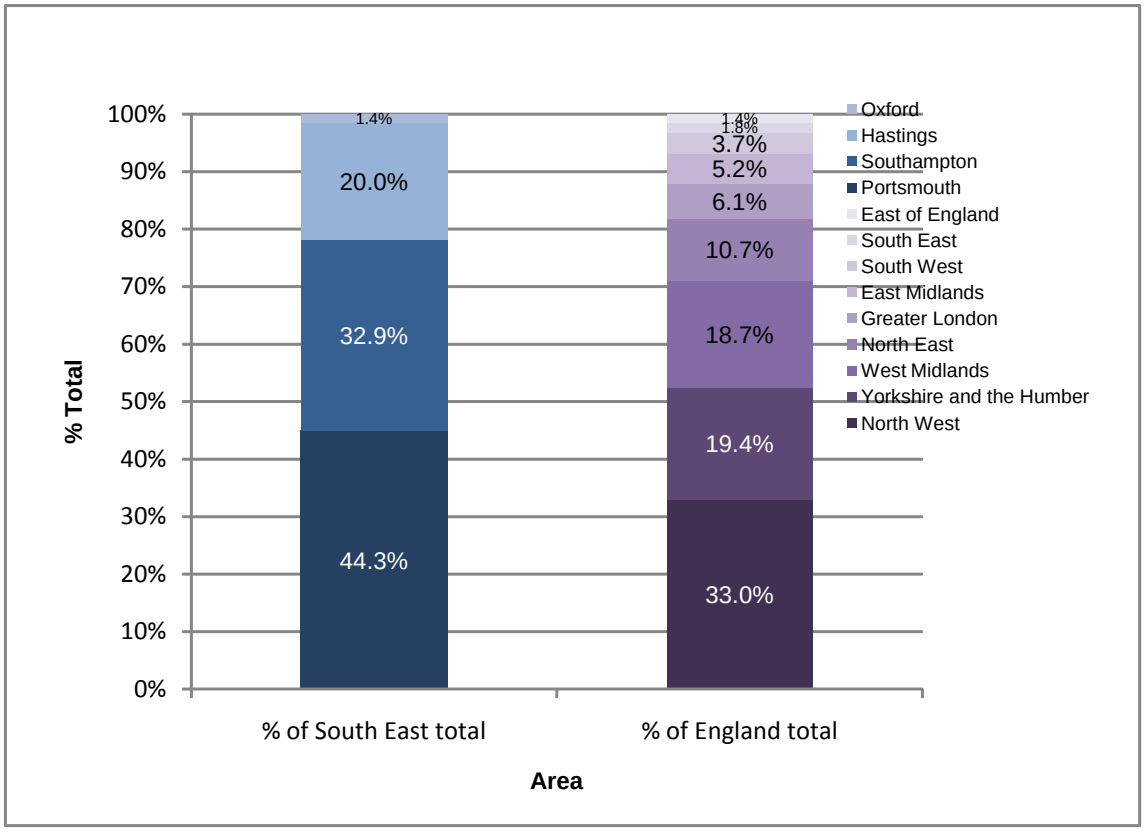


Figure 2.11: Asylum seekers supported in accommodation (excluding initial accommodation and unaccompanied asylum seeking children), by local authority and Government Office region, as at the end of September 2009.

Unsurprisingly, London and the SE host a greater proportion of asylum seekers choosing to find their own accommodation, rather than accept dispersal, and receiving 'subsistence only' funds. These numbers exclude unaccompanied asylum-seeking children, but include dependants of asylum seekers (see Figures 2.12 and 2.13).

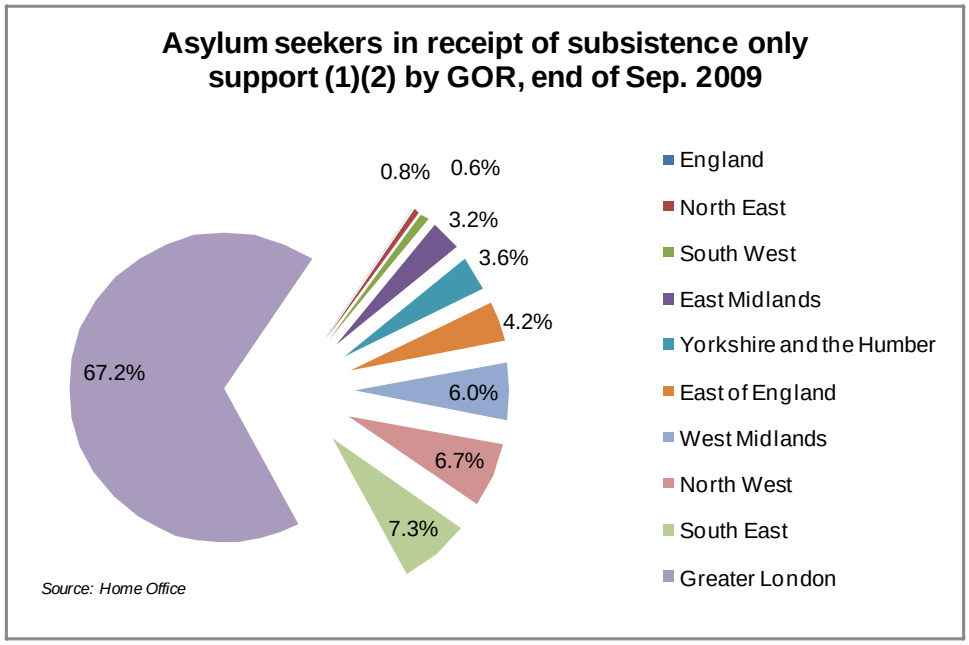


Figure 2.12: Asylum seekers in receipt of subsistence-only support, by Government Office region as at the end of September 2009.

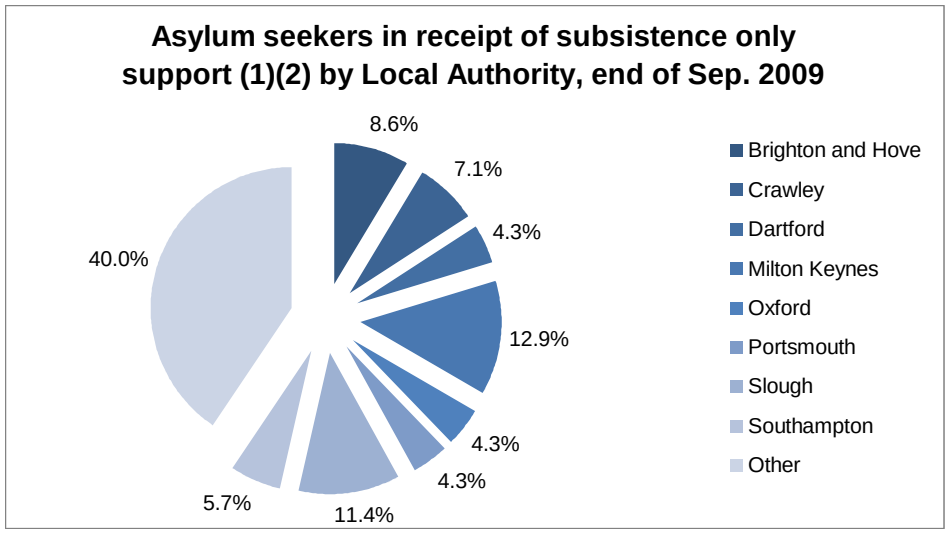


Figure 2.13: Asylum seekers in receipt of 'subsistence only' support, by local authority as at the end of September 2009. [Local authorities with fewer than 15 cases, when rounded, are grouped as 'Other'.]

UKBA provides information about country of nationality for supported asylum seekers (combined for those in dispersed accommodation and receiving 'subsistence only' support, excluding unaccompanied asylum-seeking children supported by local authorities, and people in initial detention) (see Figure 2.14).

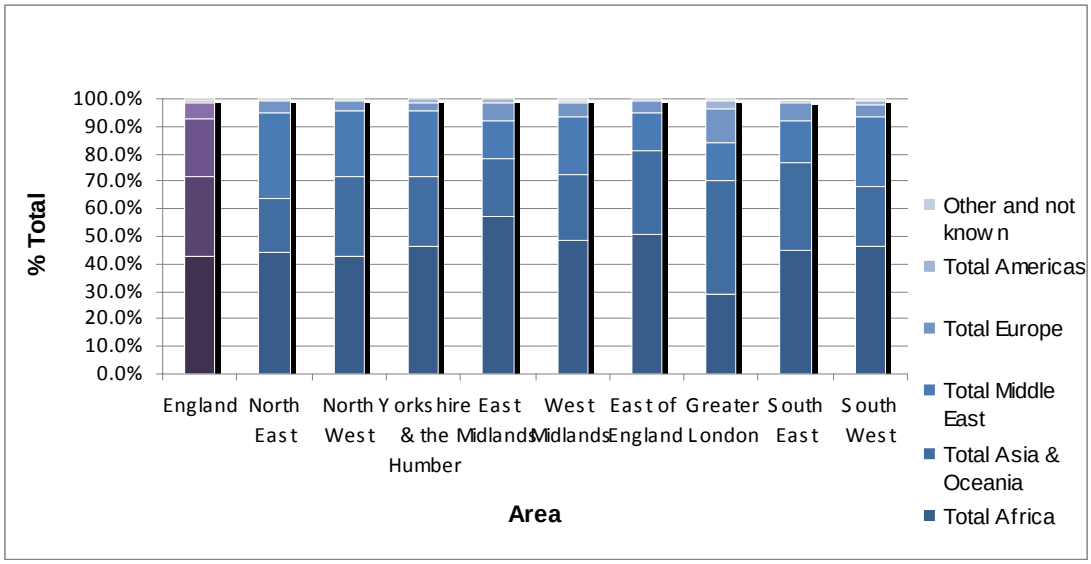


Figure 2.14: Regional distribution of supported asylum seekers, including dependants, by country of nationality, as at end December 2008.

Caution should be applied when interpreting this information in detail, as it presents a misleadingly static picture, given the dynamic nature of this population. For example, in the South East in December 2008, UKBA data showed 735 supported asylum seekers including dependants; 330 or 45% of these were African, of whom 120 Zimbabweans formed the largest national group. 235 were Asian, of whom 90 were Sri Lankan.

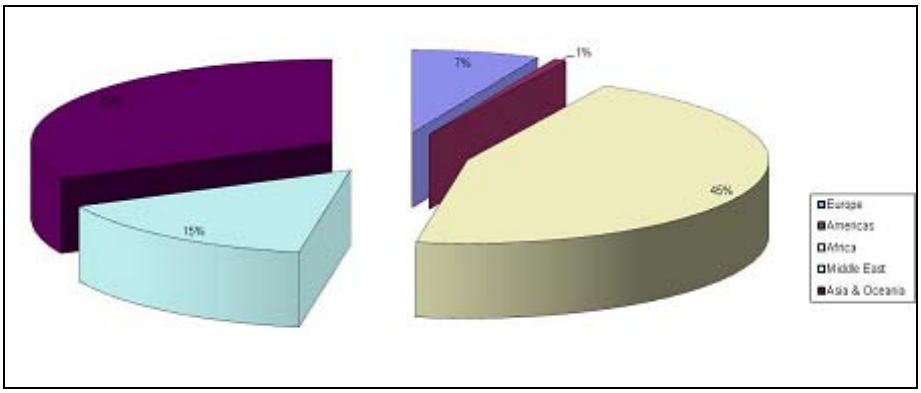


Figure 2.15: Regional distribution of supported asylum seekers in the South East, including dependents, by country of nationality, as at end December 2008.

Data sources on irregular migrants

By their very nature, irregular migrants are not recorded systematically on any database that can be interrogated for specific information on health needs or health-seeking behaviours. However, our research identified some exemplars of best

practice from a range of stakeholders, which may be useful for others to emulate, to improve intelligence and engagement with this vulnerable group.

Best Practice Example

Police-initiated research, Kent:

Kent police initiated a project with the University of Kent in response to a growing number of undocumented migrants into the area. The project aimed to identify the protection needs of undocumented migrants, gather an informed understanding of their circumstances and identify areas where improved policing might assist in meeting their needs. Several recommendations were made to the police force, including improved training, improved knowledge of the ethnic populations within their area, and a greater understanding of the unique health needs of this population.

Other data sources on migrants: Maternal birth data

Indirect or proxy measures can be used to estimate the migrant population in the SE region. This can include the birthplace of mothers giving birth to children (Figure 2.16).

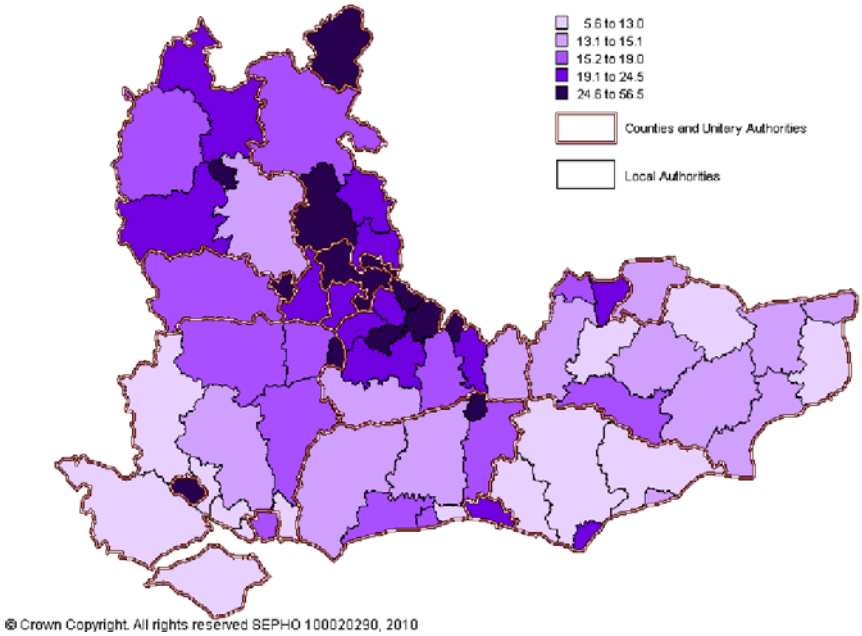


Figure 2.16: Live births where mother's birthplace was outside of the UK, as a percentage of all live births; Unitary and local authorities in the South East 2008.

This data can be further broken down by the mother's country of origin to give a sense of the diversity of origins of migrants in the region. For example, Figure 2.17 shows the distribution of mothers born in African countries.

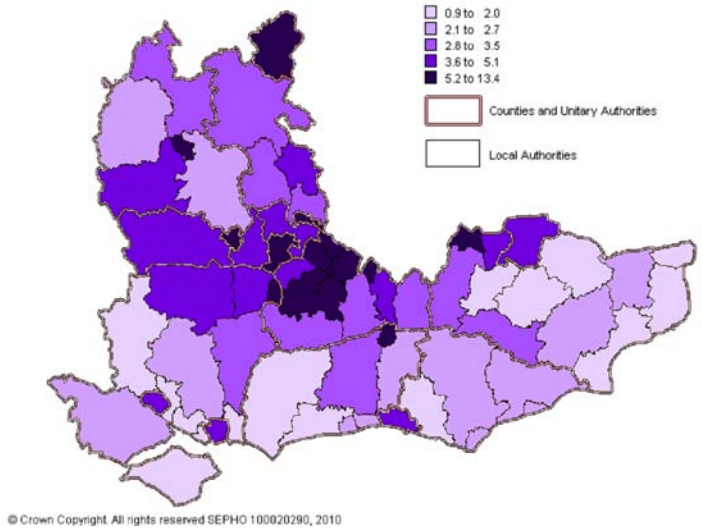


Figure 2.17 Live births where mother's birthplace was outside the UK (African countries only), as percentage of all live births. Unitary and local authorities in the South East 2008.

Figure 2.18, by contrast, shows the distribution of mothers whose country of origin was in Asia.

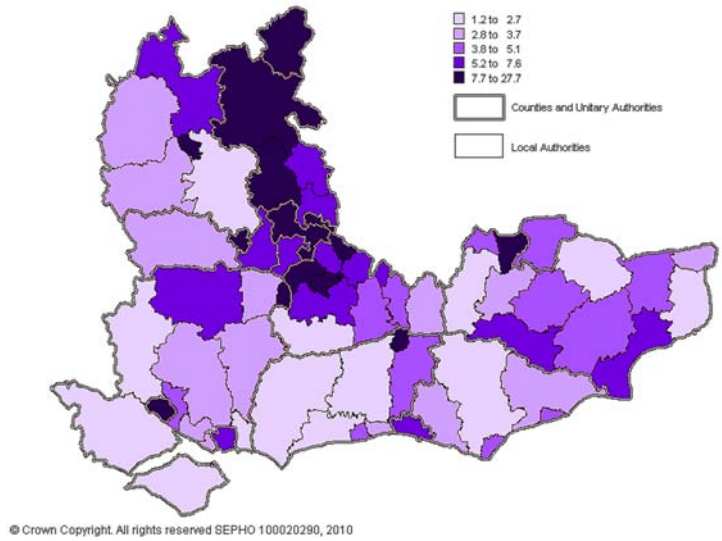


Figure 2.18: Live births where mother's birthplace was outside of the UK (Asian countries only), as percentage of all live births. Unitary and local authorities in the South East 2008.

Figure 2.19, alternatively, shows the distribution of new mothers whose country of birth was outside of the UK, but within the European Union.

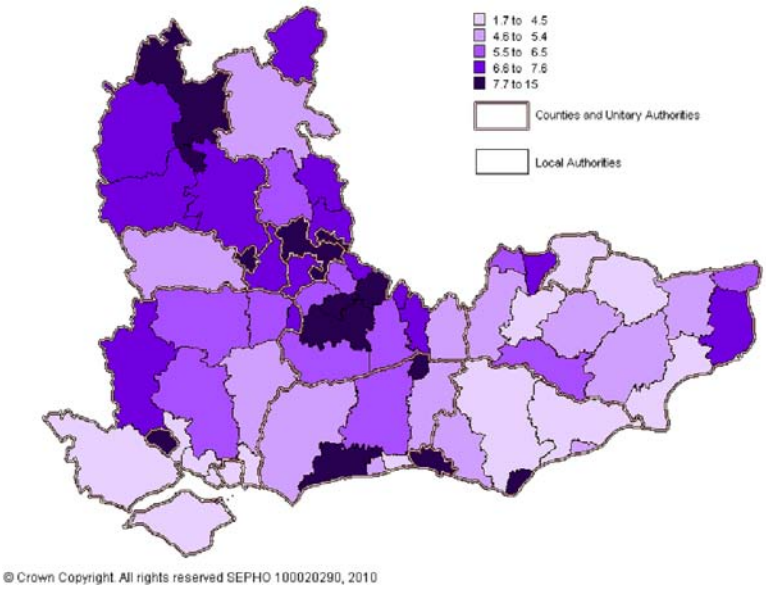


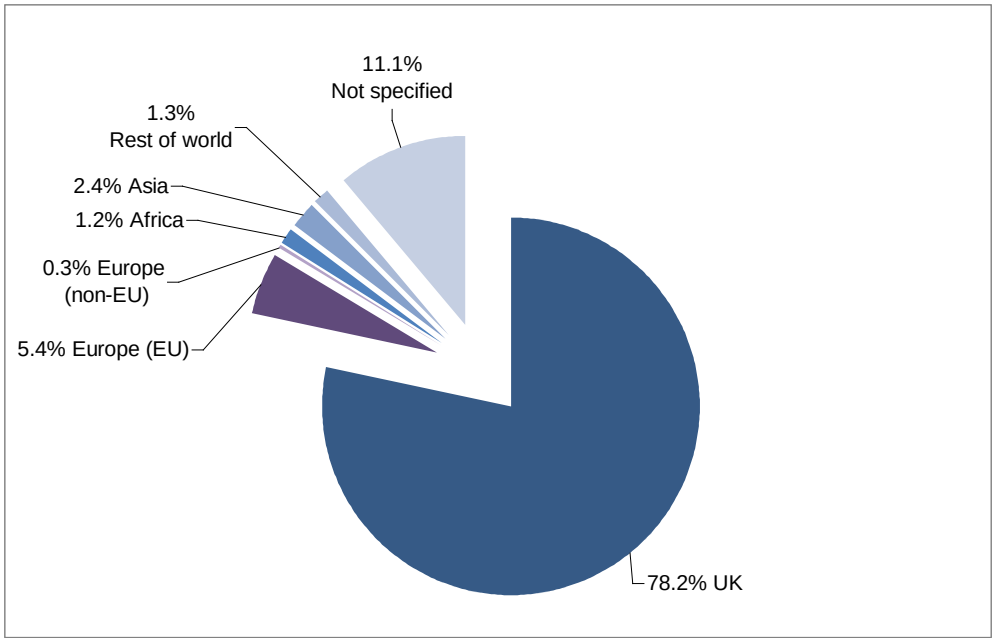
Figure 2.19: Live births where mother's birthplace was outside of the UK (EU countries only), as percentage of all live births. Unitary and local authorities in the South East 2008.

A comparison of Figures 2.16 to 2.19 reveals that, although Slough, Oxford and Reading generally show the highest percentage of all live births for mothers born outside the UK, there are some intra-regional variations for mothers born in different parts of the world. For example, Arun shows a high percentage of mothers whose birthplace was in the EU, whereas the proportions for mothers born in African or Asian countries are relatively low for this district. (More details can be found in Appendix C.)

Best Practice Example

Maternity data, West Sussex NHS Acute Hospital Trust:

A clinical effectiveness midwife with a background in audit has led the collection, since 2005, of mother's country of birth data for live births at the hospital trust. Year-on-year fluctuations have helped the PCT understand the changing demographics of local migrant groups. Maternal health indicators have been linked to country of birth data (see Chapter Three). This figure presents live births by mother's birthplace as a percentage of all live births, 2005-2009



Other data sources on migrants: School census data

Another robust source which can describe the local migrant population is the school census data, specifically the percentage of pupils who have a first language other than English (Figure 2.20).

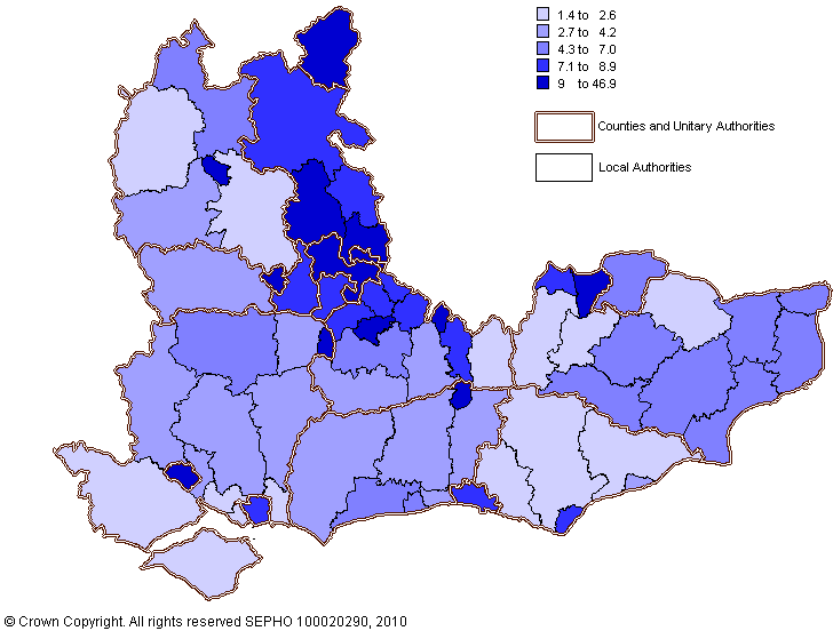


Figure 2.20: Pupils (primary and secondary) whose first language is other than English, as percentage of all pupils. Unitary and local authorities in the South East (January 2009).

This data can also be used to distinguish between primary and secondary schools, giving insights into waves of migration, if differences appear between languages spoken in primary schools(new entrants) (Figure 2.21) versus secondary schools (more established populations) (Figure 2.22). However, Slough, Oxford, Reading, Crawley and Woking show the highest percentage of pupils whose first language is not English for both the above groups. (For more details, refer to Appendix C.)

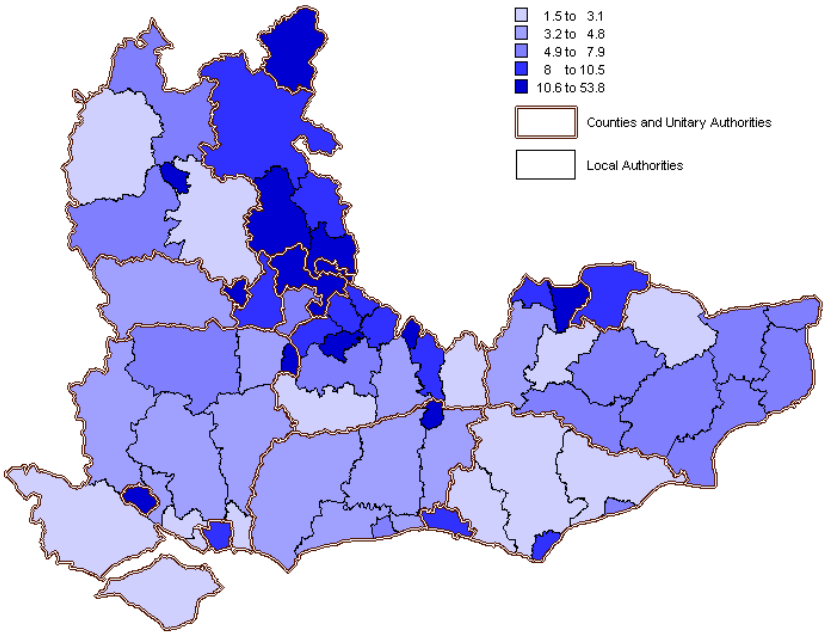


Figure 2.21: Primary pupils whose first language is not English, as a percentage of all primary pupils. Unitary and local authorities in the South East (January 2009).

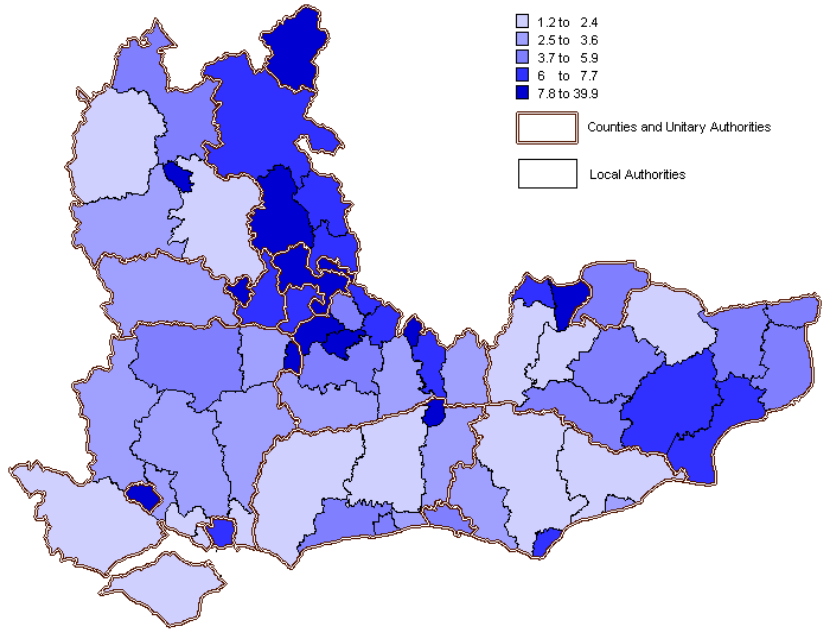


Figure 2.22: Secondary pupils whose first language is not English, as a percentage of all secondary pupils. Unitary and local authorities in the South East (January 2009).

regional and local variations in migrant populations may become apparent following such analysis. Figure 2.23 shows the striking variation in non-native English speakers in schools across the South East region.

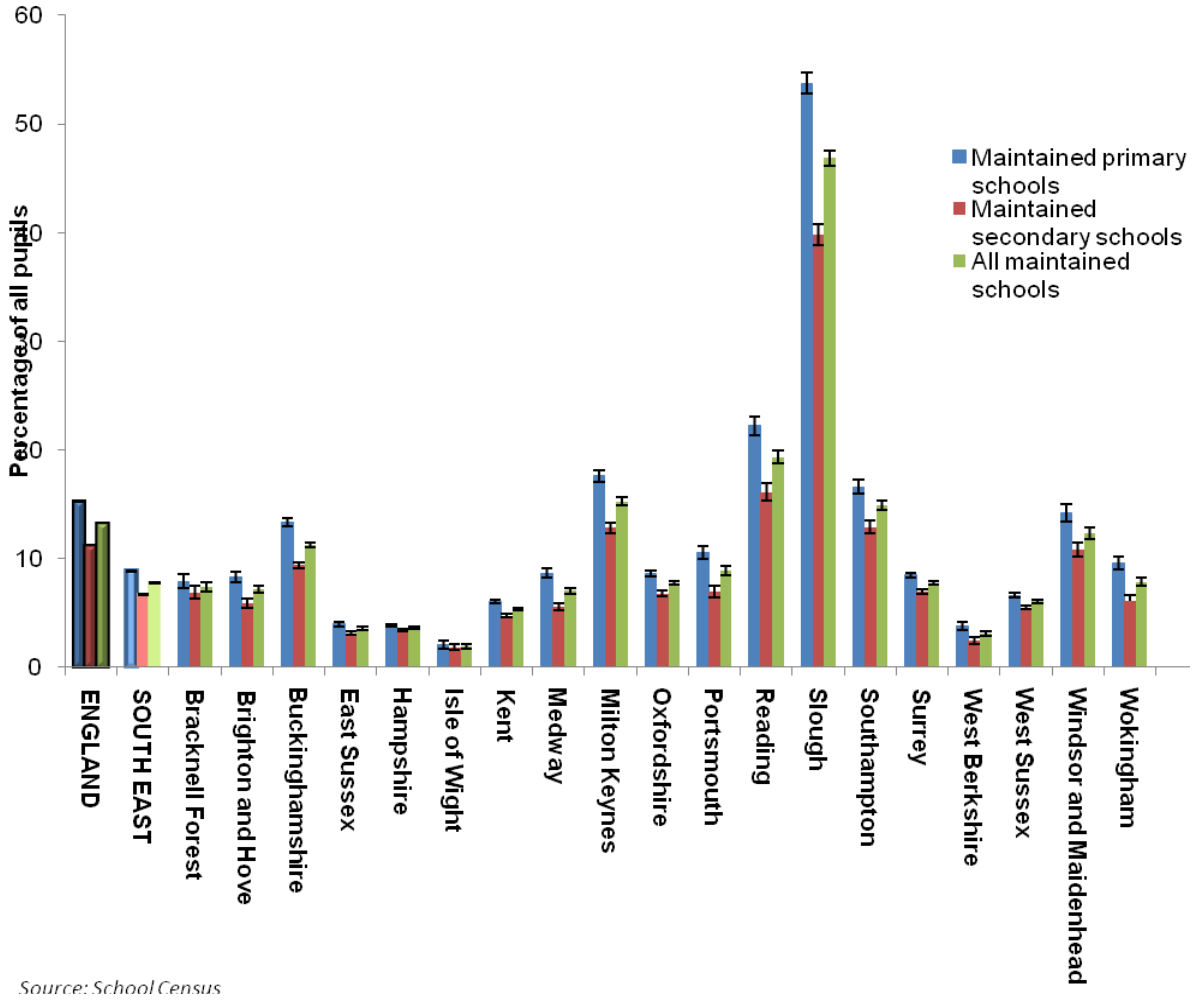


Figure 2.23: Percentage of pupils whose first language is known or believed to be other than English; counties and unitary authorities in the South East, January 2009.

Other data sources on migrants: GP registrations

New patients who are non-UK nationals registering with GPs for the first time receive a 'flag 4' on their computer records. This can be used as a way of determining use of primary care services by migrants. However, it is limited, in that only those registered will be recorded. Those who do not may be experiencing a greater health need which is not being met, or is being met inappropriately, for example, in secondary care settings which do not record this data routinely or consistently.

Figure 2.24 presents the rate of 'flag 4' GP registrations per 1000 resident population. Oxford, Reading and Slough show some of the highest rates in the SE region, which could be due to the roles of varied groups of migrants in these areas. International students are more likely to contribute to the high rate in Oxford,

whereas economic migrants are of greater importance in Reading and Slough. (Further details can be found in Appendix C.)

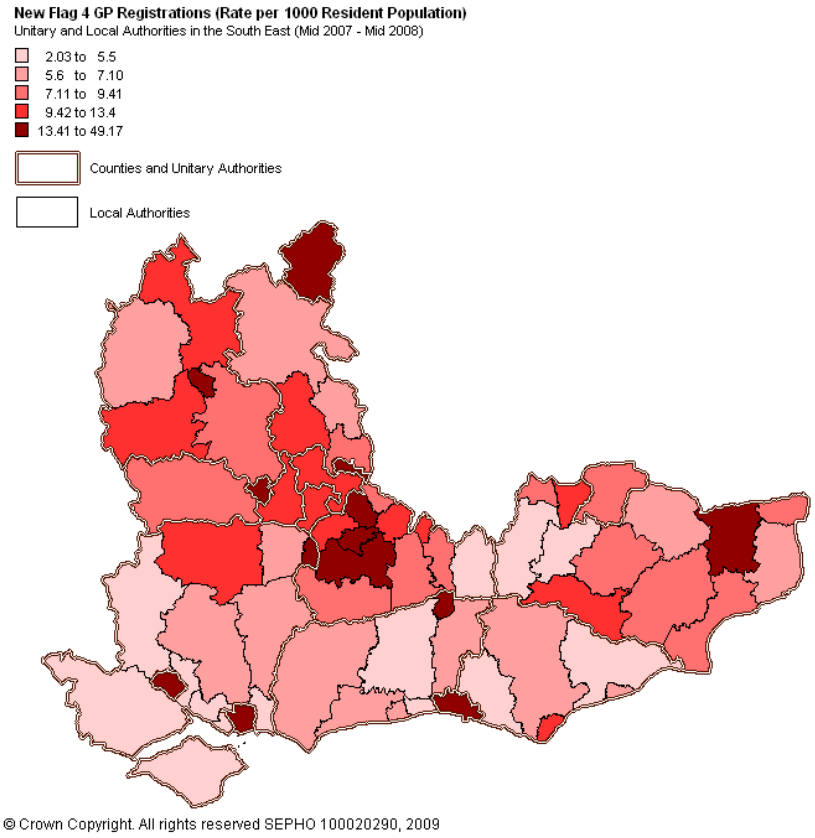


Figure 2.24: New 'Flag 4' GP Registrations: Rate per 1000 resident population; Unitary and local authorities in the South East (mid-2007 to mid-2008).

Again, this data can be used by local commissioners and health service providers to identify 'hot spots' (See Figure 2.25).

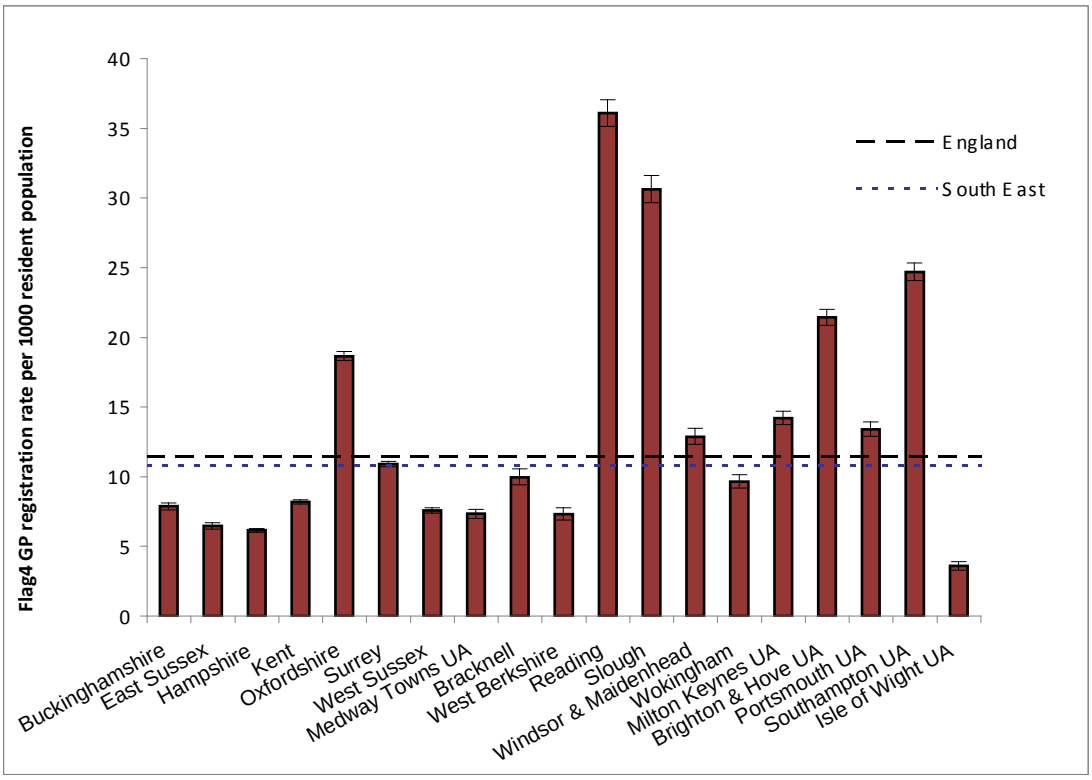


Figure 2.25: New 'Flag 4' GP registration rates in the South East region: county councils and unitary authorities (mid-2007 to mid-2008).

Conclusions and recommendations:

- Improving the data sources currently available, which do not comprehensively describe the demography of migrants in the SE region, is a priority.
- As a first step, country of origin should be routinely collected, as a better proxy for migration than ethnicity.
- Maternity data recording country of origin offers an unusually comprehensive resource, which could be put to further use.
- The SEMH should take forward the improvement of data in a coordinated way.

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Chapter Three: Physical health needs of migrants in the South East region

Key findings:

- Physical health needs vary widely and map to 'healthy migrant' effect and environmental and social issues.
- No single data resource consistently or completely captures sufficient data to allow appropriate health needs assessment of this population.
- Databases on infectious diseases are among the most useful.
- Migrants in the SE region experience disproportionate levels of infection with TB and HIV.
- Tackling key issues like TB and HIV may provide an achievable high-impact objective for further work.
- Vaccine-preventable diseases may represent another 'easy win' for vulnerable groups.
- All aspects of understanding and meeting health needs are impeded by issues around barriers to migrants accessing healthcare.

The health needs of migrants, including their physical health needs, will vary widely depending on a range of factors including a migrant's country of origin and his or her reason for leaving it. Both the prevalence of specific diseases and the health services available in different countries of origin influence migrants' health in their new countries. People who are economic migrants often represent the fit and healthy young educated members of their country of origin and are therefore generally healthy after arrival in their new countries. Those who come to the UK as asylum seekers or refugees may be suffering from diseases of poverty, trauma, malnutrition, physical effects of torture and/or deprivation, nutritional deficiencies and a range of infectious diseases (1).

No routine data source adequately or consistently captures information on the physical health needs of migrants. This makes it very difficult to get an accurate, timely, or reliable picture of the burden of disease among migrants or their experience of health services to meet identified needs. Although ethnicity is captured in data for some physical health problems, this is a poor proxy for migration (see Chapter Two and Appendix A). Country of origin is captured for very few areas of physical health and is comprehensively available only for infectious diseases.

The majority of migrants to the South East region are young adults and accompanying children. These are usually economic migrants and therefore are relatively healthy populations. However, in this group there still remain significant health needs, including provision of antenatal services, maternal and child health services and sexual health services. Furthermore, many economic migrants experience higher levels of poor dental health as they come from countries with poorer access to affordable or free dentistry, compared with the UK. Finally, as many of these economic migrants are employed as labourers in light industries such as building and construction, and agriculture (see Chapter One), they often experience traumatic injuries due to occupational hazards.

Irregular migrants are a disparate and poorly-understood group who are often without access to NHS or other public health services, except for emergency care. They may also experience diseases of poverty, including infectious diseases, nutritional deficiencies and developmental problems among children. Coverage of vaccine programmes among such irregular migrants is also a concern and many will be unprotected against diseases which are endemic or epidemic in the UK but against which they will have no natural protection.

When we asked respondents to our survey in the SE region to identify the key health issues they felt were important to migrants, the most significant need was reported as mental health, followed by smoking (see Figure 3.1).

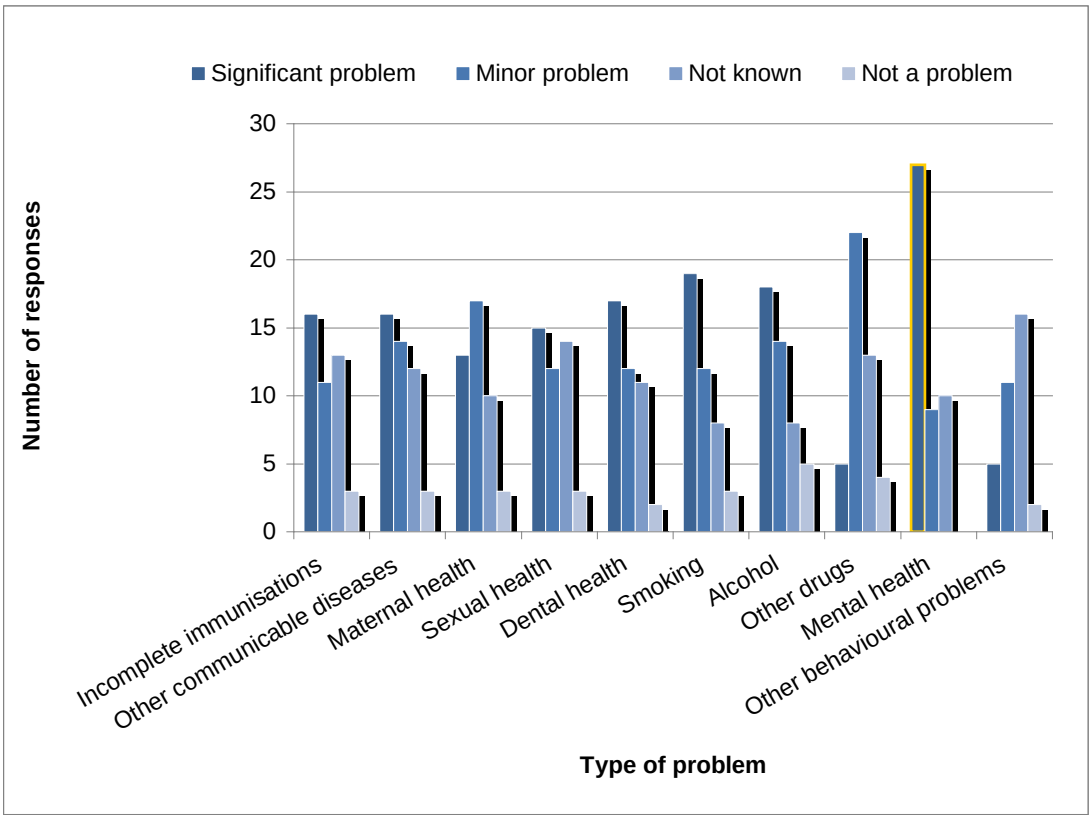
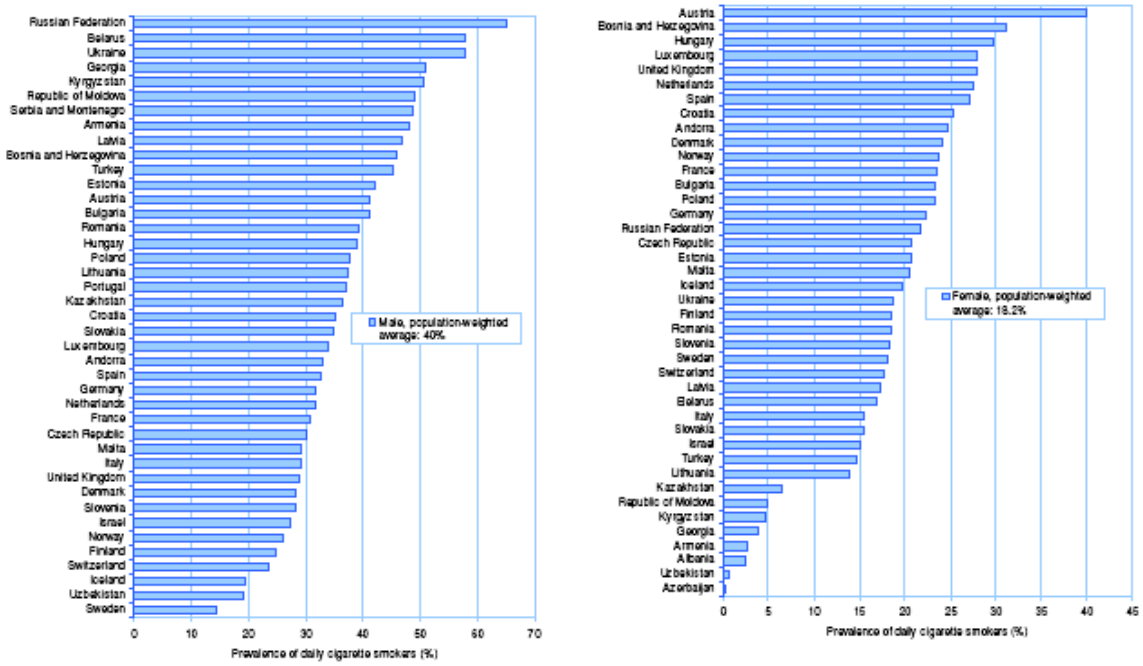


Figure 3.1: Responses to survey question 14. In your local experience, what are the greatest health issues for migrant populations?

Smoking and alcohol

Several interviewees and survey respondents identified smoking as a problem for migrant populations (see Figure 3.1). A recent equality impact assessment for a new tobacco control policy for England discussed culture, religion and socio-economic deprivation as factors possibly contributing to the 'considerable' variation between ethnic groups and between men and women within ethnic groups (2).

Data from the WHO show the extent to which the prevalence of smoking varies between men and women in different countries (see Figure 3.2).



Source: WHO Global InfoBase

Figure 3.2: WHO estimates of male (left) and female (right) daily cigarette smoking prevalence across Europe (3).

Note: these figures do not reflect the use of smokeless tobacco.

The new strategy for England, *A Smoke free Future*, aspires to reduce overall adult smoking rates to 10% or less by 2020 (2), from 21% in 2007 (4). It also aims to decrease the social gradient by which more people in socio-economically deprived groups smoke more heavily than wealthier people (2, 4). 2007 data across England also shows the highest rates of smoking are found in young adults (32% in 20-24 year olds and 26% in 25-34 year olds, compared with 12% in over-60 year olds) (4).

Migrants are a diverse group, but many migrants are young adults, living in relatively deprived circumstances, from countries with relatively high rates of smoking. Their smoking behaviour may also be influenced by cultural and religious beliefs. In support of the new strategy's aspirational targets, smoking cessation services should be accessible to migrants. In addition, country of origin data should be captured to monitor progress towards these targets.

Best Practice Example

Smoking Cessation advice, Kent:

Ashford International Association is a consortium of BME groups, supported by the local authority. This relationship provides a single point of contact for the public sector to improve access to the many BME groups in the locality. The local health and well-being teams have made some efforts to improve access to services, although the work has been difficult to sustain.

Ashford International Association has organised some presentations on smoking cessation, 'Breathing Easy', and the benefits of exercise.

The qualitative research found fewer concerns among interviewees and survey respondents about alcohol, and these were expressed about specific groups of migrants. For example, key informants from both Brighton and Southampton described small numbers of hardcore street drinkers from Eastern Europe, who are vulnerable to physical and mental health problems arising from a chaotic alcoholic lifestyle.

Best Practice Example...

Rough Sleepers Team, Brighton & Hove Local Authority:

In 2004, a multi-agency steering group of statutory agencies began to keep a watching brief on migrant workers. The only impact on services identified came from a small group of hardcore street drinkers from Eastern Europe. A specific project was commissioned to support this group.

This project, led by the local authority's Single Homelessness Learning Manager, received two years of funding via the Migration Impacts Fund. Audits on street drinking and begging by the Rough Sleepers Team identified high levels of alcohol and substance abuse, especially of high-content alcohol. High levels of inter-community violence and anti-social behaviour were also noted. Two outreach workers, who speak several Eastern European languages, were employed to work with the street community.

A needs' assessment was subsequently undertaken to explore the barriers to accessing services, including physical and mental healthcare and housing, for this group and for those who are very insecurely housed and at risk of becoming street-homeless.

Maternal health

Country of mother's birth has been recorded at birth registration in England and Wales since 1969, although only West Sussex volunteered it as a useful resource in understanding the changing demography of local populations (see Chapter Two). The required maternity dataset also includes indicators such as smoking at time of delivery and birthweight, which correlate with other health needs and with wider determinants of health. If recording of country of birth were high across the SE region, and if it were possible to link this to other maternity indicators, maternity data could provide a rich resource for building a more comprehensive picture of the distribution of health needs, in addition to the demography, of migrants across the SE region.

This project undertook an additional quick survey, writing directly to each acute trust in the SE region, asking if its maternity department routinely collected various indicators. Table 3.1 shows the results and also that the potential to improve collection of these indicators in the required maternity dataset could be an achievable step in improving the understanding of migrant health across the SE region.

	Numbers		Percentage	
	Yes	No	Yes	No
Number of Acute Trusts replying	**21**	**2**	**91%**	**9%**
1. Do you collect data on mother's place of birth?	16	5	76%	24%
2. Do you collect data on ethnicity?	20	1	95%	5%
3. Is breastfeeding initiation data collected at the same time as 1 and/or 2?	15	6	71%	29%
4. Is smoking at time of delivery collected at the same time as 1 and/or 2?	15	6	71%	29%
5. Is gestation week at initial assessment collected at the same time as 1 and/or 2?	17	4	81%	19%
6. Is delivery method collected at the same time as 1 and/or 2?	15	6	71%	29%
7. Is birth weight collected at the same time as 1 and/or 2?	15	6	71%	29%
8. Are details on admission to Neonatal Unit post delivery collected at the same time as 1 and/or 2?	15	6	71%	29%

Table 3.1: Results of direct enquiry to acute trusts across the SE region about which maternity indicators are routinely collected.

Note: Some of the above data is collected at booking and some at the delivery, so these are not always linkable as currently collected.

Two examples from the West Sussex maternity data demonstrate how useful these indicators can be, for planning health services and for highlighting areas where health promotion messages could be made more accessible to different groups among the local population.

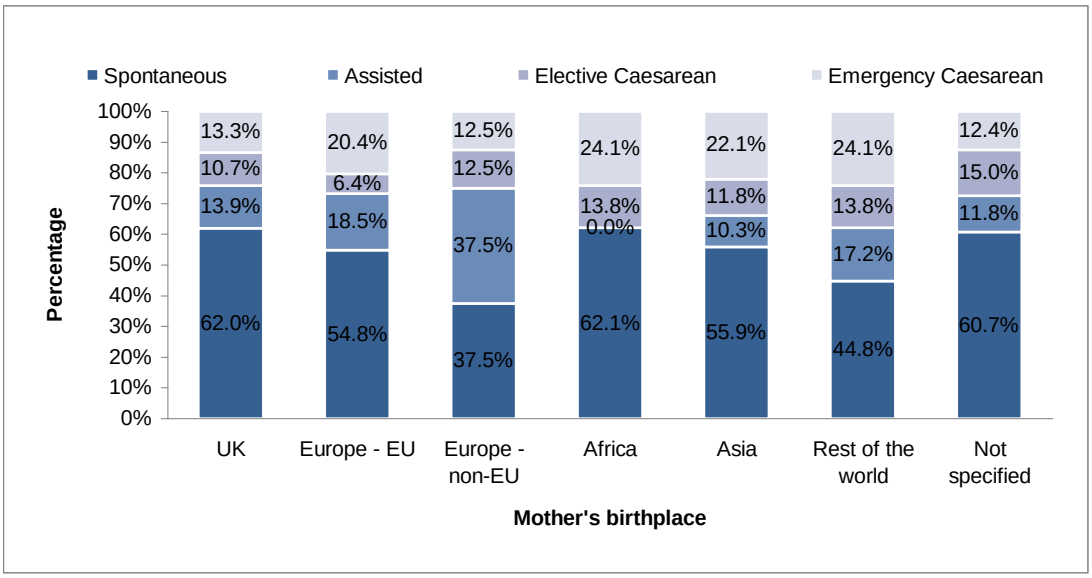


Figure 3.3: Live births at the West Sussex acute trust (2009) by group of mother's birthplace and method of delivery, % of all live births in each country group.

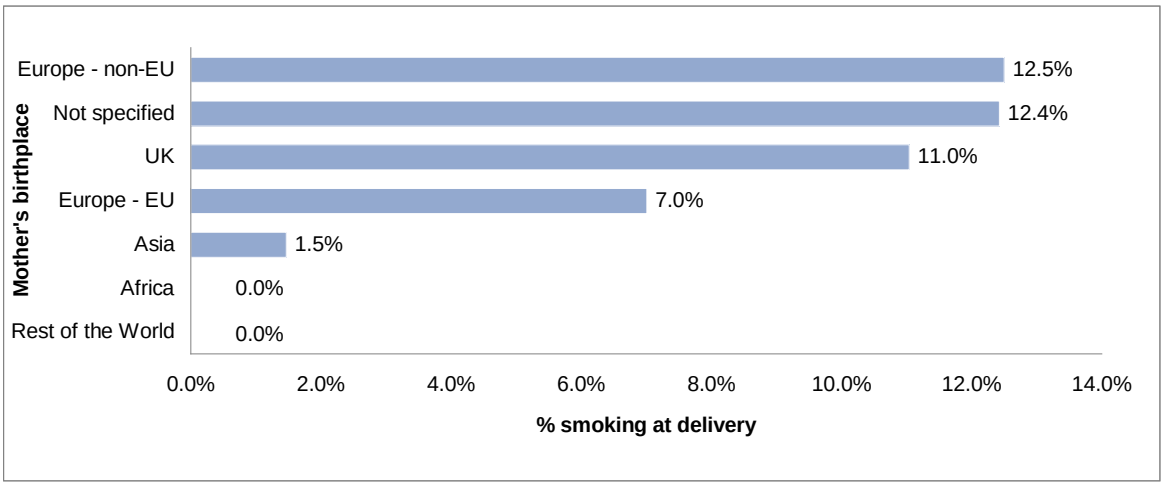


Figure 3.4: Live births at the West Sussex acute trust (2009) by group of mother's birthplace and smoking status at delivery, as a percentage of all live births in each country group.

Best Practice Example

Culturally accessible maternity services, Kent and West Sussex

Dover midwives run a group for Slovak women, and the Folkestone Migrant Support Group works closely with schools, health and other organisations to increase access to services for all migrants, especially Roma families.

West Sussex has employed a Polish midwife and translated antenatal leaflets into East European languages. Antenatal services have been moved from GP practices to Children and Family centres, to reach families who attend nursery groups at these centres. Work with a local non-statutory organisation, the Expanding Communities Project, has improved midwives' understanding of East European migrants' expectations of health services. For example, a Polish prejudice against midwife-led care, and a widely held wish to return to Poland for delivery, contributed to low levels of booking for antenatal care which can cause difficulties if antenatal emergencies arise.

Sexual health

GUMCAD, which replaced the previous dataset in April 2009, collects numbers of new diagnoses of sexually transmitted infections (STIs) at first attendance at genitourinary clinics in England. With new diagnoses, the dataset collects patient variables, including country of birth, gender, sexual orientation, ethnic group and clinic attended. This dataset is held by the HPA Centre for Infections.

Like the maternity dataset, GUMCAD should offer a rare opportunity to explore the overlap or differences between country of birth and ethnicity data for the same group of patients. Regrettably, the level of completeness of these data fields must improve before these areas can be fruitfully explored. As the users of sexual health services are predominantly young, mobile, sexually-active adults, they could include many migrants and this dataset could be valuable in understanding the health needs of migrant groups.

For example, 2009 data from the South Central SHA show the number of 'any other white' patients is greater than the number of 'born abroad' patients, for the same five STIs. This data does not support the hypothesis that 'other white' groups have increasingly been populated by migrants from the European Union since 2004 (see

Chapter Five), and illustrates the problems of using ethnicity as a proxy for migration. However, the numbers of patients in 'other or not specified ethnic groups' or with 'unknown place of birth' are greater than both 'other white' and 'born abroad' groups, making it difficult to draw any meaningful conclusions until the standard of data collection improves.

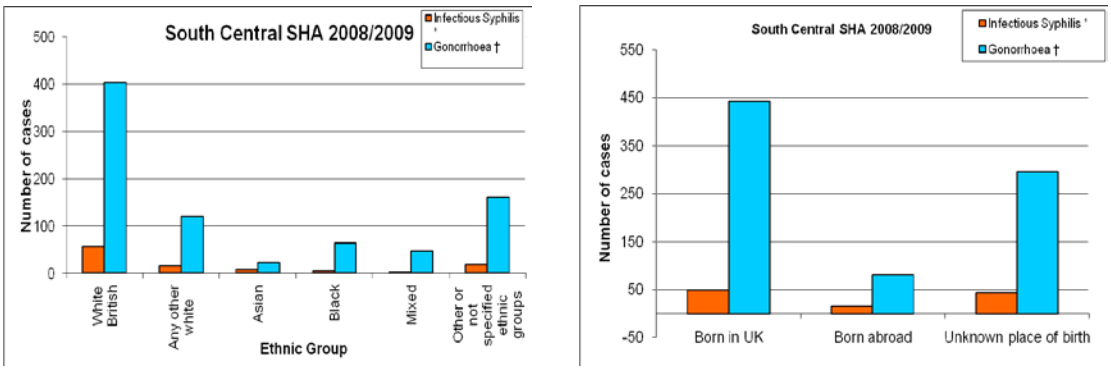


Figure 3.5: GUMCAD data (2008-09) for the South Central SHA, showing ethnic group (left) compared to country of birth (right), for infectious syphilis and gonorrhoea.

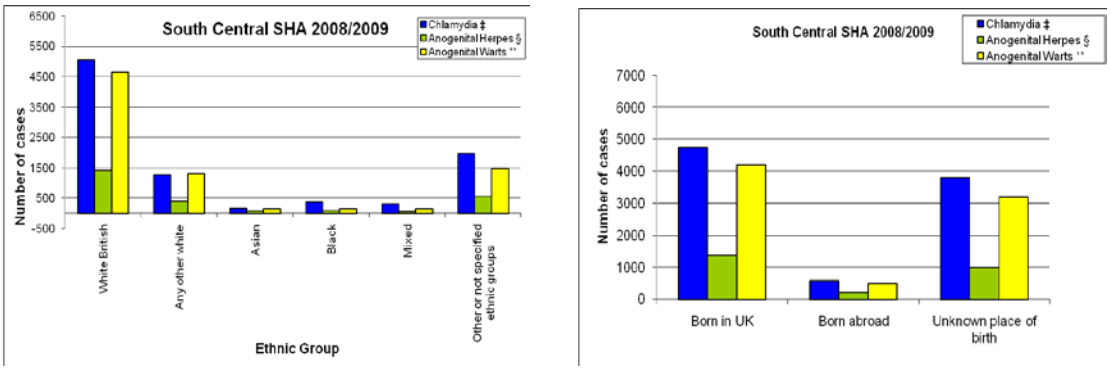


Figure 3.6: GUMCAD data (2008-09) for the South Central SHA, showing ethnic group (left) compared to country of birth (right), for chlamydia, anogenital herpes and genital warts.

Note: the equivalent numbers from the SE Coast SHA are smaller for 'any other white', making the equivalent figures even less meaningful.

Qualitative data revealed concerns about the sexual health of specific migrant groups, such as women seeking asylum from conflict situations, who are disproportionately affected by HIV. The commonest non-infectious sexual health issue raised was female genital mutilation, which is still practised in some migrant groups. For example, an outreach worker has worked with the Somali population in Slough, trying to educate and empower young women to defend themselves against this practice.

The quantitative data on HIV will be discussed below.

Dental health

Survey respondents raised concerns about dental health, particularly in migrants from East European countries, where oral health promotion and dental health services are less developed than in the UK.

Best Practice Example

Oral health promotion with Roma, East and West Sussex:

A community development worker interested in dental health worked with oral health promotion coordinators in East and West Sussex to distribute culturally appropriate training materials and free toothbrushes to Roma groups in Sussex.

Interviewees and survey respondents also raised dental health as an issue for irregular and destitute migrants, where dental health emerges as a disease of extreme poverty.

Infectious diseases and migrants in the South East region

Rates of infectious diseases vary with prevalence rates and vaccination regimes in migrants' countries of origin, in addition to increased risks they may incur before, during and after emigrating (1).

Although by no means the only physical health problem facing migrants in the SE region, infectious diseases may be an important area of work for health service providers because:

1. Many important infectious diseases are statutorily notifiable diseases, which clinicians must report to public health authorities. They must notify details of the clinical diagnosis, along with demographic and other information. This offers probably the most robust data on the burden of disease affecting specific populations.
2. Statutory responsibilities: Various agencies have a specific responsibility under the law relating to notifiable diseases. For example, the HPA has specific responsibilities around disease

surveillance and response to notifications of cases or outbreaks. PCTs and local authorities also have statutory responsibilities for the protection of the health of their populations and powers in law to do so.

3. Managing infectious diseases among migrants to the SE region may represent an opportunity to have a major impact on the health and well-being of specific individuals and the communities in which they live.
4. Improving the management of infectious diseases among migrant populations may be a task for which it is easy to get buy-in from stakeholders and the target population. This may lead to other issues being identified and managed which are not currently as understandable or amenable to solutions.

Tuberculosis and migrant populations

TB has long been described as a 'disease of poverty'. In Britain, the incidence of TB has generally decreased significantly over the course of the 20th century. However, many of the significant changes in incidence pre-dated the antibiotic era and were more directly related to improvements in housing, nutrition, sanitation and other social conditions, which McKeown famously argued were more important in reducing mortality than therapeutic medicine (see Figure 3.7).

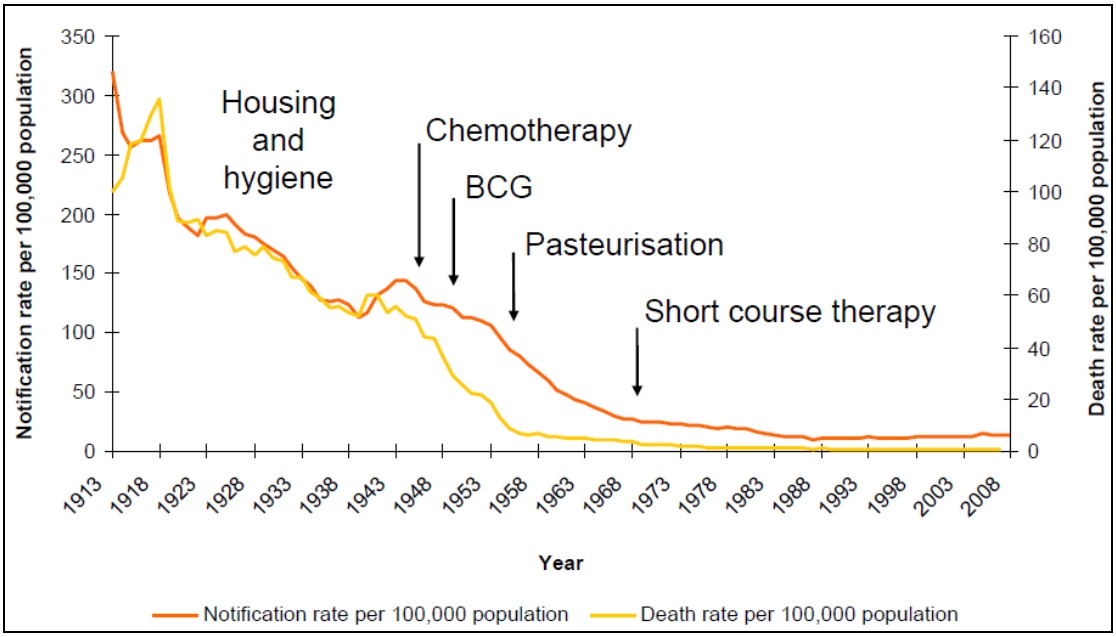


Figure 3.7: Statutory notifications and mortality, England & Wales, 1913-2008. Sources: Statutory Notifications of Infectious Diseases (NOIDs), Office for National Statistics (notifications of infectious disease deaths), Office for National Statistics mid-year population estimates.

However, during the past two decades, rates of TB have started to increase significantly (see **Figure 3.8).**

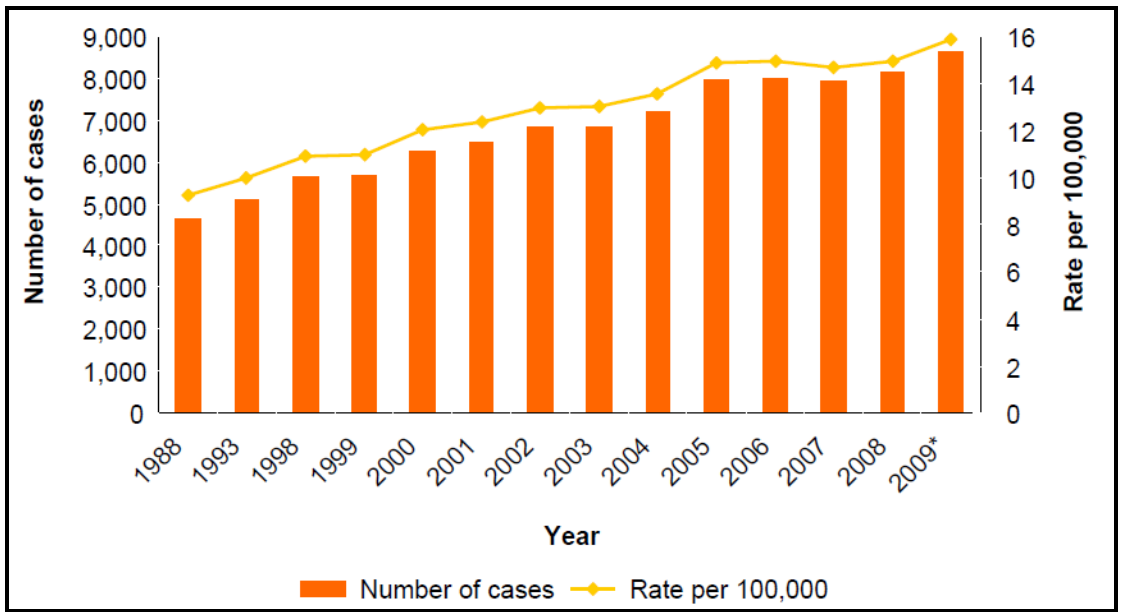


Figure 3.8: TB case reports and rates, England and Wales, 1988, 1993, 1998-2009*. * Provisional data. Rate calculated using 2008 mid-year population estimate.
Sources: 1988,1993, 1998 – National Tuberculosis Surveys, Enhanced Tuberculosis Surveillance, Office for National Statistics mid-year population estimates.

The experience of TB is not universally distributed in England and Wales. London has about half of all diagnosed cases of TB and this has been a consistent observation for the last decade.

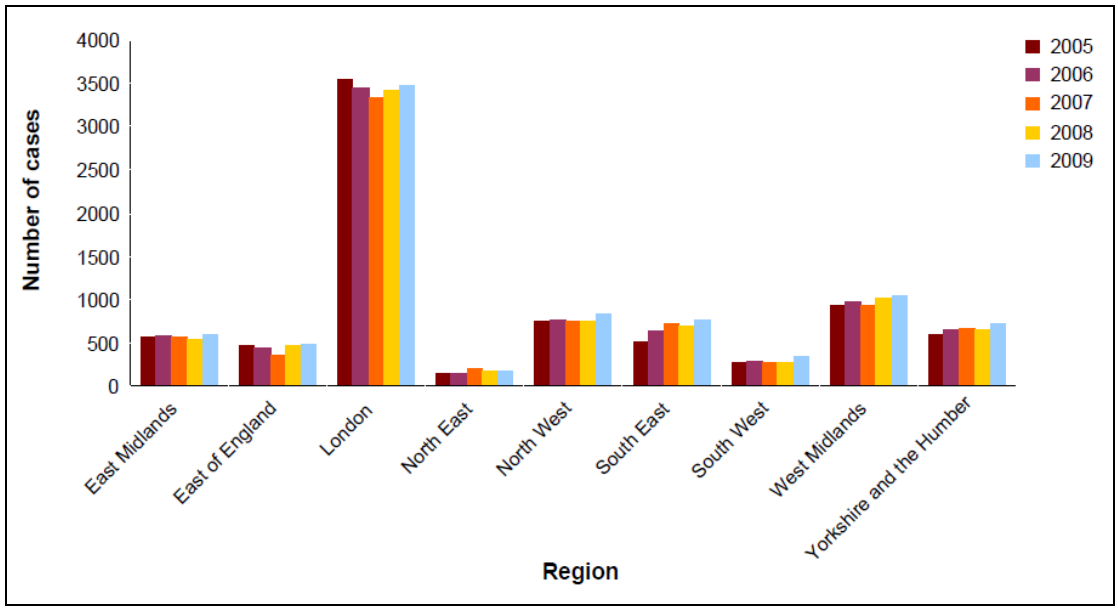


Figure 3.9: Tuberculosis case reports by region, England, 2005-2009. Provisional data.
Source: Enhanced Tuberculosis Surveillance (ETS).

However, even within specific localities, the experience of TB can vary enormously from area to area. Figure 3.10 shows how certain boroughs of London experience very high levels of disease, whereas others have almost no reported cases per year. A similar pattern is seen in the SE region where some localities are 'hot spots' and this coincides mainly with large areas of conurbation.

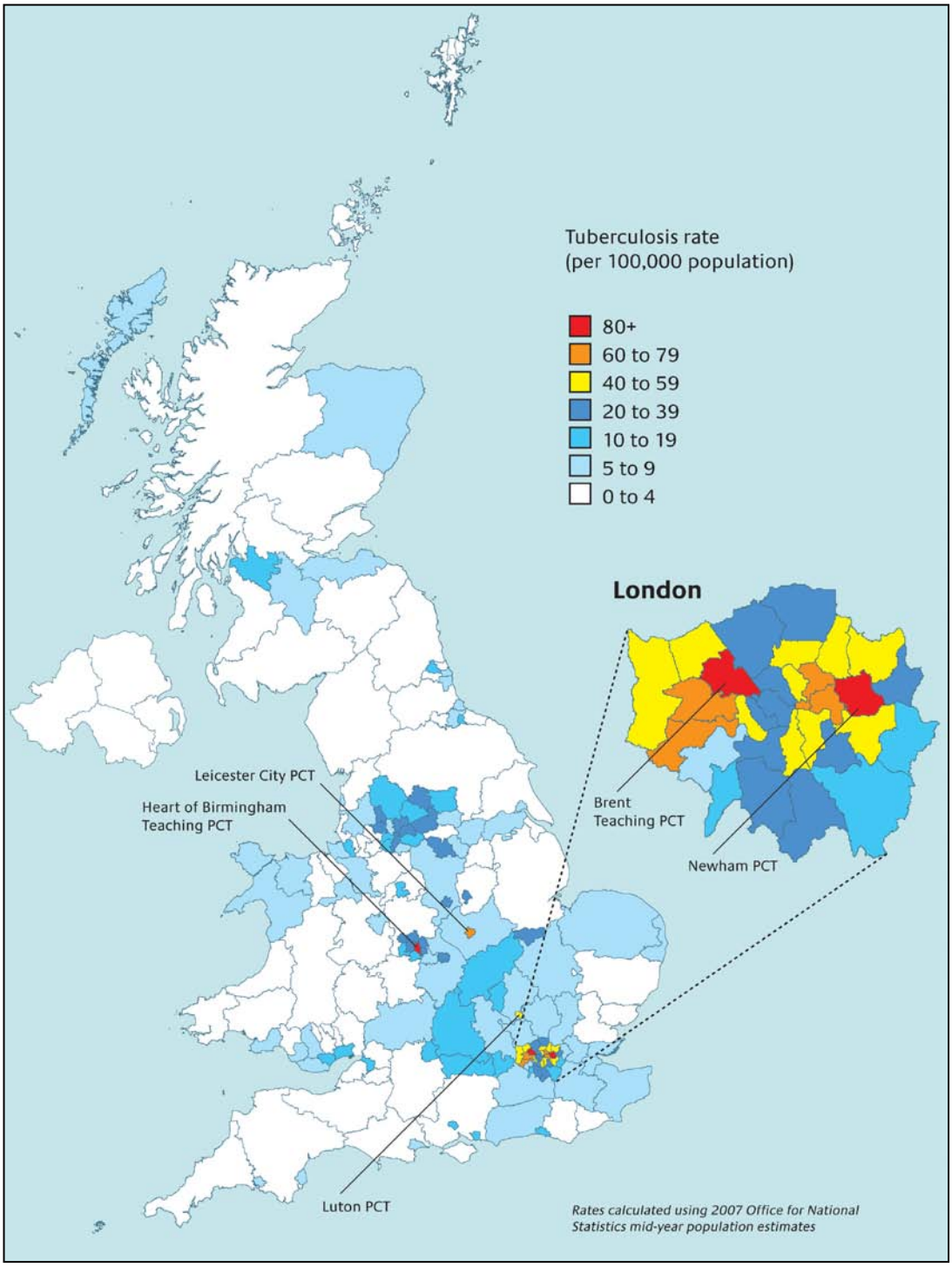


Figure 3.10: Three-year average tuberculosis case rates by primary care organisation*, UK, 2006-2008.

TB in England now affects specific sub-groups of the population and those born overseas are significantly more likely to be diagnosed with TB than those born in the UK (see Figure 3.11).

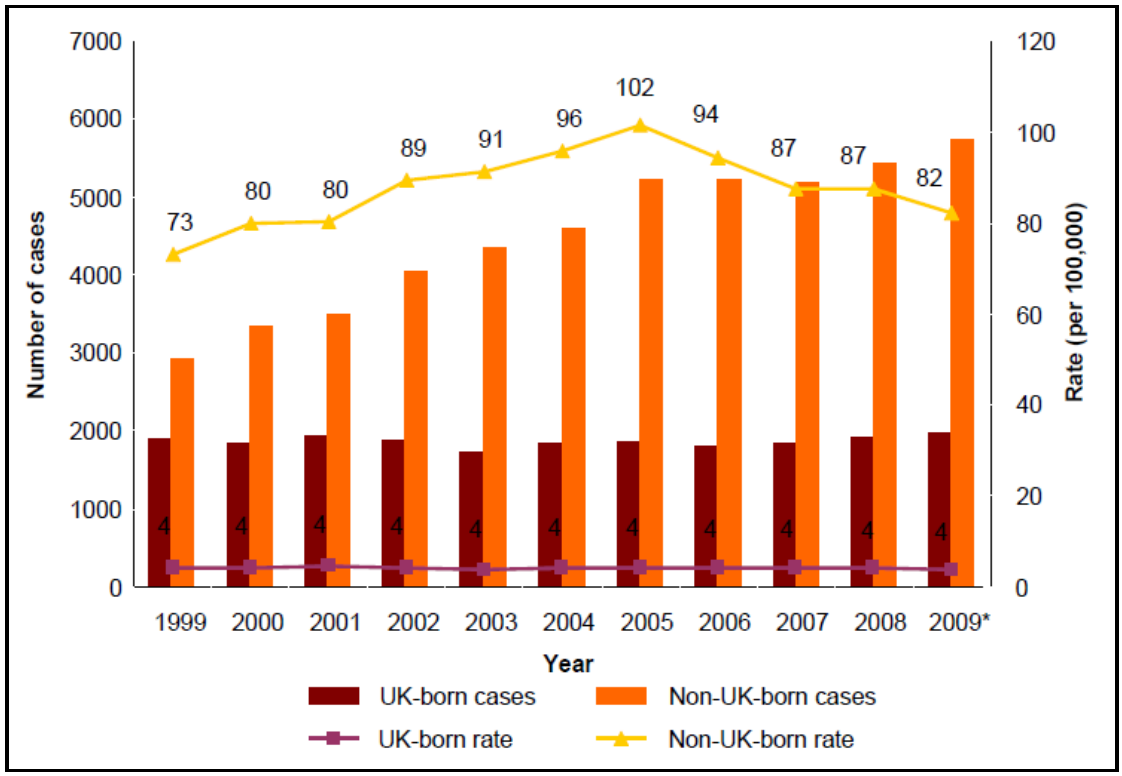


Figure 3.11: TB case reports and rates by place of birth, England 1999-2009*. * Provisional data. Rate calculated using 2008 mid-year population estimate.
Sources: Enhanced Tuberculosis Surveillance (ETS), Labour Force Survey and Office for National Statistics (ONS) mid-year population estimates

An internationally recognised indicator of transmission within families is diagnosis of cases of infection in children aged five years or younger. Evidence shows clearly that children who are non-UK-born are significantly more likely to have TB than those born in the UK (See Figure 3.12). This may be a consequence of infection from family members who have TB themselves due to exposure in their country of origin, or to other friends or family members from that country who are themselves infected.

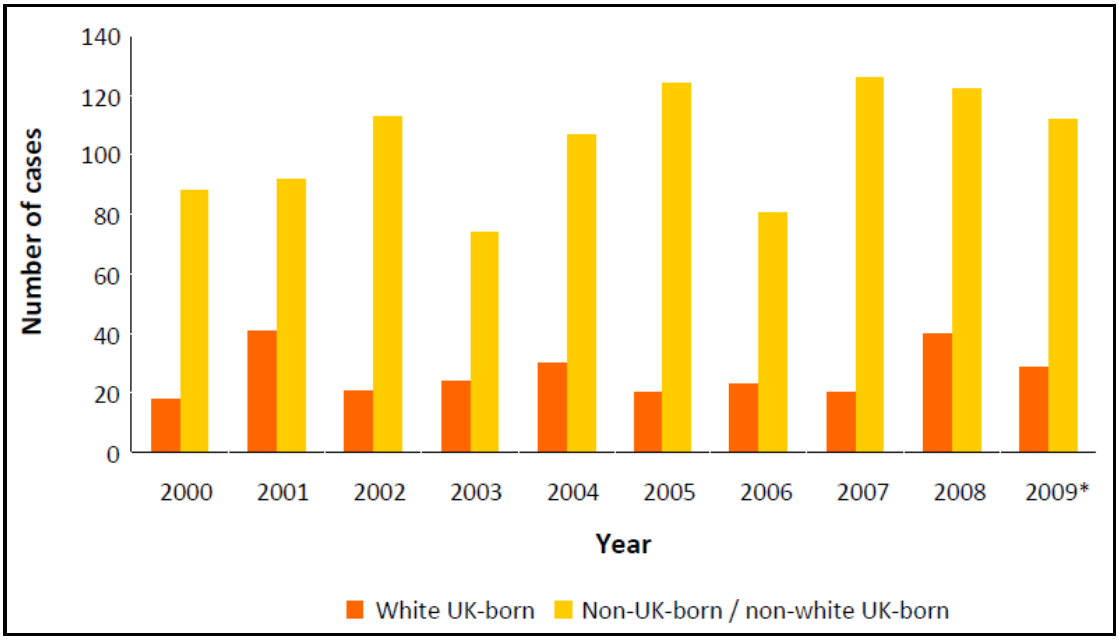


Figure 3.12: TB case reports in under-5 year olds by place of birth/ethnicity, England, 2000-2009*. * Provisional data. Sources: Enhanced Tuberculosis Surveillance (ETS).

Evidence suggests that simply screening people at port of entry to the UK will not have a significant impact on the rate of TB among migrants, as most do not get diagnosed with the infection until many years after their arrival:

- 21% within two years of entry to UK
- 24% between two and four years
- 25% between five and nine years
- 31% 10+ years in the UK before diagnosis.

The SE region has a similar experience of TB as the rest of England, with the majority of cases diagnosed by among non-UK-born residents (see Figure 3.13).

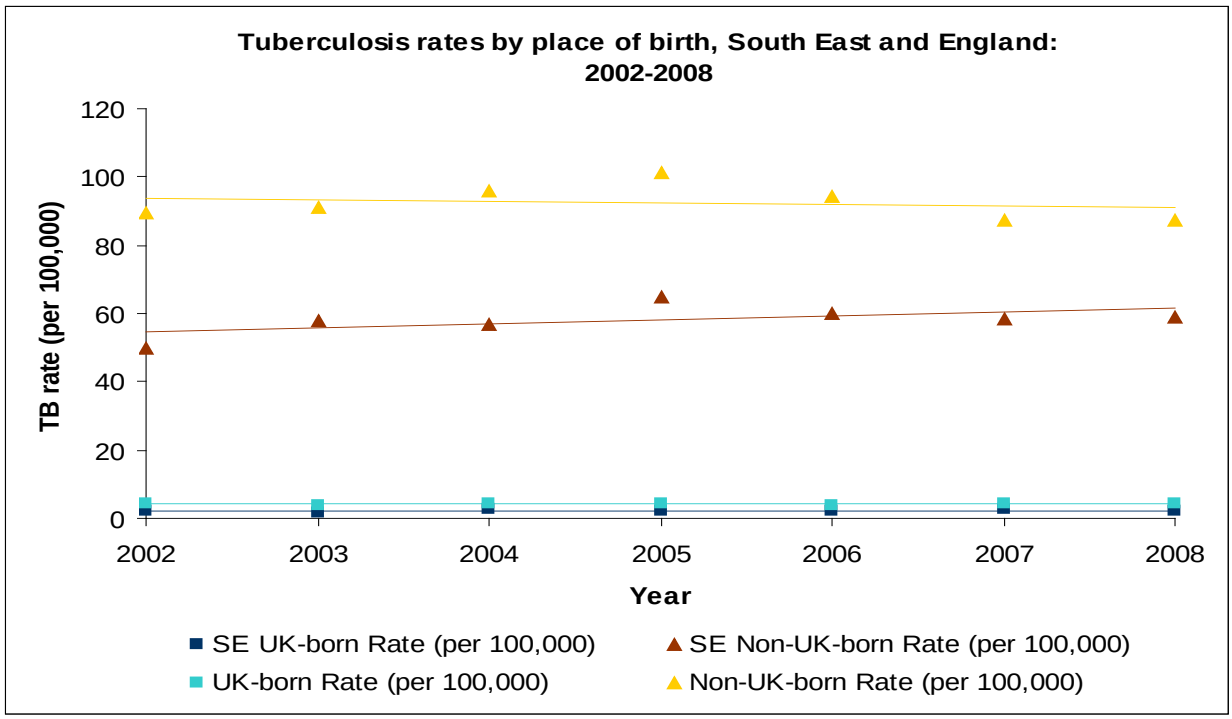


Figure 3.13: Tuberculosis rates by place of birth, South East region and England, 2002-08.

The most recent data for the SE region shows a significant difference between the rates of TB among UK and non-UK-born residents (see Table 3.2).

SHA	HPU	Country of birth					Total
		UK born	UK - %	Born abroad	Abroad - %	Unknown	
South Central	TV	56	19.4%	229	79.5%	3	288
	HIOW	30	22.6%	87	65.4%	16	133
South East Coast	SySx	53	25.7%	112	54.4%	41	206
	Kent	41	29.9%	84	61.3%	12	137
Total		180	23.6%	512	67.0%	72	764

Table 3.2: Numbers and percentages of new cases of TB by SHA and HPU in the SE region in 2009, UK-born compared to those born abroad.
Source: SE Regional Epidemiology Unit, Health Protection Agency.

Table 3.3 shows the difference in rates of TB per 100,000 population in the SE which highlights the significant differences in experience of disease between the UK-born and those born abroad.

TB rates per 100,000 by group of population			
SHA	HPU	UK born	Born abroad
South Central	TV	3.0	75.3
	HIOW	1.8	57.6
South East Coast	SySx	2.3	38.5
	Kent	2.7	73.7

Table 3.3: TB rates per 100,000 population by SHA and HPU in the South East region, comparing those UK-born and those born abroad. Source: SE Regional Epidemiology Unit, Health Protection Agency.

Comparing different countries of origin of those diagnosed with TB in the SE region, we can see significant burden of disease among those from South Asia and sub-Saharan Africa (see Figure 3.14).

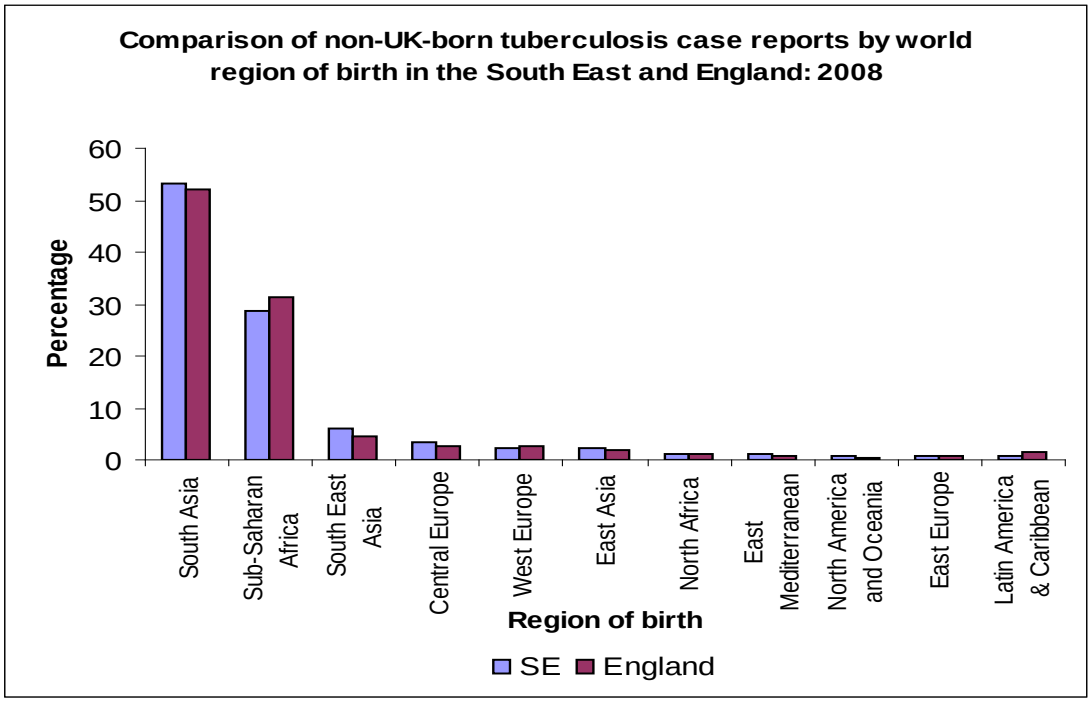


Figure 3.14: Comparison of non-UK-born TB cases by world region of birth among those diagnosed while resident in England and SE region: 2008.

TB is a disease which is usually fully treatable, but treatment requires regular medication which has to be taken for several months to be effective. The WHO has set an international target for completion of treatment of 85% of all those

diagnosed. Unfortunately, as a whole, the UK does not meet this target, achieving only just over 70% completion rates for therapy among those diagnosed (see Figure 3.15).

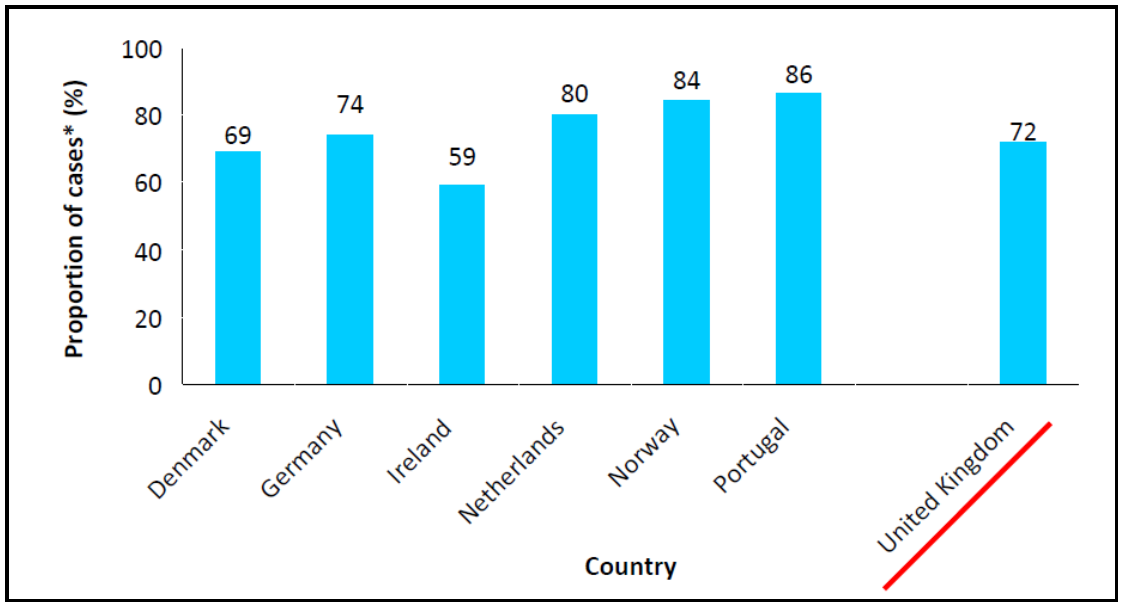


Figure 3.15: International comparisons of completion rates for treatment for those diagnosed with TB against the WHO target. *Laboratory-confirmed pulmonary cases only. Data not available for France, Italy, Spain and Sweden.
Source: European Centre for Disease Prevention and Control/WHO Regional Office for Europe: Tuberculosis surveillance in Europe 2007. Stockholm, European Centre for Disease Prevention and Control, 2009.

In the SE region of England, our completion rates for therapy for TB are almost exactly the same as the UK average, at around 73% (see Figure 3.16).

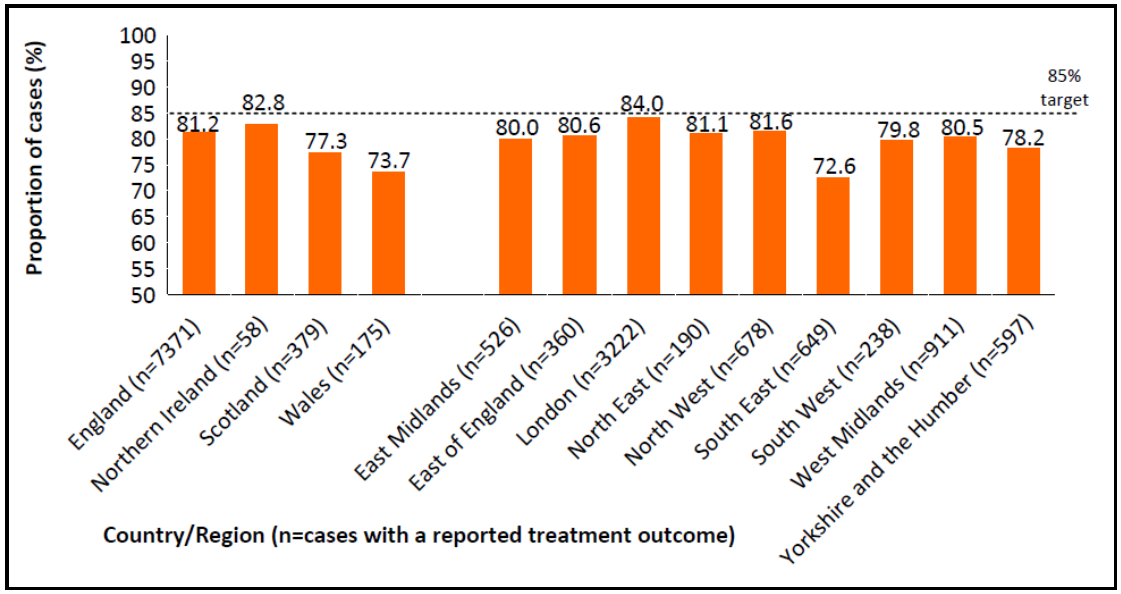


Figure 3.16: Proportion of those diagnosed with TB completing treatment by country and region in the UK, 2007.
Source: Enhanced Tuberculosis Surveillance, HPA.

Data from London shows that TB is now a disease affecting certain sub-groups within the city. The single largest sub-group are those living with HIV infection. However, specific migrant groups are also clearly represented among those with TB (see Figure 3.17).

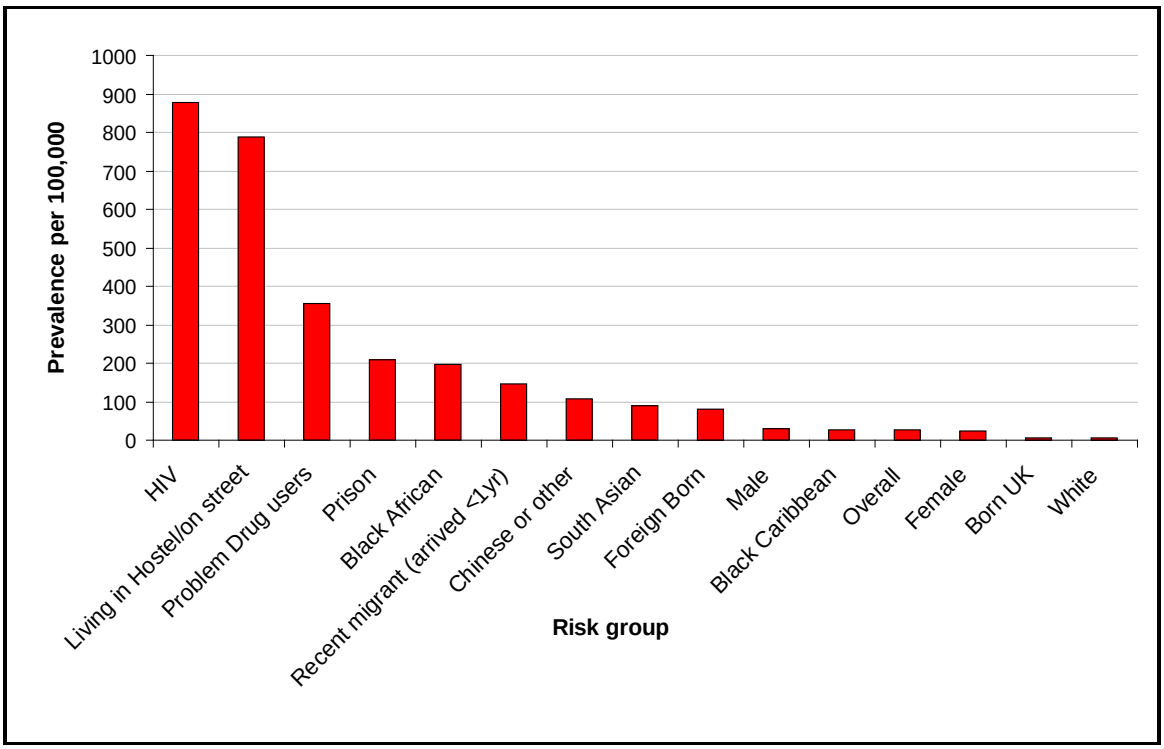


Figure 3.17: Prevalence of diagnosed TB in London among different population groups.
Source: London TB Nurses Case Load Profile.

Among the population of the UK, co-infection with TB and HIV was an increasing trend during the first decade of the 21st century, but this appears to have stabilised for now (see Figure 3.18).

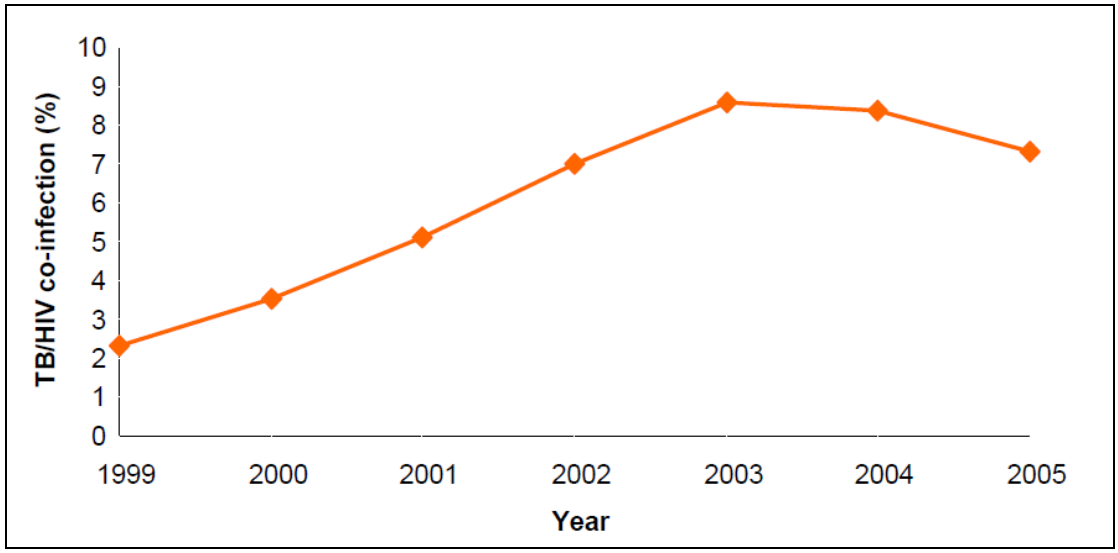


Figure 3.18: Rates of TB/HIV co-infection among patients in England and Wales. Excludes cases with missing information on previous tuberculosis diagnosis
Source: French CE, Glynn JR, Kruijshaar ME, Ditah IC, Delpech V, Abubakar I. The association between HIV and anti-tuberculosis drug resistance in England and Wales. European Respiratory Journal. 2008; 32(3):718-725.

HIV/AIDS and migrant populations

The number of people accessing HIV-related treatment or care is collected by the Survey of Prevalent HIV Infections Diagnosed (SOPHID), a surveillance system which is run by the Health Protection Agency. SOPHID is a cross-sectional survey of all people who attend for HIV-related care at an NHS site in England, Wales and Northern Ireland (E, W and NI) within a calendar year. Every year, the HPA publishes data on people attending for HIV-related care and this is distributed to PCTs and SHAs.

Annually, there are approximately 7,000 newly diagnosed cases of HIV in adults aged 15 years and over reported in the UK (Source: SOPHID, HPA).
Approximately 12% of all new cases are reported from the SE region (868/6897 new diagnoses in 2008). Of these, the country of birth is reported for approximately 70% of cases overall and 80% of cases reported from the SE region. Of the cases where country of birth is known, approximately two-thirds were born abroad.

Between 2000-08 the majority of non-UK-born people diagnosed with HIV in England, Wales and Northern Ireland probably acquired their infection through heterosexual contact. Of these, most were born in Africa (77% E, W and NI; 80% SE). By comparison, approximately a third of newly diagnosed cases probably acquired their infection through sex between men (19,411/57,656 [34%] cases in E, W and NI; 2,057/6,866 [30%] cases in SE). Of these, fewer than a third were born abroad (29% E, W and NI; 21% SE).

South Central SHA SOPHID Data 2009

In 2009, there were 251 new HIV diagnoses. The 2009 figure represents a 76% increase on the 143 new diagnoses in 2000. The overall UK increase since 2000 was 52%.

In 2009, an estimated 45% (highest after the East of England and the East Midlands) of newly diagnosed individuals acquired their infection heterosexually and were of black African ethnicity (UK average 33%) and 26% acquired their infection through sex between men and were of white ethnicity (UK average 37%).

South East Coast SHA SOPHID Data 2009

In 2009, there were 308 new HIV diagnoses. The 2009 figure represents a 33% increase on the 231 new diagnoses in 2000. The overall UK increase since 2000 was 52%. The South East Coast reported the second lowest (after London) proportional increase from 2000.

In 2009, an estimated 33% of newly diagnosed individuals acquired their infection heterosexually and were of Black African ethnicity (UK average 33%) and 43% acquired their infection through sex between men and were of White ethnicity (UK average 37%).

SOPHID data shows some quite significant differences between the two SHA areas of the South East region, in terms of the relative proportion of new HIV cases among migrants compared with men who have sex with men (MSM). Figure 3.14 shows the relative proportions by country of origin among risk groups for HIV infection in the South East region and demonstrates that among heterosexuals, we see an over-representation of Black Africans compared with their relative proportion in the community. SOPHID data further tells us that the majority of these cases are women.

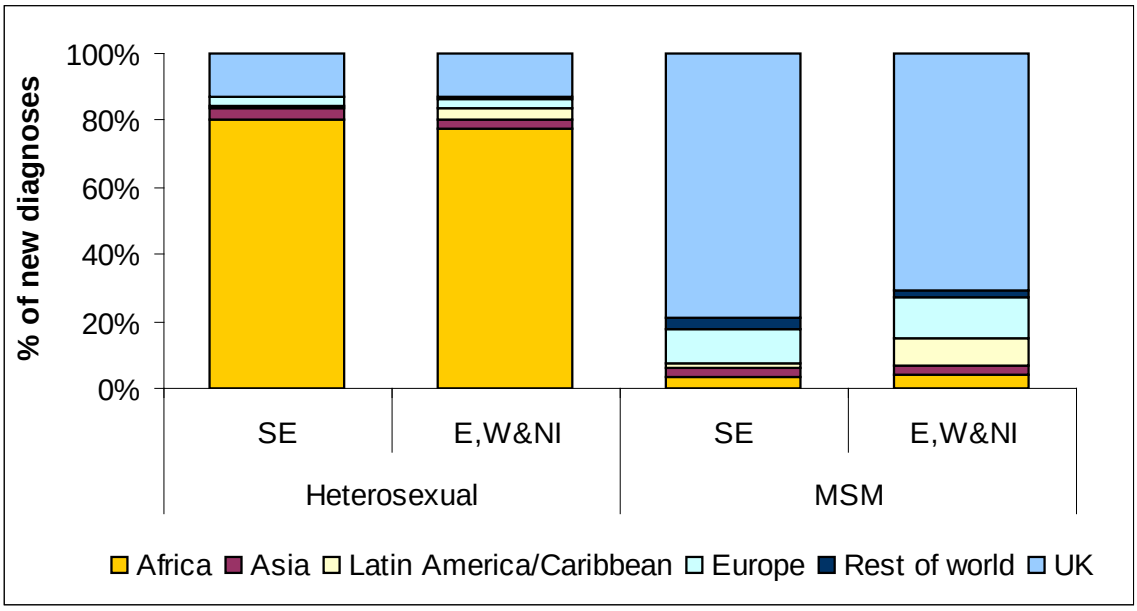


Figure 3.19: Relative proportions of non-UK and UK-born people by sexual risk group for HIV infection in the SE region.

Vaccine-preventable diseases

Migrants who come to the UK from countries with less comprehensive vaccination schedules are at risk of contracting and spreading vaccine-preventable diseases, and of impacting on health services.

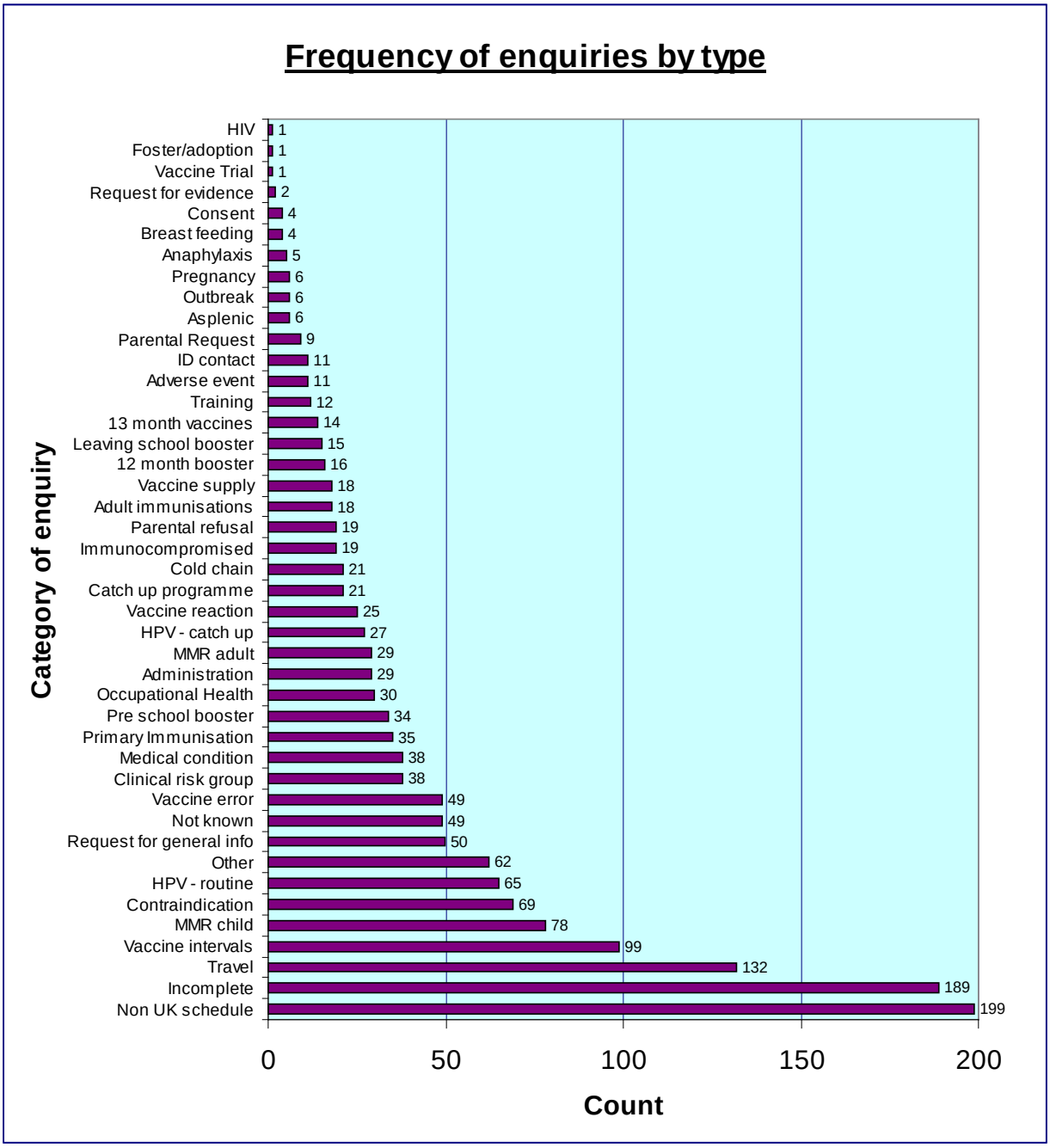


Figure 3.20: Frequency of enquiries to Oxford VACCSline by type (2008-09)

Figures 3.20 and 3.21 show the impact of these issues on one local service.

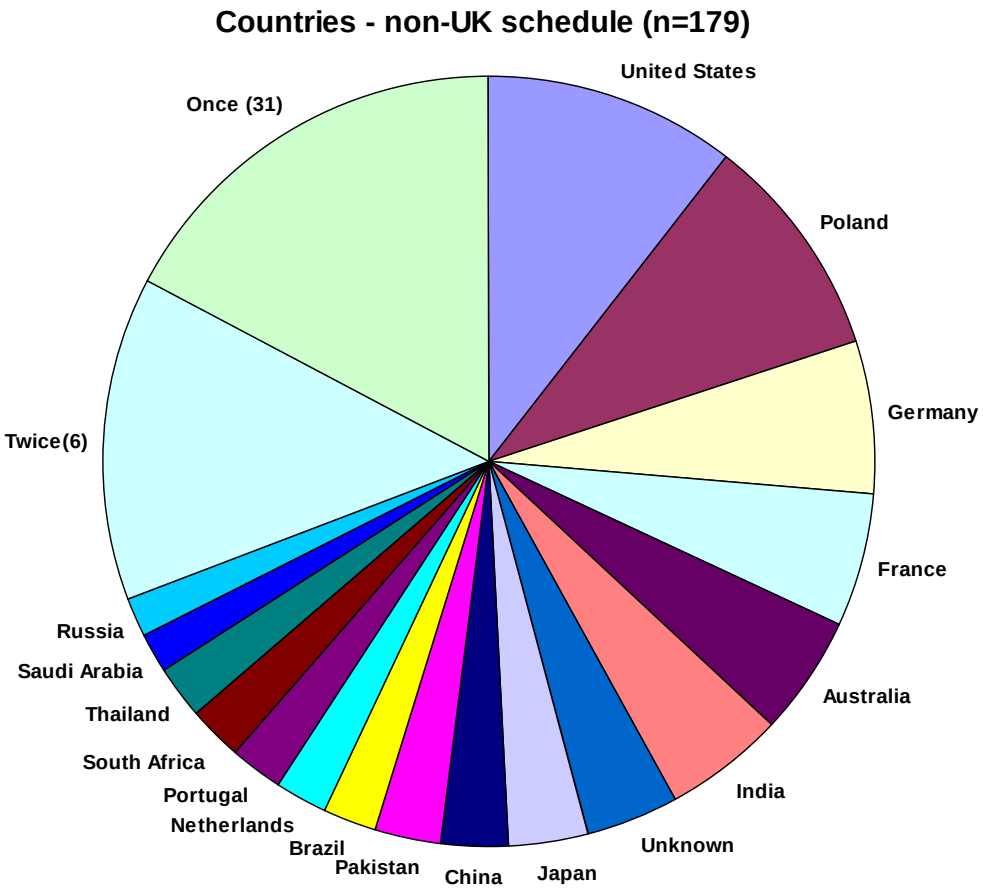


Figure 3.21: Countries of origin of patients who have incomplete immunisations according to the UK schedule, for whom Oxford VACCSline was contacted (2008-09).

Several survey respondents and interviewees identified specialist local services to ensure appropriate catch-up vaccinations were provided to unaccompanied children and young people seeking asylum.

Best Practice Example

Protecting unaccompanied children from vaccine-preventable disease,

Oxford, Hampshire and Kent:

Oxfordshire PCT and county council jointly commission a specialist nurse for looked-after children, who has increased immunisation uptake and TB screening for unaccompanied children and young people seeking asylum.

A consultant community paediatrician in Hampshire and a GP in Kent, providing sessions at a residential centre for unaccompanied young people seeking asylum, undertake the equivalent work in these areas.

Conclusions and recommendations

The physical health needs of migrants vary with their specific circumstances, their country of origin and its endemic disease prevalence and risk behaviours.

No single data resource adequately or completely captures the physical health needs of migrants in the SE region.

Databases on infectious diseases such as TB and HIV show that migrants are disproportionately affected.

There is some data from sexual health datasets on the experience of disease in these groups, but completeness of recording is not yet adequate.

Smoking prevalence and other behaviours among migrants in the UK reflect background levels of such activities in migrants' countries of origin.

Vaccination programmes are often interrupted or not started, due to migration.

Dental health may be poor among some migrants, due to poor access to services in their country of origin and within the UK.

It is recommended that:

- Routine health databases are improved to capture data on migrants.
- The South East Migrant Health Network should lead the coordinated collection of maternity data capturing country of mother's birth and linking this to other health indicators from the maternity dataset.
- Improving testing of migrants from high-risk countries for diseases like TB and HIV may improve early detection and treatment outcomes.

- Targeting health promotion and disease prevention campaigns, including vaccination campaigns, may improve the health of migrants.
- Since infectious disease surveillance is better than other databases, because of the statutory requirement on local authorities and health services to respond to such conditions, and because they disproportionately affect migrant populations, this area of work may be an appropriate focus for health services in addressing migrant health needs.

References for this chapter

1. Gilbert R, Jones J. Migrant Health: Infectious diseases in non-UK born populations in England, Wales and Northern Ireland: a baseline report: Health Protection Agency, Centre for Infections; 2006.
2. 'A smokefree future': A comprehensive Tobacco Control Strategy for England 2010-2020; Equality Impact Assessment: Department of Health; 2009.
3. The European Tobacco Control Report 2007: World Health Organisation; 2007.
4. Statistics on Smoking: England, 2009 The Health and Social Care Information Centre; 2009.

Chapter Four: Health service utilisation and barriers to access

Key findings:

- A wide range of organisations is providing services to improve migrant health in the SE region, in addition to NHS service provision.
- Qualitative research identified several wider determinants of health which affect the health of migrant groups in the SE region.
- Different cultural expectations among migrants can contribute to health-seeking behaviour which is perceived as inappropriate.
- Discrimination and abuse, and reluctance by hospitals or health workers, were identified by some respondents as barriers to access.
- Confusion over entitlement to services, and language/interpreting issues, were consistently identified as barriers to access, for migrants as well as for organisations commissioning and providing services.

Many migrants will clearly understand entitlement to care in the UK and will access both primary and secondary care services effectively within the South East region. However, for some, access problems can arise due to:

- Lack of understanding of UK health systems.
- Lack of knowledge around entitlement to care.
- Language barriers.
- Cultural barriers.

Our survey asked respondents to identify those services frequently used by migrants. The results are shown in Figure 4.1. This demonstrates that migrants frequently use A&E services. This does not tell us anything about the reason for using these emergency services. However, a concern is that some migrants use such walk-in services because they are not registered with a GP and/or do not understand their entitlement to care within the NHS. They will therefore use more accessible services, even if this is not the most appropriate way to manage their health needs.

Furthermore, they will also miss out on opportunities to access preventive, diagnostic and therapeutic services delivered through primary care, including vaccine and screening services.

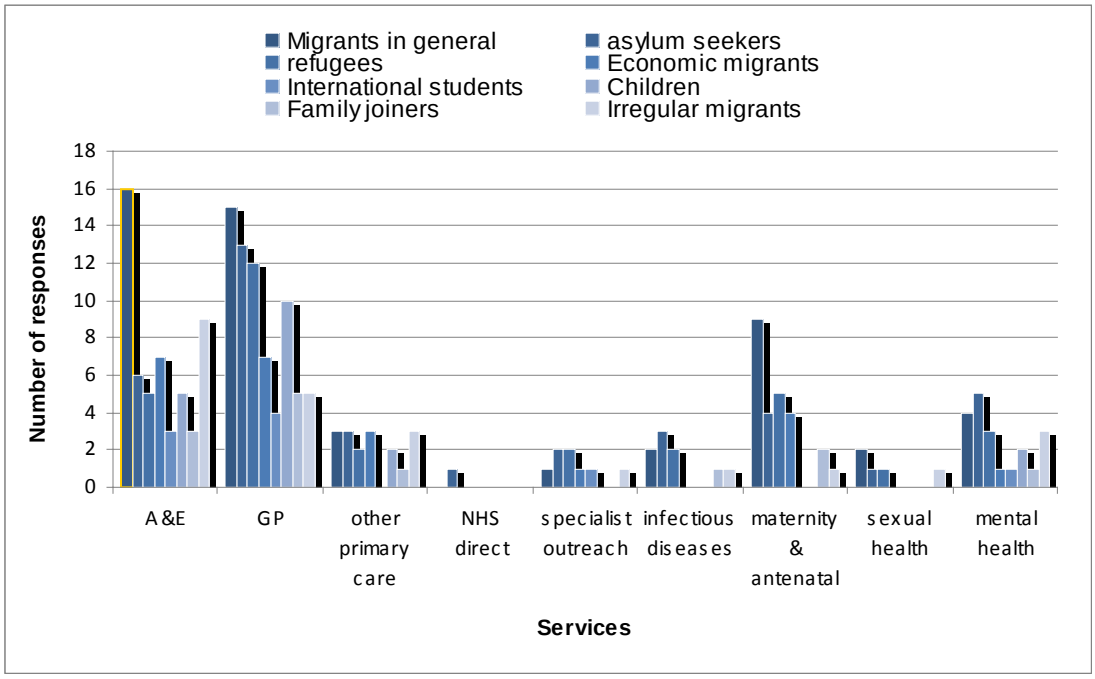


Figure 4.1: Responses to survey Question 18: Which services are most accessed by migrants in your area?

Wider determinants of health

Health services and their availability or appropriate use are not the only factors which can impact upon the health of migrants. It has long been recognised that social factors, such as socioeconomic, cultural and environmental factors, working environment, housing and education can all positively or negatively affect health in all communities (see Figure 4.2).

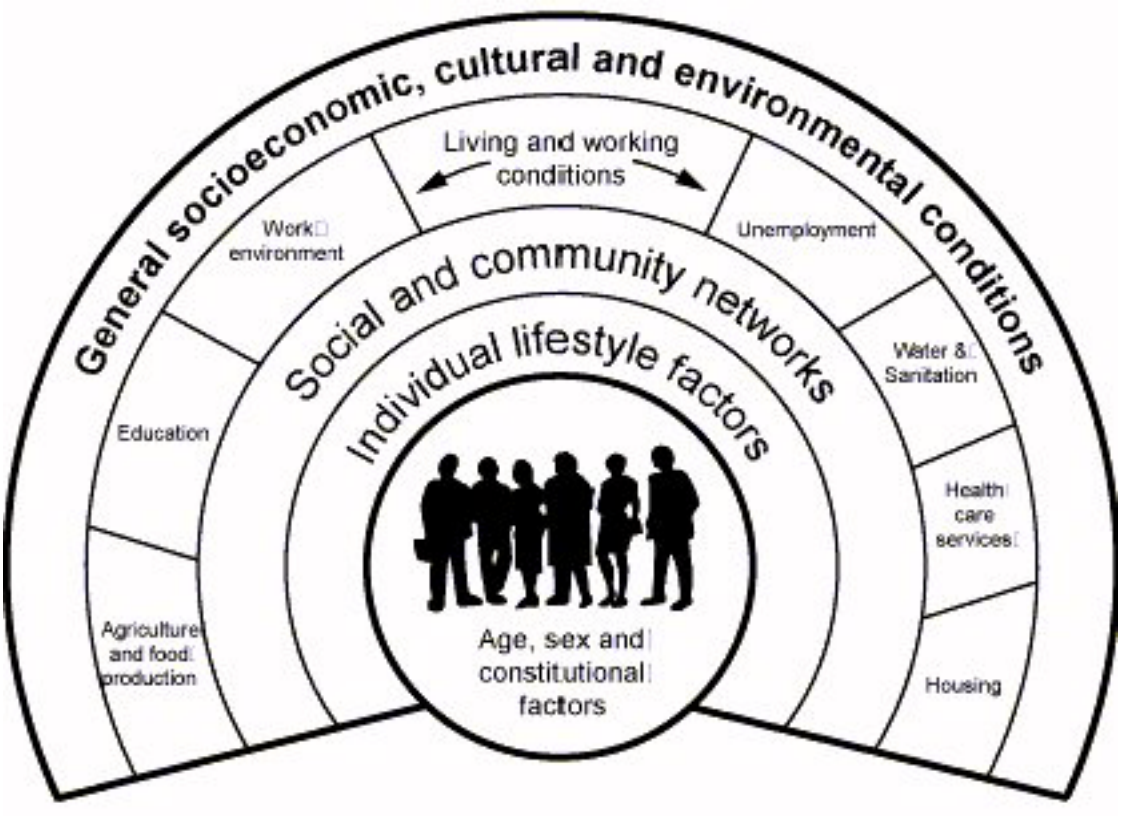


Figure 4.2: Dahlgren and Whitehead's framework of the wider determinants of health (1)

Respondents to our survey were asked about which wider issues they believed affected the health of migrants. Their responses are shown in Figure 4.3. Issues such as appropriate housing and access to employment and educational opportunities feature strongly in our respondents' answers. However, other issues such as language and interpretation problems also feature prominently and this differentiates migrants from other vulnerable groups also in need of support, suggesting a very specific response is required to improve access to services for migrants.

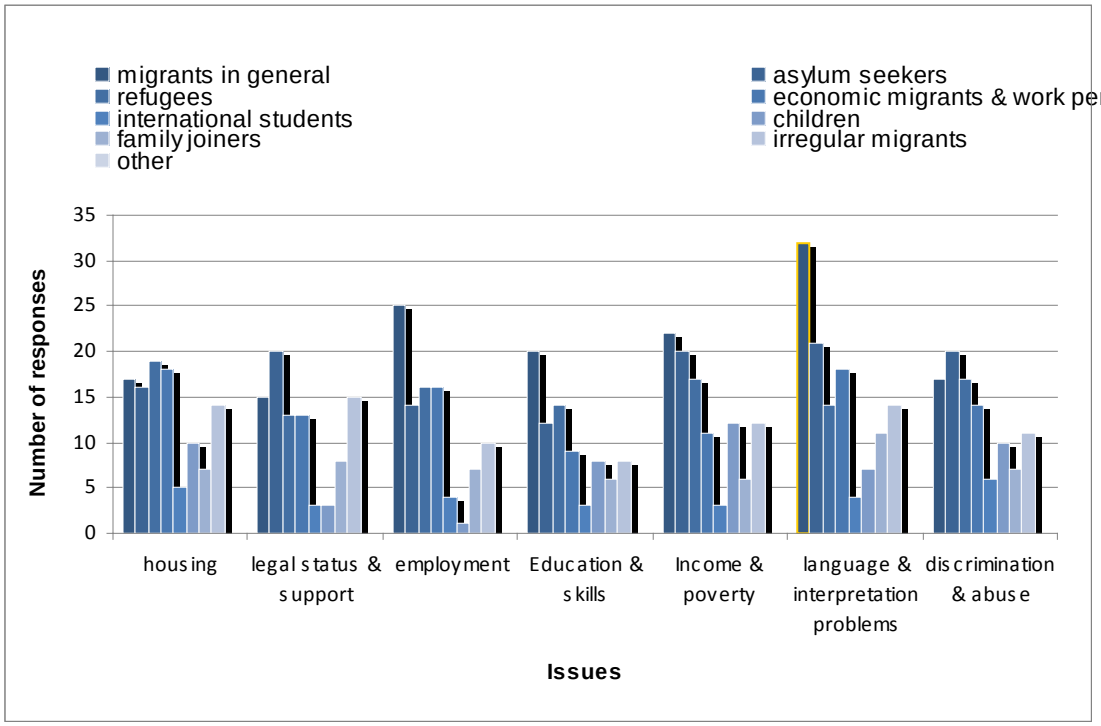


Figure 4.3: Responses to survey question 16: What are the most important wider issues affecting the heath of these groups?

Barriers to healthcare among migrants

The literature review identifies many barriers to accessing healthcare for migrants. We asked respondents to our survey for their opinions about issues encountered locally by migrants. Their answers, shown in **Figure 4.4,** validate the evidence from the published literature and identify issues including:

- Confusion over entitlement to NHS services.
- Problems registering with primary care services.
- Language and interpretation problems.
- Cultural barriers.

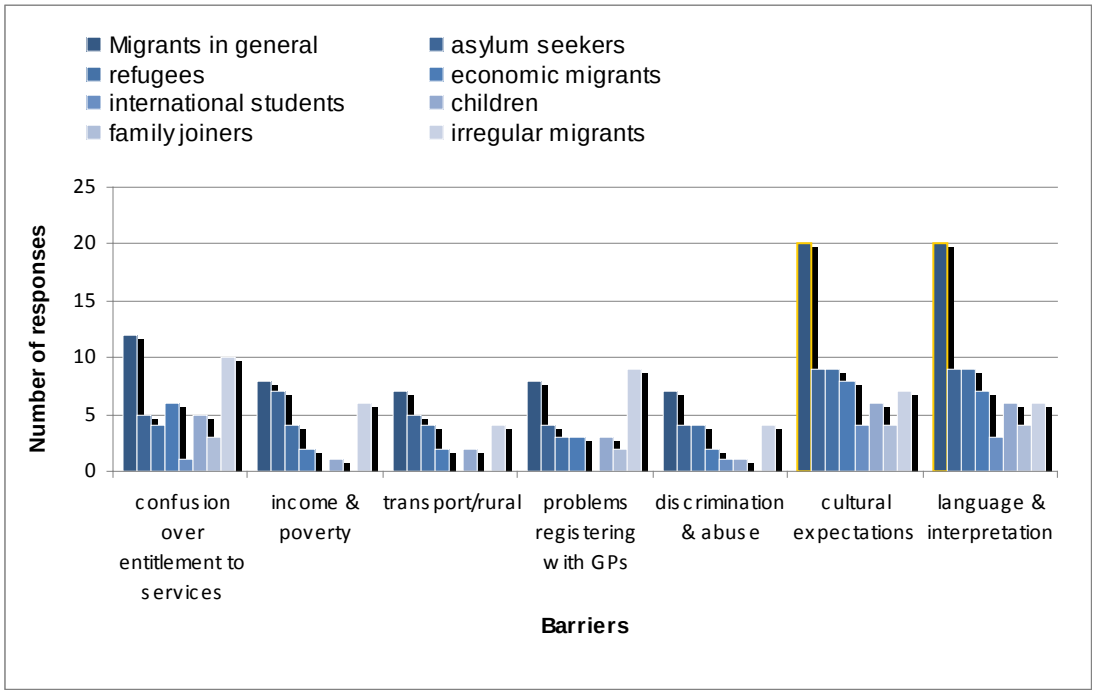


Figure 4.4: Responses to survey question 23: Are you aware of any barriers experienced by migrants, making it difficult for them to access health services appropriately in your area?

Issues representing barriers to accessing healthcare, also identified by our respondents, included discrimination. It is not entirely clear if this is perceived or experienced. However, frontline healthcare staff may need further training in ensuring that migrants are appropriately managed on initial presentation, including being greeted in a friendly manner and being offered all reasonable support to facilitate their needs being understood. The need for such additional training for frontline staff is illustrated by the difficulties which have long been described for migrants attempting to register with GPs. Further work is also required to ensure migrants understand their rights to access care in the UK.

Barriers to provision of appropriate healthcare to migrants can also be due to organisations experiencing problems in discharging their duty of care. Our survey respondents were asked if their organisations experienced any barriers in commissioning and providing healthcare to migrants. Their responses are shown in Figures 4.5 and 4.6

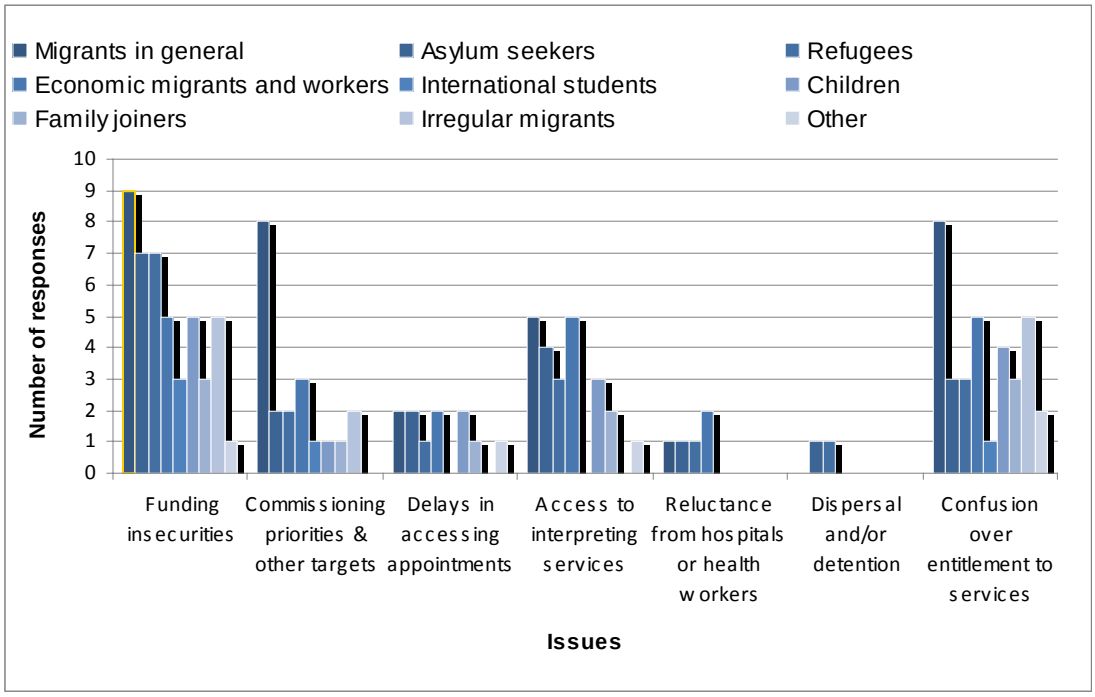


Figure 4.5: Survey responses to question 20: Does your organisation experience any barriers to commissioning services accessible to migrants?

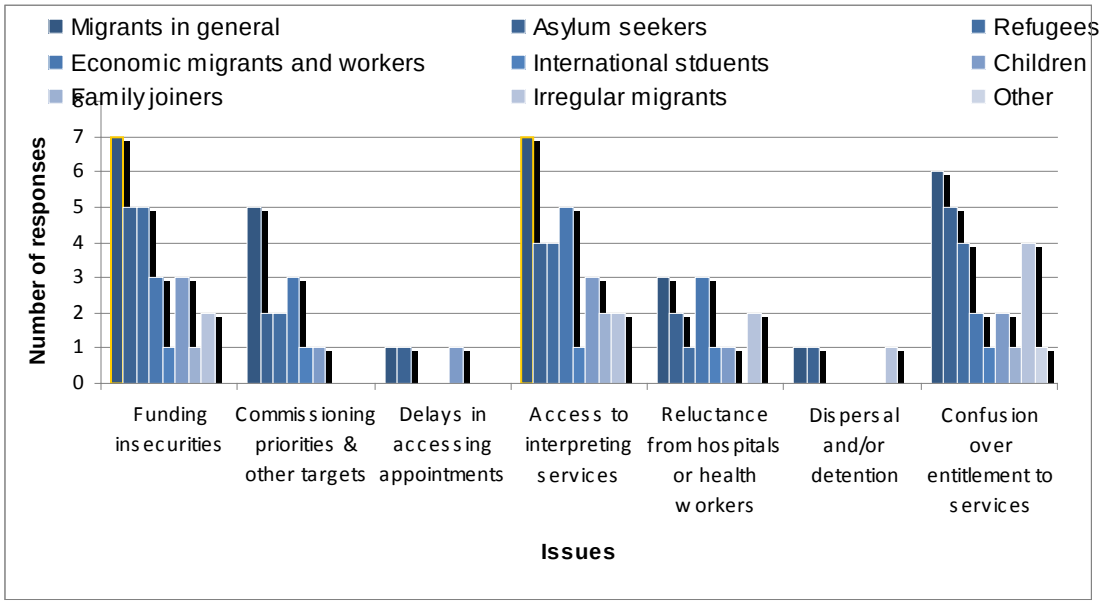


Figure 4.6: Survey responses to question 22: Does your organisation experience any barriers to providing services accessible to migrants?

Among issues identified were funding, competing commissioning priorities, access to interpreting services and confusion over entitlement to NHS care. In the current

economic climate, funding pressures will continue to be an issue for all aspects of the services provided by health and local authority commissioners.

Conclusions and recommendations

Migrants represent a diverse group with different levels of health need and different levels of knowledge of and the ability to have health needs met by existing services. However, there is a duty of care on health and local authority commissioners and service providers to ensure that all the residents of any PCT area have access to appropriate healthcare. Improvements in meeting healthcare needs could be produced by some of the following actions:

- Joint working should optimise signposting to improve access to services provided by NHS and other organisations.
- Joint working should tackle the interactions between health needs and wider determinants of health, including housing.
- Policies about entitlement to NHS services should be communicated clearly to staff in organisations providing services, as well as to service users.
- Cultural expectations of local migrant groups should be understood better and targeted, to reduce inappropriate health-seeking behaviour.
- A zero-tolerance policy should be adopted towards discrimination and abuse, with education for service providers about how barriers to access can undermine appropriate health-seeking behaviour.
- A minimum requirement for appropriate interpretation services should be set, funded and communicated to staff of all statutory organisations.

Reference

1. Dahlgren G, Whitehead M. Policies and strategies to promote social equity in health. Stockholm: Stockholm Institute for Further Studies; 1991.

Chapter Five: Mental health needs of migrants in the South East region

Key findings:

- Mental health was identified by survey respondents as a significant problem for migrant populations.
- Ethnicity data is a poor proxy for migration, but only ethnicity data is collected by mental health services.
- Where literature is available on migrant populations, it emphasises the heterogeneity of migrants.
- Particular vulnerabilities to mental health problems are emphasised in the literature and qualitative data for asylum seekers and refugees, asylum seekers in detention, unaccompanied asylum-seeking children and irregular migrants.
- Strengthening data collection was a central element of a DH strategy to improve mental health services for black and minority ethnic communities.
- Confusion over entitlement to services, language barriers, cultural differences and housing were identified by survey respondents as key barriers to migrants accessing care for mental health problems.

Introduction

Mental health, more than any other health issue, was identified by survey respondents as a significant problem for migrant populations, and no respondents judged it as 'not a problem'.

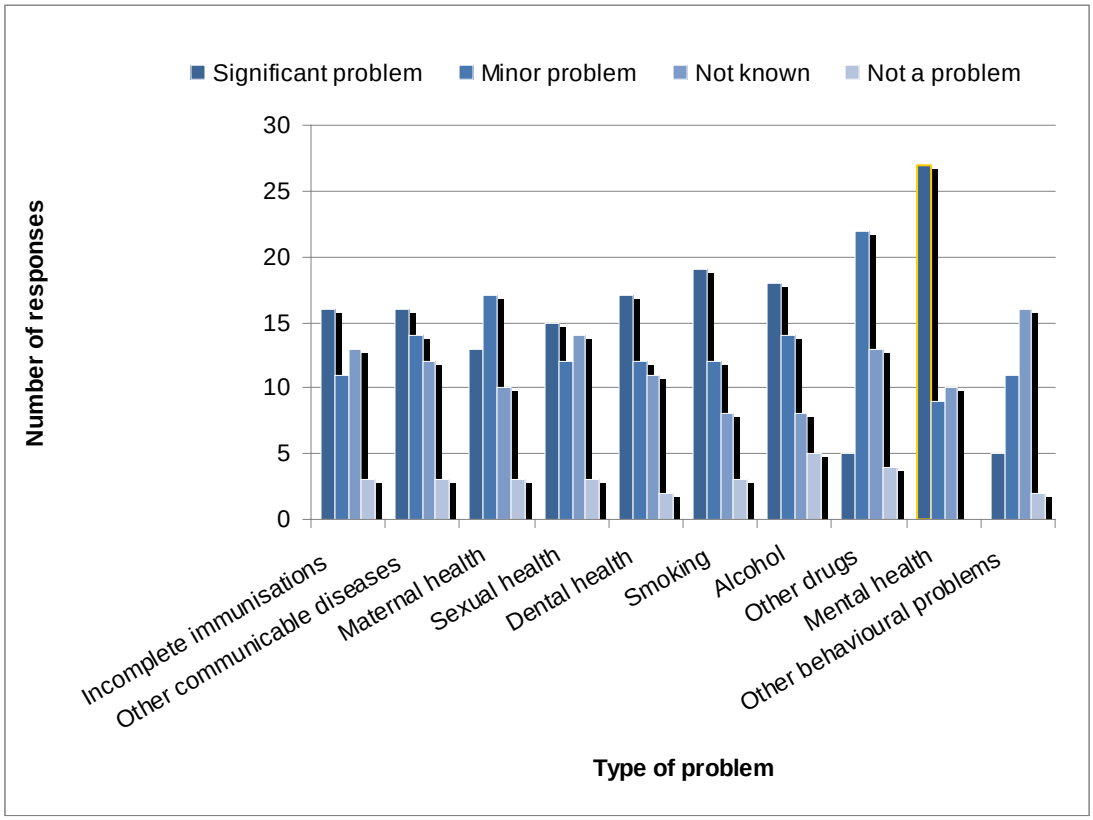


Figure 4.1: Responses to survey question 14: What are the greatest health issues for migrant populations?

In this chapter, a brief literature review summarises the limited research previously undertaken into the mental health of migrants, in addition to key issues identified for black and minority ethnic (BME) communities. Sources of operational data from NHS mental health services are then outlined. The quality and scope of quantitative data has improved over the past five years, although the information available in the public domain is still limited to ethnicity rather than country of birth. Finally, qualitative data illustrates the extent of unmet mental health needs across all migrant groups, and highlights asylum seekers, children and irregular migrants as being particularly vulnerable.

Mental health literature

Asylum seekers and refugees claim asylum due to a fear of persecution in their country of origin, and many have undergone traumatic experiences not only before emigrating, but also during the journey to a new country and afterwards (1-3). In addition, some studies argue that the mental health of asylum seekers and refugees is exacerbated by UK government policies such as dispersal, detention, the threat of

rapid removal and ineligibility to work or study during the lengthy process to evaluate asylum claims (4, 5).

Particular concerns have been raised about the mental health of asylum seekers in detention centres (3, 6), especially women who have experienced sexual violence (7) and children whose experiences can include lack of access to proper education, and witnessing violence and acts of severe distress, including self-harm (8).

Unaccompanied children seeking asylum are an exceptionally vulnerable group, negotiating a foreign society alone and often being granted temporary leave to remain in this country only until they are 17.5 years old. This leaves these children particularly unsupported at a crucial developmental stage in their lives, with the constant threat of being returned to their countries of origin. Many have undertaken particularly harrowing journeys, compounded by having to travel alone, often without understanding what is happening or might happen to them. In addition, many have experienced more severe traumatic experiences in their countries of origin, commonly including the death of a parent (2).

Best Practice Example

The Harbour Project, Oxford:

This school-based mental health service for young asylum seekers and refugees was established in 2001 and is jointly funded by the Children's Society, the University of Oxford and the Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust. A multi-disciplinary team works with children who face emotional or psychological distress or trauma as a result of their refugee experiences. Working closely with staff in schools helps to identify those at risk and build trusting relationships with children who need mental health support. Barriers to accessing mental health services for this population are much reduced through provision of this service in schools. (9)

Irregular migrants, with no recourse to public funds, include refused asylum seekers and other people who have no legal status in the host country, such as those who have entered illegally or whose visas have expired. They are vulnerable to exploitation (10) and a European working group on mental health recently highlighted the mental health vulnerabilities of irregular migrants in 'badly paid, physically and psychologically stressful jobs' in the informal sector (11).

A study of refused asylum seekers in the South East (Portsmouth, Brighton, Hastings and St Leonard's) found a high level of mental health needs, exacerbated by destitution. 64% were staying with friends or acquaintances, 8% were accommodated by charitable organisations and others were sleeping rough. Fears they described included those arising from sleeping rough, the fear of being challenged by GPs to show proof of eligibility for treatment and 90% feared returning to their country of origin. 55% were receiving medication for depression, but several described the difficulties of finding a GP whose practice would accept them. 65% thought that their problems were caused by their inability to support themselves and wanted to be able to work. Healthcare providers interviewed raised concerns about the inefficiency of the 'revolving door' situation, whereby destitute people were hospitalised after a mental health crisis, treated, discharged and re-admitted after their condition had been exacerbated by returning to destitution without adequate follow-up (5).

A systematic review and meta-analysis into the mental health of 7000 refugees resettled in western countries found that 1 in 10 adult refugees had post-traumatic stress disorder (PTSD), 1 in 20 had major depression and 1 in 25 had a generalised anxiety disorder (1). There was extensive co-morbidity, as 44% of those diagnosed with PTSD also had major depression (1).

To compare the depression and anxiety rates in refugees with those among economic migrants and host populations, a systematic review and meta-analysis evaluated 35 studies. Refugees were found to have double the prevalence rates, compared with economic migrants, whose rates were not dissimilar to the general US population (12).

Smaller studies of the diagnosis and treatment of depression and anxiety in Asian patients in the UK raise interesting questions, although they are drawn from records of ethnicity rather than country of birth. Women of Indian origin with common mental disorders consulted their GPs more frequently, were less likely to see depression as a trigger for medical intervention and were more likely to withhold some of their concerns from their GPs (13). GPs were more likely to diagnose these patients incorrectly when they did not disclose all their complaints. A larger study of 164 general practices in East London found that practices with a high proportion of

Asian patients had low practice-level prescribing for antidepressant and anxiolytic medication (14). These studies illustrate that, in addition to other barriers of access, significant cultural differences might impact on effectively diagnosing mental health issues (11).

Best Practice Example

Polish cultural awareness training: Hampshire

This workshop is jointly provided by EU Welcome, a non-statutory organisation in Southampton, and a mental health social worker with extensive experience of the Polish community. It is targeted at inpatient and community mental health teams, and explores social, cultural, economic and health issues, as well as norms and values around mental health. Different communication styles and successful methods of communication are covered, alongside helpful solutions to common mental health problems.

In discussing the differences between four distinct groups of Poles in the UK, it explains why working class labourers have more difficulty in adapting linguistically than professionally qualified people with more linguistic skills.

Studies of deliberate self-harm and suicide among asylum seekers and refugees showed increased risks in those with mental health problems such as depression, anxiety and post-traumatic stress disorder (15, 16). Despite poor records in IRCs, the risk of suicide in asylum seekers was higher in detention (4). Two studies of suicide rates in other migrant communities showed that these were higher in young Asian immigrant women than in young Asian men or UK-born women (17, 18). Suicide in young Asian immigrants may be linked to family and cultural conflicts, domestic violence, depression and anxiety, but the latter two conditions may be under-diagnosed in this group (11).

Best Practice Example

Rethink: Crawley and Kent

As the largest national non-statutory sector provider of mental health services, Rethink runs over 290 services and 139 support groups.

Rethink in Crawley employs community development workers to work with BME communities and other organisations across West Sussex. At a strategic level, they aim to raise awareness and to deliver racial equality within mental health services. Through local networks, including the Crawley ethnic minorities' partnership and service users' forum, they tackle barriers to accessing mental health services. Services provided include signposting, advocacy and support to refugees and asylum seekers, including those detained in and released from the local Immigration Removal Centre.

Rethink Sahayak, in Kent, found that South Asian women experiencing domestic violence were unable to access responsive services. Domestic violence within South Asian culture contributes to especially vulnerable situations for people with uncertain immigration status, through extended-family involvement and concepts of honour and shame. Rethink's Oppressed Voices project spoke to women and conducted multi-agency research, revealing that stigma prevented participants from reporting domestic violence, and 95% felt there was a language barrier to getting help for the resulting depression and emotional pain.

Oppressed Voices has raised awareness about the issue within South Asian communities and has led local police to look at the way they address domestic violence with young people, through early intervention work to raise the issue in schools. Work to improve access to GPs for non-English speaking women is ongoing (19).

For psychotic disorders, studies have consistently found higher rates in migrants to northern European countries than in white Europeans in their host societies (20-25). Studies from the 1970s and 1980s also found hospital admission rates for schizophrenia to be higher in people with Caribbean, Irish, Polish, Indian and Pakistani backgrounds than White British people (26-30). In 2000, a study in Trinidad and London found first diagnoses of schizophrenia to be less common in 'sending' countries than in migrants after arrival in the new country (31). A gradient between ethnic groups for rates of psychotic disorders was described in London, Nottingham and Bristol, whereby rates in African-Caribbeans were higher than those in Black Africans, which were higher than 'mixed' and 'White Other' groups, which themselves were higher than 'White British' (32).

When rates of compulsory hospitalisation for mental illness were measured, Black patients in the UK were more likely than White British patients to be admitted to

hospital (32) and non-western immigrants (of all skin colours) to the Netherlands were more likely to be hospitalised than Dutch nationals (26).

Best Practice Example

James Wiltshire Trust befriending scheme, Hampshire:

This non-statutory organisation provides advocacy, culturally appropriate counseling and research into mental health issues experienced by BME clients and their carers. Services are offered within the prison system, inpatient services and the community.

The Trust's Community Engagement Project runs a befriending scheme for BME patients in psychiatric inpatient care units in Hampshire. The scheme works to relieve the isolation felt by BME inpatients, and then helps them develop local connections to support their sustained recovery and reintegration into society after discharge from hospital.

Studies have shown associations between psychosis and perceived discrimination, high unemployment, family dysfunction and poor housing (33-36). In 2004, a study found that relative risks of psychosis in immigrants decreased after adjusting for socio-economic indicators, such as parental unemployment, rented accommodation and receiving social welfare (21). One review of 17 population-based studies discussed the challenge of formulating a life plan, which is stressful for young adults at the age when schizophrenia most commonly presents, and which is more difficult for disadvantaged ethnic minorities (37). Reviewers also noted that schizophrenia rates are highest among those immigrant groups who are least successful, such as Moroccan men in the Netherlands or African-Caribbeans in the UK (38). Another hypothesis linking an animal model to schizophrenia suggests that higher rates of psychotic disorders in immigrants may be explained by their chronic experiences of social defeat and humiliation (38).

Quantitative data

The disproportionate distribution of mental health problems across different ethnic groups is recognised by the Department of Health. A Department of Health/Care Quality Commission publication in January 2010 stated:

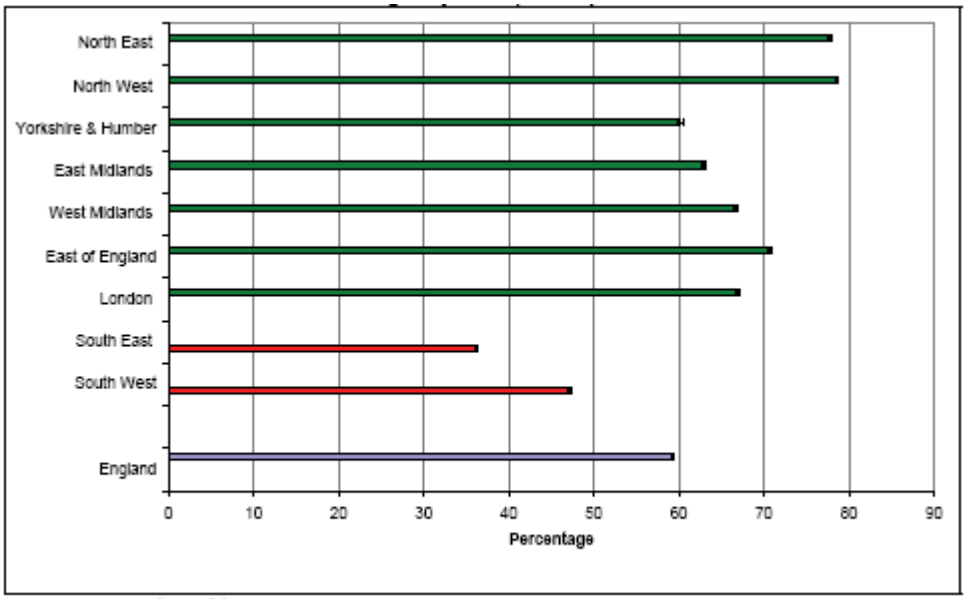
'All patients are entitled to receive the same high level of healthcare, regardless of their race, religion, age, gender, sexual orientation, and whether they have a

disability. Patterns of mental illness and use of mental health and learning disability services differ between ethnic groups.' p.2 (39)

Delivering Race Equality in Mental Healthcare (DRE) is the Department of Health's five year action plan, introduced in 2005, to improve mental health services for black and minority ethnic communities in England. A Race Equality Action Plan for adult mental health services was introduced in Wales in 2006. Of relevance to this report, DRE's website explicitly includes people of Irish, Mediterranean and East European origin in the people of BME origin it hopes will 'feel more able to access and have improved confidence in mental health services' (40).

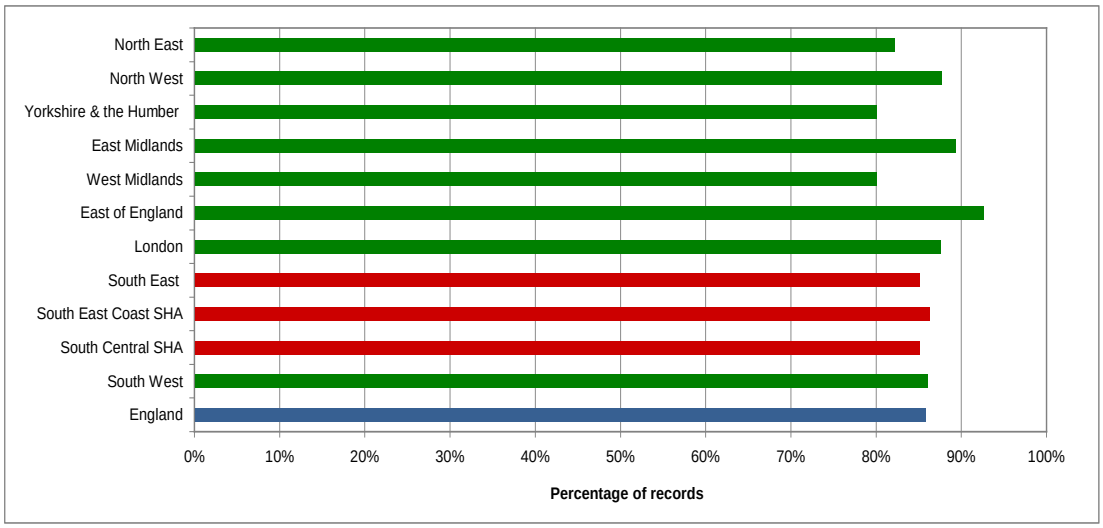
Better use of information and evidence was one of DRE's three building blocks (41). Encouraging providers to improve recording of the ethnicity of people accessing mental health services was emphasised as crucial, both to ensure that culturally appropriate services were accessible to BME communities, and 'to provide information that would help service providers to take practical steps to tackle racial discrimination' (42).

This emphasis has produced an improvement in the recording of ethnicity of people accessing mental health services. In 2004-5, only 59% of such records in England, and only 36% in the South East, included a valid and usable ethnic group code (see figure 4.2). In 2008-9, this had improved to 85% of such records in the South Central SHA and 86% in the South East Coast SHA (see Figure 4.3). Of the records without a valid and usable ethnic code, approximately 14% were not stated across the South East, with 1.1% missing for the South Central SHA and 0% missing for the South East Coast SHA (see Figure 4.4).



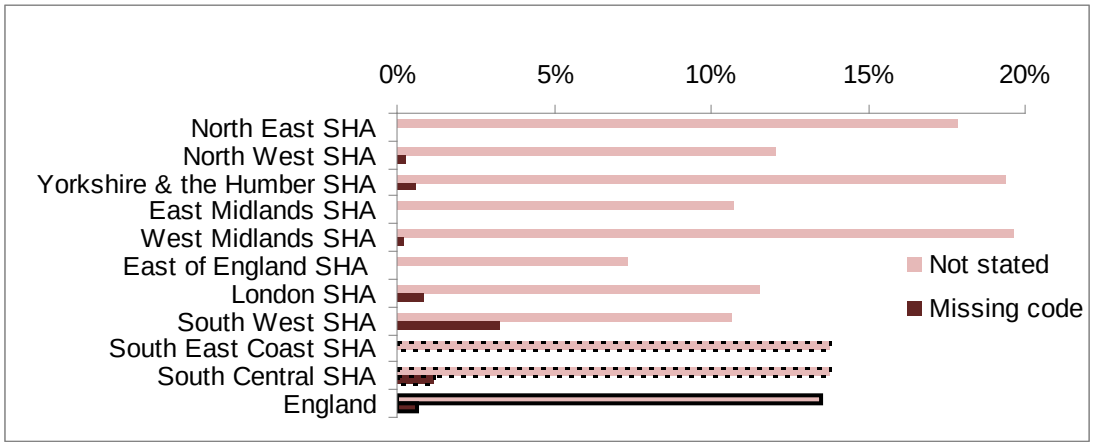
Source: Mental Health Minimum Dataset

Figure 4.2: Percentage of records in the Mental Health Minimum Dataset (MHMDS) which include a valid and usable ethnic group code, 2004-5



Source: Health and Social Care Information Centre, Mental Health and Community Care Team

Figure 4.3: Percentage of records in Mental Health Minimum Dataset (MHMDS) with a valid and usable ethnic group code, 2008-9



Source: Health and Social Care Information Centre, Mental Health and Community Care Team

Figure 4.4: Percentage of records in Mental Health Minimum Dataset (MHMDS) where the ethnic group code was not stated or missing, 2008-9

The Department of Health currently collects two sources of operational data by ethnicity, to explore how different ethnic groups access mental health services in England and Wales. Collecting country of birth information would be more valuable than ethnicity for understanding the distribution of mental health need and access to services for migrants. Nevertheless, the progress in record-keeping for ethnicity over the past five years should be acknowledged (Figures 4.2 and 4.3) and could expedite data collection on country of birth, should that decision be taken in future. Moreover, DRE seeks to include migrants as 'White Other' in the current BME data (40), and barriers to access are likely to be shared between migrants and established BME communities (3, 9).

In support of the DRE agenda, the 'Count Me In' census has been conducted annually since 2005, to monitor the ethnicity of psychiatric inpatients and, in 2009, of people subject to compulsory treatment in the community under the Mental Health Act (Community Treatment Orders) (43). The annual census provides a snapshot of the number and ethnicity of all psychiatric and learning disability inpatients in England and Wales (41).

The 2009 census found 22% of all patients to be from BME groups, compared with 20% in 2005. Of all patients counted, ethnic information was not available for 2%, 76% were White British, 2% White Irish, 4% Other White, 10% Black or Black/Mixed, 3% South Asian and 3% other BME, including Chinese. In discussing demographic changes in England and Wales since 2005, the 2009 census report noted that 6% of

patients did not use English as their first language, and observed geographical concentrations whereby 70% of all patients from BME groups were found within 28 of the 264 organisations surveyed (39).

The headline messages of the 2009 census were that black and black/mixed ethnic groups were over three times more likely to be detained under the Mental Health Act, and that there was no evidence of the DRE goal of a decline in admission rates for BME groups. Key recommendations included better partnership working between health organisations and BME communities, better local strategic needs assessment and bespoke community-based services to reduce the risk of admission and detention, early intervention and addressing contributory factors to prevent mental ill-health, and continued improvement in recording accurate patient information, including ethnicity (43).

The MHMDS is a more comprehensive approach to collecting data for all adults and older people who have used secondary mental health services in England since 2003. An anonymised unique patient identifier, through which different episodes of care can be linked, allows each MHMDS record to follow an individual's entire journey through mental healthcare services, through referral, hospital, community, outpatient and day-care episodes and final discharge. The MHMDS is collected quarterly with an additional annual submission and is used at all levels for quality improvement and service planning (44). For example, it shows that fewer than 10% of people using NHS specialist mental health services each year spend time as psychiatric inpatients, so information focusing on inpatient care gives limited information on mental health need or service usage (45).

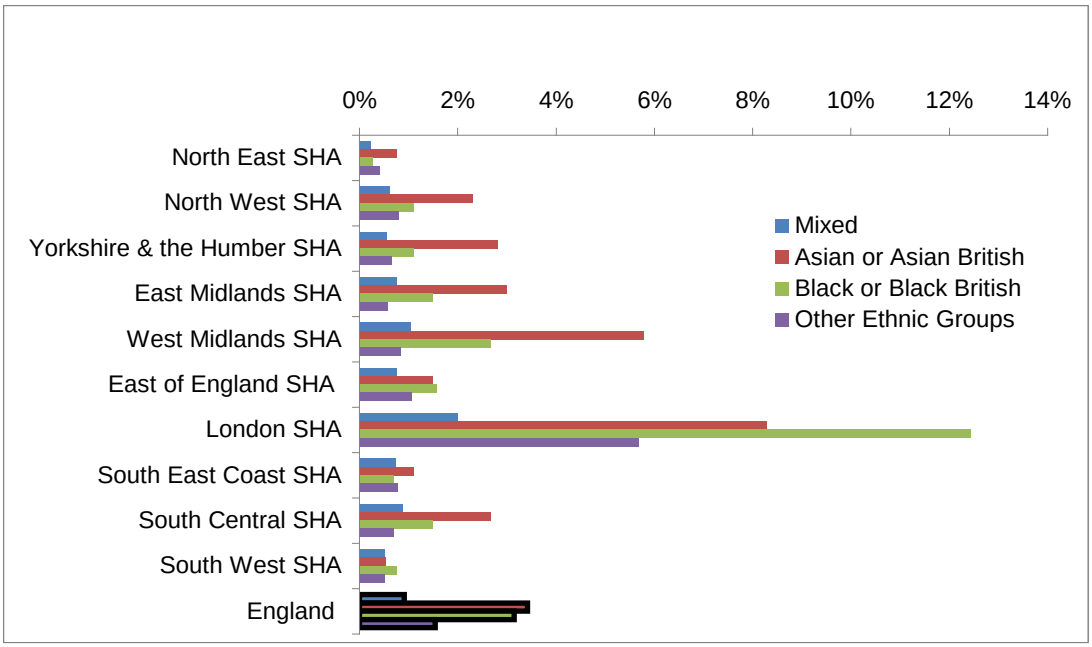
In addition to overall levels of ethnicity recording (figures 4.2-4.4), the MHMDS allows some analysis of which patients lack a valid and usable ethnic code in their records. Data show the highest level of care accessed during the year, so even a brief inpatient period will show that patient's record as 'admitted' that year. Similarly, a patient previously in contact with secondary mental health services and not formally discharged will be classified as 'no care' if they had no contact with secondary mental health services for that year (45). It is not surprising, especially given the 'Count Me In' census every March, that the lowest percentages of records without a valid or usable ethnic code are found in those including inpatient stays (see Figure 4.5). Similarly, the

highest proportion of records with no valid or usable ethnic code can be predicted to appear in the 'no care' category for each SHA. However, the 44% of 'no care' records in the South Central SHA with no valid or usable ethnic code is striking and compares unfavourably with 19% for the South East Coast SHA and 23% for the English average (see Figure 4.5).

Source: The Health and Social Care Information Centre

Figure 4.5: Percentage of records on access to NHS mental health services where ethnicity was not stated or missing, by highest category of care and SHA, 2008/09 adults 18 years and older.

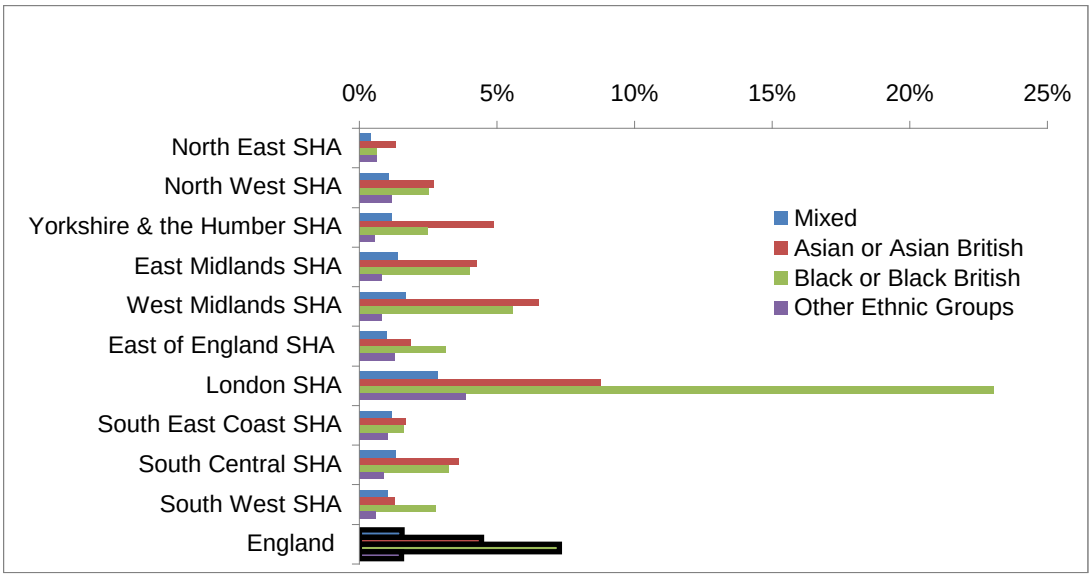
In contrast to the 'Count Me In' census data, the MHMDS classifies Irish and Other White groups within the White group, rather than among other ethnic groups represented in figures 4.6-4.9, which consequently tell us less about migrants. For example, the majority of individuals to access secondary NHS mental health services overall in 2008-9 were White, at 83% in the SE Coast SHA, 79% in the South Central SHA and a 77% average across England (see Figure 4.6). The report on the 2008-9 data does comment that the White group was the only ethnic group whose rates of access were higher in the younger working age group (18-35) than in the older working age group (36-64) (45), which could include some Other White migrants, given the generalisation that migrants tend to be young (see Chapters One and Two above).



Source: The Health and Social Care Information Centre

Figure 4.6: Access to NHS mental health services by ethnic group (other than white) and SHA, 2008/09 all categories of care adults 18 years and older.

The latest MHMDS report undertook some new population-based analysis using ONS ethnicity estimates for 2007, to calculate average rates of access (per each ethnic group across England) to mental health services. It found that rates of access to all mental health services, not just to inpatient care, were highest for Black and Black British groups (3,453 per 100,000), and lowest for Asian and Asian British groups (1,899 per 100,000), 17% higher and 36% lower respectively than the average rates across all ethnic groups (2,949 per 100,000). Rates based on ethnicity estimates should always be interpreted with caution, especially given the limitations in ONS estimates outlined in Appendix A.



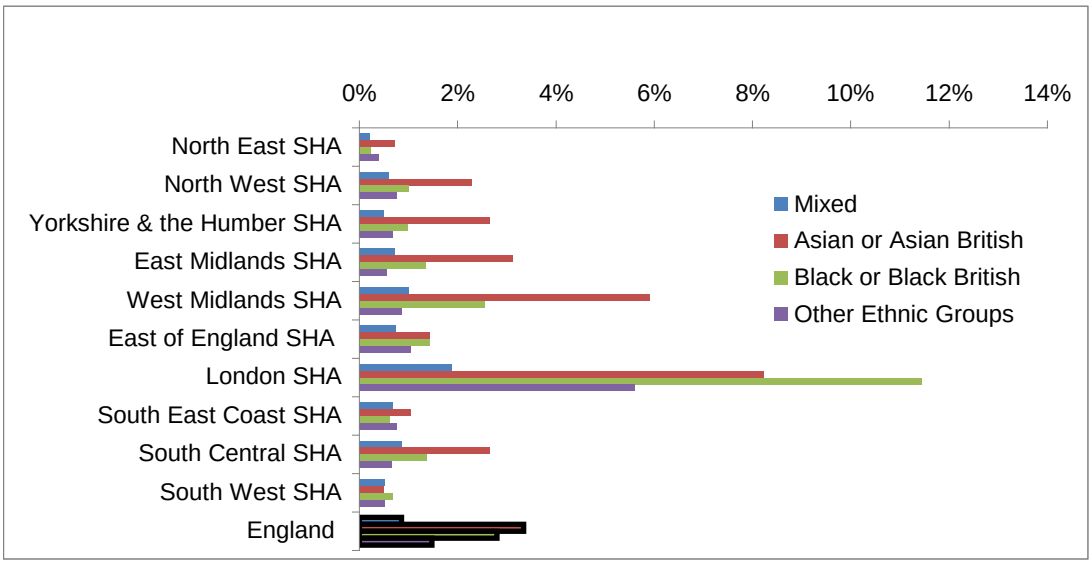
Source: The Health and Social Care Information Centre

Figure 4.7: Access to NHS mental health services by ethnic group (other than White) and SHA, 2008/09 admitted adults 18 years and older.

In discussing the ethnicity of psychiatric inpatients (see **Figure 4.7**), the report argued that increased access to all mental health services (including those in the community) for Black and Black British groups challenged the long-standing theory that these groups are over-represented as inpatients because they have poor access to mental health services until a point of crisis. However, the rates of inpatient care for Black and Black British groups (674 per 100,000) were 170 per cent higher than the rate for inpatient care across all ethnic groups. 19% of Black and Black British groups spent some time as an inpatient, compared to 8.4 of all ethnic groups who spent some time as an inpatient. Furthermore, Black and Black British groups were over-represented among inpatients subject to compulsory detention in hospital under the Mental Health Act, and the numbers of individuals from BME groups (Black, Black British, Mixed, Asian and Asian British) compulsorily detained as inpatients has risen, while the corresponding numbers of White people has fallen. These figures suggest that individuals from BME groups are still over-represented in compulsory inpatient care (45).

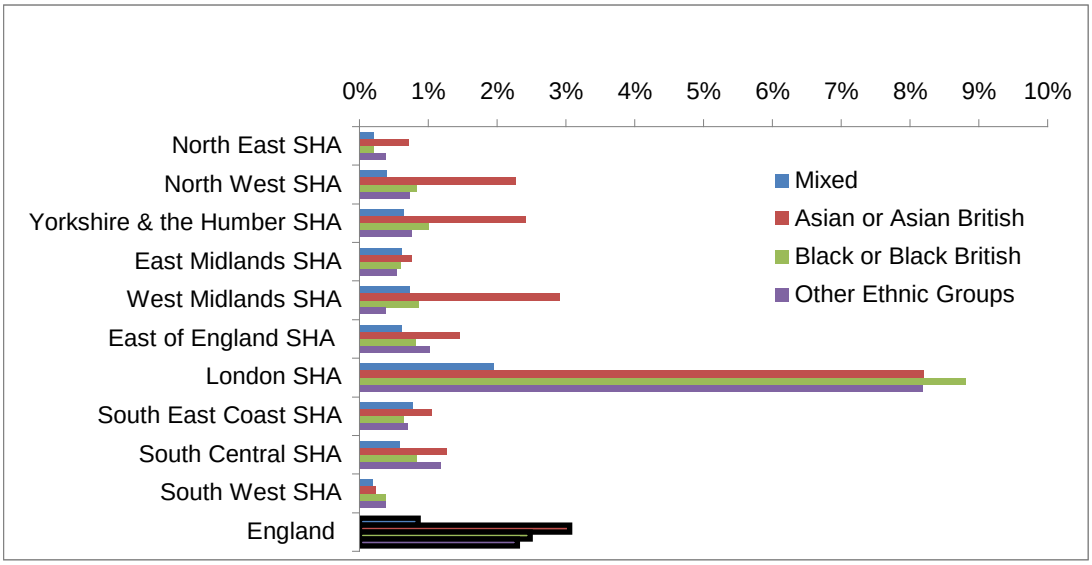
Figure 4.8 shows the numbers of individuals from BME groups who were in contact with NHS mental health services in the community, but were not admitted to inpatient care, and Figure 4.9 shows those who were not in contact with services at

all in 2008-9. [The 44% of 'no care' records in the South Central SHA with no valid or usable ethnic code are not reflected in Figure 4.9.]



Source: The Health and Social Care Information Centre

Figure 4.8: Access to NHS mental health services by ethnic group (other than White) and SHA, 2008/09 non- admitted only adults 18 years and older.



Source: The Health and Social Care Information Centre

Figure 4.9: Access to NHS mental health services by ethnic group (other than White) and SHA, 2008/09 adults 18 years and older with no care.

In addition, another data set is currently under development between the Department of Health and the Information Standards Board, to monitor the IAPT programme. IAPT aims to support PCTs 'in implementing NICE guidelines for people suffering from depression and anxiety disorders' (46). This dataset will include patient-level demographics, care pathways and routinely administered outcome measures to support monitoring of service standards and assure acceptability,

effectiveness and quality of admission. Current timelines plan for the notice to change the dataset to be issued in September 2010, and for the new standard to be mandated from September 2011 (46).

Further work on quantitative data could request disaggregated MHMDS data to explore what is available by country of birth, as the published data distinguishes between Black and Black British, and Asian and Asian British groups (45). Similarly, further work could explore the demographic and ethnic categories planned for the IAPT dataset. Ultimately, considering the recent effort and progress in improving the quality and scope of mental health data, further work could advocate that country of birth is routinely collected in mental health utilisation data.

Qualitative data

Health needs' assessments for migrants in other regions also identified mental health as the greatest health issue for asylum seekers and refugees (47, 48). The North East report described mental health issues, including anxiety and depression, as affecting other migrants to a lesser extent (47), whereas the North West report portrayed the mental health of migrant workers as affected via wider determinants of health, including exploitation and discrimination in the workplace (48).

Following the question represented in Figure 4.1, this project's survey offered respondents an opportunity to comment on the main health needs for different categories of migrants. Subgroup analysis reveals the extent to which respondents perceived mental health to be a problem for all groups of migrants (Table 4.1).

Categories of migrants	% of responses about mental health issues	Mental health issues covered in comments
Migrants in general	35	Mental health support; access to mental health services; stress due to situation; depression, anxiety, trauma
Asylum seekers	79	Mental health assessment; emotional support; access to appropriate mental health services; treatment for depression, anxiety, loss, trauma, torture, sexual violence, HIV/AIDS
Refugees	60	Appropriate treatment for depression, anxiety, trauma, survivor guilt, transition issues
Economic migrants and workers	33	Access to treatment for depression and anxiety (linked to poor housing conditions)
International students	40	Access to treatment for depression and anxiety
Children	29	Mental health issues should be included in health assessment; depression and anxiety

Family joiners	67	Access to treatment for depression and anxiety
Irregular migrants	33	Depression, stress and stress-related symptoms arising from destitution; poor sleep hygiene; access to treatment for depression & anxiety

Table 4.1: Responses to survey question 15: In your local experience, what are the main health needs of migrants? Please comment for the categories of migrants which are significant in your area.

The majority of comments about mental health issues for asylum seekers and refugees reiterated the issues explored in the literature review. The difficulties faced by asylum seekers, especially children, in accessing 'mainstream' mental health services were described. Examples of good practice were given in response to later questions, including organisations providing targeted support to asylum seekers and refugees, especially mental health support. Two examples are the Medical Foundation for the Care of Victims of Torture (www.torturecare.org.uk) (whose London head office takes referrals from across the SE) and a Portsmouth counselling service, with lottery funding to provide counselling for five years to asylum seekers and refugees, including those in IRC Haslar.

The mental health of unaccompanied asylum-seeking children was also discussed in several responses to the question about any migrant groups causing particular concern and why (question 11). One respondent mentioned 'increased levels of distress among unaccompanied minors as they are refused the right to remain in UK'.

Best Practice Example

Key2 Futures, Oxford:

Key2 is commissioned by local authorities to offer supported shared housing for young people leaving care aged 15-19, including unaccompanied young people seeking asylum. Support staff work one-to-one with young people to help build their confidence, responsibility, self-awareness and self-worth.

Services include:

Accommodation and welfare support, including a 24/7 emergency service.

Life skills and assistance in a four week orientation programme.

Supported and accompanied access to primary medical care, including TB screening and vaccinations, dental care, culturally appropriate sexual health education, emotional support and mental health assessment.

Support to social workers working with clients.

Ongoing support with education, training, life skills and handling the immigration system.

Many respondents were very concerned about the mental health of asylum- seeking children in detention, which they discussed in response to the questions above, as well as the question about particularly vulnerable groups (question 17). For example: '[There are] no detention centres in my area but I see asylum seekers who have been released from detention centres or prisons in my service. [I] am particularly concerned about young people (age disputed minors who in my opinion are clearly under 18) who have been in prison or a detention centre; the experience has a profound effect on their mental health. I am also not sure whether mental health needs of patients currently in detention are being addressed appropriately. There is poor communication between detention healthcare services and NHS services.'

Responses about irregular migrants emphasised the vulnerabilities of people with no entitlement to services except in an emergency. Mental health issues exacerbated by destitution (depression, anxiety, PTSD) were discussed alongside physical health issues, such as poor nutrition, dental and skin conditions, infectious diseases, alcohol and substance abuse. Interviewees in local authorities and mental health trusts also gave examples illustrating the benefits of early intervention for mental health problems, rather than awaiting a crisis triggering a 'revolving door' dilemma (5). For irregular migrants, however, they described their struggle to find 'creative' solutions,

allowing them to offer personalised care based on clinical need, rather than entitlement to services.

In discussing barriers to migrants accessing care for mental health problems, legal status and confusion over entitlement to services were often cited. Respondents described them not only as preventing access until a point of crisis, but also contributing to mental health problems, through destitution for irregular migrants and through dispersal, detention and preventing work or study for asylum seekers. Respondents and interviewees also described confusion in NHS providers' minds over migrants' entitlement to services, which can impede access to which some migrants are entitled. One local authority interviewee said that, helpful as it was for social workers to attend appointments as advocates for unaccompanied asylum-seeking children, there was no equivalent provision for vulnerable adults. Across the region, non-statutory organisations provide advocacy, signposting and fill gaps in statutory service provision, in addition to identifying mental health needs.

Best Practice Example

Mental Health First Aid (MHFA) courses, Oxford:

This series of four three-hour courses educate and empower people to recognise those with common mental health problems, and offer guidance and listening in a crisis. The courses are aimed at managers, volunteers and other individuals who work with community groups or the public. They are not designed to replace professional help.

The MHFA courses were developed in Australia and are now used in many countries. The Royal Society for Public Health is developing a nationally-recognised qualification in MHFA for those who have completed the training.

In Oxford, the courses are funded through the Migration Impact Project (within Oxfordshire Community and Voluntary Action) and delivered by Restore, an accredited trainer. They are offered to individuals who have contact with migrant groups, including leaders in migrant communities and volunteers at Saturday schools. Participants are actively recruited, targeting ethnic minorities who may otherwise not be aware of the MHFA training. Translation services allow the course to be taught in Arabic, Urdu, Polish and Portuguese, as well as English.

language barriers is especially critical in assessing and treating mental health problems. Respondents emphasised the need for appropriate translation and interpretation resources, which should offer continuity, cultural sensitivity and confidentiality. Insufficient access to, and funding for, such resources were frequently cited as barriers to accessing mental health services for migrants. Respondents and interviewees also expressed concerns about this barrier preventing access to IAPT services for migrants and BME communities.

Best Practice Example

Overcoming the language barriers to accessing talking-based therapies

'Mother Tongue', Reading:

This non-statutory organisation provides counselling to people in their chosen language. The service is able to provide counselling and practical support in over twenty languages and can offer support in other languages through trained and culturally sensitive interpreters. Approximately 40% of the client group are unaccompanied asylum-seeking young people.

Access to Communication, Southampton:

This multi-agency project aims to facilitate effective linguistic and cultural communication between individuals and public sector organisations within Southampton, funded jointly by the local authority, PCT and others. Continuity can be arranged to enable the same interpreter to work with the Hampshire Partnership Trust to accompany individual clients throughout their treatment and recovery.

Access to Communication recently undertook a Cultural Assessment Service, in which interpreters were trained in culturally-specific issues and aspects of mental health, to improve their effectiveness in work with mental health services and migrant/BME clients.

Alongside language issues, interviewees spoke of cultural differences being especially important in improving migrants' access to services for mental health problems. Stigma associated with mental health problems was cited as a problem with different meanings to different cultures, which requires services to be accessible outside mainstream mental health settings. Ideas of possession and witchcraft, for some African cultures, were another example given of the need for specific cultural competency in providing effective mental health services to migrants.

Best Practice Example

Cafe psychology service, Southampton:

A Polish qualified psychologist (or trainee/student) sits in a cafe in the inner city area of Southampton and the person in need of help is given a description of what they look like. The person then goes to the cafe, finds the psychologist, has a quiet, discreet chat about their problem and the psychologist recommends a local service which could help them - for example, IAPT service via GP surgery, interpreter service, or Polish online service details. They can also signpost them to SOS Polonia, EU Welcome, or any other local helping organisation. This service is used because the stigma effect is dealt with and nobody else from the community would know that the person is getting their mental health needs met.

This is the same factor that makes South Asian people want to go to general hospital settings to discuss their mental health as nobody in their communities would know why they were walking into the building. Such a service exists in Tameside/Ashton-under-Lyne area of Greater Manchester.

Housing was the final issue frequently cited by survey respondents and interviewees as a problem for migrants' mental health. Insecure and overcrowded accommodation was said to exacerbate depression, anxiety, poor sleep hygiene and PTSD. Especially in the presence of Khat and other stimulants (used by migrants to stay awake for shift work), overcrowded accommodation has contributed to domestic violence. Migrants not eligible for housing benefits are difficult to refer to residential treatment programmes, when these are part-funded through housing benefits. Southampton and Brighton both have street-homeless communities of East European migrants, whose problems are exacerbated by alcohol, and who are not eligible for treatment until they reach a point of crisis. One response to question 11 said:

'Polish - there is a disproportionate number of Polish 17-30 year-olds who have been detained under the Amended MHA 1983 in our trust area, many of these people being homeless but not all. Alcohol has been a factor for most of them.'

Conclusions and recommendations

The qualitative data raises issues strikingly similar to the Department of Health's proposals for the development of mental health services by 2020, outlined in *New Horizons* (49), which 'brings together an alliance of local government, the voluntary sector and professionals, as well as local communities and individuals to work towards a society that values mental well-being as much as physical health.'

Key themes from *New Horizons*:

- Prevention and public mental health.
- Stigma: strengthening social inclusion, tackling stigma and discrimination.
- Early intervention.
- Personalised care.
- Multi-agency commissioning/collaboration.
- Innovation.
- Value for money.
- Strengthening transition from child and adolescent mental health services to adult services.

http://www.dh.gov.uk/en/Healthcare/Mentalhealth/DH_209

This strategic direction, and the recent emphasis on improving the scope and quality of quantitative data for mental health services, should be helpful to improving the mental health of migrants in the South East.

Migrants are a heterogeneous group, in which asylum seekers and refugees, unaccompanied asylum-seeking children and irregular migrants have exceptional mental health needs. Yet the mental health of migrants in general has caused concern in this and previous research. Migrants, in common with established BME communities prioritised by the Department of Health's DRE agenda, share barriers to accessing mental healthcare, such as language, cultural issues and wider determinants of health (1, 6). With the current process of consultation about migrants' entitlement to NHS services, it is time to decide whether migrants are entitled to social inclusion alongside other BME communities in the DRE agenda.

Recommendations:

- Access to mental health services should be a priority for improving the health of migrants in the SE region.
- The MHMDS and IAPT data sets should be extended to collect country of birth, in addition to ethnicity.
- Further research about the mental health needs of different categories of migrants, especially the most vulnerable groups, would be valuable.
- Policies about entitlement to NHS services should be communicated clearly to staff in organisations providing services, as well as to service users.
- A minimum requirement for appropriate interpretation services should be set, funded and communicated to staff of all statutory organisations.

- Joint working should tackle the interactions between mental health needs and wider determinants of health, including housing.

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Chapter Six: Migrants in contact with the criminal justice system

Key findings:

- Migrants in contact with the criminal justice system include those in the community, in prisons, in immigration removal centres and in contact with the police.
- The SE region has the largest number of prisons in any region of England and several immigration removal centres, making this an important group to consider. HMP Canterbury is almost exclusively populated by non-British-born prisoners.
- Infectious diseases such as BBVs and TB may be more prevalent among foreign-born detainees and prisoners due to higher prevalence of these infections in the country of origin.
- Specific groups of migrants in detention settings, such as women and children, people who have been trafficked and those with mental health issues, may be particularly vulnerable. Isolation from social and family networks for such detainees may exacerbate other health issues.
- Prison services, which are directly commissioned by the NHS, may provide a better model for health service provision in IRCs than current mixed-economy model which reflects diversity of management. of the immigration detention estate.
- Police services may provide a point of contact for migrants with more structured health services, and appropriate referral mechanisms should be developed to enable this to happen more effectively.

Introduction

It is recognised that people in contact with the criminal justice system (whether in custody or under community supervision) are more vulnerable to mental illness, substance misuse and homelessness (1). These groups commonly struggle to access healthcare within the community prior to such contact. Many migrant groups, particularly those with a poor grasp of English or who are socially disadvantaged, already experience barriers to accessing health services within the community. Therefore, the combination of both migration and detention can create important health concerns and unique health service needs.

The SE region has the largest number of prisons of any English region and several Immigration Removal Centres (see **Figure 6.1).** Therefore, the health needs of migrants in prisons, in detention settings, and in the community in contact with the criminal justice system are an important issue for us to consider.

Figure 6.1:: Map of the prison estate in the SE region of England. HMP Haslar and Dover immigration removal centres (IRCs) are also shown under the management of the prison system.

Prisons

Foreign national prisoners are those people serving sentences within a country in which they are not normally resident. Proportions of foreign national prisoners in the UK increased between June 1998 and June 2007 in male prisoners from 8% to 15% and among female prisoners from 14% to 25%(2). On 30 June 2009 there was a total of 11,350 foreign nationals in prisons in England and Wales from 165 different countries(3). The largest group of foreign national prisoners in June 2009 were those from Jamaica (n=1,060), Nigeria (n=770), Irish Republic (n=630), Vietnam (n=560), Poland (n=520), China (n=480) and Pakistan (n=460)(4). Within the SE region, HMP Canterbury holds the highest proportion of foreign nationals, with 281 foreign national prisoners out of a total population of 295, equivalent to 95%(4). This prison detains foreign nationals for a period of up to five years with an expectation of removal.

Physical health of migrants in prison

Groups such as the homeless, people from certain ethnic minority groups and IDUs who are more likely to have an infectious disease, are disproportionately represented in the prison population(5). Factors such as overcrowding, the sharing of needles, tattooing and unsafe sexual practices increase the risk of infection being transmitted while in detention.

The last England and Wales survey of BBVs in prisoners found that 17% of those reporting having spent >3 months in Africa since 16 years of age were found to be positive for infection. This is in comparison with 20% of IDUs and 13% who reported having sex with men. Among young offenders, those reporting having spent >3 months in Africa since 16 years of age were identified as having the highest prevalence (29%) of hepatitis B infection(6). In response to this higher prevalence, a national immunisation initiative offering an accelerated programme of vaccination to all prisoners within 31 days of entering the prison establishment is now under way. In April 2009, the HPA reporting system found hepatitis B vaccination coverage in reporting SE prisons to be between 6% and 96%(7).

While TB is becoming less common in the general UK population, the majority of cases seen today are within non-UK-born, ethnic minorities, the homeless, prisoners and drug-users(8). Within European prisons, rates of TB are between 10 to 100 times higher than within the general population(9). In 2007, enhanced TB surveillance was notified of 34 cases of TB within London prisons, two-thirds of which were diagnosed in prison, while the other third was diagnosed prior to detention(5).

In the UK, foreign national prisoners from the commonest countries of origin (with the exception of the Republic of Ireland) have higher prevalence rates of TB and BBVs (such as HIV and Hepatitis B) than UK-born prisoners (see Table 6.1)

Country of origin	Tuberculosis(rate per 100,000) (10)	HIV prevalence in adults 15-49yrs (11)	Prevalence of chronic hepatitis B
Jamaica	7.9 (4.3–13)	1.6% [1.1% - 2.1%]	Intermediate (2%–7%)
Nigeria	610 (410–860)	3.1% [2.3% - 3.8%]	High (≥8%)
Vietnam	280 (140–480)	0.5% [0.3% - 0.9%]	High (≥8%)
Poland	17 (3.4–37)	0.1% [0% - 0.1%]	Intermediate (2%–7%)
Pakistan	310 (170–510)	0.1% [0.1% - 0.2%]	Intermediate (2%–7%)
China	88 (31–160)	0.1% [0.1% - 0.1%]	High (≥8%)
UK	4.5 (2–11)	0.2% [0.1% - 0.5%]	Low (<2%)

Table 6.1: Prevalence of tuberculosis, HIV and hepatitis B infection in country of origin.

Mental health of migrants in prison

Foreign national prisoners are considered at greater risk of isolation and mental health concerns than UK prisoners. This is due to additional factors such as language barriers, cultural differences, difficulties in maintaining contact with family in their country of origin, receiving fewer visitors than UK prisoners and stress regarding likely deportation following release(12,13,14).

The risk of suicide among prisoners during the period of 2000 - 2006 did not appear higher for foreign national prisoners in England and Wales. However, in 2007, a marked increase in the number of deaths in such prisoners was recorded, from six deaths in 2000-2006 to 24 deaths in 2007. The proportion of foreign national prisoner self-inflicted deaths in this year disproportionately accounted for 28% of all such deaths in the prisoner population. A link between such a rise and policy change in 2006 has been considered, whereby the Home Office was requested to ensure that no foreign national prisoner was released until full consideration had been given to their being deported. A study of these suicides by foreign nationals in this year was undertaken; while this identified similar trigger factors to that of UK prisoners, there were additional factors which needed to be taken into account, such as deportation concerns, anticipation of family shame and feelings of defeat over a failed deportation appeal(15).

Female foreign national prisoners

The health of female prisoners is recognised to be uniquely vulnerable. Female foreign national prisoners are expected to encounter more extreme health effects from detention than UK-born prisoners. Many female foreign national prisoners are incarcerated for drug smuggling and have left their country of origin, with family and friends, expecting to return shortly(16).

Among female prisoners in England and Wales, positive results for both HIV and hepatitis B infection were found to be highest in those reporting having spent >3 months in Africa since 16 years of age, at 9.5% and 29% respectively(6).

In England and Wales, 90% of women prisoners have a diagnosable mental disorder, or a history of substance misuse, or both(17). One of the most significant impacts of imprisonment on a woman's mental health is that of separation from family, most

especially their children(12,13,14). Foreign national women are more likely to be separated from their family than national prisoners. For example, an English study of 55 female prisoners found that, of the 42 mothers, just 2 (5%) had seen their children while in detention; for both of these their children happened to live in the UK(12,13,14). This is low in comparison with an American survey of female prisoners which found that half of over-18 year olds had received a visit during their period of detention(18). Such separation does not just have a detrimental effect on the mother, but also the child, and more so when the mother, as opposed to the father, is imprisoned(12,13,14).

Health service provision for foreign nationals in prison in the South East

At HMP Canterbury there are standard clinics, as in all UK prisons. These include sexual health clinics, hepatitis B immunisation programmes and 'under 25s' clinics which offer Chlamydia screening and Meningitis C vaccination. These are considered to meet the needs of the prisoners, who appear to engage well with them. Where language is a barrier, telephone translation services are used together with peer translation. Counselling services are available. However, given the common short duration of detention, prisoners suspected of having post-traumatic stress disorder, for example, are not referred on. A research project is currently under way within the prison healthcare system to identify any unmet mental health needs.

Immigration Removal Centres (IRCs)

Immigration law enables asylum seekers to be detained where there is a risk of the person absconding, as part of fast-track asylum procedures or where the person is awaiting imminent removal from the UK(19). As at the end of September 2009, there were 2,885 people detained in the UK Border Agency estate, a 19% increase from September 2008(20). Of the 2,070 people detained solely under the Immigration Act within UK IRCs, there were 26 families with children. In addition to IRCs, the UKBA also run short-term holding facilities. People whose claim has been finally determined and who are to be removed from the country are detained when they come to report.

Within the SE region there are five IRCs which can detain up to 1,234 men, five women and four family groups, together with five short-term holding facilities (see Table 6.2). This region therefore holds a considerable proportion of the total number of detainees in England and Wales.

Depending upon whether the IRCs are run by the prison service or privately, their health services are then led either by the NHS or private healthcare providers. All health services are expected to adhere to nationally-agreed operating standards(21). Short term holding facilities which detain people for 24 hours do not have health screening, but do have access to a private medical triage service.

There exists a limited body of research regarding the health needs of the asylum-seeker and refugee populations in the UK. Where research does exist, study populations often represent very specific groups within this population and there are large variations in study design and outcomes(22).

Very minimal research has been undertaken in regard to the health needs of refused asylum seekers and those who are being held in detention under immigration law(3). Detention of people seeking asylum has, however, been contested by various groups on grounds of human rights and consequences for health(23-26).

Name	Type of detention	Location	Detention capacity	Health service provision
Haslar	IRC	Gosport, Hampshire	160 males over 18 years	NHS (Portsmouth PCT provision)
Dover	IRC	Kent	316 males over 18 years	Due to be transferred to the PCT in mid-2009
Campsfield House	IRC	Oxfordshire	216 males over 18 years	Drummonds (private provider)
Brook House	IRC	Gatwick, West Sussex	426 males over 18 years	Unclear
Tinsley House	IRC	Gatwick, West Sussex	116 males, five females and four families	West Sussex PCT
Electric House (daytime hours)	Short-term holding facility	Croydon, Surrey	Last HMP Inspection: March - May 2009: 150 detainees (128 male, 22 female) including five children. Average detention of four hours (range 15 minutes to 11hours 40 minutes)(27)	Private medical triage service
Portsmouth Continental Ferry Port (daytime hours)	Short-term holding facility	Portsmouth, Hampshire	Last HMP Inspection: Nov - Feb 2009, of the 32 detainees, 22% were women and there had been four children. Length of detention ranged from 20 minutes - 9 hours(28).	Private medical triage helpline
Port of Dover (open 24 hours)	Short-term holding facility	Dover	Last HMP Inspection: Over previous three months, the facility housed a total of 1,104 detainees, (average of 368 a month). Included 219 women and four children, two of whom had been in the facility overnight. Of these, 54 had been detained for >5days(29)	Nurses on site 24 hrs a day. Confusion over relationship with PCT. Recent inspection recommends clarification over this.
Gatwick North Terminal (open 24hrs)	Short-term holding facility	Gatwick, West Sussex	Last HMP Inspection: Approx 900 people had passed through the facility in the previous three months, including 57 children, six of whom were unaccompanied minors. Most held for < 8 hrs, but 15 adult detainees had been held for > 24 hrs in facilities unsuitable for overnight stays(30)	Detainees with health issues are referred to the port medical inspector. No routine health screening.
Gatwick South Terminal (open 24hrs)	Short-term holding facility	Gatwick, West Sussex	Last HMP Inspection: During May - July 2009, 942 detainees were held. Of these, 72% were held for less than eight hours, but 1% had been held for > 24 hrs, four for over 31 hours, in facilities 'unsuitable for overnight stays'(30)	Detainees with health issues are referred to the port medical inspector. No routine health screening.

Table 6.2:: IRCs and other immigration holding facilities in the SE region, recent inspection reports and healthcare provision.

Physical health of people detained within IRCs

Over one-third of asylum seekers are from Africa, a continent with a high rate of both TB and HIV, when compared with the UK(31,32). Estimated rates of TB in asylum seekers vary widely(33,34). One study at Heathrow Airport found that 0.24% of asylum seekers had active pulmonary TB (with 23% of cases isoniazid-resistant and 7.5% multi-drug resistant) compared with 2.2% within an asylum-seeker induction centre(35,36). People seeking asylum are also considered to be more vulnerable to health risks due to stress arising from displacement as they enter a new country of

residence(24,37,38). In response to this, the British Medical Association (BMA) recommends that asylum seekers should receive testing for TB, hepatitis A, B, C, HIV and immunisation(39).

Estimated HIV prevalence in studies focusing on asylum seekers and refugees ranges from 3.8% to 6.3%, compared with a prevalence of 0.2% in the UK(40). In light of this often increased prevalence rate within the detained asylum-seeking population, the National AIDS Trust (NAT) and the British HIV Association (BHIVA) have developed a guidance document for healthcare and voluntary sector professionals in regard to working with HIV-positive detainees.

A study by TVHPU and the University of Oxford within an IRC was undertaken in 2009 to understand the burden of infectious disease within this population(41). A suspected large burden of undeclared health need was identified with language acting as a significant barrier to healthcare services for those detained. Only verbal screening for infectious disease was undertaken, contributing to what was suspected to be an under-reporting of infection within this unique population. Where status of BBV infection was known, these detainees had all been screened while previously detained in prison. Additionally, the only detainees (n=8 out of 102) who had consented to receiving the Hepatitis B vaccination course had each received this in prison. This suggests a useful model of screening and immunisation for detained people.

Verbal screening for TB is undertaken on arrival with all newly-detained people. Results from this screening suggested a much higher rate of pulmonary TB in the population studied (2.9%) compared with that found in a study screening new arrival at a UK port (0.24%). However, the rate of TB reported in this study included both current and past pulmonary TB infection.

This study suggests that instituting a healthcare model for IRCs based on current provision of healthcare within prisons would drive up the quality of care provided, including identification of infectious disease in those detained within immigration removal centres.

Mental health of people detained within IRCs

The detention of people under the Immigration Act has been contested by many health and human rights groups. The detrimental effect of detention upon the mental wellbeing of a population group already largely vulnerable to mental ill health through past trauma, feelings of cultural isolation and ongoing anxiety regarding their future is widely recognised(42). Detention can then act as a re-traumatising event and a correlation between duration of detention and severity of mental illness has been observed(43,44).

Children in detention

The experience of detention for a child can lead to significant mental and physical health effects(45,46). These include the development or exacerbation of depression, PTSD, anxiety and sleep problems, with physical effects seen such as a negative impact upon children's appetite and a cessation in breastfeeding.

Continuity of healthcare from the community is a concern, especially for children with chronic illnesses who require seamless care. Interruptions in vaccination programmes have been reported, with children arriving without a record of their received immunisations and those now due.

A recent inspection by the Children's Commission to Yarl's Wood IRC (which accommodates the majority of the 2,000 children detained each year under the Immigration Act) summarised the following health concerns of the children detained: a lack of paediatric healthcare delivery (from maintaining growth charts to responding to accidents), a need for the healthcare policy to be reviewed (for example, in accident prevention) and a lack of a permanent on-site paediatric consultant/child health practitioner(47).

In recognition of what is described as 'significant harm' to the mental and physical health of children, the Royal College of General Practitioners, Royal College of Paediatrics and Child Health, Royal College of Psychiatrists and the UK Faculty of Public Health have called for a cessation of the detention of children(48). Meanwhile, they offer safeguarding, commissioning and care delivery recommendations, calling for healthcare to be delivered by the NHS and aligned with national standards for

physical, mental and child protection. NB Since this report was written, the Coalition Government has announced that the detention of children for immigration purposes will end.

Irregular migrants

Irregular migrants are here defined as people who have entered the UK without valid documents and also those who entered legally, but whose visas have since expired. The police are often the first public sector group to identify such populations. In Kent ports where illegal migrants are identified by the police entering the country hiding in freight vehicles, numbers of detections in 2007 totalled 8,965 (an almost 50% increase from 2006)(49). The commonest nationalities of such migrants in 2007 were Iraqi and Eritrean. Due to fear of being identified, many do not access health and social services. Little is known about the health status of this group since they seek to remain unidentifiable, though it is accepted that the combination of leaving a country commonly affected by conflict and/or poverty, the often harsh process of the migration itself and then experiencing social deprivation in the UK, all contribute to a vulnerability to poor health.

People who have been trafficked

It is estimated that 4,000 victims of trafficking for prostitution entered the UK during 2003(50). This population group has unique health needs, spanning from mental to sexual health, and has been found to encounter numerous barriers in accessing health services(51). People identified by the authorities as having been, or suspected of being, trafficked to the UK are exempt from health charges(52).

Again, it is commonly the police services that are often the first point of contact with this hidden and vulnerable population. Documented detection of sex- or labour-trafficking within the local population has been identified in both Kent and East Berkshire over recent years. In such instances, victims of trafficking have been referred on to social care to provide for their needs. Specialist health and social services for trafficked people are more evident in London, though are now found further afield as the population becomes less concentrated in the capital. The Poppy Project is funded by the Office for Criminal Justice Reform to provide accommodation and support to women who have been trafficked into prostitution. Since 2003, 700 women have been referred to the service(53). While specialist services are evolving in

London, local organisations are developing in an ad-hoc way. Commissioning guidelines for PCTs are being published later this year by the Violence Against Women Taskforce at the Department of Health. Commissioning resources are also available online for PCTs through the NHS(54).

The organisation 'UK Human Trafficking' has worked closely with the police to develop mandatory training for all new recruits that includes care required by identified victims(55). Lack of funding resulted in the closure of the only specialist human-trafficking unit within the police force in 2008(56). A commitment to ongoing police training is paramount to ensure that the unique needs of this vulnerable group are met. Such training is of great importance since some anti-trafficking measures that have been implemented internationally have been criticised for worsening the health of the migrants they are trying to protect(57). Raids by police on brothels, for example, have often seen women rapidly return to the brothels, but with the women's relationships with services seeking to protect them having been damaged, resulting in their accessing services less and thus experiencing increased poverty(51).

Police services are in a unique position to detect and protect this vulnerable migrant population. With appropriate training and multi-disciplinary working they are able to act as 'signposters', referring these people to appropriate health services.

The Department of Health has published an interim response to the report of the NHS Taskforce of Violence Against Women and Children, published on 11 March 2010. The interim response promises that the Government will produce guidance for PCTs on commissioning services for women and children who are victims of violence or abuse. This, together with other resources, will be available at www.pcc.nhs.uk/violence. The aim is to help PCTs identify the range of services they are commissioning (together with a view on their effectiveness) for women and children who have experienced violence and abuse (which includes people who have been trafficked). In addition, they can be used to work with service-users and local specialised third-sector organisations to inform commissioning and also to identify need and feed in to their JSNAs.

Best Practice Example

Polish police support officer, West Berkshire:

The Thames Valley Health Protection Unit worked collaboratively with Reading Police to respond to a case of tuberculosis (TB) among a homeless population of migrants. A police community support officer who spoke the language of this population, together with a health clinic for the homeless, provided background knowledge about their context and assisted in tracing contacts for screening. Of the 10 close contacts screened for TB infection, 4 tested positive. This collaborative response was highly effective (58).

Conclusions and recommendations

It is clear that these migrant groups are particularly vulnerable to illness. The evidence also suggests that when these individuals experience detention, this can have a further negative impact on their health. Since many struggle to access appropriate care in the community, entering the criminal justice system may lead to their first contact with health professionals. Services at this point of access need to be ready and able to respond to these needs.

- Joint partnership across all sectors is essential to ensure appropriate and rapid referral and through-care. This requires a commitment for ongoing training within the police force.
- More research is required to better understand the health needs of foreign nationals in prison and detention, together with the heterogeneous population of undocumented migrants.
- Available evidence suggests that the prison system model of NHS healthcare provision is superior to current service provision in IRCs. A move towards NHS healthcare provision in IRCs should be considered as a way to drive up the quality of healthcare for detainees.

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Chapter Seven: Commissioning to improve migrant health – making it happen

Key findings:

- To commission effectively it is important to know what outcomes need improvement, how to maximise resources from a range of partners, which interventions are effective and how to measure and manage performance to achieve the desired outcomes.
- Effective coordinated commissioning between health and local authorities is enabled through the process of JSNAs.
- Effective commissioning to meet the health needs of migrants requires knowledge of the numbers and the types of migrants, in addition to evidence-based and cost-effective interventions.

This chapter illustrates examples of effective joint strategic commissioning between PCTs and their local authority partners. Options to improve 'business as usual' contracts authorised by primary care trusts are also discussed. Other commissioning at supra-PCT level is the role of specialist commissioning groups and is outside the remit of this chapter.

Basic guide to the commissioning process in PCTs

The process of commissioning is not simply understanding the commissioning cycle shown in Figure 6.1; it is about using resources wisely to achieve the desired outcomes. To commission effectively it is important to know what outcomes need improvement, how to maximise resources from a range of partners, which interventions are effective and how to measure and manage performance to achieve the desired outcomes. Effective commissioner/ provider relationships must exist for this to happen.

Each PCT must assure their SHA annually, through an externally audited assurance process, that they are improving within each of the 11 competency areas defined for World Class Commissioning (1) and improving health outcomes.

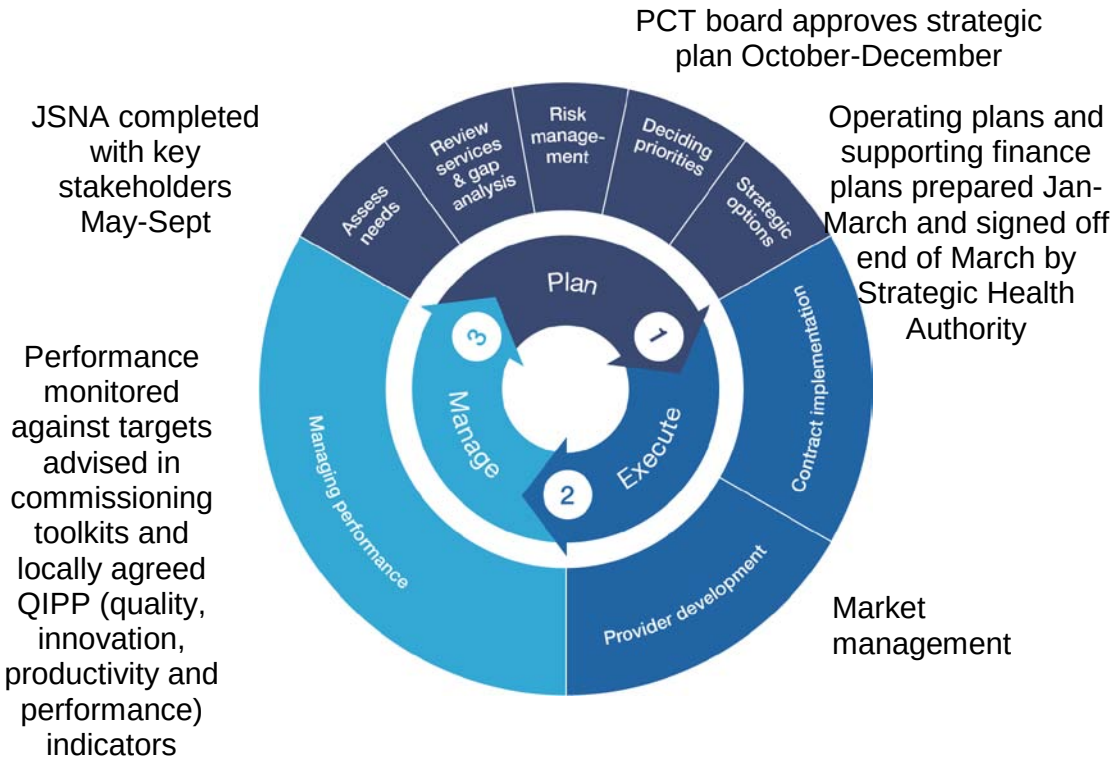

Figure 6.1: The commissioning cycle with key timescales.

PCTs are bound by law to manage their funds within their allocation and to commission effective services for the whole population they serve (resident and migrant). Outcomes may be identified from strategic needs assessments which can reflect universal needs for the resident population, as well as the migrant population, or be targeted towards the specific needs of migrants or other subsections of their population.

The commissioning steps shown in the following diagram are key stages in a continuous review cycle.

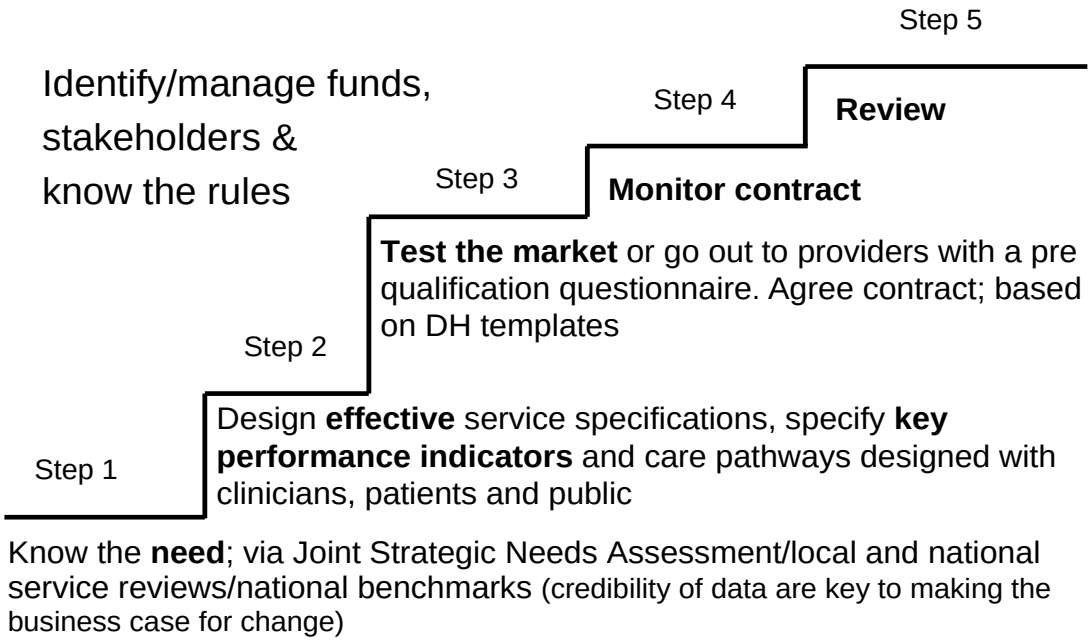

Figure 6.2: Steps towards commissioning services within Primary Care Trusts.

The key starting point is the Joint Strategic Needs Assessment.

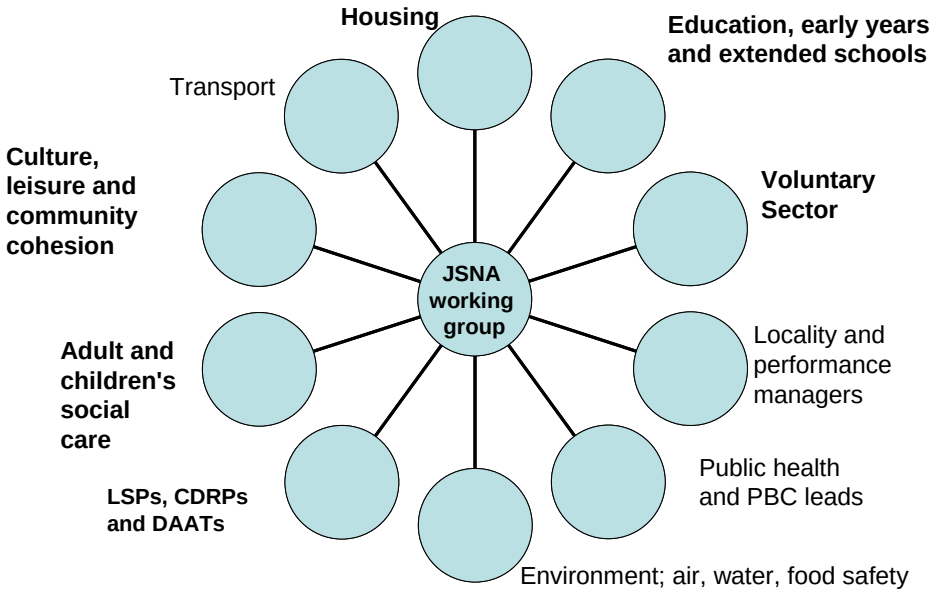

Figure 6.3 Key stakeholders of relevance to migrant health

Each year the Director of Public Health and the Director of Children's Services and Adult Social Care are mandated to produce the JSNA statutory document. It is recommended that this process is owned by a multidisciplinary group reflecting all key stakeholders and the structural and social determinants of health. Their role is to

identify the top priorities for future commissioning for health and wellbeing. Each partner will bring a different perspective. For example:

- Charities will be interested in ensuring debt management and provision for the homeless is in place.
- Housing teams working with those in homes of multiple occupation will be interested in ensuring that homes meet national safety standards.
- Environmental health teams will be concerned about food and employee safety in different workplaces.
- Social care teams may be noticing increased numbers of unaccompanied children seeking asylum.
- Others in education may be seeing increased numbers of children with English not as their first language, or cases of unaccompanied asylum seekers.
- Maternity services may be witnessing unprecedented rises in births (see example in Figure 6.4).
- Accident and emergency and primary care services may be overburdened with additional patients.

The JSNA group will need the help of local charities and faith groups to research barriers to uptake of services and expressed needs among migrants.

Maternity services are best placed to identify need as they routinely collect the country of origin of the mother. In the example that follows, the rise in births was found to reflect the peak birth age among the resident South Asian population coinciding with additional births from EU migrants (Jones, 2008).

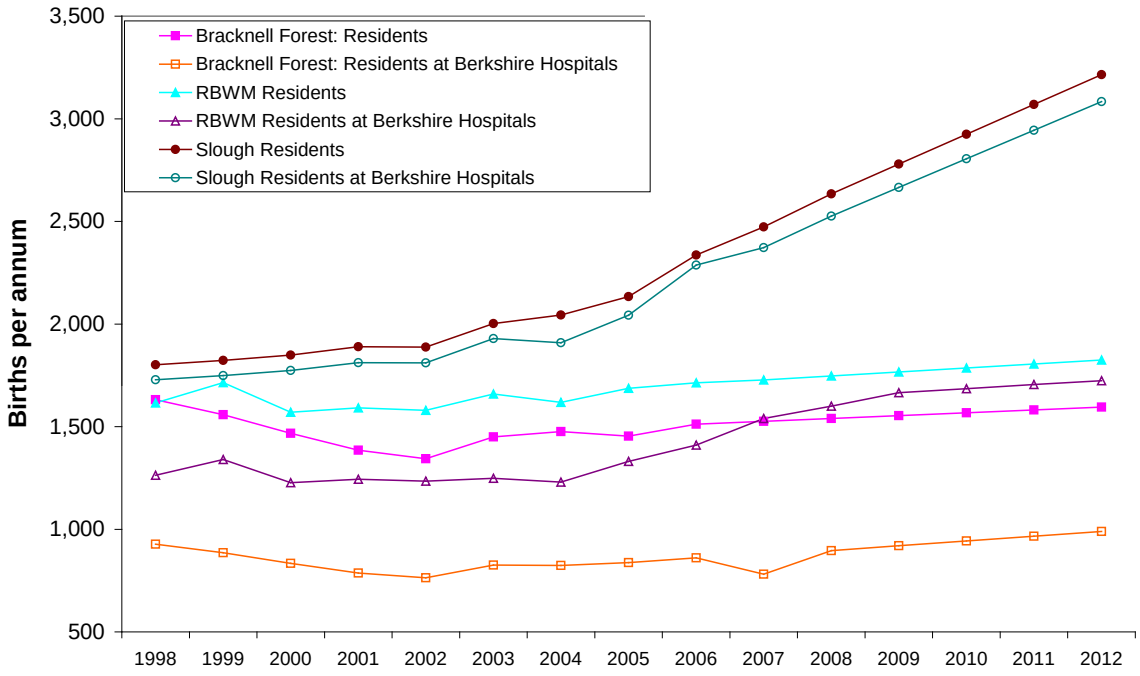

Figure 6.4: Study of births in Berkshire hospitals by ethnicity and place of birth (source Jones 2008)

The JSNA is concerned with assessing need to plan services over the next 5 to 10 years. Projections used for strategic planning purposes need to be closely monitored as migrant populations can vary over time.

Aligning strategic decision times

In the current commissioning cycle, local authority and PCT strategic planning cycles can be optimally aligned if the JSNA is completed after the end of May returns made by local authorities (when data from housing and social care returns are available, for example, on numbers of houses of multiple occupation, or asylum-seeking children). JSNA results must be ready for the beginning of October to influence the PCT strategic plan which is signed off in December.

Key data to inform those priorities is made available in June. For example, local authority health profiles are available from www.apho.org.uk. In addition, in September the PCT will have access to updated world class commissioning performance benchmarks (available from www.ic.nhs.uk). Each PCT will have a lead officer who will brief the board on the JSNA priorities it must consider in their strategic priorities for the next five years. Typically, this is the Director of Public Health.

Once the strategic priorities are agreed, further work is required to ensure that PCT strategic plans and financial plans are signed off by the board in December. Further work is required in January to March to ensure that 'in year' commissioning plans and finances are agreed by the strategic health authority by the end of March. Increasingly 'invest to save' principles are being used to fund new services and detailed business cases must be made. Timescales for change can thus be very long as shown in Table 6.1. Designing detailed service specifications, choosing key performance indicators and milestones and implementing the prescribed contracting process can take up to a year, if the total contract price is over a certain threshold.

Table 6.1: Timescales for contracting new services

Day		Action
0		Advert placed
30	30	Deadline expressions of interest (EOI)
30	0	Deadline pre-qualification questionnaire (PQQ)
46	16	Shortlist PQQ responses
53	7	Issue invitation to tender (ITT)
63	10	Tenderers' Meeting
93	30	Tenders due
96	1	Tenders opened
117	7	Initial tender review
124	7	Tender presentations
131	7	Tender recommendations
161	30	Board approval
162	1	Announce award intentions (start cooling off period).
172	10	Negotiate with preferred tenderer.
172	0	End of cooling off period
173	1	Award contract.
173	0	Place award notice.
270	97	Contract start

In order to be more flexible, as migrant needs may change quickly, some general quality and performance issues may be better addressed through variations to existing contract. These are described later. Specialist dedicated new migrant services may also be commissioned where the numbers involved and access issues are significant.

Using national benchmarks to identify key priorities for action

It is not sufficient to just use local data, although local data on the barriers to take-up of services may well inform specifications. Local data must be set in context and the following are examples of key national benchmarks for selecting outcomes in the joint commissioning process. This is not an exhaustive list and Appendix 3 shows those metrics which are most useful for migrant health in world class commissioning

National indicators (NIs)

There are 198 national indicators of the determinants of health and wellbeing available at http://www.communities.gov.uk/documents/localgovernment/pdf/505713.pdf. Each local authority and PCT is required to monitor their progress against these and select the most significant ones for joint working. In relation to migrant health these may include:

- NI 13 Migrants English language skills and knowledge.
- NI 44 Ethnic composition of offenders on Youth Justice System disposals.
- NI 50 Emotional health of children.
- NI 58 Emotional and behavioural health of children in care.
- NI 92 Narrowing the gap between the lowest-achieving 20% in the Early Years Foundation Stage Profile and the rest.
- NI 123 16+ current smoking rate prevalence.
- NI 126 Early access for women to maternity services.
- NI 187 Tackling fuel poverty – people receiving income-based benefits living in homes with a low energy-efficiency rating

Vital signs

Each PCT is monitored annually for its performance against the vital signs, which are in three tiers available at www.dh.gov.uk. Tier 1 are those which are a national requirement, Tier 2 are national priorities for local delivery and Tier 3 those for local action. Those that a local PCT chooses to prioritise within local area agreements must be selected with local partners to ensure that there is overlap with the key national indicators chosen by local authorities.

Health profiles (www.apho.org.uk)

Health profiles are designed from available and specially calculated indicators, and are helpful to local authorities and PCTs as they identify their progress towards tackling health inequalities. They provide a nationally-benchmarked and consistent overview of the population's health, to inform policy and planning.

CHIMAT (www.chimat.org.uk) publishes the Child Well Being Index which shows recent performance for indicators specific to children and young people.

ONS migration data: Estimates of international migration figures at local authority level are available from the ONS (see Appendix 1 for details).

Detailed analysis of this data has been shown earlier in this report. It is important to note that international migrants are not a homogeneous group and could comprise recent arrivals from overseas who may or may not be economically active, students and trainees, travellers, detainees, asylum seekers, refugees, those who have been trafficked, or visiting relatives, family members or friends of existing residents, or visitors. Gaine (2) noted the importance of focusing on the fact that most are economic migrants fulfilling lower-paid roles that cannot be filled within the UK, such as farm work, food processing and packing, factory work, food serving and kitchen work, cleaning, shop work and low-paid care of children and adults.

Employment profiles

Economic migrants may be living in accommodation supplied by their employers, or be living in the private rented sector. Gaine (2) noted how important it was to challenge the misperception that migrants are accessing social housing, as between 2004 and 2006 only 0.2% of A8 migrants were housed due to homelessness across the country as a whole. Nevertheless, he noted they were accessing poorer quality and more overcrowded housing.

GP registrations

Migrants who have valid ID and a place of residence and who have come into the country as visitors can register with a general practice or extended medical services

as a temporary resident with 'Flag 4' status. The eligibility criteria are being reviewed and will be released later in 2010.

School census profiles

The principal pressures of migration are on education services (2) where there is an increase in the number of children with English as an Additional Language (EAL), or on adult education for those needing access to ESOL courses. The termly school census provides useful measures for children in state education including country of origin, the young person's first language and entitlement to free school meals – the latter being highly correlated with deprivation. In addition, DCFS ethnicity codes distinguish between Western and Eastern White European groups, whereas DH codes do not.

Housing and legal services

Many economic migrants use private rented accommodation and councils have a statutory duty to inspect properties in the private rented sector, They must also keep a register of houses of multiple occupation (HMOs) and of those not meeting Category 1 Hazard standards. Local estimates of housing need are found in annual government returns from environmental health teams.

Other service data

Data from a variety of providers is now proving useful for commissioners to benchmark progress on tackling inequalities and access to services. These may include advocacy, interpreting, or community development services, all of which may help with increasing access to primary care, housing, education and legal services (3).

For example, smoking cessation providers at a local level are working to targets set as a result of the new national strategy A Smoke free Future (4), designed to reduce smoking prevalence in the most deprived and manual groups, expectant mothers and young people from the age of 16. Gaine (2) noted that 100,000 migrants were reported as working in the construction industry and this group is one of the highest-rated consumers of tobacco (4).

Choosing outcomes relevant to resident and migrant health

The choice of strategic outcomes therefore needs to relate local authority and PCT priorities and, under world class commissioning, must improve health outcomes. A selection of many possible metrics is shown in Figure 6.5 below.

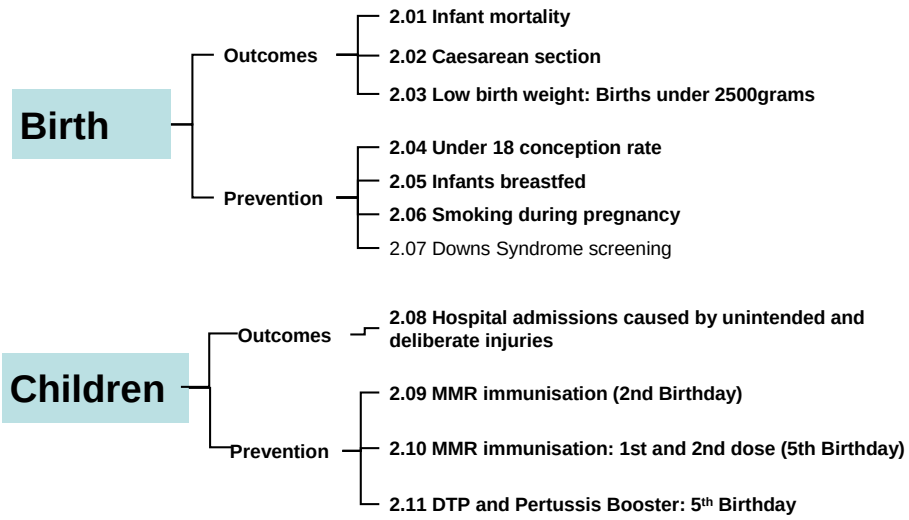

Figure 6.5: A selection of metrics for world class commissioning outcomes relevant to migrant and resident health.

Effective commissioning for improving migrant health

The following are required for effective commissioning:

- An estimation of the numbers/types of migrant.
- Knowledge of their expectations of healthcare and of the prevalence of risk factors for major communicable and non-communicable diseases from their former country of residence.
- Cost-effective interventions to address needs in a flexible way.
- Clear aims, service plans and accessible care pathways.
- A common dataset for comparing provider performance.
- SMART key performance indicators (KPIs).
- Clinical quality indicators linked to contract payments (*).

- Clear health improvement outcomes which should also include patient reported outcome measures (PROMs) which Perry and El Hassan (3) recommend should come from migrant, refugee and BME groups.

NICE has mapped guidelines for effective interventions against many of the vital signs (which are also WCC metrics) and an extract is shown below.

Table 6.2 NICE guidance on links between vital signs and the evidence base.

Smoking prevalence among people aged 16 or over, and aged 16 or over in routine and manual groups	Brief interventions and referral for smoking cessation in primary care and other settings (PH01 Public Health Intervention) www.nice.org.uk/guidance/index.jsp?action=byID&o=11375 Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities (Public Health Guidance 010) www.nice.org.uk/guidance/index.jsp?action=byID&o=11925
Percentage of women who have seen a midwife or a maternity healthcare professional, for assessment of health and social care needs, risks and choices, by 12 completed weeks of pregnancy	Antenatal care (Clinical Guideline updated March 2008) www.nice.org.uk/guidance/index.jsp?action=byID&o=11649

Evidence-based interventions

Previous chapters have described the health needs of recent arrivals and include research by the HPA (5, NEPHO (6), Gaine (2) and others. Plugge (7) has undertaken an extended literature review (including refugees, asylum seekers and immigrant detainees) which has highlighted effective interventions, as follows:

- Initial screening at port of entry for tuberculosis. Pregnant women and children under the age of 16 are excluded and follow-up is challenging where changes of address have occurred.
- Cognitive behaviour therapy (CBT) delivered by non-medics in school settings for depression. This has relevance for child and adolescent health service (CAMHS) commissioning at tier 2/3, as unaccompanied children and children who have witnessed bereavement are over- represented among asylum seekers and refugees.
- CBT for post-traumatic stress disorder and panic attacks.
- Family group therapy and sertraline, venlafaxine and paroxetine therapy for acute mental illness.

- Active health promotion, targeting specific refugee communities through local ethnic media, personal and community networks, improves understanding of diseases and access to services. The risks of acquiring infection once resident may increase because of living in poorer socioeconomic circumstances, or from travelling to visit family members overseas in areas with a higher infectious disease prevalence. For example, 76% of visits to Pakistan and 33% of visits to sub-Saharan Africa (5.).
- Support for children and mothers at risk of nutritional deficiencies, such as anaemia and vitamin D deficiency, commonest in those who have skin types associated with living in lower latitudes (8).
- Increasing access to dental healthcare, as advised in dental health commissioning guidance (9). For example, cultural influences such as the habit of adding sugar to children's food can increase the incidence of dental caries and gingivitis.
- NICE clinical diagnosis and management of TB has been included in national commissioning guidance (10). The issues around diagnosis of TB some time after entry to the UK have been well documented in Chapter Three, and reflect the conditions in which migrants live, which contribute to reactivation.
- Modernising Maternity Care: a Commissioning Toolkit for Primary Care Trusts in England (11) notes that 'stillbirth is correlated with low social class, mothers without a partner, teenage and older mothers, multiple birth and ethnicity where the mother was born abroad. Smoking is a key risk factor' p10.
- Ensuring access to screening programmes and immunisations, for example, cervical and breast screening, eye and hearing checks and tests for infectious diseases, such as viral hepatitis and genetic diseases, such as haemoglobinopathies.
- Treatment for skin diseases (common once the person has arrived and is 'hot bedding' in homes of multiple occupation) and parasitic diseases (the latter are more common in countries of origin such as Angola, Central African Republic, Chad, Egypt, Ghana, Madagascar, Malawi. Mozambique, Nigeria, Senegal, Sudan, Uganda, Tanzania, Zambia, and Zimbabwe) (5).

- NICE public health and treatment guidance is available for effective interventions for the reduction of; behavioural problems (12), drug and alcohol misuse (16), domestic violence (13), tobacco and smoking (13,14,15).

What is best practice in primary care?

A Faculty of Public Health briefing (17) made a number of recommendations to improve asylum seekers' health; not all of which are commissioned at PCT local authority level. Eling (18) extended the search to include services for vulnerable groups and provides many good practice examples. The following are a compilation of both FPH and Eling's recommendations:

- Specialist centres and support teams offering multidisciplinary approaches for asylum seekers, for example, including mental health services and specialists in services for torture survivors, and focusing on young, separated refugees and asylum seekers.
- Dedicated salaried GPs and projects to increase registration within existing practices.
- Specific enhanced services, monitored by KPIs.
- GUM clinics dealing with sexual violence, female genital mutilation and HIV/AIDS.
- Challenging stigma through diversity-awareness training.
- Annual notifications to PCTs and local authorities from the Home Office when changes occur in new arrivals.

Improving access to services

A key recommendation arising from the National Support service for tackling health inequalities (19) is to improve access by reducing to a minimum those who are excluded from primary care services. This is relevant to those migrants who are able to register, and a fundamental requirement for registration is a place of residence. This may be in one of the following forms of housing: farm buildings or caravans for agricultural or sessional workers, social housing for immigrant families, private rented 7accommodation for workers, employer supplied accommodation, university

accommodation for students and dispersal centres for those awaiting the results of their application (2).

A residential address is the first step to getting access to services. When patients first register, apart from the usual demographic data, the first thing a practice needs to know is whether a person is entitled to free NHS services. Some, or all, of the following may be recorded:

- Length of stay in the UK when first registered (the Flag 4 status within general practice will be mandatory).
- Country of origin (this is currently a free format field).
- Whether a refugee or asylum seeker (subject to practice policy).
- Whether an unaccompanied asylum seeker (subject to practice policy).
- Recent country of former residence (desirable but not currently required).

Key performance indicators

Appendix 4 summarises a review of best practice guidance (18) and guidance from Barts and the London (20).

Levers for strategic commissioning

New national priorities may also provide a rationale for commissioning new services or interventions, for example, the 2010/11 National Operating Framework (21) cites priorities relevant to migrant health including improving access to GP services, maternity services at 12 weeks, improving access to dental services and improved metrics for patient satisfaction, quality and effectiveness.

Another useful lever is the requirement in 2010 for local authorities to produce a child poverty strategy by autumn 2010 as part of the Healthy Lives, Healthy Futures strategy (22) and linked to the Marmot report on health inequalities (23), which requires every PCT to produce a health inequalities strategy.

Joint priorities within local area agreements should be related to the JSNA and to the WCC outcomes, but all national indicators are measured in a local area and poor performance in the Common Area Assessment (24) may also lever action.

Key levers within secondary care commissioning guidance (25) to reduce:

- Avoidable hospital admissions (for ambulatory care sensitive conditions).
- Non-elective admissions.
- Elective surgery rates.
- Outpatient attendances.

Increasingly sophisticated financial and health modelling is being used and the main levers for strategic commissioning are now care pathway improvements and thresholds specified as part of demand management plans. These will cover delivering prevention programmes in the community closer to peoples' homes, either via polyclinics or urgent care centres, to draw out activity from the secondary care sector and improve primary care provision.

Migrants prefer to use accident and emergency units, where they are eligible for treatment. The Choose Well project, a national campaign to explain the differences between primary, urgent and secondary care centres is under way, to help reduce the misuse of secondary care services.

As noted in the HPA report (5), 85% of migrants are between 15-44 years and the majority will have similar health needs to the general population. Where there are significant outcomes that are poorly performing compared with peer PCTs, a focus on these may well improve migrant health, as well as that of the resident population.

Choice of such strategic outcomes is likely to be supported where there are:

- Higher total fertility rates.
- Pressures on maternity and early years' services, where population profiles are younger than the UK average. Rising birth rates have been noted in urban areas such as London, the South East and in East Anglia due to the influx from A8 countries. Migrants have also featured as late presentations for 12-week bookings in maternity services.
- The identification of high acquisitive crime or domestic violence rates.
- Growing numbers of abortions.
- High use of Accident and Emergency (A&E) services.
- Levels of communicable disease, above those expected for the area.
- High unemployment.

- The volume of houses of multiple occupation in the private sector.
- High rates of alcohol and other drug misuse.

Where migrants are more dispersed, economic migrants or students, commissioners will need to consider other routes of commissioning, through optimising access to existing primary care services via 'business as usual' contracts.

Which services should be improved to increase access?

Flexibility to respond to changing need has been demonstrated by aligning health services to migration and refugee community organisations, rather than simply frontline primary care and community services (3, 9).

Services for which improved specifications can be written include primary medical services (PMS and APMS contracts) and locally-enhanced services – (LES), diagnostic and screening services, maternity and health visitor services, CAMHS, sexual health, domestic violence and family support services, the Citizens Advice Bureau, language line and advocacy services, education services, dental and smoking cessation and alcohol prevention and treatment services.

The specialties in acute services most likely to require further monitoring for increased migrant admissions are accident and emergency, maternity, paediatrics, mental health, respiratory, gynaecology and general surgery. Monitoring for overseas visitors is possible through teams who invoice for any operations carried out on those without an NHS number or a GP and who have an overseas address.

Which contracts can be used to improve services, care pathways and outcomes?

Different contract mechanisms exist according to the setting, the focus of the service and whether it is a universal or targeted service. Outline national templates for a range of contract types are available at www.dh.gov.uk.

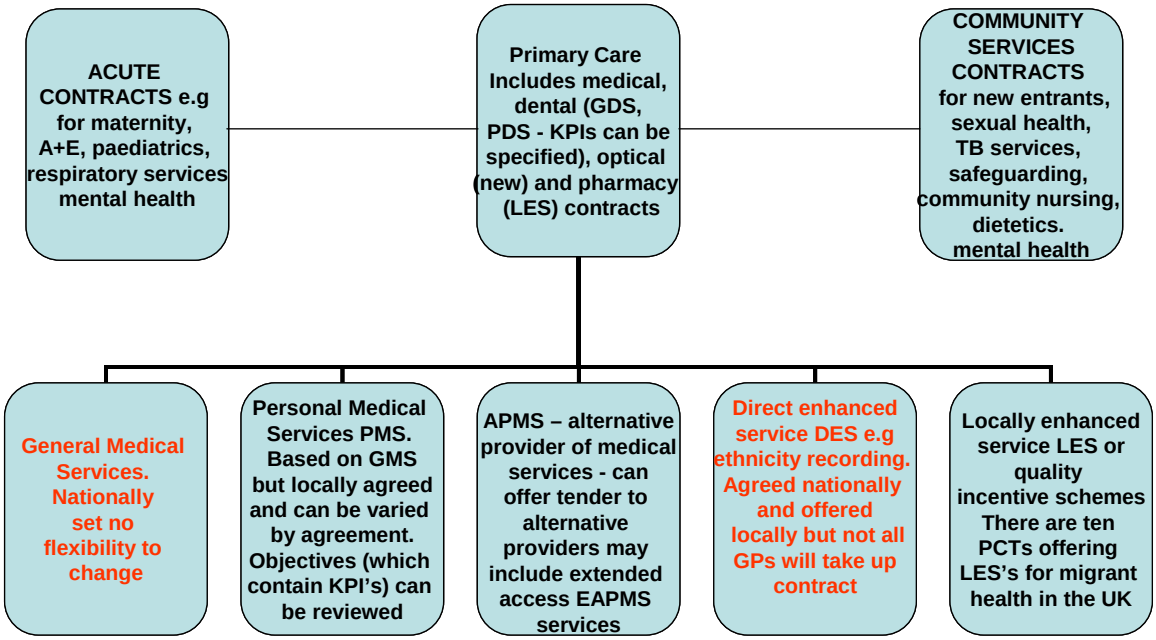

Figure 6.5: An overview of contract types used by primary care trust commissioners.

Those contracts outlined in red cannot be influenced. These include the core GMS contract which is negotiated nationally by the GMC, as are some of the nationally-enhanced services.

Others subject to local determination, such as Alternative Provider of Medical Services (APMS) and locally-enhanced services (LES), are more flexible and quicker to implement. A recent study of LES nationally identified 10 which are specifically focused on migrants and asylum seekers.

Best Practice Example

Examples of interesting services from a Kent PCT's response to the survey, NHS Hastings & Rother

- Local Enhanced Contract with GP practice to register newly-arrived asylum seekers with specialist nurse practitioner.
- Hand-held health records for gypsy and traveller families.
- Multi-agency weekly drop-in clinic for refugees and asylum seekers with nurse and other health input.
- Migrant Health Advocacy service in development, with funding from Migration Impact Fund (due to be operational April 2010).
- Bi-lingual health trainers targeting migrant community.
- Interpretation and translation services.

Using contract variations for annual contracts

Examples of contracts that can be varied to reflect local needs are:

- Community and acute services (negotiated as annual block contracts, including health visiting services, maternity and sexual health services.
- Primary care services are annually agreed, but new services such as APMS, EAPMS, and LES contracts can be implemented in under two months.
- Pharmacy and dental services are annual, nationally-defined contracts, to which local KPIs can be added.
- Mental health and learning disability services are annually agreed and follow national templates with local KPIs.
- Screening services are often commissioned nationally but, where co-provided by local community and acute services, may have flexibility for improvements at SHA level.
- Freed-up resources from practice-based commissioning contracts. PCTs have a role in supporting groups of GPs to commission services tailored to the needs of their local area and funded by annual savings from their budgets. This type of commissioning is increasingly seen as the most flexible way of testing out new targeted provision which, if successful, may be commissioned

as ‘business as usual’ thereafter. Plans need to be in place for the start of the new financial year.

- The PCT also has contractual arrangements with occupational health services for its staff, whose country of origin may make them at risk of a higher rate of TB, as may beliefs about health, faith and other cultural, political and environmental factors. Effective occupational health services should follow DH guidance for healthcare workers.

Making it happen

The following questions are important when planning new services or interventions, or adapting existing ones:

- Have you captured what your migrant populations need and want?
- Have you identified opportunities to work with other services?
- Do you need to offer a strategic change in service, or can you use contract variations to modify existing contracts?
- Can you fund this planned service/intervention in other ways?
- Is this issue one which can be funded only through specialist commissioning - that is, is it a cross-county arrangement?
- Are you using a nationally comparable set of KPIs (see Appendix 2)?
- Can your provider identify innovations’ funding to improve its own quality and performance?
- Have you provided your local practices with up-to-date guidance on eligibility, clinical assessment, diagnostics and treatment and best practice in record-keeping and communication?

Eling (9) noted the dilemma of whether to focus on specialist or ‘business as usual’ contracts. It has been clear from current directives to improve the quality of mainstream contracts and to drive down costs at secondary care level that use of ‘business as usual’ contracts will be the norm.

Commissioning of services at regional level will remain led by the Home Office, the migrant health team at the Department of Health, or regional groups, such as the SESPM or by specialist commissioning groups, for example, for the commissioning of SARCs or IRCs.

PCTs and their provider services have a major role working with local partners to commission multidisciplinary work, such as screening services for new entrants linked to TB, infectious disease and sexual health screening. They also have a role in commissioning occupational health contracts to national standards, as contracts should include the screening of staff in 'at risk' occupations, for example, for BBVs, or for non-communicable disease.

Examples have been provided for commissioners to map local need and make best use of the current levers to commission equitable, accessible and effective services for the population they serve. A range of examples of best practice (9) has indicated likely partnerships for improving health through improving access to services. This approach is in alignment with the operating plan priorities (21) and with the National Health Inequalities Support Team's advice for improving primary care access and reducing health inequalities (19) namely:

- Community-wide, rather than ad hoc approaches.
- A balanced workforce and skills mix to ensure sustainable actions
- Strong challenges to poorly performing practices in the most deprived areas.
- Support for local authorities in their neighbourhood engagement programmes to develop greater 'co-production' with people taking greater personal responsibility for their health.[1]
- Develop a strong Quality and Outcomes Framework exemptions strategy, supported by a robust validation of registers, to ensure that vulnerable patients are not removed from registers until all efforts have been made to ensure good outcomes.

Despite this period of severe financial restrictions, there is a great opportunity to commission best practice and evidence-based services, while improving access.

Opportunities exist for practice-based commissioners to build on national benchmarking in 2010/11 to drive up quality, innovation, performance and productivity standards in general practice. For example, NHS improvement tools, such as the quality and productivity calculator (25), will encourage PCTs to reshape PMS contracts, single-handed practices and enhanced services in primary care, and tackle ongoing issues in secondary care in a robust and equitable way. These tools need to be shared with practices which will need support to make the required changes to

practice, premises and workforce. Primary care commissioning leads are best placed to do this.

Similar improvements can be made by acute commissioners through standard contracts, using key performance indicators to highlight key areas, such as maternity services and accident and emergency services.

Significant reshaping of services can be developed through incentives to work with wider partners to commission services which will improve migrant health through the JSNA and subsequent joint commissioning for local area agreements. Examples of this could be the co-delivery of housing services with TB services in the community, linked to new migrant, sexual health and extended-access primary care services.

Whatever models are chosen, closer links should be made with migrant and refugee organisations. This can be done through local LINKS partnerships and specialist consultations to achieve services which provide high levels of care and equity of delivery for resident and migrant populations. Communications guidance has been released for agencies working with women and girls who have been subjected to violence. Further communications guidance will no doubt emerge as a result of the recommendations from the SEMH.

Conclusions and recommendations

- Identify a wide range of partners from health, education, housing, social care and the voluntary sector who can work collaboratively with you to identify key health outcomes and demand on existing services, via the joint strategic needs assessment process.
- Research the evidence base, key performance and outcome indicators and optimum service models for reducing pressures on those services, for example, a new entrant service closely linked to support for community development workers/health trainers from those communities, or a quality improvement plan for existing services/interventions.
- Identify ways of funding changes which will benefit both the resident and migrant health outcomes you are aiming to improve. This could be mainstreamed via cash-releasing schemes as part of contract variations, quality or innovations routes. Occasionally, large-scale externally funded

sources (such as the international research or integration funds) may offer opportunities to redesign services locally.

- Commission the service, monitor the outcomes and continuously review the demand and the business case.

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Chapter Eight: Proceedings of the first meeting of the South East Migrant Health Network (SEMH)

Introduction

On March 19 2010, the Department of Health held an event where the South East Migrant Health Study Group shared its initial findings from its research into the health needs of migrants. This event was also designed to become the inaugural meeting of the SEMH. The meeting was attended by the Regional Director of Public Health for the South Central SHA, Professor John Newton, who represented both the South Central and SE Coast SHAs.

The delegates included a broad range of stakeholders from a range of statutory and non-statutory organizations, all of whom have a direct interest, or role, in working with migrants in the SE region. A list of delegates is included, with their consent, in Appendix E.

Initial findings from this research had previously been presented at meetings of the SESPM and the SE Public Health Information Group. Members of both groups subsequently attended the inaugural meeting of SEMH.

Three presentations of the research's initial findings were interspersed with two substantial workshop sessions, in which all delegates participated. For each workshop session, four parallel groups of delegates discussed the same topics and then fed back to a plenary session. The workshops were designed to 'triangulate' the research undertaken and to enlist the expertise of delegates in shaping the next steps for SEMH. Delegates were pre-assigned to workshop groups to ensure that representatives in similar roles, organisations and localities were distributed evenly between groups.

Workshop One: Identifying the health needs of our migrant population

Delegates were asked to discuss whether they agreed that the presentations of initial findings indeed represented the major health issues for the migrant health

population in the South East, whether there were important issues overlooked, and what each group agreed were the top three priorities requiring action.
The top priorities the group work identified included:

- Improving quality of data sources: Services cannot be developed if you do not have good quality data. Currently, the level of data about migrants and their health needs is insufficient to support the development of appropriate services and needs to be improved. An example of improvements required would be to ensure all health and social care systems routinely record and report country of origin data.
- Improved access to services: Services need to be made more readily accessible to those who need them. This involves ensuring better 'signposting' of services in appropriate ways to migrant populations, using appropriate language and in appropriate places. This should include explaining the nature and range of services available, how to find them, how to use them, and explanations of entitlement to care.
- Training for staff in primary and acute healthcare settings: Front-line healthcare staff, including receptionists and administrators, need further training in appropriately understanding and meeting the needs of migrants using these services. This should include improving generic communication skills, improving knowledge about access to translation services, and a better understanding of entitlement to care services provided by the NHS to migrants.
- Interagency working: Good partnerships and joined-up working are crucial for success in dealing with any complex problem, with a particular need for clear strategic messages and leadership from the highest levels of the organisations participating. Non-statutory organisations, including faith groups, have an important role to play in working to improve the health of migrants with statutory partners.
- Addressing health policy and priorities: The workshop identified a need to avoid restricting entitlement to NHS services, which may be harmful both to individual patients and the wider public health. The workshop also identified a need to move away from simple emergency or reactive interventions to those of a preventative nature, including vaccination, screening, sexual health and mental health services.

- Addressing social care issues: The workshop recognised the important interplay of health and social issues and advised that issues such as overcrowded housing and poor employment conditions contribute to poor health. Issues which need to be better understood include poverty and the conditions in which people live, their access to ESOL resources and how this impacts on community relations.
- Changing perceptions of migrants among the general population: The workshop recognised that migrants often evoke negative reporting in the press. Popular negative perceptions have a real influence, leaving migrants feeling stigmatised and less able to access services. Changing perceptions requires joint working across all agencies.
- Barriers to delivery of accessible services need to be tackled: This includes action on all of the foregoing, recognising that several groups are particularly vulnerable and challenged, including those with mental health problems, poor levels of spoken English and/or literacy in English, children and those working in the sex industry (voluntarily or involuntarily).

A discussion followed in which common threads were acknowledged to be shared by all groups, with consistent emphasis on improving data, improving access to primary care and overcoming problems for the most vulnerable groups, arising from inequitable entitlement to services. The need for a new regional network was agreed, with unanimous approval for the idea that delegates should consider themselves founder members of the SEMH.

There was universal enthusiasm for a new web resource, targeted at organisations providing services, rather than at service users. Delegates agreed that this should be accessible to non-statutory providers and to colleagues in all sectors working with migrants, rather than limited to health professionals. Concerns were discussed that it must be updated to be useful, and that it should go beyond the facility currently available at the NHS Information Centre's website.

Workshop Two: Meeting the need, partnerships and networks

Delegates were asked to consider a template for partnership work, which could be used in all localities to take actions forward. Which partners did they think must be involved in this partnership work? Were there any existing forums in their localities,

where such partners already met and which could take this work forward? What resources would be needed to make sure this work happens locally and regionally? Finally, did they agree that a regional network would support actions and disseminate learning?

Feedback to plenary about partners who must be involved

Partnership working at different levels was discussed. At a strategic level, partnership work should involve collaboration between frontline service providers or commissioners and policy makers, for example, the Department of Health and the Home Office. . At a professional level, partnership working should include collaboration on tasks such as information-sharing and networking. At a community level, service users should be involved and participate in developing what they consider their needs to be, in addition to their needs as understood by us. All levels should be interlinked and, ideally, there should be cross-representation.

At the level of regional partnership working, about how resources are shared, workshop groups suggested that GOSE and the SHAs would be key partners. Local partnership working about how services are delivered can be very ad hoc, but should be supported by Local Strategic Partnerships.

Directors of Public Health (DsPH) were identified as key partners. Delegates felt that the new network should influence people whose mainstream work should include migrants, but who would not necessarily consider them in a targeted way.

Colleagues in the third sector must be involved, and incentives to facilitate their involvement should be considered. Such incentives could include the extent to which they might be involved in formal and informal partnership work with statutory agencies, and clear outcomes on which they are focused in a practical way, to justify the investment of their time.

Feedback about existing forums

Workshop groups were keen to avoid duplicating existing networks, but instead wanted to ensure that the new SEMH is willing to engage with such networks and help them improve their services.

The partnerships manager of the SESPM outlined its strategic function, as a conduit for discussion and consultation about migration and related issues, between statutory and voluntary sectors and the high-level representatives on its executive.

Feedback about resources needed

The political will to engage and mobilise others to get engaged in this agenda was identified as the key resource required.

A web-based resource will require facilitated support to allow sharing of ideas and solutions to problems arising, in addition to best practice. The network should be a safe forum which allows ideas, problems and solutions to be shared openly between members.

Terms of reference for the network should be identified, and could clarify how inclusive or exclusive the network should be. The network's membership will influence the website's content and how its services will be used. A steering group and secretariat could perform executive functions.

Resources may be necessary to ensure non-statutory providers are able to participate in large meetings of the network.

Feedback about ways in which a regional network might be useful:
Workshop groups were keen that this should be a 'knowledge network', facilitating sharing of knowledge and good practice both upwards (to DH and Home Office) and sideways, perhaps linking with other regional networks. Some groups also felt that a regional network would help its members to understand their local demographics, populations, and organisations already working in their localities.

A regional network would help frame the ways in which its members would like key issues to be fed upwards to DH and Home Office, and could be valuable in influencing ministers, as well as commissioners at a local level.

Workshop groups were very keen on the website at the heart of a 'virtual network'. This would facilitate cooperative working across the region more effectively and allow more resource to help poor organisations participate more effectively. The network

will be a forum and a repository of good practice. It will allow its members to identify each other and communicate together. It will also allow members to share ideas or call for support from others engaged in similar projects. The workshops at the inaugural meeting of the network had revealed agreement between delegates that common themes ran through operational problems at the sharp end of service provision, for which solutions would make life easier for everyone, especially for service users who happen to be migrants.

In the discussion concluding the feedback session, delegates agreed that the event had successfully engaged an unusual cross-section of service providers, who differed from the people delegates tended to meet in existing forums. From the range of delegates with varying backgrounds, at different levels in diverse organisations, the new network felt like a unique and useful new resource which could add value to existing forums. In addition to this good representation, other people who had expressed strong interest but were unable to attend the inaugural meeting would subsequently receive an invitation to join the network via the new web resource.

Conclusions and recommendations

Delegates at this event broadly agreed with the initial findings presented, and strongly endorsed the formation of a SEMH as the most effective way forward in understanding and meeting the health and social care needs of migrants in the region. In order to facilitate networking and partnership working, it was agreed that an on-line networking resource would be an appropriate tool.

The SEMH Working Group, following discussions with the commissioners, contracted a web-designer to develop a website which will act as:

- A contact point for all members of the network to identify colleagues working on areas of mutual interest.
- A forum to allow discussions, share information and disseminate learning.
- A repository of key documents and other resources likely to be useful for members of the network.
- A communications network allowing cascades of information or bulletins of relevance to reach all members of the network.

- A legacy for this project to allow it to continue to influence action beyond its lifetime.

The website will be found at www.migranthealthse.co.uk . The new logo for the network, which will be used to brand all materials, can be found below.

Chapter Nine: Conclusions and recommendations

Conclusions:

The following conclusions can be drawn from the research project:

- Migrants in the SE represent a large and diverse population, whose size and nature is influenced by economic and geopolitical events.

- No single data resource in health, social care or other systems completely or even adequately captures the key health issues of concern to this population, its experience of health and disease or its health service utilisation.

- Such health data as we have does not differentiate adequately between migrants, for example asylum seekers versus economic migrants versus international students.

- The best data sources on disease we have are for infectious diseases (collected by the HPA) which demonstrate over-representation of foreign-born individuals among those affected by TB and by HIV in the SE region. Even these sources are limited in their ability to differentiate between different types of migrants.

- Surveys among stakeholders, service providers and commissioners provide a useful source of qualitative data which can help in the understanding of need, but which are limited by size, scope and generalisability.

- Social issues can have a significant impact on health.
    - Housing was a particular social issue identified as a concern in this report. Poor housing and over-crowded living conditions among some migrants could contribute to transmission of infectious diseases, like TB.

- Contact with the criminal justice system, through prisons, immigration removal centres or the police and probation services, may be an opportunity to identify and meet health needs among some migrants.

- Barriers to accessing health services include:
  - Understanding of entitlement to care.
  - Understanding of the roles of various parts of the health service in meeting specific needs.
  - Language issues.
  - Cultural expectations.
  - Stigma.
  - Uncertainty around legal status.

- The research identified a broad range of both statutory and non-statutory agencies, organisations and individuals working to identify and meet the health needs of migrants in the SE region.

- However, joined-up coordinated action between these various players was not consistent throughout the region.

- There were some localities and regions where partnership work was more developed and these may be useful as exemplars of good practice.

- Effective partnership working is essential to meet the complex health and social care needs of this diverse and changing group.

- Partnership work should include health authorities, local authorities, other statutory agencies, third sector and voluntary organisations and service users.

- Commissioners and service providers need to work together to design and deliver the best model of care.

Recommendations:

- More 'intelligent' data sources are needed to map across health and social care databases to appropriately describe this population's experience of health and disease, health service utilisation and access to services.

- Migrants need better information about the range of health services available to them and their appropriate use.

- Health and social care partners require better training in understanding their roles in meeting the needs of migrants.

- Such databases that do exist currently need to be upgraded to improve their ability to capture important information which may influence both treatment and prevention of infectious diseases and other health problems.
  - For example, better, more consistent and more complete capture of country of origin, occupation and ethnicity across all routine data capture structures in health and social care services.
  - Duration of stay in UK may also be an important health factor which is not routinely recorded in many systems.

- Joint working across agencies is required to address the range of social problems which may have a negative health impact.
  - For example, housing, employment, care of children.

- The criminal justice system may be able to both identify and treat migrants who come into contact with any of its agencies, and provide pathways into primary and secondary healthcare and social services in the community.
  - Improving Health, Supporting Justice (DH, November 2009).

Language issues need to be addressed to ensure that migrants understand their entitlement to care from NHS and other providers, and how to access it. Include improving opportunities to learn English for already established migrant communities and the higher level of understanding of spoken and written English

required by new migrants, especially economic migrants (asylum seekers may be exempt).

- Migrants need better information on the range of healthcare services available in the region and their appropriate use:
  - For example, differences in care provided by GPs, walk-in centres, minor injuries and A&E Departments.

- Exemplars of good practice in the region should be identified and evaluated as potential models for other localities or partnerships to use in meeting the needs of migrants.

- The establishment of a SE regional network on Migrant Health may enable this process to be progressed more effectively.

- The most effective way to coordinate joined-up multi-agency work across a whole region is to establish a regional network of commissioners, providers, non-statutory and statutory agencies and service users, to inform the design and delivery of appropriate healthcare services. There is a need for a leadership role to make this happen at SHA and/or Government Office level.

- The network may bring with it economies of scale, allow effective sharing of information and models of care, and allow dissemination of learning.

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Appendix A:

Data critique report

Understanding the health needs of migrants in the South East region

Delivered by Solutions for Public Health

Contents

Introduction

Although a substantial increase in the inward migration has been recorded in the UK over the last decade, information on migrant population remains often inadequate. As a result of enhanced complex lifestyles and changes in migration, it has become increasingly important to have high quality statistics on migrant population. It has long been recognised that international migration is one of the most difficult components of population change to measure accurately. Currently, many systems are being reviewed and work is being conducted to improve data quality. For example, in May 2006 the Office for National Statistics (ONS), together with other government departments, set up an Interdepartmental Task Force on Migration Statistics. The objective of the task force is to recommend timely improvements that could be made to estimates of migration and migrant populations in the UK, both nationally and at local level. Despite the current lack of a single, comprehensive source of data which can provide the information, there are various alternatives that can help to build up a reasonable picture in terms of migrant population. Furthermore, health related datasets often record ethnicity. However, ethnic background is considered to be an inaccurate proxy for migration. Country of origin or nationality that gives a better indication of migration status is rarely available or incompletely collected inn health data.

The following data sources have been proposed for further consultation:

- 2001 UK Census
- International Passenger Survey (IPS)
- Electoral Register
- Labour Force Survey (LFS)
- Death registration
- Birth Registration
- Marriage & civil partnership registration
- Driving Licence Exchange
- National Insurance Number
- Workers Registration Scheme (WRS)
- School Census
- International Student Register – Higher Education Statistics Agency
- CORE (COntinuous REcording system)
- Percentage of stock privately rented
- Houses of Multiple Occupancy
- Health and hazard rating system
- Ministry of Justice Prison Population Statistics
- Supported Asylum Seekers
- Flag 4 registrations
- HPU Enhanced Surveillance Forms
- Health Statistics Quarterly
- Oxford Deliberate Self-Harm Statistics
- Suicide rates
- General Household Survey
- Cancer registries
- Hospital Episode Statistics
- Birth weight/infant mortality data
- GP prescribing data
- Maternity data from PCT commissioners.

Recommended data sources

Data has been reviewed in terms of its statistical robustness, geographical coverage, the way migration status is defined and the information the data provides. The latter criteria concentrated on how the figures are, or can, be expressed (rates or proportion of resident population), comparability with other data sources and confidentiality issues due to low

counts. Consequently, the following sources of information, discussed in more details below, are recommended for further analysis and mapping:

- Population Turnover
- Population estimates by country of birth and nationality
- National Insurance Number
- Workers Registration Scheme (WRS)
- Supported Asylum Seekers (UK Border Agency)
- School Census
- International Student Register – Higher Education Statistics Agency
- Flag 4 GP registrations
- Birth Registration - live births by birthplace of mother
- Maternity data from PCT commissioners;

How migrant status is determined will vary between different datasets. Some, for example the Workers Registration Scheme or Supported Asylum Seekers information from the UK Border Agency, are purposely design to collect figures on a specific group of the migrant population. However, if migrant status cannot be directly determined, country of origin or nationality are used. If both variables are available from the data of interest, country of birth should preferentially be selected as it will give a more robust estimate of migration and change over time. It is possible that an individual's nationality may change, but the respondent's country of birth remains the same. Although country of birth is the more robust variable for analysing the impact of international migrants, it does not represent a precise proxy. The category 'UK born' will include second and third generation migrants (born to earlier in-migrants). Similarly, the category 'foreign born' will include some UK nationals, for example those born to UK service people stationed abroad.

1. Population Turnover

Background

Annual rates of the volume of migration show the amount (as estimates) of migration into and out of each local authority area in England and Wales. Figures show the number of moves and the volume of movement per 1,000 population, both within the UK and internationally. Estimates are produced by ONS using the following data sources:

- International Passenger Survey (IPS)
- Labour Force Survey (LFS)
- Home Office data on asylum seekers and their dependents
- international migration data from the Northern Ireland Statistics and Research Agency (NISRA) for estimating international migration to and from Northern Ireland.

Period and geography covered

Latest data covers the period mid-2007 to mid-2008. Historical data is available back to mid-2001-mid-2002. Data is available only for lower-level areas, that is, local and unitary authorities. Data can be obtained from the ONS website at http://www.statistics.gov.uk/StatBase/Product.asp?vlnk=15001.

Strengths

Estimates combine modelling of various data sources. Compared with statistics on net migration, presented in most population change tables (that is, the difference between in- and out-migration), the volume of migration based on the sum of in and out flows provides a better indicator of areas with high levels of both in- and out-migration.

Weaknesses

At present, figures are not shown for higher level areas such as counties, Government Office regions, or England and Wales. As some migrants move between local authorities within counties or regions, their move is not across a county or regional boundary. For this

reason, internal migration into and out of the higher-level areas is not the sum of numbers moving into or out of the component lower level areas. Data from IPS and LSF will not capture all migrants due to small sample size. Home Office data will not included refused asylum seekers or refuges. Estimates for smaller areas or areas with little migration may be unreliable.

2. Population estimates by country of birth and nationality

Background

Population estimates by country of birth and nationality are produced using the Annual Population Survey (APS), which is the Labour Force Survey plus various sample boosts. The LFS is household survey of people in the UK. In some areas of the UK, the boost makes up the bulk of the APS dataset, with smaller contribution from the main LFS. The APS datasets are produced quarterly, with each dataset incorporating a 12-month collection period. There are approximately 360,000 people per dataset. Estimates at regional, upper and lower tier geographical level are reported by grouping the country of birth. The 60 most common countries of birth in the UK are also available. Data for Government Office regions and counties, however, is only provided for the five most frequent countries of birth.

Using the coefficient of variation, information on the accuracy and robustness of all estimates is provided. The coefficient of variation (where standard error is an estimate of the margin of error associated with a sample survey) is defined as follows:

$$\text{coefficient of variation} = \frac{\text{Standard error of the estimate}}{\text{Estimate}} \times 100$$

The coefficient of variation has been categorised in four groups; details of the categories can be found in table 1. Confidence intervals (CI) at 95% level are also provided for each estimate. The 95% CI indicate that across the dataset as whole, the confidence intervals are expected to contain the true values around 95% of the time.

Table 1. Statistical robustness of the population estimates by birth place

Coefficient of variation	Description of robustness
0 ≤ coefficient of variation < 5	Estimates are considered precise
5 ≤ coefficient of variation < 10	Estimates are reasonably precise
10 ≤ coefficient of variation < 20	Estimates are considered acceptable
Coefficient of variation ≥ 20	Estimates are not considered reliable for practical purposes

Period and geography covered

Latest estimates cover the period April 2008 to March 2009. Historical data is available back to 2004. The following data is available:

- South East estimates by the country of birth for the following groups: United Kingdom; Non-United Kingdom; Republic of Ireland; European Union 13 (EU countries up to May 2004)); European Union A8 (countries that acceded to the EU on May 2004); European Union 26 (all EU countries, excluding UK, as constituted on 1 January 2007); and Rest of the World (all other countries). Estimates are predominantly considered as precise or reasonably precise.
- Data by unitary authorities or counties in the South East by the country of birth defined as UK and non-UK. Estimates are considered as acceptable or reasonably precise.
- South East estimates for the five most common countries of birth. Estimates are predominantly considered as acceptable.

- South East estimates by nationality for the following groups: British; non-British; European Union 14 (EU13 grouping plus Republic of Ireland); European Union A8; European Union 26; and Rest of the World. Estimates are considered as precise or reasonably precise.
- Data by unitary authorities or counties in the South East by nationality defined as British and non-British. Estimates are predominantly considered as acceptable.
- South East estimates for the five most common nationalities. Estimates are considered as acceptable.

Estimates are produced by ONS and are downloadable from the website (http://www.statistics.gov.uk/statbase/Product.asp?vlnk=15147).

Strengths

Population estimates are provided by Government Office regions, unitary authorities and counties. Because APS is used rather than LFS, estimates are more robust than those from the main LFS. The robustness of each estimate is described using the coefficient of variation.

Weaknesses

Although the APS has a larger sample size than the LSF, it is still likely to catch only a proportion of migrants. It may underestimate the number of people born overseas because:

- It includes those deemed resident at private address, so it covers students in halls of residence, however, with parents resident in the UK only.
- it does not sample communal living.
- it excludes certain people who have been residents in the UK for less than 6 months.
- it is weighted to population estimates that exclude migrants staying for less than 12 months.

Language barrier may be an issue not only with postal and telephone contact, but also with willingness to participate in the survey. The LSF is collected in five quarterly waves, whereas the APS boost has a four-yearly wave structure. Therefore, the boosts may be slower to react to change in migration patterns than the main LFS. The speed with which the APS sample responds to changes in the household population may vary across the UK. District level estimates are not provided. For smaller areas, or areas with little migration, estimates may be unreliable.

3. National Insurance Number (NINO)

Background

National insurance numbers are a necessary first step for employment/self employment and for claiming benefits and tax credits. Migrant National Insurance Number allocations show the number of NINO allocations to overseas nationals, aged 16 and over, entering the UK who are planning to work or claim benefits legally in the UK. NINOs provide a record of residential postcode, arrival and registration date, country of origin and age. The data is available at local level and provides valuable information about migrants who have come to work in a particular area; although the individual may live in one and work in another neighbouring authority, depending on housing availability and transport links.

Period and geography covered

Latest data covers the calendar year 2008. Information for 2009 is also available, but it is incomplete. Historical data is available back to 2002. Data is available at the national level, for Government Office regions, counties, and unitary and local authorities.

Strengths

All migrants who are planning to work or claim benefits in the UK have to register. Data is broken down by nationality or world area of origin (European Union, EU Accession States, other European, Africa, Asia and Middle East, the Americas, Australasia and Oceania or unknown).

Weaknesses

Administrative sources are not primarily designed for statistical purposes. The coverage of international migrants joining an administrative source will depend on the purpose of the particular administrative system and will invariably differ between sources. They will cover both short- and long-term migrants. There is no minimum stay requirement to register for a NINO. Research into short-term migration has suggested that of all stays for less than a year there is a particular skew towards stays of less than a month[1]. No information on outflows is available. National Insurance Number data reflect a migrant's first destination or location at registration and, therefore, it does not reflect the stock of migrants nationally or where they may settle. Coverage is also limited to the population over 16 eligible to work or claim benefits. It excludes dependents of applicants. There may be a considerable delay between arrival and registering for a NINO. Data is based on the date of registration and not the date of arrival. Asylum seekers are not eligible to register for a NINO until their case has been approved. Migrant NINO data is often presented as proportion (or percentage) of resident population and, therefore, is not directly comparable to other migration indicators presented per 1000 resident population.

4. Worker Registration Scheme (WRS)

Background

The Worker Registration Scheme was introduced specifically to regulate access to the labour market and restrict access to benefits for the A8 countries that joined the EU in 2004 (together with Malta and Cyprus, which are not covered by the scheme). It was intended to be a temporary measure. There is a charge for registration and the scheme was initially planned to end on 30th April 2009, but has been extended. Registration is required to take employment (but not self employment) in the UK. Data is produced for first job by occupational status, date of birth, gender and nationality.

Period and geography covered

Data is available at the national level, for Government Office regions, counties, and unitary and local authorities. The initial dataset was published for the period May 2004 to March 2006. Data after March 2006 is published quarterly. Data by calendar years is also available.

Strengths

It includes long-term and short-term (staying for over a month) international migrants from A8 countries working as employees in the UK since 1 May 2004. Dependents of WRS are also includes.

Weaknesses

The WRS dataset is an administrative source and, therefore, is not primarily designed for statistical purposes. Although it provides useful information about the arrival of specific types of migrants to an area, data is grouped by address of employer rather than applicant and it records first rather than subsequent employment. Residential address is also collected. However, Home Office research indicates that workplace is more accurate on the WRS[1]. Data is based on the date of application rather than entry into the UK (as used in ONS mid-year population statistics). Coverage is limited to A8 citizens who are working (or intend to work) and, therefore, this indicator is not directly comparable to other migration indicators.

As with much of the other administrative data, there is no way of recording how long someone on the register stays or whether they have left. Thus the figures should not be used to suggest numbers currently resident in a place. Interviews with migrants have suggested that WRS is regarded by some as a tax and evasion contributes to under-counting[2]. Some double counting may also occur as dependents (recorded together with WRS applicant) may also be registered. This indicator is often presented as a proportion (or percentage) of the resident population and, therefore, figures are not directly comparable with those presented per 1000 resident population. The population covered on the WRS excludes:

- Individuals from A8 countries who are self employed.
- A8 migrants staying for less than a month.
- A8 migrants who migrate or visit the UK for reason other than work.
- EU national from the latest accession countries (Bulgaria and Romania).
- Individuals providing services in the UK on behalf of an employer who is not established in this country.

5. Supported Asylum Seekers (UK Border Agency)

Background

UK Boarder Agency (UKB) data provides up to date figures on the numbers of asylum seekers supported by the agency. This information covers asylum seekers supported under Section 95, and subsistence only and refused asylum seekers who are supported under Section 4.

Period and geography covered

Latest data is available up to September 2009. Historical, quarterly data is available back to Q3 2001 and before that monthly updates go back to October 1998. Data broken down by Government Office region or local authority is only reported for asylum seekers (including dependants) supported in dispersed accommodation and those in receipt of subsistence only support.

Strengths

Data is routinely collected and is reported on quarterly basis.

Weaknesses

Data on refused asylum seekers and refuges is not collected. It excludes unaccompanied asylum-seeking children supported by Local Authorities. From Q2 2009 any cases with an invalid application status are excluded. Local authorities with fewer than 15 cases, when rounded, are grouped by region as "Other".

6. International Student Register – Higher Education Statistics Agency (HESA)

Background

The HESA maintains a record of all students in the UK including those whose country of usual residence is outside the UK. These students comprise a large percentage of migrants coming to the UK (nearly 300,000 from outside the EEA in 2004). Students give an estimate of their intended length of stay. Data includes details on institution, nationality and level of study. Students from outside of the UK are grouped in *Other European Union* and *Non-European-Union*.

Period and geography covered

Data is available by institution. Latest data covers academic year 2007/08. 2008/09 data is planned to be released in March 2010. All students studying in the UK are recorded since 1996.

Strengths

There is an eleven-year time series of data which can provide information on stock (the total number of international students) and flow (new students and departing students).

Weaknesses

The main drawback is that data is recorded by administrative address of the institution, not domicile. However, the latter is to be introduced from 2007 and should provide a complete picture by 2010. Data on dependents is not recorded. Students who work should also be included in the data on applications for national insurance numbers, therefore some double counting may occur. Data is available by academic year and, therefore, may not be comparable with other data sources.

7. School Census (or Pupil Level Annual School Census/PLASC)

Background

The School Census, available on a consistent national basis since 2002, collects information from every school in England under Section 29 of the Education Act 1996 and Section 42 of the Schools Standards and Framework Act. The provision by schools of individual learner records is a statutory requirement under Section 537A of the Education Act 1996. The School Census replaced the Pupil Level Annual School Census (PLASC) in 2006 for all maintained Secondary Schools and from January 2007 it also includes all Nursery, Primary, and Special Schools. The School Census consists of pupil and school level data. As well as numbers of pupils in schools, information on pupil characteristics is collected. This includes gender, eligibility for free school meals, ethnic group, first language, numbers of pupils with special needs, and also class sizes. There is no question on nationality but first language provides a reasonable proxy.

Using the School Census information can be provided on proportion of pupils whose first language is known or believed to be other than English. Furthermore, languages (other than English) most frequently spoken (as proxy for country of origin) can also be identified. A first language other than English is recorded where a child was exposed to this language during early development and continues to be exposed to this language in the home or in the community. If a child was exposed to more than one language (which may include English) during early development, a language other than English should be recorded, irrespective of the child's proficiency in English. In the case of an older pupil, who is no longer exposed to the first language in the home, and who now uses another language, the school consults with the pupil or parent to determine which language should be record.

Period and geography covered

Latest available School Census is January 2009. Historical data goes back to 2002. Using the pupils' level data, information can be aggregated to any geography of interest by direct data request from the Department for Children, Schools and Families. However, for lower geographies, such as Super Output Areas, low numbers will have to be suppressed due to confidentially issues. Readily available data, covering England, Government Office regions, counties and unitary authorities, can be accessed though the DCSF website (http://www.dcsf.gov.uk/rsgateway/DB/SFR/s000843/index.shtml).

Strengths

Data is collected for all maintained Nursery, Primary and Secondary Schools. Maintained and non-maintained Special Schools are also included in the School Census. Schools are

required to return the census three times a year. Different modules are collected in each census with January being the main, and largest, collection. Information on language is routinely collected as part of the Census.
Year on year comparison can provide a strong indicator of migration by families with children using the variables described and by identifying children who join the system at an age above the start of schooling, although this will not capture children arriving and leaving during the year. Fuller use could be made of the information on date of arrival at the school to give an indication of 'churn' where migrants are accompanied by their children.

Weaknesses

Pupils are recorded when they enter the system but not when they leave. Independent schools are not included. Number of children in the reception year may be underestimated in the October Census. In 2007, changes have been introduced in language coding, therefore information pre and post this change may not always be directly comparable. In most cases, the collection of language information should be a relatively simple process. Some pupils or parents, however, might be reluctant to provide the information requested or might offer an incomplete response. Pupils or parents from minority language backgrounds may be reluctant to respond if they believe that:

- The school might favour respondents who describe themselves as speakers of English, especially where these are in the majority.
- The name of their language might not be known to the school; and/or
- Their language has a relatively low status or might be perceived as such by those asking for the information.

In such cases, pupils or parents may need to be given support in providing the information. In general, both pupils and parents will be encouraged to respond more openly and confidently if a positive attitude to multilingualism and linguistic diversity is promoted within the school[3].

8. Patient Register Data System (PRDS) – Flag 4 GP registrations

Background

Information derived from patient re-registration following a change of address (or change of GP) is the principal source of data used by the ONS to estimate internal migration. A person registering with a GP whose previous address is outside the UK is flagged (and a different flag is given to a returning migrant where this is known). Flag 4 data can, therefore, provide an indication of international migration to an area. Flag 4 data can be valuable in capturing those who may be staying for less than 12 months (although those staying for a short period are less likely to register). The PRDS is due to be replaced by a new system (The Patient Data Service) in the longer-term through the modernisation of NHS systems. Although registered as a requirement, it is unclear at this stage what information on international migration will be made available from this new source. ONS are continuing to liaise with the Department for Health on these developments.

Period and geography covered

Latest data is covering the period mid-2007 to mid-2008. Historical data goes back to mid-2000 to mid-2001. Data covers national figures, Government Office regions, counties, and unitary and local authorities.

Strengths

The population covered includes all people requiring access to NHS services through a GP, regardless of age or reason for visit. So, for example, many children and students will be covered. All Individuals staying in the UK for longer than three months can register with a GP.

Weaknesses

The PRDS dataset is an administrative source and, therefore, is not primarily designed for statistical purposes. The main limitations are that there is a time lag between entering the UK and registering and some, particularly young men, are known not to register, or to delay registration unless and until they have a medical need[3]. The flag is lost when a patient moves within the UK and registers with another GP. Research carried out by ONS, using International Passenger Survey data, indicated that international migrants initially moving to London were more likely to move to another region of the UK than international migrants initially moving to other regions. This may help explain the lower flag 4 data observed for some London local authorities, such as Westminster, Hackney and Brent[1].

Individuals who are not wishing to access NHS services from a GP are not included. Short-term stays (under three months) are not recorded. Information on country of origin is not routinely collected for all new registrations so varied groups of migrants, for example A8 migrants, cannot be separately identified.

9. Birth Registration - live births by birthplace of mother

Background

The estimated Total Fertility Rates (TFR) for foreign born women in 2007 was 2.51 children, up slightly from 2.48 in 2004. In contrast, the TFR for UK born women increased from 1.68 children in 2004 to 1.79 in 2007. Data published by ONS provides evidence that in both the UK and England and Wales, the recent rapid increases in the TFR are mainly due to increasing fertility among UK born women. It should be remembered, however, that foreign born women, who have higher fertility than their UK born counterparts, are making up an increasing share of the childbearing population. This population change will impact on the overall TFR, causing it to increase, even though fertility among foreign born women is fairly stable[4]. In England and Wales in 2008, births to mothers born in the EU, as constituted in 2008, represented 6.1 per cent of all live births while births to mothers born in one of the twelve countries which have joined the EU since 2004 represented 3.6 per cent of all live births. Mothers born in Asia contributed to 8.6 per cent of all live births and mothers born in Africa contributed 5.6 per cent[5].

The details of groupings used by live birth statistics for the country of birth are presented in table 2.

Table 2. Groupings of birthplace of mother; live births statistics

Group Name	Country Name
United Kingdom[1]	England, Wales, Scotland, Northern Ireland, Channel Islands, Isle of Man, UK (not otherwise stated)
European Union[1]	Austria, Belgium, Bulgaria, Cyprus, Czech Republic, Denmark, Eire, Estonia, Finland, France, Germany, Greece, Hungary, Ireland (not otherwise stated), Italy, Latvia, Lithuania, Luxembourg, Malta, The Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden
New EU – Countries which have joined the EU since 2004	Bulgaria, Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Romania, Slovakia, Slovenia
Rest of Europe (non EU)	All other European countries, including Turkey, Russia and the rest of the former Soviet republics
Asia	All Asian countries
Africa	All African countries
Rest of the World	Includes Not Stated

[1] 27 countries in the European Union as constituted in 2008.

Period and geography covered

Latest data is available for 2008. Data back to 2001 can be accessed via ONS website (http://www.statistics.gov.uk/StatBase/Product.asp?vlnk=14408). Data for each grouping of mother's birthplace is expressed as percentage of all live births and is available at national level, for Government Office regions, counties, and unitary and local authorities.

Strengths

Mother's birthplace for children born in England and Wales has been recorded at birth registration since April 1969. Data is routinely collected as part of birth statistics.

Weaknesses

Issues associated with using the country of birth as proxy of migration were discussed above in the *Recommended data sources* section.

Case studies

Locally collected data provides often an excellent source of demographic and health-related information on migrant population. Two data sets have been identified as examples of good practice and are recommend for preliminary analysis and mapping.

1. Maternity data

Maternity data collected by the West Sussex Hospitals NHS Trust provides valuable information on maternal needs of migrant mothers. Birthplace of mother is collected together with the following information:

- gestation at initial assessment;
- method of delivery;
- birth weight in grams;
- admission to Neonatal Unit;
- feeding Intention at delivery;
- current smoker at delivery

2. Houses of Multiple Occupancy (HMO)

Houses in Multiple Occupation are a key source of housing for significant and often vulnerable groups of people in society, including some groups of migrant population including irregular migrants. Slough Unitary Authority has been collecting data on HMOs in relation to migrant population and this information will provide a basis for qualitative analysis.

3. Migration Indicators Tool

The Migration Indicators Tool enables comparison of varied data sources relating to migrant population. It compromises data published by the ONS, Population Estimates Unit (PEU), Migration Statistics Unit (MSU), Annual Population Survey (APS), the Department for Work and Pensions (DWP) and Patient Register Data Services (PRDS). It is an excellent resource that can be used to gain an indication of migration at local level. The tool contains information for the years 2004 - 2008. Figures are available for Local and Unitary Authorities, 41 Counties, 9 Government Office regions and the 4 Countries of the UK. The following information is displayed in tabular and graphical format:

- Migration data (PEU)

  International and Internal migration 'component of population change' data used to calculate the rates for Turnover and International In and Out flow Indicators. Available for England and Wales at Country, GOR, County and Local Authority Level. Scotland at National.
- Non-UK estimates (APS)

  APS derived estimates of the resident population with Non-UK country of Birth, used to calculate proportions for the Non-UK Indicator.

Available for England, Wales and Scotland at Country, GOR, County and Local Authority Level. Northern Ireland at National.

- Non-British estimates (APS)

APS derived estimates of the resident population with Non-British nationality, used to calculate proportions for the Non-British Indicator.
Available for England, Wales and Scotland at Country, GOR, County and Local Authority Level. Northern Ireland at National.

- NINO data (DWP)

Migrant NINo registrations, used to calculate proportions for the NINo indicator.
Available for England, Wales and Scotland at Country, GOR, County and Local Authority Level. Northern Ireland at National.

- New Flag4 GP registrations (PRDS)

Flag4 GP registrations used to calculate the rates for the Flag4 indicator.
Available 2001 - 2008 for England and Wales at Country, GOR, County and Local Authority Level.

- Workers Registration Scheme (Home Office)

Registrations data used to calculate proportions for the WRS indicator.
Available for England, Scotland and Wales at Country, GOR, County and Local Authority Level. Northern Ireland at National.

Care should be taken when comparing varied indicators as different data periods are used. For example, some information is presented for calendar years whereas mid-year values are used in others. The way the data is expressed may also vary between different data sources. The tool and metadata file can be accessed at http://www.statistics.gov.uk/statbase/product.asp?vlnk=15239.

References for Appendix A

[1] Office for National Statistics. (2007*). A Review of the Potential Use of Administrative Sources in the Estimation of Population Statistics.*
[2] The Institute of Community Cohesion. (2007). *Estimating the scale and impacts of migration at the local level.*
[3] Department for Children, Schools and Families. (2008). *Pupil Language Data Guidance for Local Authorities on schools' collection and recording of data on pupils' languages (in compliance with the Data Protection Act).*
[4] Tromans, N., Natamba, E. and Jefferies, J. (2009) Have women born outside the UK driven the rise in UK births since 2001? *Population Trends*, vol Summer 209 (no 136): pp 28-42.
[5] Office for National Statistics. (2008).Births, selected background data, England and Wales. Available at http://www.statistics.gov.uk/StatBase/Product.asp?vlnk=14408

Table A.1 Latest data and period covered by source of infomation

Source of information	Latest data	Period covered
Population Turnover	Mid-2007 to mid-2008	July 2007 to June 2008
Population estimates (by country of birth and nationality)	2008-2009	April 2008 to March 2009
National Insurance Number	2008-2009	April 2008 to March 2009
Workers Registration Scheme	2008	January to December 2008
Supported Asylum Seekers (UK Border Agency);	June 2009	Numbers as end June 2009
School Census	January 2009	School year 2008/09
International Student Register	2007/08	August 2007 to 31 July 2008
Flag 4 GP registrations	2007/08	August 2007 to July 2008
Birth Registration (live births by birthplace of mother)	2008	January to December 2008

This report has been compiled by

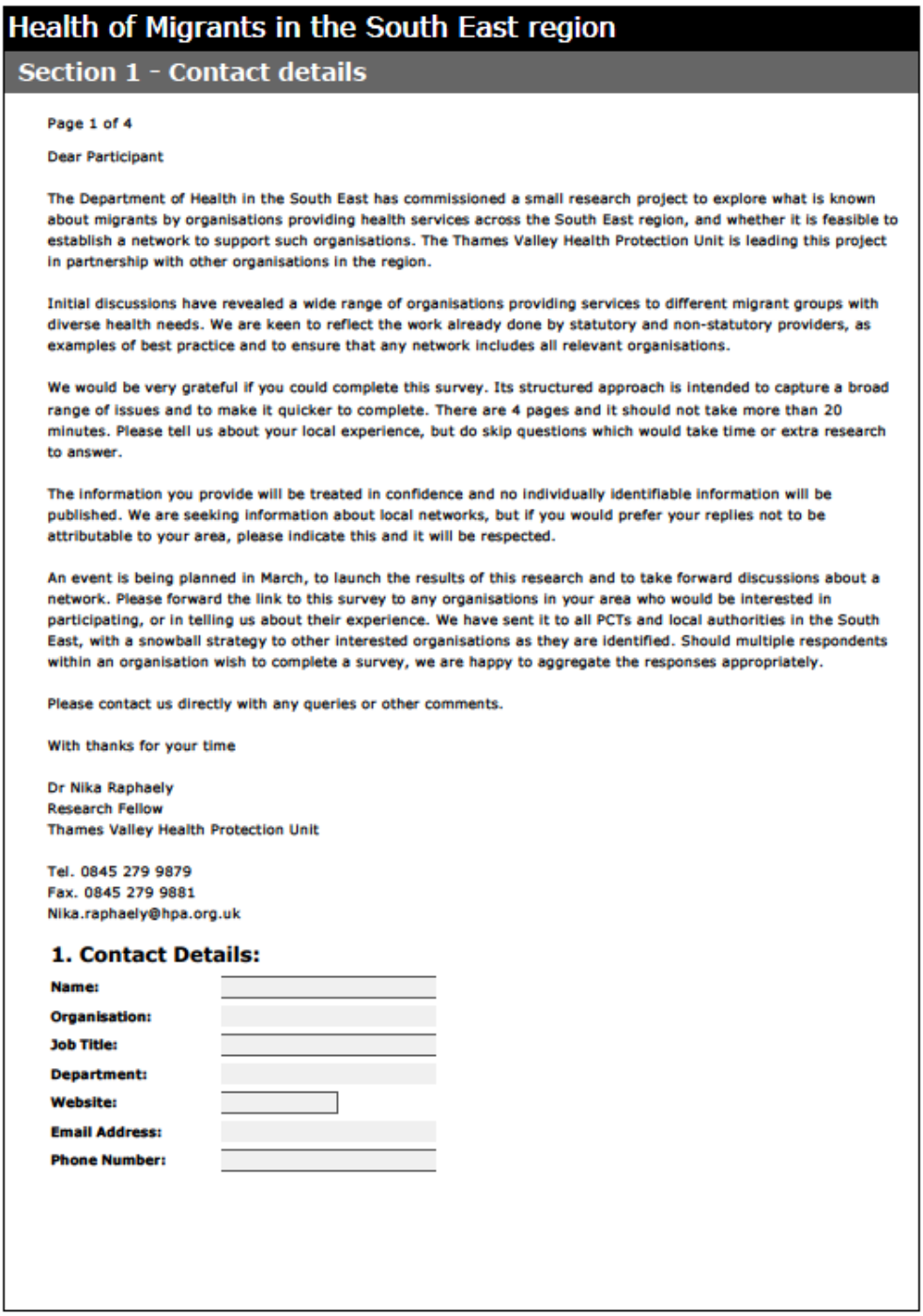
- Gabriele Price PhD, Senior Public Health Intelligence Analyst

South East Public Health Observatory

DELIVERED BY SPH Solutions for Public Health

February 2010

Appendix B: Online Survey



Health of Migrants in the South East region

Section 1 - Contact details

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Dear Participant

The Department of Health in the South East has commissioned a small research project to explore what is known about migrants by organisations providing health services across the South East region, and whether it is feasible to establish a network to support such organisations. The Thames Valley Health Protection Unit is leading this project in partnership with other organisations in the region.

Initial discussions have revealed a wide range of organisations providing services to different migrant groups with diverse health needs. We are keen to reflect the work already done by statutory and non-statutory providers, as examples of best practice and to ensure that any network includes all relevant organisations.

We would be very grateful if you could complete this survey. Its structured approach is intended to capture a broad range of issues and to make it quicker to complete. There are 4 pages and it should not take more than 20 minutes. Please tell us about your local experience, but do skip questions which would take time or extra research to answer.

The information you provide will be treated in confidence and no individually identifiable information will be published. We are seeking information about local networks, but if you would prefer your replies not to be attributable to your area, please indicate this and it will be respected.

An event is being planned in March, to launch the results of this research and to take forward discussions about a network. Please forward the link to this survey to any organisations in your area who would be interested in participating, or in telling us about their experience. We have sent it to all PCTs and local authorities in the South East, with a snowball strategy to other interested organisations as they are identified. Should multiple respondents within an organisation wish to complete a survey, we are happy to aggregate the responses appropriately.

Please contact us directly with any queries or other comments.

With thanks for your time

Dr Nika Raphaely
Research Fellow
Thames Valley Health Protection Unit

Tel. 0845 279 9879
Fax. 0845 279 9881
Nika.raphaely@hpa.org.uk

1. Contact Details:

Name:
Organisation:
Job Title:
Department:
Website:
Email Address:
Phone Number:

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Health of Migrants in the South East region

2. Postal Address:

Address1:

Address2:

Address3:

Postcode:

3. What type of organisation do you work for?

- ☐ Primary Care Trust
- ☐ NHS acute trust
- ☐ NHS mental health trust
- ☐ Local authority
- ☐ Immigration Removal Centre
- ☐ Police or Criminal justice system
- ☐ Non-statutory
- ☐ Other

Other (please specify)

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Health of Migrants in the South East region

Section 2 – Understanding of migrant numbers and their health issues

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4. What population does your organisation provide services for?

- ☐ Whole population in your geographical area
- ☐ Black and ethnic minority population in your geographical area
- ☐ Asylum seekers and/or refugees
- ☐ Economic migrants/work permit holders
- ☐ International students
- ☐ Other migrant population

Please give details, if applicable

5. What is the approximate size of population your organisation provides services for? (if known)

Please specify:

6. How many migrants are estimated to be in your population? Please estimate a number for each category (if known).

Migrants in total	
Asylum seekers	
Refugees	
Economic migrants or work permit holders	
International students	
Children	
Family joiners	
Irregular migrants*	
Other	

*NB irregular migrants includes failed asylum seekers, expired visas, undocumented etc.

7. Please use this for any additional comments for the previous question.

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Health of Migrants in the South East region

8. Please estimate a percentage of the migrant population in your area which is formed by each category.

Asylum seekers	
Refugees	
Economic migrants or work permit holders	
International students	
Children	
Family joiners	
Irregular migrants	
Other	

9. Please use this for any additional comments for the previous question.

10. Do children form significant proportions of migrant populations in your area? If yes, please describe which populations, and whether the children are unaccompanied or with family members.

- ○ Yes
- ○ No

If yes (please comment)

11. Are any migrant groups in your area causing particular concern to your organisation? If yes, please describe which groups and why they are causing concern.

- ○ Yes
- ○ No

If yes (please comment)

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12. What sources of information do you find helpful to understand the NUMBERS of migrants in your area? Please select any which are helpful for each category.

	Local authority information	NHS information	ONS statistics	NI numbers issued	Workers registration scheme	School census	Electoral registers	Non-statutory sources	None of these
Migrants in general	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asylum seekers	☐	☐	☐	☐	☐	☐	☐	☐	☐
Refugees	☐	☐	☐	☐	☐	☐	☐	☐	☐
Economic migrants or work permit holders	☐	☐	☐	☐	☐	☐	☐	☐	☐
International students	☐	☐	☐	☐	☐	☐	☐	☐	☐
Children	☐	☐	☐	☐	☐	☐	☐	☐	☐
Family joiners	☐	☐	☐	☐	☐	☐	☐	☐	☐
Irregular migrants	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐	☐

Any additional comments

13. What sources of information do you find helpful to understand the HEALTH NEEDS of these groups in your area? Please select any which are helpful for each category.

	Local authority information	NHS information	Information gathered by your organisation	Other local or regional sources	National statutory sources	Non-statutory sources	None of these
Migrants in general	☐	☐	☐	☐	☐	☐	☐
Asylum seekers	☐	☐	☐	☐	☐	☐	☐
Refugees	☐	☐	☐	☐	☐	☐	☐
Economic migrants or work permit holders	☐	☐	☐	☐	☐	☐	☐
International students	☐	☐	☐	☐	☐	☐	☐
Children	☐	☐	☐	☐	☐	☐	☐
Family joiners	☐	☐	☐	☐	☐	☐	☐
Irregular migrants	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐

Any additional comments

Health of Migrants in the South East region

14. In your local experience, what are the greatest health issues for migrant populations? Please select one option for each category.

	Not a problem	Minor problem	Significant problem	Not known
Incomplete immunisations	○	○	○	○
Other communicable diseases	○	○	○	○
Mental health	○	○	○	○
Maternal health	○	○	○	○
Sexual health	○	○	○	○
Dental health	○	○	○	○
Smoking	○	○	○	○
Alcohol	○	○	○	○
Other drugs	○	○	○	○
Other behavioural problems	○	○	○	○

Other (please specify)

15. In your local experience, what are the main health needs of migrants? Please comment for the categories of migrants which are significant in your area.

Migrants in general	
Asylum seekers	
Refugees	
Economic migrants or work permit holders	
International students	
Children	
Family joiners	
Irregular migrants	
Other	

Health of Migrants in the South East region

16. In your local experience, what are the most important wider issues affecting the heath of these groups?

	Housing	Legal status & support	Employment	Education & skills	Income & poverty	Language & interpretation problems	Discrimination & abuse
Migrants in general	☐	☐	☐	☐	☐	☐	☐
Asylum seekers	☐	☐	☐	☐	☐	☐	☐
Refugees	☐	☐	☐	☐	☐	☐	☐
Economic migrants or work permit holders	☐	☐	☐	☐	☐	☐	☐
International students	☐	☐	☐	☐	☐	☐	☐
Children	☐	☐	☐	☐	☐	☐	☐
Family joiners	☐	☐	☐	☐	☐	☐	☐
Irregular migrants	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐

Any additional comments

17. Are you concerned about health issues and challenges facing particularly vulnerable migrant groups in your area, such as migrants in detention centres or prisons?

Migrant groups

Health issues or challenges

Any further details?

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Health of Migrants in the South East region

Section 3 - Health services for migrants

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18. Which health services are most accessed by migrants in your area? Please select more than one if appropriate, for each category

	A&E	GP surgeries	Other primary care (out of hours, walk-in)	NHS direct	Specialist outreach services	Infectious diseases services	Maternity & antenatal services	Sexual health services	Mental health services
Migrants in general	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asylum seekers	☐	☐	☐	☐	☐	☐	☐	☐	☐
Refugees	☐	☐	☐	☐	☐	☐	☐	☐	☐
Economic migrants or work permit holders	☐	☐	☐	☐	☐	☐	☐	☐	☐
International students	☐	☐	☐	☐	☐	☐	☐	☐	☐
Children	☐	☐	☐	☐	☐	☐	☐	☐	☐
Family joiners	☐	☐	☐	☐	☐	☐	☐	☐	☐
Irregular migrants	☐	☐	☐	☐	☐	☐	☐	☐	☐

Other (please specify)

19. Does your organisation commission any services specifically for migrants?

○ Yes

○ No (Go to next question)

If yes (please specify)

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Health of Migrants in the South East region

20. Does your organisation experience any barriers to commissioning services accessible to migrants? Please select more than one if appropriate, for each category.

	Funding insecurities	Commissioning priorities & other targets	Delays in accessing appointments	Access to interpreting services	Reluctance from hospitals or health workers	Dispersal and/or detention	Confusion over entitlement to services
Migrants in general	☐	☐	☐	☐	☐	☐	☐
Asylum seekers	☐	☐	☐	☐	☐	☐	☐
Refugees	☐	☐	☐	☐	☐	☐	☐
Economic migrants or work permit holders	☐	☐	☐	☐	☐	☐	☐
International students	☐	☐	☐	☐	☐	☐	☐
Children	☐	☐	☐	☐	☐	☐	☐
Family joiners	☐	☐	☐	☐	☐	☐	☐
Irregular migrants	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐

Other (please specify)

21. Does your organisation provide any services specifically for migrants?

○ Yes

○ No (Go to next question)

If yes (please specify)

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Health of Migrants in the South East region

22. Does your organisation experience any barriers to providing services accessible to migrants? Please select more than one if appropriate, for each category.

	Funding insecurities	Commissioning priorities & other targets	Delays in accessing appointments	Access to interpreting services	Reluctance from hospitals or health workers	Dispersal and/or detention	Confusion over entitlement to services
Migrants in general	☐	☐	☐	☐	☐	☐	☐
Asylum seekers	☐	☐	☐	☐	☐	☐	☐
Refugees	☐	☐	☐	☐	☐	☐	☐
Economic migrants or work permit holders	☐	☐	☐	☐	☐	☐	☐
International students	☐	☐	☐	☐	☐	☐	☐
Children	☐	☐	☐	☐	☐	☐	☐
Family joiners	☐	☐	☐	☐	☐	☐	☐
Irregular migrants	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐

23. Are you aware of any barriers experienced by migrants, making it difficult for them to access health services appropriately in your area? Please select more than one if appropriate, for each category.

	Confusion over entitlement to services	Income & poverty	Transport or other problems in rural areas	Problems registering with GPs	Discrimination & abuse	Cultural expectations of health & health services	Language & interpretation problems
Migrants in general	☐	☐	☐	☐	☐	☐	☐
Asylum seekers	☐	☐	☐	☐	☐	☐	☐
Refugees	☐	☐	☐	☐	☐	☐	☐
Economic migrants or work permit holders	☐	☐	☐	☐	☐	☐	☐
International students	☐	☐	☐	☐	☐	☐	☐
Children	☐	☐	☐	☐	☐	☐	☐
Family joiners	☐	☐	☐	☐	☐	☐	☐
Irregular migrants	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐

Other (please specify)

24. What would help your organisation to improve services to meet the health needs of migrants in your area, and in what ways?

Health of Migrants in the South East region

25. Do other organisations provide services which aim to improve migrant health in your area? Please select more than one if appropriate, for each category

	Hospitals	Mental health trusts	GPs	Other NHS services	Other mental health support	Support in accessing UK services including health	Local authority eg social services	Non-statutory organisations	Targeting migrants from a particular area
Migrants in general	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asylum seekers	☐	☐	☐	☐	☐	☐	☐	☐	☐
Refugees	☐	☐	☐	☐	☐	☐	☐	☐	☐
Economic migrants or work permit holders	☐	☐	☐	☐	☐	☐	☐	☐	☐
International students	☐	☐	☐	☐	☐	☐	☐	☐	☐
Children	☐	☐	☐	☐	☐	☐	☐	☐	☐
Family joiners	☐	☐	☐	☐	☐	☐	☐	☐	☐
Irregular migrants	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐	☐

Please identify any organisations providing these services, plus any additional comments.

26. Are you aware of any joint working between organisations in your area, to enable migrants to access health services more effectively? (For example, collaboration between organisations in identifying priorities or delivering services)

○ Yes

○ No (Go to next question)

If yes (please specify)

27. Can you tell us about any interesting services or other examples of good practice, provided by your organisation or other organisations for migrants in your area?

○ Yes

○ No (Go to next question)

If yes (please specify)

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Health of Migrants in the South East region

28. Are you aware of any specific gaps in health service provision to migrants in your area?

- ○ Yes
- ○ No (Go to next question)

If yes (please specify)

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Health of Migrants in the South East region

Section 4 – Key Contacts and networking

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Who is/are the lead individuals in your organisation working at a strategic level with other local organisations on migrant issues?

29. Contact 1

Name:
Position
Email:
Tel.

30. Contact 2

Name:
Position
Email:
Tel.

31. Contact 3

Name:
Position
Email:
Tel.

Who is/are the main operational contacts for services accessed by migrants?

32. Contact 1

Name:
Position
Email:
Tel.

33. Contact 2

Name:
Position
Email:
Tel.

34. Contact 3

Name:
Position
Email:
Tel.

Please give details for any other organisations you are aware of which work on migrant health issues in your area.

Health of Migrants in the South East region

35. Organisation 1

Organisation:
Key Contact
Address1:
Address 2:
Address 3:
Postcode:
Website:
Email:
Tel.

36. Organisation 2

Organisation:
Key Contact
Address1:
Address2:
Address3:
Postcode:
Website:
Email:
Tel.

37. Are you aware of any formal or informal networking between organisations in your area, seeking to help provide health services to migrants more effectively?

	Multi-agency?	Non-statutory participants?	Meet once/more per month?	Virtual network only? (no formal meetings)	Migrants issues on agenda formally?	Migrant issues discussed informally between participants?	Wider agenda, not only health focus?
Forum 1	☐	☐	☐	☐	☐	☐	☐
Forum 2	☐	☐	☐	☐	☐	☐	☐
Forum 3	☐	☐	☐	☐	☐	☐	☐
Forum 4	☐	☐	☐	☐	☐	☐	☐
Forum 5	☐	☐	☐	☐	☐	☐	☐

If yes (please specify)

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Health of Migrants in the South East region

38. Would you be interested in participating in a regional network to support and share resources amongst organisations providing services to migrants in the South East?

- ○ Yes
- ○ No (Go to next question)

If yes (please specify)

39. Please use this text box for any additional comments you may have.

Thank you. Please click done to submit the survey.

Appendix C: Additional data tables for Chapter Two

Population estimates for individuals born outside the UK, as percentage of total population estimates. Counties and Unitary Authorities in the South East (April 2008 to March 2009)

Name	United Kingdom		Non United Kingdom		
	estimate	CI +/-	estimate	CI +/-	% of total population estimates
Bracknell Forest UA	98,000	9,000	15,000	3,000	**13.3%**
Brighton and Hove UA	213,000	18,000	38,000	8,000	**15.1%**
Isle of Wight UA	131,000	11,000	6,000	2,000	**4.4%**
Medway UA	230,000	19,000	19,000	6,000	**7.6%**
Milton Keynes UA	190,000	19,000	40,000	9,000	**17.4%**
Portsmouth UA	179,000	14,000	18,000	5,000	**9.1%**
Reading UA	112,000	11,000	31,000	6,000	**21.7%**
Slough UA	80,000	7,000	39,000	5,000	**32.8%**
Southampton UA	204,000	18,000	28,000	7,000	**12.1%**
West Berkshire UA	139,000	12,000	12,000	4,000	**7.9%**
Windsor and Maidenhead UA	121,000	11,000	20,000	4,000	**14.2%**
Wokingham UA	139,000	12,000	17,000	4,000	**10.9%**
Buckinghamshire	434,000	37,000	53,000	13,000	**10.9%**
East Sussex	463,000	36,000	39,000	10,000	**7.8%**
Hampshire	1,163,000	59,000	97,000	17,000	**7.7%**
Kent	1,295,000	65,000	95,000	18,000	**6.8%**
Oxfordshire	555,000	43,000	77,000	16,000	**12.2%**
Surrey	955,000	56,000	136,000	21,000	**12.5%**
West Sussex	701,000	46,000	68,000	14,000	**8.8%**

Source: Annual Population Survey (APS)/Labour Force Survey (LFS), ONS
Totals may not sum due to rounding

Population estimates for non-British nationals, as percentage of total population estimates. Counties and unitary authorities in the South East (April 2008 to March 2009)

Name	British		Non British		
	estimate	CI +/-	estimate	CI +/-	% of total population estimates
Bracknell Forest UA	103,000	9,000	10,000	3,000	8.8%
Brighton and Hove UA	226,000	18,000	25,000	6,000	10.0%
Isle of Wight UA	134,000	11,000	3,000	2,000	2.2%
Medway UA	236,000	20,000	13,000	5,000	5.2%
Milton Keynes UA	204,000	20,000	26,000	7,000	11.3%
Portsmouth UA	184,000	15,000	12,000	4,000	6.1%
Reading UA	118,000	11,000	25,000	5,000	17.5%
Slough UA	97,000	8,000	23,000	4,000	19.2%
Southampton UA	212,000	18,000	20,000	6,000	8.6%
West Berkshire UA	143,000	12,000	8,000	3,000	5.3%
Windsor and Maidenhead UA	131,000	11,000	10,000	3,000	7.1%
Wokingham UA	146,000	12,000	10,000	3,000	6.4%
Buckinghamshire	453,000	38,000	33,000	10,000	6.8%
East Sussex	480,000	36,000	21,000	8,000	4.2%
Hampshire	1,209,000	61,000	51,000	12,000	4.0%
Kent	1,336,000	66,000	54,000	13,000	3.9%
Oxfordshire	578,000	43,000	55,000	13,000	8.7%
Surrey	1,008,000	57,000	82,000	16,000	7.5%
West Sussex	729,000	47,000	39,000	11,000	5.1%

Source: Annual Population Survey (APS)/Labour Force Survey (LFS), ONS
Totals may not sum due to rounding

Volume of international migration per 1,000 population. Districts and unitary authorities in the South East (Mid-2007 to Mid-2006)

	International Migration		Volume of international migration per 1,000 population		International Migration		Volume of international migration per 1,000 population
Area	In	Out		Area	In	Out	
Bracknell Forest UA	1,300	800	18	Dartford	300	300	6
Brighton and Hove UA	4,500	2600	28	Dover	500	500	10
Isle of Wight UA	700	700	10	Gravesham	300	300	6
Medway UA	1,000	600	6	Maidstone	700	400	8
Milton Keynes UA	2,100	1500	16	Sevenoaks	700	500	10
Portsmouth UA	3,500	1300	24	Shepway	600	600	12
Reading UA	3,800	1900	39	Swale	300	300	4
Slough UA	1,300	900	18	Thanet	600	700	11
Southampton UA	5,300	2500	33	Tonbridge and Malling	500	200	6
West Berkshire UA	1,300	1100	16	Tunbridge Wells	800	500	12
Windsor and Maidenhead UA	2,300	1500	26	Cherwell	900	1100	15
Wokingham UA	2,700	1700	27	Oxford	6,100	3500	62
Aylesbury Vale	1,400	1300	15	South Oxfordshire	1,500	1200	21
Chiltern	800	800	18	Vale of White Horse	1,300	1400	23
South Bucks	600	600	19	West Oxfordshire	500	900	14
Wycombe	1,100	1300	15	Elmbridge	2,400	1800	32
Eastbourne	400	700	11	Epsom and Ewell	1,200	500	22
Hastings	200	600	9	Guildford	2,200	1700	29
Lewes	600	400	11	Mole Valley	600	700	17
Rother	200	500	7	Reigate and Banstead	1,800	800	19
Wealden	500	800	9	Runnymede	1,400	700	26
Basingstoke and Deane	800	700	9	Spelthorne	600	500	11
East Hampshire	600	500	11	Surrey Heath	900	800	20
Eastleigh	700	600	11	Tandridge	900	400	15
Fareham	300	400	7	Waverley	1,200	1200	20
Gosport	200	200	5	Woking	1,100	1000	23
Hart	600	500	12	Adur	200	200	5
Havant	500	300	7	Arun	400	500	6

New Forest	1,200	900	12	Chichester	700	600	11
Rushmoor	400	600	12	Crawley	1,400	400	18
Test Valley	1,000	800	15	Horsham	700	600	10
Winchester	900	700	15	Mid Sussex	1,100	700	13
Ashford	600	300	8	Worthing	400	400	8
Canterbury	2,400	1500	26	*Source: Office for National Statistics (ONS)*			

National Insurance Number registrations for non-British nationals as percentage of resident population: Unitary and local authorities in the South East (April 2008 to March 2009)

Area	Number of NI registrations	NI registrations % of resident population	Area	Number of NI registrations	NI registrations % of resident population
Bracknell Forest UA	850	0.74%	Dartford	710	0.77%
Brighton and Hove UA	4670	1.82%	Dover	550	0.51%
Isle of Wight UA	580	0.41%	Gravesham	1220	1.24%
Medway UA	2310	0.91%	Maidstone	1500	1.03%
Milton Keynes UA	3010	1.30%	Sevenoaks	500	0.44%
Portsmouth UA	2430	1.22%	Shepway	590	0.59%
Reading UA	4000	2.75%	Swale	1140	0.86%
Slough UA	3920	3.23%	Thanet	920	0.71%
Southampton UA	4430	1.89%	Tonbridge and Malling	640	0.55%
West Berkshire UA	970	0.63%	Tunbridge Wells	970	0.90%
Windsor and Maidenhead UA	1480	1.04%	Cherwell	1210	0.88%
Wokingham UA	1070	0.67%	Oxford	4710	3.06%
Aylesbury Vale	1040	0.59%	South Oxfordshire	910	0.70%
Chiltern	480	0.53%	Vale of White Horse	770	0.66%
South Bucks	480	0.74%	West Oxfordshire	540	0.53%
Wycombe	1520	0.94%	Elmbridge	1210	0.91%
Eastbourne	760	0.79%	Epsom and Ewell	580	0.80%
Hastings	490	0.57%	Guildford	2320	1.71%
Lewes	430	0.45%	Mole Valley	520	0.63%
Rother	240	0.27%	Reigate and Banstead	990	0.73%
Wealden	450	0.31%	Runnymede	920	1.10%
Basingstoke and Deane	1300	0.80%	Spelthorne	720	0.79%
East Hampshire	510	0.46%	Surrey Heath	630	0.76%
Eastleigh	330	0.27%	Tandridge	370	0.44%
Fareham	240	0.22%	Waverley	670	0.56%
Gosport	180	0.23%	Woking	1220	1.32%
Hart	500	0.55%	Adur	170	0.28%

Havant	200	0.17%	Arun	1310	0.89%
New Forest	910	0.52%	Chichester	1250	1.13%
Rushmoor	1070	1.19%	Crawley	1950	1.92%
Test Valley	550	0.48%	Horsham	520	0.40%
Winchester	590	0.52%	Mid Sussex	770	0.59%
Ashford	730	0.64%	Worthing	570	0.57%
Canterbury	1540	1.03%	*Source: National Insurance Recording System*		

Worker Registration as percentage of resident population; Unitary and local authorities in South East

Area	Number of Worker Registrations (WRS)	WRS % of resident population	Area	Number of Worker Registrations (WRS)	WRS % of resident population
Bracknell Forest UA	165	0.15%	Dartford	325	0.36%
Brighton and Hove UA	550	0.22%	Dover	160	0.15%
Isle of Wight UA	205	0.15%	Gravesham	495	0.50%
Medway UA	495	0.20%	Maidstone	500	0.35%
Milton Keynes UA	575	0.25%	Sevenoaks	195	0.17%
Portsmouth UA	390	0.20%	Shepway	195	0.20%
Reading UA	580	0.41%	Swale	465	0.36%
Slough UA	775	0.65%	Thanet	145	0.11%
Southampton UA	1295	0.56%	Tonbridge and Malling	220	0.19%
West Berkshire UA	340	0.23%	Tunbridge Wells	380	0.37%
Windsor and Maidenhead UA	300	0.21%	Cherwell	365	0.26%
Wokingham UA	765	0.49%	Oxford	620	0.41%
Aylesbury Vale	275	0.16%	South Oxfordshire	890	0.70%
Chiltern	65	0.07%	Vale of White Horse	220	0.19%
South Bucks	180	0.28%	West Oxfordshire	210	0.21%
Wycombe	255	0.16%	Elmbridge	360	0.27%
Eastbourne	170	0.18%	Epsom and Ewell	60	0.09%
Hastings	60	0.07%	Guildford	205	0.15%
Lewes	80	0.09%	Mole Valley	130	0.16%

Rother	70	0.08%	Reigate and Banstead	370	0.29%
Wealden	90	0.06%	Runnymede	590	0.72%
Basingstoke and Deane	410	0.26%	Spelthorne	85	0.09%
East Hampshire	135	0.12%	Surrey Heath	225	0.27%
Eastleigh	70	0.06%	Tandridge	100	0.12%
Fareham	110	0.10%	Waverley	205	0.18%
Gosport	30	0.04%	Woking	155	0.17%
Hart	220	0.25%	Adur	30	0.05%
Havant	75	0.06%	Arun	780	0.54%
New Forest	605	0.35%	Chichester	445	0.41%
Rushmoor	60	0.07%	Crawley	390	0.39%
Test Valley	190	0.17%	Horsham	205	0.16%
Winchester	275	0.25%	Mid Sussex	105	0.08%
Ashford	225	0.20%	Worthing	40	0.04%
Canterbury	355	0.24%			

Source: Local Government Association website

Live births where mother's birthplace was outside of the UK, as percentage of all live births; Unitary and local authorities in the South East 2008

Area	Mothers born outside UK (% of all live births)							Area	Mothers born outside UK (% of all live births)						
	Total	EU	New EU	Rest of Europe	Asia	Africa	Rest of World		Total	EU	New EU	Rest of Europe	Asia	Africa	Rest of World
Medway	14.9	4.5	3.0	0.8	4.5	3.9	1.2	Dartford	18.8	5.6	3.4	0.5	4.9	6.2	1.8
Bracknell Forest	23.5	6.6	3.3	1.1	5.8	7.4	2.6	Dover	12.9	6.6	4.2	0.8	2.7	1.2	1.7
West Berkshire	15.6	5.4	2.0	0.5	3.3	4.3	2.1	Gravesham	23.8	7.3	5.7	0.9	9.1	5.1	1.5
Reading	42.3	11.4	6.8	1.7	14.5	11.3	3.3	Maidstone	14.5	5.1	3.2	1.0	5.1	2.0	1.3
Slough UA	56.5	15.0	12.8	1.2	27.7	10.1	2.4	Sevenoaks	13.5	4.7	1.8	0.8	2.0	3.3	2.9
Windsor and Maidenhead	27.4	8.9	3.6	1.5	8.4	4.9	3.7	Shepway	14.9	4.5	2.4	0.8	6.4	1.8	1.4
Wokingham	21.5	6.6	2.4	1.0	7.2	4.3	2.5	Swale	8.9	3.7	2.0	0.6	1.8	1.8	1.1
Milton Keynes	33.0	6.7	4.0	0.8	8.3	13.4	3.8	Thanet	13.1	6.1	4.9	1.3	3.1	1.4	1.2
Brighton and Hove	23.3	8.3	3.4	1.3	5.4	4.6	3.6	Tonbridge and Malling	10.9	4.1	1.7	0.7	2.8	1.7	1.6
Portsmouth	18.6	4.5	2.9	1.0	7.3	4.2	1.7	Tunbridge Wells	17.2	6.3	3.4	0.3	5.4	3.0	2.3
Southampton	29.1	10.8	8.3	0.8	11.9	4.5	1.2	Cherwell	21.7	7.9	4.7	0.5	6.4	3.4	3.5
Isle of Wight	8.9	3.7	2.0	0.5	2.7	0.9	1.2	Oxford	42.6	11.2	4.8	1.9	15.1	8.4	6.0
Aylesbury Vale	18.9	4.9	2.7	0.3	8.8	3.5	1.5	South Oxfordshire	14.6	6.6	2.7	0.5	2.7	2.2	2.6
Chiltern	21.6	6.6	2.8	0.6	6.8	3.6	3.9	Vale of White Horse	20.7	7.6	2.6	1.0	3.7	5.1	3.4
South Bucks	22.5	7.1	3.0	1.0	7.6	3.3	3.5	West Oxfordshire	15.2	6.7	3.0	0.3	2.9	2.3	3.0
Wycombe	26.7	6.0	3.1	1.1	12.9	3.5	3.2	Elmbridge	28.8	8.6	3.0	1.6	6.2	6.3	6.1
Eastbourne	19.1	8.7	4.7	1.4	5.0	2.7	1.3	Epsom and Ewell	26.3	6.9	2.9	1.2	7.1	6.4	4.8
Hastings	13.9	4.6	2.9	1.1	4.3	2.1	1.7	Guildford	24.4	7.7	3.3	1.0	6.1	5.3	4.2
Lewes	12.5	5.2	2.1	0.9	3.6	1.4	1.4	Mole Valley	17.2	6.0	2.5	0.7	4.2	3.0	3.3
Rother	9.3	1.7	0.7	0.9	2.9	2.1	1.7	Reigate and Banstead	20.1	6.8	2.7	1.2	5.0	4.3	2.7
Wealden	11.2	4.3	1.7	0.7	2.2	2.1	1.9	Runnymede	23.5	6.5	2.9	1.5	6.3	5.4	3.8
Basingstoke and Deane	18.1	6.1	3.1	0.7	5.4	3.7	2.1	Spelthorne	24.6	7.1	4.5	1.0	8.9	5.2	2.4
East Hampshire	15.5	5.0	2.2	0.8	3.3	3.5	2.9	Surrey Heath	22.9	6.4	2.7	1.1	8.2	4.9	2.4
Eastleigh	11.1	3.8	1.3	0.5	3.8	1.8	1.2	Tandridge	14.9	5.4	2.6	0.3	2.8	3.1	3.2
Fareham	9.4	3.5	0.8	0.2	2.8	1.8	1.2	Waverley	14.6	5.9	2.2	0.6	2.0	2.8	3.2
Gosport	11.4	4.5	1.8	0.5	2.9	1.4	2.1	Woking	34.8	8.1	4.1	1.6	14.4	6.5	4.2
Hart	16.3	6.1	2.4	1.0	3.1	3.6	2.6	Adur	11.0	2.9	0.9	0.8	3.4	2.5	1.4
Havant	5.6	2.7	0.8	0.1	1.2	1.0	0.6	Arun	15.8	9.3	7.4	0.7	2.6	1.8	1.3
New Forest	11.3	4.5	2.2	0.6	1.7	2.1	2.4	Chichester	13.1	5.4	2.2	0.5	2.7	2.0	2.5
Rushmoor	25.5	6.9	3.2	0.8	8.8	5.7	3.5	Crawley	35.8	8.9	5.6	1.6	11.5	8.9	4.9
Test Valley	12.2	6.7	2.1	0.3	2.1	1.3	1.8	Horsham	13.5	5.6	2.0	0.5	2.7	3.0	1.7
Winchester	14.9	6.0	1.9	0.6	3.7	2.7	1.9	Mid Sussex	15.6	5.0	2.1	1.0	4.0	2.5	3.2
Ashford	14.6	5.2	2.5	0.7	4.3	2.6	1.8	Worthing	15.6	5.3	2.3	1.0	5.0	2.7	1.6
Canterbury	15.0	5.3	2.1	0.9	4.6	2.4	1.8								

Source: Office for National Statistics (ONS)

Pupils whose first language is other than English, as a percentage of all pupils (January 2009)

Area	% pupils with English as an additional language			Area	% pupils with English as an additional language		
	Primary Schools	Secondary Schools	All Schools		Primary Schools	Secondary Schools	All Schools
Bracknell Forest	7.9	6.8	7.4	Dartford	8.8	6.0	7.3
Brighton and Hove	8.3	5.9	7.2	Dover	5.1	3.9	4.5
Isle of Wight	2.0	1.8	1.9	Gravesham	16.8	12.9	14.8
Medway	8.7	5.5	7.0	Maidstone	5.5	4.5	5.0
Milton Keynes	17.6	12.8	15.2	Sevenoaks	3.4	1.9	2.6
Portsmouth	10.5	6.9	8.9	Shepway	6.9	6.2	6.5
Reading	22.2	16.1	19.3	Swale	2.2	1.4	1.7
Slough	53.8	39.8	46.8	Thanet	5.4	5.6	5.5
Southampton	16.6	12.9	14.9	Tonbridge and Malling	3.1	1.8	2.5
West Berkshire	3.8	2.5	3.1	Tunbridge Wells	5.7	3.7	4.6
Windsor and Maidenhead	14.2	10.8	12.3	Cherwell	7.5	5.4	6.5
Wokingham	9.6	6.1	7.8	Oxford	25.3	22.3	23.9
Aylesbury Vale	10.1	7.0	8.6	South Oxfordshire	3.1	2.0	2.6
Chiltern	8.5	6.4	7.4	Vale of White Horse	4.9	3.3	4.1
South Bucks	10.8	7.5	9.0	West Oxfordshire	2.9	2.1	2.5
Wycombe	19.7	14.3	17.0	Elmbridge	8.4	7.3	7.9
Eastbourne	8.3	7.4	7.9	Epsom and Ewell	12.9	9.5	11.2
Hastings	4.9	3.4	4.2	Guildford	7.8	5.7	6.8
Lewes	2.6	2.5	2.6	Mole Valley	3.5	2.7	3.1
Rother	2.4	1.8	2.1	Reigate and Banstead	8.6	6.7	7.7
Wealden	2.2	1.7	1.9	Runnymede	8.2	5.8	7.1
Basingstoke and Deane	5.7	4.7	5.2	Spelthorne	8.5	7.2	7.9
East Hampshire	3.3	2.5	2.9	Surrey Heath	8.9	7.8	8.4
Eastleigh	4.0	2.7	3.4	Tandridge	2.5	2.6	2.5
Fareham	1.7	1.2	1.5	Waverley	2.7	3.2	2.9
Gosport	2.1	1.5	1.8	Woking	21.3	17.2	19.4
Hart	3.8	3.2	3.5	Adur	3.6	3.5	3.5

Havant	1.5	1.2	1.4	Arun	4.8	3.7	4.3
New Forest	1.9	1.9	1.9	Chichester	3.3	2.2	2.8
Rushmoor	11.8	14.7	13.1	Crawley	21.3	16.7	19.0
Test Valley	3.4	2.5	3.0	Horsham	3.2	2.4	2.8
Winchester	3.3	2.5	2.9	Mid Sussex	3.8	3.4	3.6
Ashford	6.6	6.1	6.3	Worthing	5.1	5.1	5.1
Canterbury	5.1	4.5	4.8				

Source: School Census

New Flag 4 GP Registrations: Rate per 1000 Resident Population Unitary and local authorities in the South East (Mid-2007 to Mid-2008)

Area	Number of Flag 4 GP registrations	Rate per 1000 resident population	Area	Number of Flag 4 GP registrations	Rate per 1000 resident population
Medway	253,500	7.33	Dartford	92,000	7.25
Bracknell Forest	114,700	9.97	Dover	106,900	6.32
West Berkshire	152,800	7.32	Gravesham	98,000	10.70
Reading	145,700	36.10	Maidstone	145,400	7.18
Slough	121,200	30.63	Sevenoaks	114,700	5.42
Windsor and Maidenhead	142,800	12.88	Shepway	100,100	7.58
Wokingham	159,100	9.65	Swale	131,900	6.91
Milton Keynes	232,200	14.21	Thanet	129,900	7.11
Brighton and Hove	256,600	21.43	Tonbridge and Malling	117,100	4.39
Portsmouth	200,000	13.41	Tunbridge Wells	107,400	9.74
Southampton	234,600	24.71	Cherwell	138,200	10.38
Isle of Wight	140,200	3.59	Oxford	153,900	49.17
Aylesbury Vale	176,000	6.42	South Oxfordshire	129,100	7.41
Chiltern	90,900	5.87	Vale of White Horse	116,900	11.39
South Bucks	64,800	8.23	West Oxfordshire	101,600	6.33
Wycombe	161,500	10.43	Elmbridge	132,400	12.65
Eastbourne	96,100	11.23	Epsom and Ewell	72,400	9.42
Hastings	86,400	6.27	Guildford	135,700	17.30
Lewes	95,200	4.65	Mole Valley	82,000	7.37
Rother	88,800	4.84	Reigate and Banstead	134,800	7.38
Wealden	143,300	5.60	Runnymede	83,400	18.79
Basingstoke and Deane	161,700	9.88	Spelthorne	91,200	7.99
East Hampshire	111,700	5.63	Surrey Heath	83,400	9.69
Eastleigh	121,000	3.96	Tandridge	83,500	4.85
Fareham	110,300	3.36	Waverley	118,700	7.34
Gosport	80,000	3.54	Woking	92,200	15.22
Hart	90,600	6.67	Adur	60,700	3.13
Havant	117,600	2.03	Arun	146,600	7.07

New Forest	175,400	5.15	Chichester	110,500	6.43
Rushmoor	89,600	15.46	Crawley	101,300	18.53
Test Valley	115,400	5.42	Horsham	130,700	5.03
Winchester	112,700	7.05	Mid Sussex	131,600	6.49
Ashford	113,500	8.00	Worthing	100,200	6.05
Canterbury	149,700	16.07			

Source: Patient Register Data Services (PRDS)

Appendix D: World Class Commissioning outcomes relevant to migrant health

Apart from selecting contractual mechanisms, the PCT selects ten priority health and wellbeing outcomes it wishes to improve over the next five to ten years. Two of the outcomes are mandatory; reducing health inequalities and increasing life expectancy. Others are selected from an extensive list. The following are particularly related to migrant health.

REF	Type	Risk factors
2.01	Infant mortality	Risk factors include maternal obesity and malnutrition, poor maternal health, violence in pregnancy, late presentation for antenatal care, lack of access to diagnostic services for infectious diseases, maternal infections and poor communication with local services due to language, cultural or behavioural differences (HPA,2006).
2.02	Caesarean section	The country of origin was a statistically significant risk factors for higher rates of caesarean section and lower breastfeeding rates in a Swiss study of rates in 22 countries. Higher C-section rates were notes in sub-Saharan African, Latin American and Asian mothers.
2.03	Low birthweight under 2500gm	In addition to gestational age, specific factors related to geo-demographics (maternal age, consanguinity and nationality), maternal health (anaemia) and pregnancy history (abortion/miscarriage) were significantly associated with the incidence of LBW.
2.08	Hospital and emergency admissions for unintended and deliberate injuries to under- 18's	100% of women who had been trafficked had experienced physical and sexual abuse (HPA 2006). Domestic violence is more acceptable in some cultures.
2.09-2.11	Proportion of children who complete immunisations by 2nd and 5th birthdays	For those who have recently travelled from countries with different immunisation regimes or who have missed first or second doses for cultural or travel-related reasons. The HPA guidance on vaccination for Vaccination of Individuals with Uncertain or Incomplete Immunisation Status should be used.
2.15	HIV prevalence	BHIVA guidelines recommend that HIV testing should be offered to any individuals who live in a PCT with a high prevalence of HIV infection. 70% of reported TB cases and HIV cases in England, Northern Ireland and Wales are in people born outside the UK. NB prevalence rates vary by country of residence with the highest rates in sub- Saharan Africa and Lithuania and Romania and Estonia among EU countries (HPA 2008).
2.16	Smoking quitters	Smoking prevalence is higher in A8 countries than in the UK resident population and the provision of accessible services with own language advisers is recommended.

2.20	GUM access within 24 hours	Some asylum seekers have suffered sexual violence and this is compounded by the anxiety and stigma of being HIV- positive. GU clinics running weekly sessions with interpreters are effective (ERPHO 2006).
2.33	Prevalence of obesity in reception children	NCMP data (200 8/9) show that obesity rates are disproportionately higher in Black African and Caribbean and Pakistani boys and in the most deprived wards.
2.34	Prevalence of obesity in year 6 children	NCMP data (200 8/9) show that obesity rates are disproportionately higher in Black Africa and Caribbean and Pakistani boys and in the most deprived wards.
2.36	Proportion of women aged 25-49 who have received cervical screening	Access to the national screening programme is reliant on a GP registration and a call and recall system. If addresses change then coverage and take up rates will fall.
3.09	Suicide and injury of undetermined intent	Mental health admissions are more common and more likely to receive a poorer outcome. Suicide risk increases five-fold at the end of an inpatient spell and is more common in males in their mid-40s. Irish people have a higher rate of admissions and Afro-Caribbeans are more likely to receive a diagnosis of severe mental illness and be over-represented in secure mental health institutions.
3.19	Diabetes controlled blood sugar	The prevalence of diabetes is higher in Black Caribbean and many Asian populations. Migrants may have missed a diagnosis or follow up tests.
3.21	CHD controlled blood pressure	The prevalence of heart attacks and strokes is greatest in Pakistani men.
3.27	For IAPT (Improving Access to Psychological Therapies) services the number of people assessed as moving to recovery as a proportion of those who have completed a course of psychological treatment	Improving access to psychological therapies is a national driver for 2010-2013. Providing early intervention cognitive behavioural programmes for all vulnerable groups including migrants and those out of work.
3.29	The proportion of those discharged from inpatient care and on the new Care Programme approach with whom there was a follow-up (by face-to-face or phone contact) within seven days	IAPT is for adults and attendees may be referred on to further mental health services which may include the prevention of self-harm and the reduction of PTSD as recommended in NEPHO guidance 2008.
NI 51	National indicators are not required for WCC but are used in LAA choices made between partners. As yet, CAMHS is a self-assessment but could in future reflect work with vulnerable groups where there is a strategic commitment	Practices and schools refer into local CAMHS hubs for children and families at risk of complex mental health disorders. Unaccompanied minors have been reported as suffering from anxiety, depression to post-traumatic stress disorder (RCOG 1999). Mentoring and befriending services are effective (Stein et al 2004).

Appendix E: Best practice Key Performance Indicators

Language and communication (not routinely specified in GMS)

- % of patients for whom main language spoken is recorded.
- The practice knows the languages and literacy of its patients and communicates with them in these languages.
- Interpreters are provided for all patients who need them through the interpretation service (which is commissioned via the PCT).
- The practice (where it has a pharmacy on-site) uses simple labelling of prescriptions to ensure people understand what they are for (this is not routine and would need to be specified in pharmacy contracts).
- Policies are in place for patients to receive copies of information written about them on request (again this is not routine and would need to be so, as a written request is required).

Access to extended appointments and health checks

- New patients are invited for health checks and followed up if they don't attend.
- Double appointments are offered to those who do not have English as a first language (as opposed to the condition and treatment driving the length of an appointment).

Best practice in record-keeping

- Maintaining the practice list (writing to people who may have left the area to make sure the practice has no ghost patients).
- Enhanced access to records (ensuring medical records are easily available for people who move at short notice).
- The practice has a register of unaccompanied minors (practice policy required on management of minors or vulnerable people).
- The practice has a register of patients who are homeless (currently not recorded, as registration is based on an address).
- The practice has a written policy on screening patients for a history of torture (not yet, unless relevant to treatment).
- % of patients who have been asked if they require help with family tracing.

Access to effective clinical assessment, diagnostics and treatment

- % of patents offered sexual health screening (read code dependent on data quality).
- Whether the practice has a register of patients who are Hepatitis B surface antigen positive (read code from a diagnostics report or from initial registration diagnostics or patient registration which is practice- specific).
- HIV/AIDS (offering testing for HIV and STIs to high-risk groups and managing people with HIV with immunisations (don't know).
- TB screening is offered in high-risk areas.
- Catch-up vaccinations are routinely offered by the practice to new entrants, travellers and others at risk (only if patients know).
- For those who have been victims of torture or violence, access to PTSD counselling is offered from referral via IAPT services.
- Health advocacy is offered through CAB or IAPT.

Sample performance targets

The following based on maternity services guidance may be adapted into contracts with the above.

- Level of 'did not attend' (DNA) rates for antenatal appointments to decrease by a minimum of 5% per year from 2005–2006, baseline (the *Children's NSF*).
- Percentage of women with contact with midwife in first trimester to rise each year from 1.4.06 baseline, with targeted work towards more vulnerable groups (NICE).
- Percentage of women offered parenting programmes accessible locally (the *Children's NSF*).
- Percentage of women offered antenatal service in accessible local venue with choice of times and days of the week (the *Children's NSF*).
- Evidence of effective shared information, where appropriate, with other health providers.
- To reduce inequalities by targeting services to those areas with most need.
- Interpreter services to be available to all women who are not fluent in English, rather than relying on family members (the *Children's NSF*).
- Report of numbers of women who have been assessed and received care using complex and targeted integrated care pathways (the *Children's NSF*).
- Report of birthweight by gestational age.

Appendix F: Founder members of the SEMH Network

Attended 19 March launch event

Title	Firstname	Lastname	Position	Organisation	Department	Town	Email
Mr.	Parvaiz	Asmat	Policy Projects Manager	UK Border Agency		Croydon	parvaiz.asmat@homeoffice.gsi.gov.uk
Ms.	Vanessa	Baugh	Health Protection Practitioner	Health Protection Agency	Thames Valley Health Protection Unit	Chilton, Oxfordshire	vanessa.baugh@hpa.org.uk
Mr.	Sid	Beauchant	Information Adviser	Berkshire Shared Services	Information	Reading	Sid.Beauchant@berkshire.nhs.uk
Miss	Cate	Bell	IT Audit and Clinical Effectiveness Midwife	Western Sussex Hospitals NHS Trust	Maternity	Chichester	cate.bell@wsht.nhs.uk
Mrs	Mary	Blanche	Senior Policy Manager	Kent County Council	Communities	Maidstone	mary.blanche@kent.gov.uk
Miss	Elzbieta	Botkowska	Police Community Support Officer	Thames Valley Police		Reading	e.botkowska@hotmail.co.uk
Mr.	Richard	Brooks	Equality & Diversity Officer	Oxfordshire County Council		Oxford	Richard.heatonbrooks@oxfordshire.gov.uk
Mrs	Eleanor	Brown	Senior Research Officer	Options UK	Research	London	e.brown@options.co.uk
Ms.	Lucy	Bryson	Community Safety Manager - Refugees and migrants	Brighton & Hove City Council	Partnership Community Safety Team	Brighton	lucy.bryson@brighton-hove.gov.uk
Dr.	Angela	Burnett	Lead doctor	Sanctuary Practice		London	a.c.burnett@qmul.ac.uk
Mrs	Pamela	Campbell	Nurse Consultant Homelessness and Health Inequalities	Southampton City PCT	Homeless Healthcare/Nichols Town Surgery	Southampton	pamelacampbell2@nhs.net
Ms.	Arlene	Cardinez	Public Health Nurse Specialist- Migrant Health	Berkshire East PCT		Slough	arlene.cardinez@berkshire.nhs.uk
Dr.	Marie	Casey	Specialty Registrar in Public Health	NHS Hampshire	Public Health	Southampton	mariecasey@nhs.net
Mr.	Cass	Casseem	BME Community Development Worker	RETHINK		Crawley	cass.casseem@rethink.org
Ms.	Amina	Chitembo	Chief Executive	BME Community Services - West Sussex		Worthing	amina@bme-cs.org.uk
Mrs	Sarah	Coleman	Equality and Diversity Officer	Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust	Communications	Oxford	sarah.coleman@obmh.nhs.uk
Dr.	*Christine*	*Cook**	*Head of Immunisation and Screening*	*NHS Berkshire West*	*Public Health*	*Reading*	*christine.cook@berkshire.nhs.uk*
Ms.	Alice	Corfield	Specialist Social Worker	East Kent Social Services		Folkestone, Kent	alice.corfield@kent.gov.uk
Mr.	Robin	Correa	Community Development Worker	NHS	Primary Care Mental Health Team	Newport, Isle of Wight	robcorrea21@yahoo.co.uk
Mrs	Manju	Dhar	Private Sector housing manager	Slough Borough Council	Housing	Slough	manju.dhar@slough.gov.uk
Mrs	Lisa	Duff	Healthcare Manager	Drummonds Medical	Campsfield House (Immigration Removal Centre)	Kidlington, Oxfordshire	lisa@drummonds-medical.co.uk

Mrs	Anne	Easterbrook	Public Engagement Lead	NHS West Sussex		Worthing	anne.easterbrook@westsussexpct.nhs.uk
Mrs	Thelma	Edwards	Oral Health Promotion Co-ordinator	West Sussex Health, NHS West Sussex	West Sussex Community Personal Dental Services, Oral Health Promotion	Chichester	thelma.edwards@westsussexpct.nhs.uk
Mr.	Jay	Edwins	Head of Strategic Partnerships	NHS West Kent	Public Health	Gravesend	jay.edwins@nhs.net
Dr.	Sam	Ejide	Consultant in Communicable Disease Control	Health Protection Agency	Thames Valley Health Protection Unit	Chilton, Didcot	sam.ejide@hpa.org.uk
Mr.	Arran	Evans	Director	Sussex Interpreting Services		Brighton	arran@sussexinterpreting.org.uk
Miss	Samantha	Fox	Public Health Specialty Registrar	NHS Medway	Public Health	Chatham	samantha.fox@medwaypct.nhs.uk
Dr.	Alison	Frater	Associate Director (Health Protection)	South Central Strategic health Authority	South East	Newbury	alison.frater@southcentral.nhs.uk
Prof.	Chris	Gaine	Professor of Applied Social Policy	University of Chichester		Chichester	c.gaine@chi.ac.uk
Mr.	Chris	Gale	Communications & Engagement Assistant	NHS Isle of Wight	Communications & Engagement	Newport, Isle of Wight	ppi@iow.nhs.uk
Miss	Fiona	Gaylor	Engagement Coordinator	NHS Medway	Commissioning	Chatham	fiona.gaylor@medwaypct.nhs.uk
Dr.	Ruth	Gilbert	Migrant Health Scientist	Health Protection Agency	Travel and Migrant Health Section	London	tmns@hpa.org.uk
Mrs	Anjum	Gray	Equality and Diversity manager	South Central SHA	Leadership and OD	Newbury	Anjum.Gray@southcentral.nhs.uk
Mr.	Frederik	Grunta	Web Developer	Web Developer		London	fgrunta@gmail.com
Mrs	Sue	Hathaway	Development Officer	Rushmoor Voluntary Services		Farnborough	sue@rvs.org.uk
Miss	Christine	Hill	Sexual Health Promotion Specialist	NHS Berkshire East	Public Health	Slough	christine.hill@berkshire.nhs.uk
Mrs	*Kate*	*Hitchcock**	*Head, Managed Migration Research*	*UK Border Agency*		*Croydon*	
Miss	Sara	Hutchinson	Community Development Worker	Rethink		Maidstone	Sara.Hutchinson@rethink.org
Mrs	Patricia	Illingworth	specialist health Visitor Homeless	Berkshire East Community Health Services	Cedar House Upton Hospital	Slough	pat.illingworth@berkshire.nhs.uk
Dr.	Laura	Ingle	GP Trainee	Health Protection Agency	Thames Valley Health Protection Unit	Chilton, Oxfordshire	laura.ingle@hpa.org.uk
Ms.	Tamsin	Jewell	Migration Impacts Project Manager	Oxfordshire Community and Vountary Action		Oxford	tamsin.jewell@ocva.org.uk
Ms.	Suzette	Jones	Open to All Adviser	The Church of England	The Diocese of Guildford	Guildford	suzette.jones@cofeguildford.org.uk
Miss	Eleanor	Kilsby	Unit Administrator	Health Protection Agency	Thames Valley Health Protection Unit	Chilton, Oxfordshire	elly.kilsby@hpa.org.uk
Ms.	Eva	Korosi	Volunteer	Church	Pastoral	Newport, Isle of Wight	pollon229@hotmail.com
Mrs	Janet	Lacey	Specialist Nurse for Children in Care	Hampshire Community Healthcare	Children in Care Team	Southampton	janet.lacey@nhs.net
Mr.	James	Lloyd-Williams	Specialist Mental Health Services Commissioning Manager (Sussex)	NHS West Sussex		Worthing	james.lloyd-williams@westsussexpct.nhs.uk
Ms.	Marcia	Martins	Refugee Health Team Leader	Lambeth Community Health - NHS	Refugee Health Team	London	marcia.martins@lambethpct.nhs.uk

Miss	Susan	Mcgillivray	HIV Community Services Manager	West Sussex PCT	Specialist Services	Goring-by-sea	susan.mcgillivray@westsussexpct.nhs.uk
Dr.	Bruce	McKenzie	Public Health Doctor	NHS West Sussex	Public Health	Worthing	b.mckenzie@nhs.net
Dr.	Jabulani	Mdlalose	Lecturer - Minister	Church of the living		Portsmouth	jemdlalose@yahoo.co.uk
Miss	Rebecca	Mear	Equalities and Community Engagement Manager	NHS Kingston/Royal Borough of Kingston		Kingston upon Thames	rebecca.mear@rbk.kingston.gov.uk
Mrs	Katrina	Middleton	Team Leader for the Expanding Communities Project	Council for Voluntary Service Arunwide	Expanding Communities Project	Littlehampton	teamleader.expcomm@cvs-arunwide.org.uk
Mr.	Roy	Millard	Partnership Manager	South East Strategic Partnership for Migration		Dover	roymillard@se-partnershipboard.org.uk
Ms.	Clare	Muir	Senior Policy Officer	Reading Borough Council	Chief Executives	Reading	clare.muir@reading.gov.uk
Miss	Tiga-Rose	Nercessian	Migrant Communities Project Officer	East Sussex County Council	Chief Executive's	Lewes, East Sussex	tiga-rose.nercessian@eastsussex.gov.uk
Mrs	Carolyne	Newall	Public Health Coordinator (Vulnerable Groups)	Oxfordshire PCT	Partnership and Health Inequalities	Oxford	carolyne.newall@oxfordshirepct.nhs.uk
Prof.	John	Newton	Regional Director of Public Health	South Central Strategic Health Authority		Newbury	john.newton@southcentral.nhs.uk
Ms.	Asmat	Nisa	Consultant in Public Health	NHS Berkshire East	Public Health	Windsor	asmat.nisa@berkshire.nhs.uk
Mrs	Karen	Norman	Locality Manager	West Sussex PCT	Primary Care Development	Chichester	karen.norman@westsussexpct.nhs.uk
Dr.	Eamonn	O'Moore	Interim Director	Thames Valley Health Protection Unit	LaRS	Chilton, Oxfordshire	Eamonn.O'Moore@hpa.org.uk
Ms.	Adwoa	Owusu	Public Health Analyst	NHS Surrey	Public Health	Leatherhead	adwoa.owusu@surreypct.nhs.uk
Mr.	Graeme	Potter	Health Improvement Manager	NHS West Sussex	Public Health	Crawley	graeme.potter@westsussexpct.nhs.uk
Dr.	Gabriele	Price	Senior Public Health Intelligence Analyst	Solutions for Public Health	SEPHO	Oxford	Gabriele.Price@sph.nhs.uk
Ms.	Sarah	Radcliffe	Policy Officer	NAT (National AIDS Trust)		London	sarah.radcliffe@nat.org.uk
Ms.	Kirat	Randhawa	PhD Researcher	University of Sussex	Interdisciplinary Migration Studies	Brighton	k.randhawa@sussex.ac.uk
Dr.	Nika	Raphaely	Research Fellow	Health Protection Agency	Thames Valley Health Protection Unit	Chilton, Oxfordshire	nika.raphaely@hpa.org.uk
Ms.	Debbie	Sagar	Public Health Analyst	Isle of Wight Primary Care Trust	Public Health	Newport	debbie.sagar@iow.nhs.uk
Ms.	Philippa	Secretan	Neighbourhood Development Coordinator	Rushmoor Borough Council	Community Development	Farnborough	philippa.secretan@rushmoor.gov.uk
Mr.	David	Sheehan	Senior Development Manager	Department of Health	DH South East	Guildford	david.sheehan@dh.gsi.gov.uk
Miss	Anupama	Shrestha	Advanced Public Health Analyst	NHS Surrey	Public Health	Leatherhead	anupama.shrestha@surreypct.nhs.uk
Mr.	Balkrishna	Shukla	Senior Officer - BME CDW - Service West Sussex	Rethink		Crawley	bal.shukla@rethink.org
Dr.	Angela	Snowling	Consultant in Public Health	NHS Berkshire East	Public Health	Windsor	angela.snowling@berkshire.nhs.uk

Mr.	Michael	Swaffield	Asylum and Migration Policy Lead	Department of Health	Asylum and Migration Team	Leeds	michael.swaffield@dh.gsi.gov.uk
Ms.	*Susan*	*Thompson**	*Community Nurse Practitioner*	*New Entrants Service*	*Berkshire West PCT*	*Reading*	*susan.thompson@berkshire.nhs.uk*
Mr.	Anthony	Tukai	Specialist Social Worker	Oxfordshire County Council	Social Services	Oxford	
Ms.	Claire	Turner	StR - Public Health	St Georges Healthcare NHS Trust	Strategic Development	London	claire.turner@stgeorges.nhs.uk
Miss	Agnieszka	Tworkowska	Polish speaking Community Worker	Council for Voluntary Service Arunwide / Crawley Borough Council	Expanding Communities Project	Crawley	polishcw.crawley@cvs-arunwide.org.uk
Ms.	Bharti	Vyas	Service User	Mindinharrow	not aplicable	Harrow,middx	bharti27@hotmail.co.uk
Ms.	Lauren	Watts	Pathways Team Manager	Slough Borough Council		Slough	Lauren.Watts@slough.gov.uk
Ms.	Lauren	Watts	Team manager	Slough Borough Council	Childrens Services	Slough	lauren_watts@sky.com
Miss	Patsy	Wimbush	Rural Black and Minority Ethnic Network Officer	Action in Rural Sussex	Fieldwork	Lewes	Patsy.Wimbush@ruralsussex.org.uk
Ms.	*Lesley*	*Wyman**	*Head of Vascular Health Programmes*	*NHS Berkshire West*	*Public Health*	*Reading*	*lesley.wyman@berkshire.nhs.uk*
Mrs	Lorraine	Yates	Community Development Worker	Surrey Community Action	BME Mental Health	Guildford	lorrainey@surreyca.org.uk

** Attended launch, but have nominated others from their organisations to take the work forward.*

Committed to the Network, but unable to attend launch

Title	Firstname	Lastname	Position	Organisation	Department	Town	Email
	Dave	Adcock	Project Manager	EU Welcome		Southampton	euwelcome@yahoo.co.uk
	Becky	Ansari	Outreach Worker	Oxfordshire Community and Voluntary Action	Migration Impacts Project	Oxford	Becky.Ansari@ocva.org.uk
	Kristian	Armstrong	Head of Central Policy Unit & Children's Champion	UKBA		London	Kristian.Armstrong@homeoffice.gsi.gov.uk
	Ruth	Bagley	Chief Executive	Slough Borough Council		Slough	ruth.bagley@slough.gov.uk
	Nick	Birtley	Equality and Diversity Manager	Hampshire PCT			nick.birtley@hampshire.nhs.uk
	Simon	Bowden	LPA Commander	Thames Valley Police		Bracknell Forest	Simon.bowden@thamesvalley.pnn.police.uk
	Emily	Bowerman	Youth Worker	Asylum Welcome		Oxford	emilyintheworld@yahoo.co.uk
	Martin	Campbell	Patient & Public Engagement Manager	NHS Brighton & Hove		Brighton & Hove	Martin.Campbell@BHCPCT.nhs.uk
	James	Crane				Brighton & Hove	James.crane@brighton-hove.gov.uk
	Melissa	Cross			Early Years & Family Support	Oxford	Melissa.Cross@Oxfordshire.gov.uk]
	Claire	D'Cruz	Specialist in Public Health		Directorate of Public Health	Windsor	Claire.D'Cruz@berkshire.nhs.uk
	Caroline	Dod		Children and Families, Oxford County Council	Leaving Care Team	Oxford	Caroline.Dod@Oxfordshire.gov.uk
Dr.	Judith	Eling	GP in Refugee Health	Lambeth PCT	Primary Care	London	juditheling@nhs.net
	Bob	Evans	Deputy Director	UKBA	Criminality and Detention Group	Croydon	Bob.Evans51@homeoffice.gsi.gov.uk
Mrs	Jennifer	Evans	Volunteer Adviser	Citizens Advice Bureau		Aldershot	evans.jenniferevans@gmail.com
	Susan	Fawcus		Migrant Helpline			susan.fawcus@migranthelpline.org
Dr.	Mina	Fazel	Clinical Lecturer, Child & Adolescent Psychiatry	University of Oxford	University Department of Psychiatry	Oxford	minafazel@yahoo.com
Dr.	Gracia	Fellmeth	Specialty Registrar			Oxford	gracia.fellmeth@nhs.net
Dr	Anand	Fernandes	Consultant in Communicable Disease Control	Health Protection Agency	Hampshire & Isle of Wight Health Protection Unit		anand.fernandes@hpa.org.uk
Dr	Pam	Griffiths	Consultant Community Paediatrician	Buckinghamshire PCT			Pam.Griffiths@buckspct.nhs.uk
	Marcia	Guy		IRC Haslar			marcia.guy@hmps.gsi.gov.uk
Dr	Ivo	Haest	Director of Public Health	NHS Milton Keynes		Milton Keynes	Ivo.Haest@miltonkeynes.nhs.uk
Ms.	Caz	Hailstone	ESOL Tutor	Equals	Voluntary Sector	Newport, Isle of Wight	taki@preno.org.uk
	Mary	Hardwick	Equality & Diversity Specialist	Oxfordshire PCT			Mary.Hardwick@oxfordshirepct.nhs.uk

Dr	Ruth	Harrison	Junior Doctor	Health Protection Agency	Thames Valley Health Protection Unit	Chilton, Oxfordshire	ruthharrison111@googlemail.com
	Rosa	Hossain	Associate Lecturer	University of Kent	School of Social Policy, Sociology and Social Research	Canterbury	R.Hossain@kent.ac.uk
Dr	Cliff	Howells		Southampton City PCT	Nichols Town Surgery	Southampton	cliff.howells@nhs.net
	Elizabeth	Hughes		IRC Haslar			elizabeth.jane.hughes@hmps.gsi.gov.uk
Mrs	Krishna	James	Harrow-Use-group	Mindinharrow	not applicable	Harrow	kiku5496@hotmail.co.uk
	Mark	Johnson	Director	De Montfort University	MSRC/CEEHD	Leicester	mrdj@dmu.ac.uk
Dr	Jane	Jones	Consultant Epidemiologist	Health Protection Agency	Travel and Migrant Health Section	London	jane.jones@hpa.org.uk
DS	Andrew	Lyttle	D.Superintendent, Frontier Operations	Kent Police	Operations Support Directorate		andrew.lyttle@kent.pnn.police.uk
	Claudette	Maharaj	Community Development Lead (BME Mental Health & Wellbeing)	NHS Berkshire West		READING	Claudette.Maharaj@berkshire.nhs.uk
	Julie	Marron				Southampton	J.Marron@southamptonvs.org.uk
	Andy	Martin	Head of Specialist Healthcare, Ridgeway Partnership	Oxfordshire Learning Disability NHS Trust			andy.martin@ridgeway.nhs.uk
Dr.	Emma	McLaren	Academic Clinical Fellow, Child Health			Oxford	emmalou1605@hotmail.com
Dr	Sarah	Montgomery	Lead Doctor for Asylum Seekers	EASTERN AND COASTAL KENT PCT		Folkestone	sarah.montgomery@nhs.net
	Busi	Mutambara	HIV Community Nurse Specialist	NHS West Sussex	HIV Community Services	Crawley	sibusisiwe.mutambara@westsussexpct.nhs.uk
Ms	Ann	Norman	RCN Nurse adviser CJS Nursing	Royal College of Nursing	Nursing Department	London	Ann.Norman@RCN.ORG.UK
	Sian	Oram	Lecturer	London School of Hygiene & Tropical Medicine	Gender Violence & Health Centre	London	Sian.Oram@lshtm.ac.uk
	Brendan	O'Reilly	Modern Matron			Southampton	Brendan.OReilly@hantspt-sw.nhs.uk
	Jan	Palmer					Jan.Palmer@dh.gsi.gov.uk
	Karina	Paturel	Health Intelligence Manager	Solutions for Public Health	SEPHO	Oxford	karina.paturel@sph.nhs.uk
Ms.	Kelly	Pierce	Public Health and Community Lead Midwife	Western Sussex Hospitals NHS Trust	Maternity	Chichester	kelly.pierce@nhs.net
Mr.	Andrew	Pilley	Community Development Manager	Chichester District Council	Community Development	Chichester	apilley@chichester.gov.uk
Dr	Emma	Plugge	Director, MSc Global Health Science	Oxford University	Department of Public Health	Oxford	Emma.Plugge@dphpc.ox.ac.uk

Mr.	Kevin	Pritchard	AD Commissioning	Berks East PCT	Commissioning	Windsor	kevin.pritchard@berkshire.nhs.uk
	Shahnaz	Raven	Counsellor & International Student Adviser	University of Reading	University of Reading Counselling and Psychological Services	Reading	s.raven@reading.ac.uk
Mrs	Jenny	Robson	Head of Minority Communities Achievement Service	Kent County Council	Children, Families & Education	Maidstone	jenny.robson@kent.gov.uk
	Neil	Sanyal	Mental Health Social Worker				neil.sanyal@hants.gov.uk
	Jayne	Shervill	Regional Partnerships Manager	Jobcentre Plus, South East		Guildford	jayne.shervill@jobcentreplus.gsi.gov.uk
	Amy	Skea				Oxford	amy.skea@oxfordshire.gov.uk
	Debbie	Smith	Policy Manager	Kent County Council	Kent Public Health Department	Maidstone	Deborah.Smith@kent.gov.uk
Mr	Robert	Sookoo	Head of Port Health	Health Protection Agency		London	robert.sookoo@hpa.org.uk
	Pat	Storey		Folkestone Migrant Support Group		Folkestone	fmsg@btconnect.com
Mr.	Marc	Turczanski	Project Coordinator	The Links Project		St Leonards on Sea	mturczanski@btinternet.com
Mrs	Bobbie	Walkem-Smith	PALS Officer	NHS Medway	Corporate Affairs	Chatham	bobbie.walkem-smith@medwaypct.nhs.uk
	Charles	Watters		University of Kent	School of Social Policy, Sociology and Social Research	Canterbury	C.Watters@kent.ac.uk
	Kim	Wilkins	Locality Public Health Lead	NHS Berkshire West		Reading	kim.wilkins@berkshire.nhs.uk
Mrs	Lenka	Wyatt	Private Sector Community Support Officer	Medway Council	Private Sector Housing	Chatham	lenka.wyatt@medway.gov.uk
	Cathy	Zimmerman	Lecturer	London School of Hygiene & Tropical Medicine	Gender Violence & Health Centre	London	Cathy.Zimmerman@lshtm.ac.uk

Health Protection Agency
Central Office
7th Floor
Holborn Gate
330 High Holborn
London WC1V 7PP
www.hpa.org.uk

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