Chapter title: **Asylum seeker, Refugee and Migrant Health**

Topic information	
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Executive summary

Introduction

Asylum seekers, refugees and migrants are distinct groups of people with distinct differences from each other, however, they have a common factor in that they have all migrated from their country of origin. Reasons for migrating from a country of origin are the main difference in whether these individuals are referred to as asylum seekers, refugees or migrants. It is important to examine the differences between those who are considered 'asylum seekers' and those who have been granted refugee status as this may have a clear effect on their health needs and access to health care. The differences between the groups can be better understood from the following definitions:

An asylum seeker "*is a person who has applied for protection through the legal process of claiming asylum, they have left their country of origin and are waiting for a decision as to whether or not they are a refugee. In other words, an asylum seeker is someone who has asked the Government for refugee status and is waiting to hear the outcome of their application.* (UNHCR, 2017)

A refugee is, "*someone who has been forced to flee his or her country because of persecution, war, or violence. A refugee has a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership in a particular social group. Most likely, they cannot return home or are afraid to do so. War and ethnic, tribal and religious violence are leading causes of refugees fleeing their countries"* (UNHCR, 2017)

A migrant "*should be understood as covering all cases where the decision to migrate is taken freely by the individual concerned, for reasons of 'personal convenience' and without intervention of an external compelling factor"* (UNHCR, 2017)

This definition indicates that "migrant" does not refer to refugees or others who are forced to leave their homes. Migrants are people who make choices about when to leave and where to go, even though these choices can sometimes be very restrained.

It is evident from these definitions that there are distinct differences between these groups, and as such, each group has different needs. Research and evidence has been gathered from local, regional and national sources and analysed to understand the needs of asylum seekers, refugees and migrants in Nottingham. This JSNA chapter aims to recognise and understand the current health and wellbeing needs of these population groups, and contribute towards improving their health and wellbeing.

Unmet needs and service gaps

- There is a lack of sufficient records on the number of asylum seekers, failed asylum seekers and number of deportees within Nottingham. This could be due to the lack of ethnicity recording among some services. This has shown to be particularly challenging in determining the needs of this population group and the commissioning of appropriate services.
- Some groups of migrants experience difficulties accessing healthcare services due to a number of barriers, including poor understanding of the role of the NHS, language and healthcare entitlements.
- There are challenges around GP registration and difficulties accessing primary and community healthcare services, this is primarily due to an inability to provide the necessary documentation, particularly in 'failed' asylum seekers. There is also often a misconception of what is required for GP registration
- There are difficulties in accessing dental services due to the associated costs, particularly for those with no recourse to public funds (NRPF)
- There is work undergoing to help improve access to interpreting provision at dental practices, however, local intelligence suggest that some dentist are not aware of the free translation services. In addition, there are challenges around accessing face to face translation services which can be a barrier when undertaking physical examinations.
- Mental Health provision is not tailored to meet the needs of asylum seekers, refugees and migrants and some people struggle to manoeuvre through the healthcare system.
- There is no commissioned Mental Health trauma service to respond to the needs of asylum seekers, migrant's and refugees who have experienced incidences such as torture, violence and trafficking.
- There is a lack of interpreting services to cover out of hour's services.
- Nationally, pregnant women with complex social factors are much less likely to access maternity services early in pregnancy and data suggests this is also the case in Nottingham. Early access amongst these groups during 2014/15 ranged from 10% to 83% (all below the 90% target).

- Pregnant women who are recent migrants, asylum seekers or refugees, or those who have difficulty reading or speaking English are the least likely to access Maternity services within recommended timescales.
- Issus such as forced marriage & honour-based violence needs to be further explored, local intelligence suggests that there is lack of awareness of legal services that advocate against honour base violence in Nottingham.
- Migrants in Nottingham are being exploited by working long hours for low wages; this can have a detrimental effect on physical and mental health.
- There are concerns that Unaccompanied Asylum Seeking Children (UASC) are finding it difficult to access secondary school education at certain times in the year and at a specific age, also the numbers of exclusions from school are rising in children from refugee backgrounds as well as other emerging communities
- There is no access to ESOL classes for asylum seekers until after 6 months of being in the country, this is preventing people from learning to speak English and is therefore a barrier to accessing services.
- The Gypsy, Roma and Traveller (GRT) communities are less likely to access healthcare, ESOL and other public services due to a lack of knowledge about how to navigate through the UK systems and a lack of trust in authorities. There is a need for targeted interventions that foster community engagement within these communities.
- There are delays in accessing benefits and employment due to language barriers. This can lead to poverty and destitution, which can have adverse effect on physical and mental health.
- There is a lack of a standardised approach/pathway or protocol to assessing individuals for social support who have No Recourse to Public Funds.
- Discussing mental health difficulties within many asylum seeker, refugee and migrant communities is a cultural taboo and therefore identifying and supporting need is difficult as families are reluctant to access support. In addition, some medical terms do not exist in other languages, particularly learning disabilities and mental health problems, and this can cause difficulties and fear accessing support.

Recommendations for consideration by commissioners:

This JSNA chapter identifies several factors that will affect the health and wellbeing of refugees. It is recommended that commissioners consider the following elements in relation to the needs of this population group when developing services:

Data

- Development of more sophisticated data gathering techniques to enable a better understanding of the demographics of asylum seekers, refugees and migrants in Nottingham. This data should be used to inform and plan policy and service developments.
- Schools do not routinely ask if children are asylum seekers, refugees or migrants and therefore data is not recorded and schools may not be aware of children's support needs. Schools must adapt a more robust data gathering

system to help ensure the needs of the asylum seeker, refugee or migrant children are being met.

- The lack of robust monitoring of ethnicity by local authorities and national health services means there is a significant gap in understanding the needs of BME communities. Commissioners and service providers need ensure that robust measures are in place to support routine data collection, such as removing the "not known" category in ethnic monitoring and adding a Migrant, European Citizen or Commonwealth Citizen option. This will help to enable the appropriate planning and commissioning of services and ensure equity of access.

Partnership working

- Commissioners and providers of health services in Nottingham need to look outside traditional structures in order to meet the diverse needs of this cohort. Partnership working with the private sector and other public services and community groups is essential in achieving a positive impact on the mental and physical health and wellbeing.
- The community and voluntary sector to work collaboratively to provide advocacy services aimed at new and emerging communities. This should include mapping which organisations currently deliver advocacy work and how this can be improved through greater joined up and partnership working.
- Continue the implementation of work funded through the Migration Impacts Fund which includes, commissioning a health outreach team to work with asylum seeker and refugee communities.
- Partnership working to Improve private housing conditions in the City & particularly in areas where there is a large migrant population.
- Assist migrants to exercise their housing rights to secure appropriate housing that is not overcrowded or in disrepair.

Access to services

- Commissioners to consider setting up a "one stop shop" for health with trained healthcare professionals who are able to respond to the cultural and diverse needs of this population group.
- Caseworkers assigned to Asylum seekers on arrival to aid with the process of applications leading to resettlement and to support with issues including housing, legal aid, the UK health system and entitlements.
- Cultural diversity training to healthcare professionals, frontline staff and staff working in public sector organizations such as The Home Office, Transport services and Job centres, this will help to create cultural awareness and improve access to mainstream services.
- Transportation funding for asylum seekers to enable them to get to their appointments with GPs, the Home Office, solicitors etc.
- Commissioners to undertake an assessment of the interpreting services to better understand why the service is not meeting the needs of this group.
- Standardise the approach for assessing and providing social support for individuals with No Recourse to Public Funds.

Mental health

- Consider targeted mental health work with the asylum seeker and refugee communities to encourage access to mainstream mental health services. There needs to be a particular focus on Unaccompanied Asylum seeking Children (UASC) and their specific needs.
- Clarity of the mental healthcare structures and pathways to care for migrant communities.
- Work with the Department of Health and other regulatory bodies to mitigate the impact of the new NHS charging regulations
- Interpreters when used sometimes may misinterpret or minimise information; offer their own interpretation of events rather than convey the citizen's words, or become emotional whilst discussing sensitive topics, especially if they share a similar background or lived experience. In addition, interpreters lack specific knowledge or training in mental health; therefore resulting in a lack of knowledge of specific terminology and a lack of empathy. Commissioners should consider undertaking a review of translation services to ensure services are culturally competent and are meeting the needs of asylum seekers and refugees.

Capacity building

- More specialist workers/support services for migrants who have been trafficked, sexually exploited including Forced Marriage & Honour Based Violence as part of the serious crime bill 2015.
- Training for professionals on their responsibilities in reporting FGM, HBV, sexual exploitation & FM as part of their professional responsibility and the Serious Crime Bill 2015.
- Undertake an assessment to understand access to education for young migrants and the reasons for an increase in the numbers of young migrants being excluded from school.
- All organisations who work with asylum seekers, refugees and migrants should be aware of the Health Access for Refugees Programme (HARP) directory website, which is beneficial in assisting GPs with translating prescriptions and frontline staff with appointment letters as well as signposting to relevant services.
- Provide training opportunities for key organisations in relation to the social and health needs of migrant communities and information on the support services available.
- Provide training for key organisations around providing support for survivors of modern slavery and trafficking.

Community engagement

- National evidence suggest that health care services should improve their routine engagement with BME communities to provide more opportunities for citizens to inform the planning and commissioning of health services. This will help to ensure services are accessible and meet the needs of Nottingham's diverse communities.

- The community and voluntary sector to work in partnership with NCC and wider stakeholders to capacity build community organisations to act as a mechanism to encourage greater voice and representation within new and emerging communities and develop pathways to which their voice can be
- heard, such as through area based forums

Education and communication

- Ensure that GPs and other health care workers understand what services are available for supporting asylum seekers, refugees and migrants in Nottingham.
- Targeted support and interventions tailored to the specific needs of new and emerging communities, for example there are high smoking rates amongst some Eastern European migrant groups compared to the general population, further work may be required to establish why this is and whether a targeted intervention for this group is required.
- There are high numbers of teenage pregnancies in Gypsy Roma and Traveller (GRT) communities. Further work may be required to establish why this is and whether a targeted intervention for this group is required.
- Work with third sector organisations and community organisations in order to disperse health information and target at risk groups. For example, dispersal of smoking cessation information through Polish groups.
- Promote antenatal & maternal services including access amongst migrant communities.(Obstetric & Screening)

What do we know?

1) Who is at risk and why?

Whilst there is a clear legal distinction between asylum seekers and those with Refugee Status, the subjective experiences of those going through the process will make it difficult to differentiate the health needs of these two groups. Therefore, this chapter will focus on, (1) the health needs of asylum seekers and refugees as collective and, (2) the health needs of migrants.

(1) Asylum seekers and refugees

It is estimated that 1 in every 113 individuals in the world are now displaced from their homes and countries as a result of human rights violations, war and unrest (DOH 2016). As of December 2015, an unprecedented 65.3 million people were reported to have been coerced from their homes; in which, nearly 21.3 million are refugees and over half of this population are under 18 years of age (UNHCR, 2017). However, these numbers continue to grow, in the first half of 2016, the total numbers of refugees were estimated to be 16.5 million and nearly 3.2 million were displaced for the first time. Figures have since increased, see link: (http://www.unhcr.org/uk/figures-at-a-glance.html)

Trends in the origin of Asylum seekers and refugees largely reflect current socio-political situations in the world. From 2013 to 2014, individuals seeking asylum in the UK were mainly from Eritrea, Pakistan, Iran and Syria; 2016 being, Iran, Iraq, Afghanistan, Bangladesh and Pakistan; and in 2017 being Iran, Eritrea, Sudan and Syria. (Home Office, 2017)

Heath needs of asylum seekers and refugees

Data on the refugee and asylum seeking population in the East Midlands is limited and not collected, or maintained to the same depth and quality that underpins the official data sources used for other indicators in this report. Therefore**,** it is difficult to gain a comprehensive account of the health needs of Asylum seekers and refugees because much existing evidence on health includes ethnic group, but not migration variables such as country of birth, length of residence in the UK, or immigration status (UNHCR, Global Trends Forced Displacement, 2017). However, it is recognised that Asylum seekers and refugees do have high health needs compared with other population groups, with evidence that their health deteriorates in the first two to three years following arrival in the UK (Fassil B. A., 2002)

This is especially so for their psychological health which, evidence shows, worsens on contact with the UK asylum system (Nottinghamshire Refugee Forum, 2012)

Asylum seekers tend to be young people, thus commonly experiencing low incidences of chronic conditions such as hypertension and diabetes. However, they

tend to have a high prevalence of acute mental health; this could be attributed to the repercussions of torture, persecution and rape. With regards to accessing health services, asylum seeker women often access antenatal services late because of fears that they will be reported to the Home Office or face high medical bills, as reported by the charities that work with vulnerable migrant women, see link below. (https://www.doctorsoftheworld.org.uk/news/pregnant-women-should-never-be-frightened-away-from-antenatal-care)

Black African women including asylum seekers and newly arrived refugees have a maternal mortality rate nearly 6 times higher than white women (Stephens, 2015). Literature identifies the four key health needs of asylum seekers as being:

Mental health: Asylum seekers commonly experience anxiety, depression, and post-traumatic stress disorder and sleep problems. These symptoms result from the multiple losses and atrocities people have experienced, alongside displacement from their country of origin, social isolation, poverty and the uncertainty of the asylum process.

Maternal health: Women may have experienced rape or sexual violation leading to unwanted pregnancies or sexually transmitted infections. Delayed access to antenatal care and female genital mutilation can lead to obstetric complications. The 7th Confidential Enquiry into Maternal and Child Health identified black African women including asylum seekers and newly arrived refugees as having a mortality rate nearly six times higher than white women. Following delivery, women may struggle as a single parent in poverty and isolation. There is low uptake of breast and cervical screening amongst asylum seeker and refugee women.

Communicable diseases: Depending upon the country of origin and circumstances of migration, some groups of asylum seekers and refugees can have high rates of TB, HIV and Hepatitis. Fear, stigma and mistrust of healthcare workers can lead to these conditions being under diagnosed.

Sexual health: Contraception may not be used due to cultural or religious reasons. Some may have experienced rape or sexual violation putting them at risk of sexually transmitted infections.

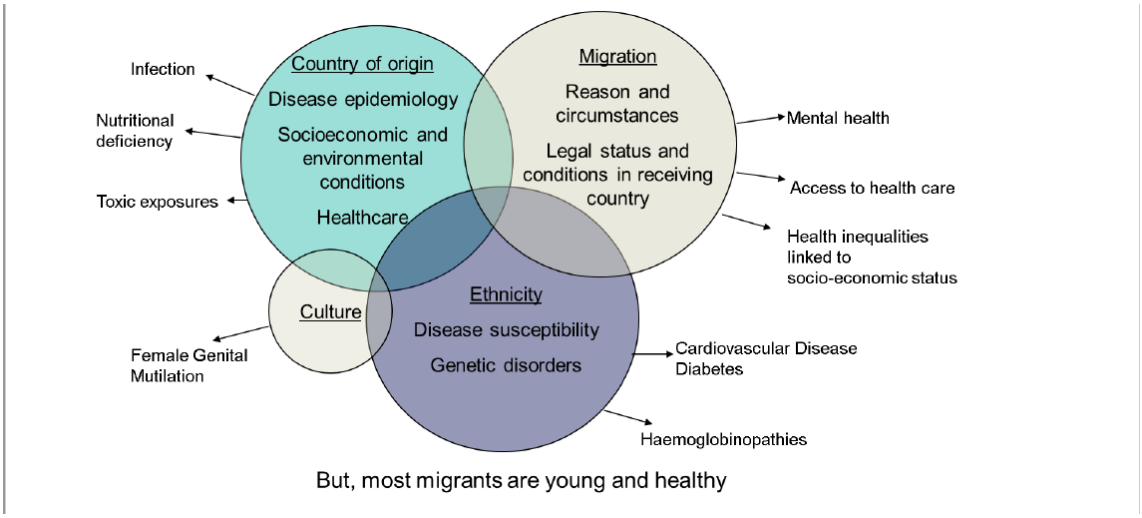
(2) Migrants

Migrants are people who make choices about when to leave a country and where to go, even though these choices are sometimes extremely constrained. Literature suggests that in the UK, the majority of migrants tend to be from member states of the European Union (EU). In May 2004, ten countries became members of the EU; the countries included Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia. All but two countries (Cyprus and Malta) had certain restrictions placed upon them. The other eight countries are identified as A8 countries. In 2007, Bulgaria and Romania also joined the EU and are known as the A2 countries.

Health needs of migrants:
Most migrants in the UK are young and healthy, but it is necessary to understand the health needs of migrant populations so that services can be planned effectively. The health of migrants is influenced by many complex factors, as illustrated in Figure 1. These factors can be grouped into four broad themes:

- Country of origin
- Migration
- Culture
- Ethnicity

Figure 1: Factors affecting the health of migrants



Source: *(Image was supplied by the Travel and Migrant Health Section (TMHS), PHE)*

Evidence also suggests that whilst there are specific health conditions that affect some groups of migrants, the main issue common to them all is one of accessing health services. A number of factors leading to low uptake of services by migrants include:

- Limited understanding of the UK health system, and in particular the role of the GP
- Differing health seeking behaviours and expectations of healthcare services
- Returning home for medical care amongst some groups of migrants
- Language barriers and cultural differences
- Changing entitlements to healthcare services
- Some migrants are not able to access healthcare services due to poverty and destitution; particularly migrants with No Recourse to Public Funds (NRPF)

Determinants Health: Whilst there is a clear legal distinction between asylum seekers, refugees and migrants, wider issues affecting the health needs of this population are very similar. Evidence suggests that three main aspects determine the health and wellbeing of these population groups:

1: Individual characteristics:

1.1 Age: Most migrants, whether asylum seekers, refugees or EU migrants tend to be young with general health needs similar to those of the UK population of the same age. For young age groups, acute infectious illnesses, minor accidents and trauma, reproductive health issues and child health concerns tend to be the most commonly encountered health needs. In addition, there is an increase in the number of Unaccompanied Asylum seeking Children (UASC) in the UK. This group is the most vulnerable requiring specific attention especially in the psychological sphere of their lives as well as refugee youngsters (Asylum Seekers, Refugee & Migrant Health JSNA, 2015)

1.2 Gender: More women are now principle applicants and there are more single female asylum seekers, refugees & migrant workers. Females have a lower mortality than males, but use health services due to maternity, screening checks and are more inclined to use health services for general health inquiries.

1.3 Ethnicity: Acts as a risk factor for conditions such as sickle cell disease, thalassemia occurs amongst certain populations.

2: Country of origin and the circumstances of migration: Further issues that affect the health of asylum seekers, refugees and migrants include the country of origin and the circumstances of migration: some of the issues that affect the health and wellbeing of these population groups are detailed below:

2.1 Affluence of the country of origin: Individuals migrating from relatively affluent countries in order to work are likely to have good baseline health, whereas many asylum seekers come from low-income countries affected by war where they may have experienced poor nutrition, unclean water and poor access to healthcare. In countries with a lack of healthcare services, immunisation levels may be low alongside other preventative healthcare measures.

2.2 Prevalence of infectious diseases in country of origin: Many countries from which asylum seekers originate have high prevalence rates of infectious diseases. Some asylum seekers may be at risk of blood borne viruses (HIV, Hepatitis B&C) due to unprotected sex (including being due to rape), blood transfusions, contaminated medical equipment or maternal-foetal transmission. Low rates of port of entry screening for tuberculosis on arrival in the UK, cramped living conditions and increasing rates of HIV co-infection put individuals at risk of increased morbidity and mortality.

2.3 Cultural and behavioural practices in country of origin: Cultural practices such as female genital mutilation (FGM) has prevalence rates of more than 90% in countries such as Djibouti, Guinea, Somalia, Eritrea, Mali, Sierra Leone and Sudan. FGM involves all procedures which involve the partial or total removal of the external genitalia or other injury to the female genital organs for non – medical reasons.

FGM involves all procedures which can causes a number of immediate and long term complications including difficulties urinating, recurrent urinary tract infections, fistulae, sexual dysfunction and obstetric complications. Women with FGM are more likely to have a caesarean section, episiotomy, post-partum haemorrhage or neonatal death.

2.4 Honour Based Violence, Domestic Violence & Forced Marriages; Victims with an insecure immigration status are particularly vulnerable as their rights to settlement or public funds, such as social security benefits and public housing, may be limited. They may be reluctant to come forward to seek help as they may fear deportation and/or destitution. Some stay in, or return to, abusive relationships, as they fear removal to their country of origin and the risk of further abuse, harassment and acts of violence. In some cultures, separated or divorce women are ostracised and harassed for bringing shame and dishonour on their families and communities.

2.5 Circumstances of migration. For most migrants who voluntarily choose to enter the UK, the journey will be inconsequential. However, for some migrants including asylum seekers and those trafficked to the UK, the circumstances of their migration may have led to poor health. Some may have faced imprisonment, torture, sexual violation or unsanitary living conditions. Some estimate that up to 30% of asylum seekers may have experienced either physical or psychological torture depending upon the country of origin and definitions of torture.

3: Post migratory factors: Once migrants enter the UK, their health will be affected by a number of physical, social, economic and cultural factors some of which are outlined below.

3.1 Employment: EU migrant workers commonly undertake work that is low paid and described as “3-D jobs” (dirty, dangerous and degrading). In 2008, the three most common occupations of EU migrants were process operators, cleaners/domestic staff and warehouse operators. There is concern over exploitation of some migrant workers. Studies have demonstrated that EU migrants are employed in jobs that do not use their pre-existing qualifications or skills, have restrictive contracts and low pay. Employment can also be a protective factor against poor mental health as it provides purpose and social networks. Asylum seekers are not allowed to work leading many to struggle with enforced unemployment, social isolation and boredom.

3.2 Destitution and poverty. Many migrants face challenges in accessing services due to being unable to afford public transport, medications or childcare. Limited finances and limited access to culturally familiar food may lead to poor nutrition post migration. HIV positive asylum seeker mothers are unable to access vouchers to assist them in buying formula milk for their babies leading some to continue breastfeeding

their babies. Failed asylum seekers live in destitution, face homelessness, and have limited access to services. They may have unrecognised and untreated medical problems.

3.3 Anecdotally, the economic downturn has led to an increased number of A8/A2 migrants facing homelessness and destitution. Where A8/A2 migrants have not been working for a full year whilst being appropriately registered and then become unemployed or, when they come to England without a job, they will have no recourse to public funds.

3.4 Housing conditions- Nationally it is recognised that some asylum seekers can be housed in substandard living conditions. There can be overcrowding, and scenarios of individuals being housed with members of the opposing tribal, social or political group. 80% of migrant workers live in privately rented accommodation some of which may be in poor condition and/or be over occupied (including hot bedding etc) which is similar to sofa surfing. In addition, there are some economic migrants that have tied tenancies which compromise their ability to exercise their housing rights.

3.5 Social isolation and hostility: There are concerns about the increase in hostility towards refugee and other migrant communities, following the result of the EU referendum and the reported increase in hate crime. Negative portrayals of refugees and asylum seekers in the media and a lack of understanding amongst the general public of the difference between an asylum seeker, a refugee and an economic migrant can lead to discrimination, racism and a breakdown in community cohesion. Many organisations are investing resources into raising awareness and bringing people in the community together, however, it seems that a lot more can be done in this area, particularly in places which are relatively new to welcoming refugees. In addition, some asylum seekers, refugees and migrants face considerable social isolation through loss of friends, family and social networks (Final Sanctuary Report, 2017).

3.6 Legal claim: The processes of migration and asylum-seeking are inherently tedious and stressful as well as the uncertainty in which asylum seekers live can cause additional mental health strains. Legal aid can help meet the costs of legal advice, family mediation and representation in a court or tribunal. This service offers legal guidance for those who are seeking asylum, those at risk of destitution, discrimination, domestic violence, human trafficking and those accused of crime, face prison or detention. However, the eligibility of those seeking these services is based on the type of case and financial circumstances. This can be a limitation to refugees, asylum seekers and migrants who may not have the finances to acquire these services (Gov.UK.2017). Furthermore, services that may be of benefit to this cohort such as family reunion for refugees and human rights claims for asylum seekers are not covered by legal aid (Nottingham Citizens, 2017).

3.7 Language and literacy. Language is a vital tool for integration and accessing services. At least two thirds of asylum seekers arrive in the UK without English language skills. Some migrants may not be literate in their own language. This affects the ability of individuals to describe their symptoms and understand both verbal and written information given by the doctor. In some areas there is a shortage of interpreting services, particularly for out of hours work or acute situations; difficulties

with interpreters cancelling appointments or failing to attend; a lack of continuity of interpreters; and concerns over confidentiality. Children can inappropriately be used as interpreters.

3.8 Understanding of services: Migrants are unfamiliar with the UK health services and may be seen to misuse services such as A&E due to their understanding of services that exist in their country of origin. Many young and healthy migrants, as with UK residents will not register with a GP unless they become unwell as they do not perceive it as a priority; Some EU migrants return home for their healthcare due to perceptions about longer waiting times in the UK compared to some EU countries.

3.9 Entitlements to healthcare services: Asylum seekers and refugees are entitled to free primary and secondary healthcare under the NHS. Legislation regarding the changes did not affect GP registration; treatment of failed asylum seekers has undergone numerous changes in recent years leading many healthcare providers to be confused and potentially deny treatment to some who are entitled.

3.10 Continuity of care: Asylum seekers can be "moved from place to place" by the Home Office or target contract providers with little warning, leading to difficulties with GP registration, healthcare programmes, fragmented treatment and a lack of medical records.

3.11 No Recourse to Public Funds (NRPF): Some migrants (Failed asylum seekers not on section 4 support, A8/A2 migrants and some other migrants) who have no housing or income approach Nottingham City Council (NCC) for assistance. Where these individuals have no recourse to public funds, Nottingham NCC is limited in the support it is able to offer. All those with NRPF who approach NCC are given an assessment to see whether they are eligible for support under the various pieces of relevant legislation. Nottingham City Council (NCC) is currently in the process of standardising its assessment process and the way in which support will be provided. For more information on NRPF visit:

http://www.nrpfnetwork.org.uk/policy/Documents/NRPF_national_picture_final.pdf

http://guidance.nrpfnetwork.org.uk/reader/practice-guidance-families/introduction/

2) Size of the issue locally

Asylum seekers

In 2017, there were between 900 and 1,000 asylum seekers including dependents and unaccompanied minors living in Nottingham city who receive financial and/or housing support from United Kingdom Visa & Immigration (UKVI) formerly United Kingdom Borders Agency (UKBA) (Nottingham City Council/G4S, June 2017). The national current agreed limit for Asylum seekers is 1 Asylum seeker to 200 local residents, for Nottingham this equates to 1,626 because there are around 325,282 local residents in the city. There is no limit for refugees, as they are free to move to whichever part of the UK they choose.

Failed asylum seekers are Individuals who receive a negative asylum decision and are obliged to leave the UK once all appeals have been concluded. In reality, their numbers are not known. However, many continue to live in destitution rather than return to their country of origin. It is estimated that there are 500 destitute asylum seekers living in Nottingham based upon national estimation work (Nottingham City Council G4S report, 2018)

Nottingham City asylum seeker data shows that:

- An increasing number of asylum seekers are being placed in Nottingham as individuals, rather than as part of family groups. Historically, the majority of people placed in Nottingham have been part of family groups, but in recent months at least half of all those placed in Nottingham have been individuals. This is likely to continue to increase.
- Asylum seekers are predominantly young, with 75% of principle applicants being between 18 and 39 years old.
- 45% of principal asylum applicants are male; this is a considerable change compared with 2010 when 61% were male. Of those who are male, more than half are single. Comparatively, 85% of female principle applicant asylum seekers come to Nottingham as part of a family unit.
- Data is no longer available about the languages spoken by asylum seekers. However, in September 2013, the most common languages spoken by asylum seekers were English, Urdu, Arabic and French. Of all asylum seekers supported by UKVI living in Nottingham City, 79% were non English speakers in September 2013.

Table 1 illustrates the number of asylum seekers from different countries residing in Nottingham City as of April 2018, the main countries of origin being Pakistan, Iran, Iraq, Nigeria and China.

Table 1: Number of asylum seekers from different countries residing in Nottingham City.

Country	Number of people
Iraq	149
Pakistan	117
Iran	95
Nigeria	75
China	74

Source: Nottingham City Council / G4S April 2018

Table 2 shows the areas in Nottingham City where asylum seekers are housed. NG7 has considerably more asylum seekers residing in this area, followed by NG3 and

NG2. This information is helpful when planning health services, considering the demand for school places and considering the demand for housing.

Table 2: Where asylum seekers are housed in Nottingham City

Area/Postcode	Number of properties	Percentage of people housed
NG1 (City Centre)	Less than 5	1.2
NG2 (Bridge and Dales)	39	5.7
NG3 (Mapperley & St. Ann's)	37	2.8
NG5 (Berridge, Sherwood, Bestwood)	17	1.4
NG6 (Bulwell, Basford)	15	1.1
NG7 (Radford, Arboretum, Leen Valley)	99	6.8
NG8 (Aspley, Wollaton, Bilborough)	22	1.5
NG9 (Wollaton East)	7	1.0
NG11 (Clifton)	Less than 5	0.8

Source: *(Nottingham City Council / G4S June 2018)*

Refugees

Estimating numbers of refugees and failed asylum seekers is difficult as it is not possible to measure migration into and out of Nottingham. Using national estimates applied to Nottingham, it is estimated that there are about 7000 refugees and about 500 destitute asylum seekers living in Nottingham.

EU Migrants

In May 2004, ten countries joined the EU: Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia. All but two (Cyprus and Malta) had certain restrictions placed upon them. These eight countries are known as the EU8 countries. In 2007, Bulgaria and Romania also joined the EU and are known as the EU 2 countries. Individuals from the A2 and A8 countries can enter other member states without a visa for a period of 6months and can reside in that country for a longer period if they are employed, self-employed, able to financially support themselves or a student.

EU migrant workers are mainly young with general health needs similar to those of the UK population of the same age. Prevalence rates of smoking are higher amongst many EU countries, such as Poland where the prevalence is about 32% (national UK rate 22%) In addition, the influence of migration to the UK upon smoking habits is largely unknown. Alcohol excess has also been highlighted as an issue amongst some groups.

National insurance numbers (NINO) issued to overseas nationals show the number of new migrants applying for work when they came to live in UK. This data only includes those in work, looking for work or claiming benefits. It excludes dependents and students (unless in part time work) and does not indicate when individuals leave the UK.

Table 3: Annual applications from persons outside the UK who registered for a National Insurance Number (NINo) in Nottingham City (2016 – 2017)

	Year to Dec 2016	Year to Dec 2017	Change	% change
Total	6,648	5,469	-1,179	-17.7
European Union EU15	1,509	1,178	-331	-21.9
European Union EU8	1,494	968	-526	-35.2
European Union EU2	1,298	1, 093	-205	-15.8
European Union Other	48	44	-4	-8.3
Other Europe	93	60	-33	-35.5
Middle East and Central Asia	244	226	-18	-7.4
East Asia	193	168	-25	-13.0
South Asia	718	663	-55	-7.7
South East Asia	225	281	56	24.9
Sub-Saharan Africa	477	427	-50	-10.5
North Africa	165	145	-20	-12.1
North America	73	75	2	2.7
Central and South America	83	105	22	26.5
Oceania	28	41	13	46.4
Unknown	10	0	-10	-100.0

Source: (ONS, 2017)

Table 3 illustrates the number of NINo applications in Nottingham City during 2016 – 2017, the data shows the following:

- In 2017, a total of 5,469 people registered for a NINo in Nottingham, a 17.7% reduction from 2016. Of these 1,178 were from the original 15 EU countries, 968

were from the EU8 countries and 1,093 from the EU2. The countries with the biggest number of registrations were Romania (956), Poland (644) and Italy (413).

- The number of NINo registrations from EU8 countries significantly reduced from 1,494 in 2016 to 968 in 2017. Evidence from the Home Office (2017) suggests that the reduction in migration is a defining issue following the 2016 referendum on EU membership.
- Outside of the EU, the countries with the largest NINo applications are from South Asian, followed by Sub-Saharan Africa, Middle East and Central Asia and South Asia.

The most recent Nottingham City Migrant data shows that:

- At the time of the 2011 census, 59,234 (19.4%) Nottingham City residents were born outside of the UK. These included: original EU member states 4,963 (1.6%), EU accession countries 9,826 (3.2%).
- The ONS mid-year population estimates for 2016 (the latest available) give the City's population as 324,779 at 30th June 2016. This is a 5,843 (1.9%) increase on the 2015 mid-year estimate which is in line with the increase in population for England and for the core cities.
- The Components of Change released with the MYEs suggest that 'natural change' (the excess of births over deaths) accounts for 2,000 of the increase between 2015 and 2016. Net migration accounts for a further 3,748 although there is a difference in net *internal* (within the UK) and *international* migration: the City lost 158 people due to internal migration, and gained 3,906 from international migration.
- The City also continues to see a large amount of population 'churn', with 25,864 people arriving from elsewhere within the UK and 26,022 leaving. A table showing population by age and sex is available on Nottingham Insight at the following link http://www.nottinghaminsight.org.uk/d/124594 (Office for National Statistics, 2016)

Migrant Homelessness in Nottingham City

Quarterly data on homelessness is submitted by local authorities and collated into the detailed local authority level homelessness tables available at https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness#detailed-local-authority-level-responses.

The data collected is on statutory homelessness and so will not give a whole picture of homelessness within the area, as data is not included for homeless single adults or couples (approx. 1 in 10 approaches to the local authority results in a statutory homeless application). Nottingham data shows that between April 2014 and March 2015, 85 of the 664 (13%) of the homeless people that accessed housing aid were foreign nationals. Of foreign nationals, nearly a third were from the countries that had joined the EU since 2004, with the majority of those being Polish. A further 17% were from other European Economic Area (EEA) countries and around half were from other regions of the world other than the EEA (, Nottingham City Council Housing and Homelessness JSNA, 2017)

Framework Housing Association supplied data from the Street Outreach Team street count, which is a physical count of the number of rough sleepers in the area. Half of those that had slept rough on the morning of the count in July 2017, were from countries that joined the EU in 2004 (based on fewer than 20). During the previous quarter, 22% of those in contact with the service had been non-UK nationals. In the last financial year, the service worked with 604 individuals of which 109 were from countries that joined the EU after 2004 (18%) and a further 13 from other parts of the EU (2%) (Nottingham City Council Homeless JSNA 2017)

Other areas of work in Nottingham have looked at wider housing issues such as insecure tenancies and poor housing standards among Polish, Romanian and Roma Romanian groups. At focus groups, those taking part often reported overcrowding and poor treatment by landlords. The Nottingham Law Centre and Environmental Health are now working to improve the standard of some accommodation and bring rogue landlords to justice. The Romanian Society is also doing lots of work to ensure this population understands their tenant's rights. Anecdotally, this group may be unwilling to disclose housing issues as there may be the widespread belief that social services can extricate children from their families if they cannot house them adequately. (European Commission , 2014)

Communicable disease among non-UK born migrants

Data collection on migrant health is difficult and is only available for a limited selection of infectious diseases. This means that the main discussion about migrant health has been in relation to communicable diseases, which is stigmatising and contributes to a public perception of migrants as a 'threat'. However, as migrants bear the greatest burden of communicable disease in the East Midlands, data describing this burden has been included in this JSNA where a breakdown of non-UK born is available at a local level (Public Health England , 2013)

Tuberculosis (TB)

The number of cases of TB in Nottingham City has significantly risen over the last 10 years, giving a rate of TB more than double the national average in In 2008, 65% of cases of TB in Nottingham City were amongst the non-UK born, with the main countries of origin being Pakistan, India, Malawi, Zimbabwe, Sudan and South Africa. Nearly half of all cases were amongst those who had entered the UK within the previous 5 years. A notable change over the last 12 years is a large increase in the number of cases amongst those of African ethnicity. In 1996, 2% of cases of TB occurring in Nottingham were amongst those of African ethnicity compared to 34% in 2008.

In 2014-16 there were 151 cases of TB in Nottingham (15.7 per 100,000 population). This is a slightly lower rate than 2003-05 when there were 141 cases (16.8 per 100,000 population). The rates for England were 14.1 in 2003-05 and 10.9 in 2014-16.
(Public Health Outcomes Framework 2017)

HIV

The number of people living with HIV has climbed from 371 cases in 2005 to 697 in 2016. of those diagnosed, 380 (number rounded up to nearest 5) were males and 320 (number rounded up to nearest 5) (Table 4 shows the number of people living with HIV in Nottingham by ethnicity in 2012 and 2016, of these, 33.0% were white, 43.8% black African and 5.0% black Caribbean. With regards to exposure, 23.0% probably acquired their infection through sex between men and 61.7% through sex between men and women

Table 4: Number of people living with diagnosed HIV by ethnicity in Nottingham: 2012 and 2016

Ethnicity	2012	2012%	2016	2016%
White	200	33.4	230	33.0
Black African	285	47.7	305	43.8
Black Caribbean	30	5.0	35	5.0
Other	90	15.1	110	15.8
Not known	0	0	30	4.3

Source: Public Health England. Nottingham Local Authority HIV, sexual and reproductive health epidemiology report (LASER): 2016. Numbers rounded up to nearest 5.

Hepatitis

Recent work calculating practice level prevalence estimates for Hepatitis B and C based upon demographic and drug user data has shown Nottingham City to have high rates above the national figures. There are an estimated 3683 cases of Hepatitis B (1.2% prevalence), and an estimated 3350 cases of Hepatitis C (1.0% prevalence) in Nottingham City. The UK is classified as a low prevalence country; most infections are acquired from adult risk taking behaviour associated with sexual practices & drug use. Estimates however suggest a small proportion of chronic infections are established as a result of infection acquired in the UK (around 200 per year) but an estimated 7,000 chronic persistent cases of Hep B in the UK are a result of immigration to the UK from high prevalence areas. (Viral hepatitis JSNA, 2017)

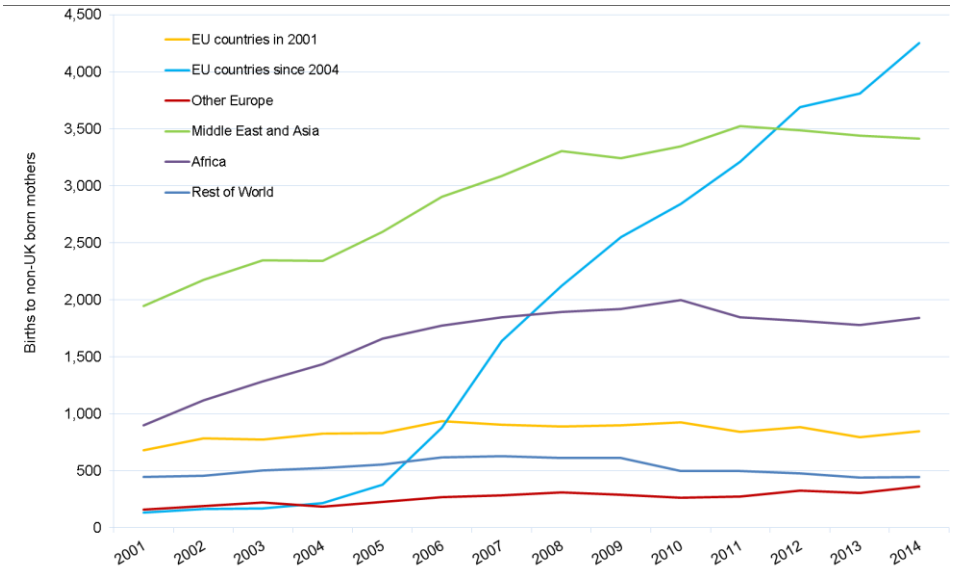
Chronic viral hepatitis remains strongly linked to social deprivation, hepatitis C because of its primary risk factor of previous injecting drug use and hepatitis B because it is primarily a disease of migrant populations where it is spread by maternal transmission or poor health care. There is lack of targeted prevention activities amongst these groups. There is also under-diagnosis of viral hepatitis due to lack of awareness amongst disadvantaged and migrant groups (people from countries of high prevalence) about viral hepatitis as well as amongst the public and health professionals.

Hepatitis B is transmitted through contact with infected blood or body fluids. Some examples of people who are therefore at risk include babies born to mothers who have hepatitis B infection, particularly in migrant populations from hyper-endemic areas of the world, people who inject drugs (PWID) and sexual contacts of people with hepatitis B. Around one in 200 PWID are living with hepatitis B in the UK (PHE, 2016).
The most common age group within the East Midlands to have the infection was 25-34 years. 86% of cases were between the ages 15-54 and the majority were male.

Cases of acute hepatitis C are difficult to estimate as people are often asymptomatic and therefore it can go undiagnosed. Most of the new cases found were in those who inject drugs. According to the Nottinghamshire ODN (Operational Delivery Network) data, roughly 814 people have been newly diagnosed with hepatitis C in the past 5 years across Nottingham City and Nottinghamshire County. This is extrapolated from data from 2 years. Between May 2015 and July 2017, Nottingham University Hospital started 408 people on treatment.
(Viral hepatitis JSNA 2017) https://www.nottinghaminsight.org.uk/themes/health-and-wellbeing/joint-strategic-needs-assessment/adults/viral-hepatitis-2017/

Maternity data: Births to non-UK born mothers
The number of births to non-UK born mothers in the East Midlands has more than doubled; from 4,263 births in 2001 to 11,162 births in 2014, this represents 1 in 5 births in the East Midlands were from non-Uk born mothers. Figure 2 illustrates that in the 10 years that preceded 2014, there was a change in the country of origin of non-UK born women giving birth in the East Midlands. Births to mothers, from countries that joined the EU since 2004, increased significantly since 2005 and since 2012, they have represented the largest number of births to non-UK mothers.

Figure 2: Trends showing the number of births to non-UK born mother by region of the world, 2001-2014, ONS25



Source: (ONS 2001 -2014)

In 2001, there were 3,279 live births to mothers within Nottingham unitary authority of which 14% were born to non-UK born women. Since then, the proportion of births to non-UK mothers has increased, so that in 2016 37% of live births in Nottingham were to mothers born outside the UK. One of the most notable changes is in births to mothers from the EU accession states who now represent 12.3% of all live births in Nottingham (see table 5). Births to mothers born in African and Asian nations have also increased.

Table 5: Live Births in Nottingham according to place of birth of mother in 2001 – 2016

Year	Total number of births in Nottingham UA for UK and non UK born mothers	Percentage of total number of births to non- UK born mothers (%)	Number of births to mothers born in EU accession countries (% of total births)	Number of births to mothers born in Africa (% of total births)	Number of births to mothers born in Asia (% of total births)
2001	3,279	14%	7 (0.2%)	51 (2%)	304 (9%)
2008	4,181	28%	192 (5%)	301 (7%)	487 (12%)
2016	4,320	37%	530 (12.3%)	328 (7.6%)	474 (11%)

Source*: (NUH, 2017)*

Maternity access

Saving Lives, Improving Mothers' Care (2014) identified that women born outside the UK were significantly more likely to die in or near to childbirth than those born in the UK. Refugee and asylum seeking women make up 12% of all maternal deaths, but only 0.3% of the population in the UK. Pregnant asylum seeking women are seven times more likely to develop complications and three times more likely to die during childbirth than the general population. (Perinatal Mortality Surveilence report , 2013)

This picture is supported by recent research in London with evidence of the deterrent effect of entitlement checks and charging (Shortell, 2014). Many of the women in their study did not have a GP, despite being in the UK for on average 4.6 years at the time of delivery. Antenatal care was frequently received late and often did not meet the minimum standards for care recommended by NICE, putting women and their unborn children at increased risk.

Whilst the numbers of maternal deaths has decreased overall reflecting improvements in maternity services, women who have sought refuge within our shores may present with medical and social challenges. Some women may have been victims of rape or sexual violation leading to unwanted pregnancies or sexually transmitted infections. In certain migrant populations, female genital mutilation is more prevalent and this can lead to obstetric complications. (Parliamentary inquiry into asylum support for children and young people, 2013)

According to NUH maternity data, during 2014/15, 319 (6.5%) of pregnancies were to recent migrants, asylum seekers or refugees, or those who have difficulty reading or speaking English. It appears that only 52% of recent migrants, asylum seekers or refugees, or those who have difficulty reading or speaking English accessed maternity (booking) within the recommended gestation. It is noteworthy that of the 10 births to asylum seekers or refugees, 9 (90%) accessed maternity services later than recommended and all of these accessed after 20 weeks gestation.

Female mutilation (FGM)

Female genital mutilation (FGM) includes procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons. The procedure has no health benefits for girls and women. These procedures are mostly carried out on young girls between infancy and age 15. Procedures can cause severe bleeding and problems urinating, and later cysts and infections, as well as complications in childbirth and increased risk of newborn deaths. More than 200 million girls and women alive today have undergone FGM in 30 countries in Africa, the Middle East and Asia where FGM is concentrated (WHO, 2017)

http://www.afro.who.int/health-topics/female-genital-mutilation

The FGM Enhanced Information Standard was introduced in April 2015, the standard instructs all clinicians to record into clinical notes when a patient with FGM is identified and what type it is. Data should be submitted every time the woman or girl has treatment related to her FGM or gives birth to a baby girl, and every time FGM is identified (by a clinician or self-reported), not just the first time (Female Genital Mutilation (FGM) Experimental Statistics, 2016)

Data collected on the number of Nottingham residents who have undergone FGM showed that during 2017, there were 80 cases of FGM reported by Nottingham University Hospital Trust. This will include women who are resident outside of Nottingham City, yet gives a good indication of the prevalence within the local population. (Health and Social Care Information Centre, 2016)

To find out more about FGM in Nottingham see the FGM JSNA https://www.nottinghaminsight.org.uk/themes/health-and-wellbeing/joint-strategic-needs-assessment/adults/female-genital-mutilation-2017/

People smuggling

The majority of illegal migrants are thought to rely on organised crime groups when coming to the UK, or during their time here. Criminals involved in immigration crime operate in various ways; some may act alone or be part of a small group, whilst others form extensive global networks with members based in a number of countries to facilitate illegal migration.
The producers and suppliers of false travel and supporting documents are also key specialists in this criminal market. Counterfeit and forged documents are used in illegal immigration by air. They are also used by criminals for fraudulent visa applications, applications for leave to enter and for leave to remain. Fake documentation is also used to make applications for legitimate travel documents, which the applicant would otherwise not be eligible for.

Organised crime groups assist illegal immigrants to attempt entry to the UK clandestinely or overtly by the abuse of legitimate means of entry and use a variety of methods and routes to do this. There are key gathering points on these routes where the facilitators and smugglers

congregate. Turkey is a key point for illegal migrants, Greece is the principal gateway into the EU from Turkey and France is the main point for clandestine entry into the UK. Attempts to enter the UK by illegal methods remain focused on South East ports.

Criminals also assist migrants to enter and regularise their stay in the UK illegally by establishing bogus colleges, organising sham marriages and exploiting a range of other migration categories. Document forgers, money launderers and corrupt professionals such as solicitors are involved

For more information visit the National crime Agency http://www.nationalcrimeagency.gov.uk/

Human trafficking/modern slavery

Human trafficking is the movement of a person from one place to another into conditions of exploitation, using deception, coercion, the abuse of power or the abuse of someone's vulnerability. It is possible to be a victim of trafficking even if your consent has been given to being moved. Although human trafficking often involves an international cross-border element, it is also possible to be a victim of human trafficking within your own country.
There are three main elements of human trafficking:

- The movement – recruitment, transportation, transfer, harbouring or receipt of people
- The control – threat, use of force, coercion, abduction, fraud, deception, abuse of power or vulnerability, or the giving of payments or benefits to a person in control of the victim
- The purpose – exploitation of a person, which includes prostitution and other sexual exploitation, forced labour, slavery or similar practices, and the removal of organs

Children cannot give consent to being moved; therefore, the coercion or deception elements do not have to be present.

Countries throughout Europe translate and interpret the Palermo Protocol in different ways so the definition of what constitutes human trafficking can differ between nations.
The UK Human trafficking centre (UKHTC) plays a central role in the NCA's fight against serious and organised crime. There are several broad categories of exploitation linked to human trafficking, including:

• Sexual exploitation
• Forced labour
• Forced labour involves victims being compelled to work very long hours, often
• Domestic servitude
• Organ harvesting
• Child trafficking

Find out more about the UK Human Trafficking Centre UK Human Trafficking Centre

Report human trafficking

In the first instance, the point of contact for all human trafficking crimes should be the local police force. If you have information about human trafficking or hold urgent information that requires an immediate response dial 999. If you hold information that could lead to the

identification, discovery and recovery of victims in the UK, you can also contact the charity Crime stoppers anonymously on 0800 555 111. (Source: National Crime Agency (NCA)

3) Targets and performance
Public Health Outcomes Framework (2014 -2016)

Domain 3: Health Protection – Objective: The population's health is protected from major incidents and other threats, whilst reducing health inequalities.

People presenting with HIV at late stage of infections:

- In 2016, Nottingham City's HIV prevalence was 3.0 per 1000 of the population (Public Health England, 2016), exceeding the national threshold recommended for universal screening in GP practices and acute hospital admissions, which is set at 2.0 per 1000 of the population.
- In Nottingham City in 2016, 49% of persons living with HIV were of Black African or Black Caribbean ethnicity. In 2016, 20% of new HIV diagnoses were in black African populations.
- In Nottingham City, between 2014 and 2016, 35.9% of new diagnoses were made late (CD4 <350). This is a decrease when compared to the period 2010-12, when 66% of new diagnoses were made late. This is considerably poorer than other high prevalence areas in England. (Source: Public Health England (LASER report 2016).
- Nationally, in 2014-16 the proportion of HIV diagnosed late among black African and black Caribbean men was 54%, compared to 35% in white men and women.

Mortality from communicable diseases Directly standardised rate - per 100,000

- Mortality from communicable diseases (Male) – 11.6 (ENG), 14.5 (NOT) – no significant difference to England
- Mortality from communicable diseases (Female) – 9.9 (ENG), 14.6 (NOT) - significantly worse than England
- Mortality from communicable diseases (Persons) – 10.7 (ENG), 14.8 (NOT) - significantly worse than England

(4) Current activity, service provision and assets

<u>Specialist Services</u>

Nottinghamshire and Nottingham Refugee Forum (NNRF)
Nottingham & Nottinghamshire Refugee Forum (NNRF) is an independent voluntary organization and registered charity set up in 2000 to work with and for asylum seekers and refugees in Nottingham and Nottinghamshire, offering practical advice, information, support and advocacy, some of the services include:

- General Advice Service**:** It offers information on a range of issues including claiming benefit, opening bank accounts, applying for integration loans and helping clients to access emergency hardship

- One Stop Shop (OSS) which aims to provide clients with information about their options and entitlements, in-depth case work support with destitute families with No Recourse to Public Funds)
- From November 2016, NNRF was contracted to provide resettlement support to refugees given leave whilst in Nottingham.
- Into the Mainstream (ItM) Health Project**:** aims to improve access to healthcare services, increase knowledge and capacity around health needs of asylum seekers and refugees in mainstream healthcare systems.
- The forum has a team dedicate to the Syrian Vulnerable Persons Resettlement Programme (SVPRP) and provides services which include: Young People's Project, Anti-Destitution Project, Legal Project, ESOL classes, Interpreting Project.

NHS Nottingham City Clinical Commissioning Group Local Enhanced Services (LES)

The NHS Nottingham City Clinical Commissioning Group has commissioned a LES for refugees and asylum seekers. GP practices are required to have a minimum of 10 asylum seekers or refugees to be eligible to take part with a payment given for every 10 consultations with asylum seekers or refugees. Failed asylum seekers, including those receiving section 4 supports whilst awaiting departure from the UK are not eligible for payment under the LES. During 2016/2017, 305 checks were undertaken, however, this number significantly decreased during 2017/2018, where only 132 checks were undertaken. The reason for the reduction are being investigated and measures will be put in place to address the issue.

New Arrivals Coordinator Service

The New Arrival Coordinator is based within Nottingham City Council's Community Cohesion Team which is part of Community Protection. The team responds to the needs of newly arrived asylum seekers and refugee families by assisting them to access mainstream and specialist services, benefits and entitlements that will help families to integrate. They receive referrals from UKVI and G4S for all families dispersed to Nottingham. Once families arrive, an appointment is arranged immediately, assisting with the completion of school registration or early years documents and providing help and information about other services including healthcare.

Nottingham City Council's asylum and refugee support service

This is a service also part of the NCC Community Cohesion Team. The Asylum Seeker and Refugee Co-ordination Officer works city-wide to provide:

- A single point of contact for the Home Office, housing providers, schools, and statutory/voluntary partners requiring NCC services;
- Information, advice and guidance on support available in Nottingham;
- Help into education and educational support services;
- Effective signposting and referrals to enable families to access specialised service

FGM Clinic

Nottingham has one FGM specialized clinic as part of maternity services where women can access specialist healthcare for health issues relating to the FGM . Women with suspected or known FGM are referred from the community to the clinic for examination and appropriate planning for antenatal and labour care. There are two FGM specialist nurses based at Nottingham at QMC and the Mary Porter Health Centre.

Interpreting and Translating Services

There are various Interpreting and translating services within both Nottingham city and Nottinghamshire county which offer interpreting and translation services to different sectors and departments. GPs, hospitals and other practitioners working in the health trust contract services from city care or language line. Other interpreting services available include DA languages which have a large pool of freelance interpreters to provide telephone Interpreting, Face-to-Face Interpreting and Document Translation. They cover over 450 different languages and dialects with languages that are requested more frequently than others and are well-equipped to provide services for rare and hard-to-source languages/dialects. They also provide interpreting services for the deaf and blind communities. Services are available to public and private companies, as well as individual clients for private assignments. In addition, DA languages offer 'Out-of-Hours service' which runs Monday to Friday from 5.30pm (when the office closes) to 9am (when the office re-opens). Out-of-Hours is also available at all times on Weekends, Bank Holidays, Christmas and New Year.

English for Speakers of Other Languages (ESOL) provision

The ability to speak English is a crucial skill to be able to access services. BEGIN (Basic Educational Guidance in Nottinghamshire) (BEGIN) acts as the central portal for ESOL classes in Nottingham. They manage all the college waiting lists in Nottingham, matching individuals to courses that suit their requirements. BEGIN collects data on all their applicants storing this in a central database then screen for eligibility, fee remission, level, suitable location, times, travel, childcare needs. In addition, they signpost to informal conversation groups and website learning (for higher levels with ICT skills & internet access)

STEPS (Support Towards Empowering Peoples Service)

The Metropolitan Black Minority and Ethnic (BME) Mental Health service was commissioned in 2015. This specialist service provides targeted outreach support to BME groups. The service helps to identify the mental health needs of BME population groups and addresses these needs through personalized support plans in order to foster positive mental health and wellbeing within Nottingham's communities.

Sign Post to Polish Success

This is a charity organization that provides services and activities for the Polish community as well as other newly arrived EU migrants in Nottingham. They offer

signposting, information session and English language lessons on Monday and Tuesday evenings. Other services offered include assistance in filling out forms, translating correspondence, advocacy and community events.

Nottingham Arimathea Trust

The Nottingham Arimathea Trust provides housing and support for refugees and refused asylum seekers, in addition, they support this cohort to access healthcare services including registration with GPs, they work with solicitors to assist with new applications and re-applications to the Home Office as well as signpost to other services. Furthermore, NAT organizes events that promote social integration within this group, provide English classes once a week.

The National Transfer Scheme (UASC)

The interim National Transfer Scheme was introduced in July 2016 to enable an equitable distribution of unaccompanied asylum seeking children (UASC) across the country and to ensure that no local authority faces an unmanageable responsibility in accommodating and looking after unaccompanied children. The expectation for each region under the transfer scheme is for the number of UASC to be no higher than 0.07% of their overall child population, which for the East Midlands as a whole equates to a total of 676 unaccompanied children. Within the East Midlands, five of the nine upper tier authorities are currently accepting transfers, and the numbers of unaccompanied children transferred into the region under the Scheme has increased over recent months. Participation in the scheme remains voluntary.

Nottingham City Child and Adolescent Mental Health Services (CAMHS)

Nottingham City CAMHS is part of the Behavioural, Emotional, and Mental Health (BEMH) Pathway for children and young people up to 18 years old. CAMHS works with and supports professionals working with children, young people and their families in relation to emotional health and wellbeing. In addition, they provide training and consultation to empower and support professionals to extend their range of skills and knowledge in mental health difficulties to ensure that children and young people's needs are met within the appropriate service. CAMHS have a specific Asylum Seeker and Refugee CAMHS Practitioner post, which has been funded as part of the Vulnerable Persons Resettlement Scheme (VPRS), initially for one year until October 2018. The programme recognised that families and particularly young people who have experienced and or witnessed significant trauma are likely to experience many difficulties and therefore require a more specialised CAMHS service.

Belong Nottingham

Belong is a user led centre for migrants and refugees supporting them to reach their full potential by understanding their needs. The service aims to provide a platform to enable integration into the country, some of the services they provide include:

- **Employability programmes**: Assisted job search, application forms, CV help, careers advice and interview techniques.

- **Welfare**: Help with benefits, school admissions, help with form filling, employment support and signposting.
- **Language and Learning**: English speaking classes (ESOL), overcome communication barriers basic internet/computer course and money management training.
- **Youth Programme (Age 7-19**): Social development activities, encourage extra-curricular, workshops on current issues and bonding sessions

The Syrian Vulnerable Persons Resettlement Scheme:
The scheme was launched in 2014 in response to the protracted conflict in Syria. From 2014 until October 2015 when the programme was expanded to resettle 20,000 people over a five- year period. Local Authorities are able to sign up to the programme voluntarily and will receive funding from central government to cover the first 12 months of a refugee's resettlement costs. In Nottinghamshire, both the City and a number of District and Borough Councils signed up to the scheme and worked together on a joint approach to ensure that the needs of the resettled refugees were met (Final Sanctuary Report, 2017).

Al-Hurraya (Freedom)
Al-Hurraya provide support for Refugees, Asylum seekers and new emerging BME communities. They currently support beneficiaries from Syria, Sudan and Romania. The service also supports young children who present with challenging behaviours due to the impact of Trauma and adverse childhood experiences. Al-Hurraya work with Djanogoly School where they support beneficiaries who have regular detentions and exclusions from School.

Al-Hurraya work in Partnership with the Javaid Khaliqe Boxing Academy and provide Refugees and asylum seekers from ages 8-15 with free boxing and group mentoring sessions Al-Hurraya also provide 1-1 and group counselling which is culturally specific.

GENERIC PROVISION:

Emmanuel House Support Centre
Emmanuel House exists to support homeless, vulnerable or isolated adults in and around Nottingham where they receive almost 2000 visits a month, with approximately 200 new visitors each year, all of whom have complex and multiple needs. They provide support and services including advice and advocacy around tenancies, benefits, mental health support, training and workshops, drug & alcohol support, a daily nurse and a core programme of social activities

The Friary
Drop-in centre for homeless and unemployed people, Advice on issues around housing, debt and benefits. Food parcels, bedding, clothing, Showers, laundry and barber. They have a homeless health team, including GP and nurse, Dentistry, optometry and chiropody. Support around substance misuse issues including Hepatitis A and B vaccinations, HIV and hepatitis C tests and Social activities, IT suite.

Street Outreach Team

Frame work's Street outreach Team has two main functions, the first is engage with rough sleepers and help them access accommodation and support. The second is to work in partnership with other agencies such as local authorities to quantify the extent of street homelessness. Staff members visit known rough sleeping hotspots in the early hours of the morning in order for them to identify and engage with those in the greatest need of support. Working with housing, health, the police and voluntary sector agencies the service works to identify the most appropriate accommodation and support options. This can also include referral to drug and alcohol treatment services or assistance in returning to their town or country of origin.

Homeless Health Team:

This service aims to address the specific healthcare needs and improve the health and social care of local homeless people by providing them with access to appropriate community nursing services. They offer nurse Specialist Health care and advice for homeless people at hostels and day centres and street outreach. There is a Midwife and health visitor for homeless families at refuges and other temporary accommodation. Outreach health care and help with accessing mainstream services, Joint clinics with local GPs and other voluntary sector agencies.

British Red Cross (BRC)

The British Red Cross assists asylum seekers and refugees to access essential services and adapt to life in a new country by providing practical and emotional support. The BRC responds quickly and effectively to support large-scale arrivals (asylum seekers and refugees) and provide emergency provisions to those facing severe hardship. Other services they provide include; orientation, destitution support, support for young people and refugee women, family reunion and resettlement and also English classes.

Adult/Children's Social Care

The various social services teams within Adult Support and Health (ASH) and Children's Services (CS) provide support as appropriate to those with no recourse to public funds. This includes accommodation, subsistence payments as well as social care services. Those that may be eligible can be assessed by the relevant social work team.

Community midwifery services

Midwifery care is delivered at GP surgeries and children's centres across the city. Community midwives provide antenatal support and post-natal care for 28 days following delivery. Mothers are assessed as to their need for extra support in the postnatal period which is provided by Maternity Support Workers who provide help on issues such as breast feeding and accessing benefits. Antenatal clinics are held in the community for Polish, Punjabi and Urdu speakers. There are specialist midwives with a focus on homelessness, drugs and alcohol, domestic violence and mental health issues..

Nottingham City Genito-Urinary Medicine (GUM) Clinic

Nottingham City GUM clinic is located at Nottingham City Hospital and is the central point for sexual health screening and treatment for patients across Nottinghamshire. Patients can be referred by their GP or can attend drop in sessions. Services include testing for sexually transmitted infections, HIV testing and psychosexual counselling. Interpreters are available when booked in advance. The clinic has specialist HIV nurses who are involved in the counselling and follow up of those with HIV. The team works with the HIV Positive Care team.

Terrence Higgins Trust (THT)

THT is the largest voluntary sector provider of HIV and sexual health services in the UK, running services out of local centres across Great Britain. Their local services fall into three areas:

- **Long-term condition management:** Offering advice on benefits, housing and employment for people with HIV who need help in getting their legal entitlements. Professionals work with people on a range of issues associated with their condition, including treatment and taking their medicines correctly; Informing people about their HIV status; sexual health and reducing the risk of onward transmission; maintaining good overall physical and mental health. In addition, they offer emotional support and counseling for people struggling with HIV.
- **Health improvement:** This involves working in communities to promote better sexual health, particularly among those groups at risk of contracting HIV and other sexually transmitted infections (STIs). They reach out to these communities on a large scale by providing information about HIV and better sexual health through posters, campaigns and leaflets.
- **Clinical services:** This offers rapid HIV testing in community settings and testing for other Sexually Transmitted Infections (STIs) as well as treatment for non-complex STIs; some their clinics also offer an integrated contraception service.

Prostitute Outreach Workers (POW)

POW Nottingham is a peer-founded charity supporting individuals involved in or affected by sex work. POW promotes health and dignity by empowering, supporting and educating clients with the aim of ending sexual violence and stigma through, advocacy and peer support. Their services including; providing a diverse range of health and wellbeing services via drop-in and outreach provision to those involved in sex work, wishing to exit from it, or at risk of being involved in sex work. THT also provide satellite clinics for sexual health, contraception and drug misuse as well as delivering outreach sessions.

Nottingham Tuberculosis Specialist Services

The service has a team consisting of Respiratory Consultants and Three specialist TB Nurses. It provides outpatient and inpatient support for the diagnosis and management of those with suspected and confirmed TB. It receives referrals for TB screening from

port of entry. These individuals are followed up and invited for screening. All those requiring further investigation with a Mantoux test are referred to the TB services

Mental Health: CCG commissioned Psychological Therapies

In Nottingham, Improving access to Psychological Therapy (IAPT) is offered by 4 providers:

- **Let's talk wellbeing** - providing a range of talking therapies for people experiencing common difficulties such as feeling low, anxious or stressed. This service is provided by Nottinghamshire Healthcare in partnership with Rethink and the Nottingham Counselling Service and provides services in Nottinghamshire County and Nottingham City.
- **Insight Healthcare** - Insight Healthcare works throughout Nottingham City to provide NHS funded talking therapies. They offer services in Nottingham City to provide a range of therapies to help clients cope better with mental issues.
- **Trent PTS** – This is a service commissioned by the NHS to provide free, flexible, responsive and accessible high quality psychological therapy service. They provide treatment for depression, anxiety, loss, grief, trauma relationship problems and many other conditions. They provide services to Derbyshire, Nottingham City and North Wirral.
- **Turning Point-** This is a social enterprise, which offers mental health services as well as other services to support people to turn their lives around. These services include floating support, supported housing, integrated community support for people with complex needs, talking therapies for conditions such as stress, anxiety and depression, crisis interventions, independent hospitals, residential rehabilitation, forensic services.

Awaaz

This is a registered charity that provides mental health services to BME groups in Nottingham and Nottinghamshire. It is an established organisation that provides support to those who have a mental health problem both in primary and secondary care.

Advice Nottingham

This is a consortium of advice agencies based in Nottingham City providing a joined up approach to the delivery of free, confidential, independent, and impartial advice on benefits, debt, employment, housing and other issues**.**

East Midlands Strategic Migration Partnership Board (EMSMP)

The aim of the EMSMP is to provide a regional advisory, development and consultation function for member organisations from the statutory, voluntary, community and private sectors to co-ordinate the provision of advice, support and services for migrants. There are three unitary authorities in the East Midlands: Derby, Leicester and Nottingham, membership is open to all local authorities, other statutory authorities, voluntary sector organisations and private sector organisations that are involved or have an interest in the health and wellbeing of migrants.

Multi-agency Forum (MAF)

The Multi –Agency Forum is a group of services that have the remit of working with Asylum seekers, refuges and migrants. The group meet quarterly to look at all different aspect of Asylum seekers /Refugees & Migrant issues from health, housing, social care, education and immigration.

5. Evidence of what works

What works in overcoming structural and individual barriers?

- NICE Guidance: advice on improving access to healthcare services: Improving access to health and social care services for people who do not routinely use them (Local government briefing [LGB14] Published date: January 2014)
- Clarity on the laws involving GP registration (NHS England, 2015).
- Targeted Interventions and health assessments(Renton, Hamblin, & Clements, 2016)
- Culturally competent health Interventions: (Henderson, Kendall, & See, 2011) (Access to healthcare in the UK, 2015) (Aung, Rechel, & Odermatt, 2010)
- Cross-sectional Intercultural training: (Heathcock, 2016)
- Quality translation and Interpreting services (Heathcock, 2016).
- Increased awareness of health services available and education on the healthcare system:. (Aspinall , 2014)
- Partnership Working with the statutory sector and volunteer groups has to improve health care access in migrant populations. (McCarthy, Winder, & Newburn, 2013)

What works in improving sexual health?

- Increasing awareness of sexual health services among migrant groups (Madden, et al., 2011).
- Awareness on available support services to help FGM victims (Norman, Gegzabher, & Otoo-Oyortey, 2016).
- Same-gender practitioners and Diversity in practitioners and staff (Shangase & Egbe, 2015).
- Specialist FGM clinics (McCracken, Fitzsimons, Priest, & Torchia, 2017) s.
- Acknowledging traditional therapies in African communities. (Shangase & Egbe, 2015)

What works in improving access to maternal and child health?

- NICE Guidance: This guideline covers antenatal care for pregnant women with complex social factors
  Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors (Clinical guideline [CG110] Published date: September 2010)
- Development of specialist midwifery services for vulnerable women. (McCarthy, Winder, & Newburn, 2013).

- Peer-led education and awareness programmes- (Haithe-cooper, 2014)
- Increase awareness on the importance of child immunisation in hard-to-reach groups (Gypsies, travellers and Roma communities) (Dar, 2013)
- Use of progressive policy and targets by Healthcare professionals (McCarthy, Winder, & Newburn, 2013)

What works in improving the management of communicable diseases?

- Providing a 'one-stop' community-based package for health screening: (Seedat, Hargreaves, & Friedland, 2014).
- Nice Guidance: Tuberculosis in vulnerable groups (Local government briefing [LGB11] Published date: September 2013).
- Tackling tuberculosis, how TB Control boards and their partners can effectively address the needs of under-served populations. Tackling tuberculosis in under-served populations: a resource for TB Control Boards and their partners
- Early identification and treatment of communicable disease in migrant populations (Panachal , Browne, Monk, Woltmann, & Haldar , 2014).
- Expanding treatment access and increasing awareness on health entitlement (Falla, Veldhuijzen, Ahmad, Levi, & Richardus, 2017).

What works in in improving access to mental health services

- Commissioning mental health services for vulnerable adult migrants: guidance for commissioners. (Mind; NHS England, September 2015)
- **Awareness and training of service providers** to promote awareness of mental health issues delivered to staff at the Home Office (Mental Health Foundation, 2016).
  Guidance on cultural competence training
  EPA guidance on cultural competence training
- **Culturally-sensitive workforce and training** (Mitschke, Praetorius, & Kelly, 2011) (Sen, 2016)
- **Independent advocacy**: Interventions that involve mental health services that offer "In house" independent advocacy (Karpuk, et al., 2012).
- Social inclusion approaches which build on social adaptation and integration, (Mitschke et al. 2016).
- Interventions that involve improving access to primary mental health services and Psychological Therapy with BME communities (Jackson-Blott, O'Ceallaigh, Wiltshire, & Hunt, 2015) t..
- interventions targeted at improving access to mental health services in Gypsies Roma & Travellers communities (Smolinska-poffley & Ingmire, 2012).

6) What is on the horizon?

- Coram Children's Legal Centre has published an updated guide, "Seeking Support: a guide to the rights and entitlements of separated children" providing comprehensive, practical advice to professionals on how to work with unaccompanied or separated children and young people and ensure they

access the support and protection they need. The guide is free and available to download or via mail order (postage and packaging cost applies).

- New TB test service using Interferon Gamma Release Assay (IGRA) among healthcare professionals. IGRA has been recommended by NICE to diagnose in certain situations such as LTBI, TB in children under 5 years and those who have returned from TB high-risk areas.
- The Refugee and Migrant Forum have produced a directory of local specialist services working with refugees, asylum seekers and other vulnerable migrants in Nottinghamshire (inset link to document)
- New NHS surcharge to migrants
- FGM pathway for non-pregnant women
- Increase in Maternity services use for non UK born mothers in particularly (Polish)
- Increase in dispersal numbers & asylum claims in Nottingham city
- The Bail 201 Forms & Study Ban for Asylum-Seekers, this will have a negative impact on ESOL/study for asylum seekers including young people. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673954/immigration-bail-v1_0.pdf
- The recent NHS charging regulations which extended charging to all NHS funded services regardless of the nature of the provider including charities and services like drug and alcohol treatments. Maternity and mental healthcare will be affected and will have a negative impact on asylum seekers and refugees

  https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/697626/guidance_on_implementing_the_overseas_visitor_charging_regulations_april_2018.pdf

7) Local Views

Asylum seekers, refugees and migrants' health continues to be an issue of concern. Asylum seekers in particular, who have no access to full health benefits have shown to deteriorate in their health over time as a result of socio-economic factors. It has been noted that perhaps the biggest challenge regarding this issue is their lack of access to healthcare services and social benefits. In June 2017, interviews were undertaken with service users from the Refugee Forum, some of the comments included:

- "Some Asylum seekers, refugees and migrants' do not access healthcare because they have no knowledge of the UK health system and what services they are entitled to."
- "Asylum seekers (including those awaiting the outcome of re-appeals) and other emerging migrant groups with NRPF may be reluctant to access services for fear of authority due to uncertainty of their immigration status"
- "*Some GP practices appear to be reluctant to register asylum seekers because of issues around lack of documentation including proof of ID and address."*

- *"Other GPs may find the health needs of asylum seekers complex and time consuming particularly in their already overstretched practices. "*
- *"Gate keeping by frontline staff has also contributed to asylum seekers and migrants not having access to healthcare as they ask too many questions that hinder the individuals from accessing practices and opting to go to A&E where they can see a doctor without having to book or give too much information to the frontline staff."*
- *"Local Enhancement Services (LES) have helped to improve GP registration and access to health care in this group however there needs to be more GP practices that offer this service."*
- *"Some communities particularly in the EU community do not seek healthcare services and either return to their home countries to see doctors or buy antibiotics illegally available at corner shops."*
- *"Hospitals are struggling to discharge homeless people who have NRPF. "*
- "Lack of *Interpreting services in the health sector is a key issue especially in dentists, opticians and Out of hours services in emergency cases."*
- *"Interpreters when available, sometimes may not be as effective in conveying the message to the GP with issues around information being misinterpreted or watered down following a lengthy explanation by the patient therefore failing to determine the full extent of the issue. "*

8) Unmet needs and service gaps

- There is a lack of sufficient records on the number of asylum seekers, failed asylum seekers and number of deportees within Nottingham. This could be due to the lack of ethnicity recording amongst some services. This has shown to be particularly challenging in determining the needs of this population group and the commissioning of appropriate services.
- Some groups of migrants experience difficulties accessing healthcare services due to a number of barriers, including poor understanding of the role of the NHS, language and healthcare entitlements.
- There are challenges around GP registration and difficulties accessing primary and community healthcare services, this is primarily due to an inability to provide the necessary documentation, particularly in 'failed' asylum seekers.
- There are difficulties in accessing dental services due to the associated costs, particularly for those with no recourse to public funds (NRPF)
- There is a lack of interpreting provision at some dental practices, which prevents people from accessing dental care.
- Mental Health provision is not tailored to meet the needs of asylum seekers, refugees and migrants and some people struggle to manoeuvre through the healthcare system.
- There is no commissioned Mental Health trauma service to respond to the needs of asylum seekers, migrant's and refugees who have experienced incidences such as torture, violence and trafficking.
- There is a lack of interpreting services to cover out of hour's services.

- Nationally, pregnant women with complex social factors are much less likely to access maternity services early in pregnancy and data suggests this is also the case in Nottingham. Early access amongst these groups during 2014/15 ranged from 10% to 83% (all below the 90% target).
- Pregnant women who are recent migrants, asylum seekers or refugees, or those who have difficulty reading or speaking English are the least likely to access Maternity services within recommended timescales.
- Issus such as Female Genital Mutilation (FGM), forced marriage & honour-based violence requires more specialist workers in order to meet the needs of the population group. For example, at present, there are only two FGM midwife specialists in Nottingham, which may not adequately meet the needs of FGM victims in Nottingham City. Additionally, there is lack of awareness of legal services that advocate against honour base violence in Nottingham.
- Migrants in Nottingham are being exploited by working long hours for low wages; this can have a detrimental effect on physical and mental health.
- There are concerns that Unaccompanied Asylum Seeking Children (UASC) are finding it difficult to access secondary school education at certain times in the year and at a specific age, also the numbers of exclusions from school are rising in children from refugee backgrounds as well as other emerging communities
- There is no access to ESOL classes for asylum seekers until after 6 months of being in the country, this is preventing people from learning to speak English and is therefore a barrier to accessing services.
- The Gypsy, Roma and Traveller (GRT) communities are less likely to access healthcare, ESOL and other public services due to a lack of knowledge about how to navigate through the UK systems and a lack of trust in authorities. There is a need for targeted interventions that foster community engagement within these communities.
- There are delays in accessing benefits and employment due to language barriers and a lack of skills. This can lead to lead to poverty and destitution, which can have adverse effect on physical and mental health.
- There is a lack of a standardised approach/pathway or protocol to assessing individuals for social support who have No Recourse to Public Funds.
- Discussing mental health difficulties within many asylum seeker, refugee and migrant communities is a cultural taboo and therefore identifying and supporting need is difficult as families are reluctant to access support. In addition, some medical terms do not exist in other languages, particularly learning disabilities and mental health problems, and this can cause difficulties and fear accessing support.

9) Knowledge gaps

Data collection on ethnicity or recording of immigration status or country of origin is very weak and in some cases, none existent. Therefore, it is very difficult to get an accurate picture of the demographics of the asylum seeker, refugee and migrant populations. The lack of robust data makes it very challenging to understand services the needs of this population group, therefore, it is difficult for commissioner to plan and deliver services that meet the needs of this population group.

What should we do next?

10) Recommendations for consideration by commissioners

Data

- Development of more sophisticated data gathering techniques to enable a better understanding of the demographics of asylum seekers, refugees and migrants in Nottingham. This data should be used to inform and plan policy and service developments.
- The lack of robust monitoring of ethnicity by local authorities and national health services means there is a significant gap in understanding the needs of BME communities. Commissioners and service providers need ensure that robust measures are in place to support routine data collection, such as removing the "not known" category in ethnic monitoring and adding a Migrant, European Citizen or Commonwealth Citizen option. This will help to enable the appropriate planning and commissioning of services and ensure equity of access.
- Schools do not routinely ask if children are asylum seekers, refugees or migrants and therefore data is not recorded and schools may not be aware of children's support needs. Schools must adapt a more robust data gathering system.

Partnership working

- Commissioners and providers of health services in Nottingham need to look outside traditional structures in order to meet the diverse needs of this cohort. Partnership working with the private sector and other public services and community groups is essential in achieving a positive impact on the mental and physical health and wellbeing.
- The community and voluntary sector to work collaboratively to provide advocacy services aimed at new and emerging communities. This should include mapping which organisations currently deliver advocacy work and how this can be improved through greater joined up and partnership working.
- Continue the implementation of work funded through the Migration Impacts Fund which includes, commissioning a health outreach team to work with asylum seeker and refugee communities.
- Partnership working to Improve private housing conditions in the City & particularly in areas where there is a large migrant population.
- Assist migrants to exercise their housing rights to secure appropriate housing that is not overcrowded or in disrepair.

Access to services

- Commissioners to consider setting up a "one stop shop" for health with trained healthcare professionals who are able to respond to the cultural and diverse health needs of this population group.

- Caseworkers assigned to Asylum seekers on arrival to aid with the process of applications leading to resettlement and to support with issues including housing, legal aid, the UK health system and entitlements.
- Cultural diversity training to healthcare professionals, frontline staff and staff working in public sector organizations such as The Home Office, Transport services and Job centres, this will help to create cultural awareness and improve access to mainstream services.
- Promotion of the new TB test service using Interferon Gamma Release Assay (IGRA) among healthcare professionals. IGRA has been recommended by NICE to diagnose in certain situations such as LTBI, TB in children under 5 years and those who have returned from TB high-risk areas.
- Transportation funding for asylum seekers to enable them to get to their appointments with GPs, the Home Office, solicitors etc.
- Commissioners to undertake an assessment of the interpreting services to better understand why the service is not meeting the needs of this group.
- Standardise the approach for assessing and providing social support for individuals with No Recourse to Public Funds.

Mental health

- Consider targeted mental health work with the asylum seeker and refugee communities to encourage access to mainstream mental health services. There also needs to be a particular focus on Unaccompanied Asylum seeking Children (UASC).
- Clarity of the mental healthcare structures and pathways to care for migrant communities.
- Interpreters when used sometimes may misinterpret or minimise information; offer their own interpretation of events rather than convey the citizen's words, or become emotional whilst discussing sensitive topics, especially if they share a similar background or lived experience. In addition, interpreters lack specific knowledge or training in mental health; therefore resulting in a lack of knowledge of specific terminology and a lack of empathy. Commissioners should consider undertaking a review of translation services to ensure services are meeting the cultural needs of asylum seekers and refugees.

Capacity building

- More specialist workers/support services for migrants who have been trafficked, sexually exploited including FGM, Forced Marriage & Honour Based Violence as part of the serious crime bill 2015.
- Training for professionals on their responsibilities in reporting FGM, HBV, sexual exploitation & FM as part of their professional responsibility and the Serious Crime Bill 2015.
- Undertake an assessment to understand access to education for young migrants and the reasons for an increase in the numbers of young migrants being excluded from school.

- All organisations who work with asylum seekers, refugees and migrants should be aware of the Health Access for Refugees Programme (HARP) directory website, which is beneficial in assisting GPs with translating prescriptions and frontline staff with appointment letters as well as signposting to relevant services.
- Provide training opportunities for key organisations in relation to the social and health needs of migrant communities and information on the support services available.
- Provide training for key organisations around providing support for survivors of modern slavery and trafficking.

Community engagement

- National evidence suggest that health care services should improve their routine engagement with BME communities to provide more opportunities for citizens to inform the planning and commissioning of health services. This will help to ensure services are accessible and meet the needs of Nottingham's diverse communities.
- The community and voluntary sector to work in partnership with NCC and wider stakeholders to build the capacity of community organisations to act as a mechanism to encourage greater voice and representation within new and emerging communities and, develop pathways to which their voice can be
- heard, such as through area based forums

Education and communication

- Ensure that GPs and other health care workers understand what services are available for supporting asylum seekers, refugees and migrants in Nottingham, for example, raise awareness of the free baby formula milk available for HIV positive mothers with no recourse to public funds.
- Targeted support and interventions tailored to the specific needs of new and emerging communities, for example there are high smoking rates amongst some Eastern European migrant groups compared to the general population, further work may be required to establish why this is and whether a targeted intervention for this group is required.
- There are high numbers of teenage pregnancies in Gypsy Roma and Traveller (GRT) communities. Further work may be required to establish why this is and whether a targeted intervention for this group is required.
- Work with third sector organisations and community organisations in order to disperse health information and target at risk groups. For example, dispersal of smoking cessation information through Polish groups.
- Promote antenatal & maternal services including access amongst migrant communities.(Obstetric & Screening)

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