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Drawings by people seeking asylum from different countries of Africa and Asia – source www.dgsjournal.org

The Health, Wellbeing and Safeguarding Needs of Individuals Seeking Asylum

National Scope Findings & Recommendations June 2021

Foreword

Professor Keith Brown

Independent Chair of Safeguarding Adults National Network

I am pleased to introduce this report, commissioned by the Safeguarding Adults National Network (SANN), focusing on the key national findings and recommendations in relation to the health, wellbeing and safeguarding needs of individuals seeking asylum. SANN commissioned the report following an After-Action Review looking at safeguarding adults in the context of the Covid-19 pandemic. The After-Action Review highlighted concerns across regions in England in relation to the health and well-being of people seeking asylum and how the systems respond, particularly during times of immense pressures brought by the pandemic on all sectors.

The collective expertise of the SANN recognises that vulnerability is one of the most relevant problems brought by the pandemic and that vulnerabilities and inequalities have increased for many individuals and groups, including those seeking asylum. The work of the SANN has brought system intelligence together to show this is not one single pandemic, but various experiences of the pandemic.
Although people, including children, seeking asylum can show great resilience despite the adversity they face, many have significant vulnerabilities in terms of poor health and the risk of, or experience of, all forms of abuse and exploitation.
This report has collected and analysed evidence from the regions across England and utilised current available literature and expertise to make recommendations for improvements in the health, safety and wellbeing of people seeking asylum.
I would like to thank the authors and the SANN for their work in highlighting this issue and producing this report. The SANN remains committed to supporting improvements in care for the most vulnerable people in the country.

Acknowledgements

Many thanks to the SAAN for commissioning this report, the authors and the task and finish group who helped to support the scoping exercise. Additionally, thanks to all the stakeholders who fed into the key findings at a national, regional and local level. This included people seeking asylum, unaccompanied young people's foster carers, VCSE, regional safeguarding and inclusion health leads, CCGs, strategic migration partnerships, the Home Office (HO), Public Health England (PHE) and NHS England and Improvement (NHSEI).

Authors

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As a member of society, Nurse, Health Visitor and NHS leader, Elaine is passionate about ensuring the transformation of safe, quality and effective services to improve access and ensure the best possible health outcomes of the most excluded and disadvantaged people and their communities.

Elaine has worked at a senior level in the NHS for over 25 years in a range of inclusion health areas at a Leeds, Yorkshire/ Humber and national level, that include Refugee, Homeless, Sexual health, Mental health, Substance Misuse, Prisons and Police Custody services.

Elaine established the Health Access Team for People Seeking Asylum and Refugees in Leeds and the Yorkshire Initial Accommodation Centre, in 2000 and led the service for 10 years working as a Specialist nurse and lead for the service. During this time Elaine also worked nationally with the Department of Health Refugee Team to ensure best possible practice.

Since 2020 Elaine has been working as National Lead Nurse for Homeless and Inclusion Health at NHSEI in the CNO's team.

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Vikki has worked as a nurse in prison and education settings before going on to hold senior safeguarding roles in both NHS Provider and Clinical Commissioning Groups.
Vikki is committed to working to reduce health and social inequalities for individuals and populations who are seldom heard and who face adversity across the lifespan.
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Contents

1 Background and Purpose

The provision of health care for asylum seeking individuals and families is a global issue[1]. A recognised goal of health policy for people seeking asylum is to meet their individual health, safeguarding and wider public health needs by supporting access to existing mainstream services and ensuring the same rights to high quality treatment and care as others[2].

The purpose of this report is to set out the key health and safeguarding issues and concerns related to adults and children seeking asylum in England. The report sets out recommendations for improvements to systems and practice with the aim of reducing health inequality and better support for the workforce. Whilst the report focusses on England, many if not all the key findings and subsequent recommendations apply also to the wider UK.

The report is set in the context of the COVID-19 pandemic outbreak throughout 2020, which caused the usual processing of applications and movement of people to cease or slow while the numbers of people entering the UK claiming asylum did not. As a result, asylum accommodation became gridlocked and in response HO procured a range of hotels and other contingency accommodation across the country.

When new asylum accommodation is set up in an area, Local Authorities and Clinical Commissioning Groups (CCGs) are usually informed in advance by HO as part of the planning process. Due to the urgent need for accommodation during the pandemic, this did not always happen, or it occurred within as little as twenty-four hours before residents arrived. Also, due to the temporary nature of some accommodation, residents were often being moved across different areas of the country with little or no notice. The necessary use of such contingency accommodation presented challenges to local health and safeguarding systems and partnerships tasked with providing care for people placed in their areas.

The National Homeless and Inclusion Nursing Lead for NHS England and NHS Improvement/I (NHSEI) identified in October 2020 concerns across England in relation to the health, wellbeing and safeguarding of people seeking asylum and the lack of system capability to identify and meet their needs. In response to similar concerns raised in an After-Action Review at the Safeguarding Adults National Network (SANN), SANN commissioned a scoping exercise to examine the issues further and to make recommendations for improvement to be presented at the National Safeguarding Steering Group (NSSG).

This subsequent scoping exercise has reviewed the health, wellbeing and safeguarding needs of people seeking asylum placed in HO accommodation in England. This has been achieved by seeking feedback from all regions via a bespoke template (Appendix 1) and

[1] O'Donnell, C.A., Higgins, M., Chauhan, R. and Mullen, K., 2007. " They think we're OK and we know we're not". A qualitative study of asylum seekers' access, knowledge and views to health care in the UK. *BMC Health Services Research*, *7*(1), pp.1-11.

[2] Audit Commission for Local Authorities and the National Health Service in England and Wales, 2000. *Another Country: Implementing Dispersal Under the Immigration and Asylum Act 1999; National Report*. Audit Commission for Local Authorities and the National Health Service in England and Wales.

health, HO, housing and voluntary, community and social enterprise (VCSE) networks and meetings. A reference group was set up to assist with analysis and discussion of the findings which are presented in this paper.

2 Definitions

When considering the health, wellbeing and safeguarding needs of individuals seeking asylum it is important to clarify the asylum context within wider migration.

A 'migrant' moves from one country to another, often to find work. There may also be other reasons such as wanting to join relatives, or to escape natural disasters. Some move because they want to, while others feel forced to leave because of poverty or other serious problems.

An 'Asylum Seeker' is a person who is seeking asylum under Article 14 of the United Nations Convention Relating to the Status of Refugees [3] on the grounds that they have a well-founded fear of persecution should they return to their home country. To be granted Refugee status in the UK under Article 1A of the Convention, a person seeking asylum must prove that they are unable to live safely in any part of their own country because of the fear of persecution there and that they have failed to get protection from authorities in their own country.

An unaccompanied asylum-seeking child (UASC) is a person under 18years, or in the absence of proof of age documentation is thought to be under 18years of age, separated from both parents and without a guardian, who is applying for asylum.

2.1 Migration to the UK

More people are migrating than ever before, some of whom have been forcibly displaced[4]. Despite the World Health Organisation Constitution of 1948 stating that everyone has a right to health, migrants experience difficulties in accessing health services and this has resulted in migration and health becoming well recognised as a global public health priority[5].

Health is a crucial aspect of immigration as much as immigration is a crucial aspect of health. The British Medical Journal[6] discuss how, in the current political climate where debates are often dominated by immigration and border control, the health needs of migrants are being overlooked. It is more challenging than ever for them to access our healthcare system due to this and the changes to NHS charging make it more difficult[7].

In 2019, it was estimated that around 14% of the UK's population was made up of migrants with the number almost doubling since 2004[8]. Migrants should not be viewed as

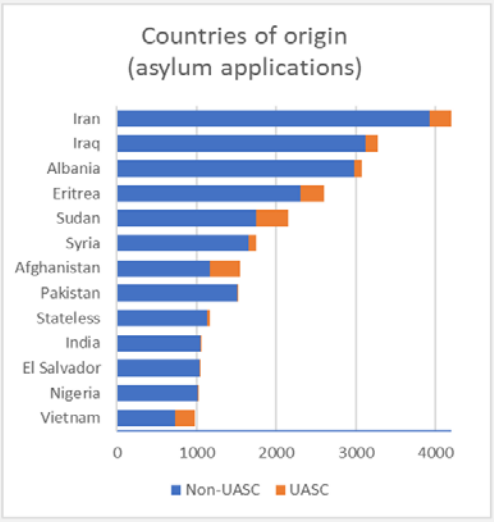
[3] https://www.unhcr.org/4ca34be29.pdf
[4] WHO | Refugee and migrant health
[5] https://www.iom.int/sites/default/files/our_work/DMM/Migration-Health/GC2_SriLanka_Report_2017_FINAL_22.09.2017_Internet.pdf
[6] Migration and health | The BMJ
[7] Guidance on implementing the overseas visitor regulations (publishing.service.gov.uk)
[8] Briefing-Migrants-in-the-UK-An-Overview.pdf (ox.ac.uk)

one homogeneous group; overseas students and non-UK born workers are likely to have different health needs to trafficked migrants or people seeking asylum[9].

2.2 UK asylum applications

UK asylum applications are reflected below with adults from Iran being the top nationality. Amongst UASC the largest numbers of applications have come from Afghanistan and Sudan.

Slide 1 shows 2021 data regarding the countries of origin of asylum seekers to the UK



Source: Home Office UK Immigration Statistics.
Last updated 25th February 2021

Asylum seeker

Person who has departed their country of origin and officially applied for asylum in another country but is awaiting a decision on their request for refugee status

Refugee

A person who 'owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country

Undocumented migrant

Undocumented migrants may have entered the UK legally but have lost their right of residence or entered the UK illegally and do not have the right of residence

2.3 Destitute people seeking asylum

People seeking asylum who would otherwise be destitute can obtain support under section 95 of the Immigration and Asylum Act 1999 from the time they arrive in the UK, until their claim is fully determined, and they have exhausted their appeal rights.

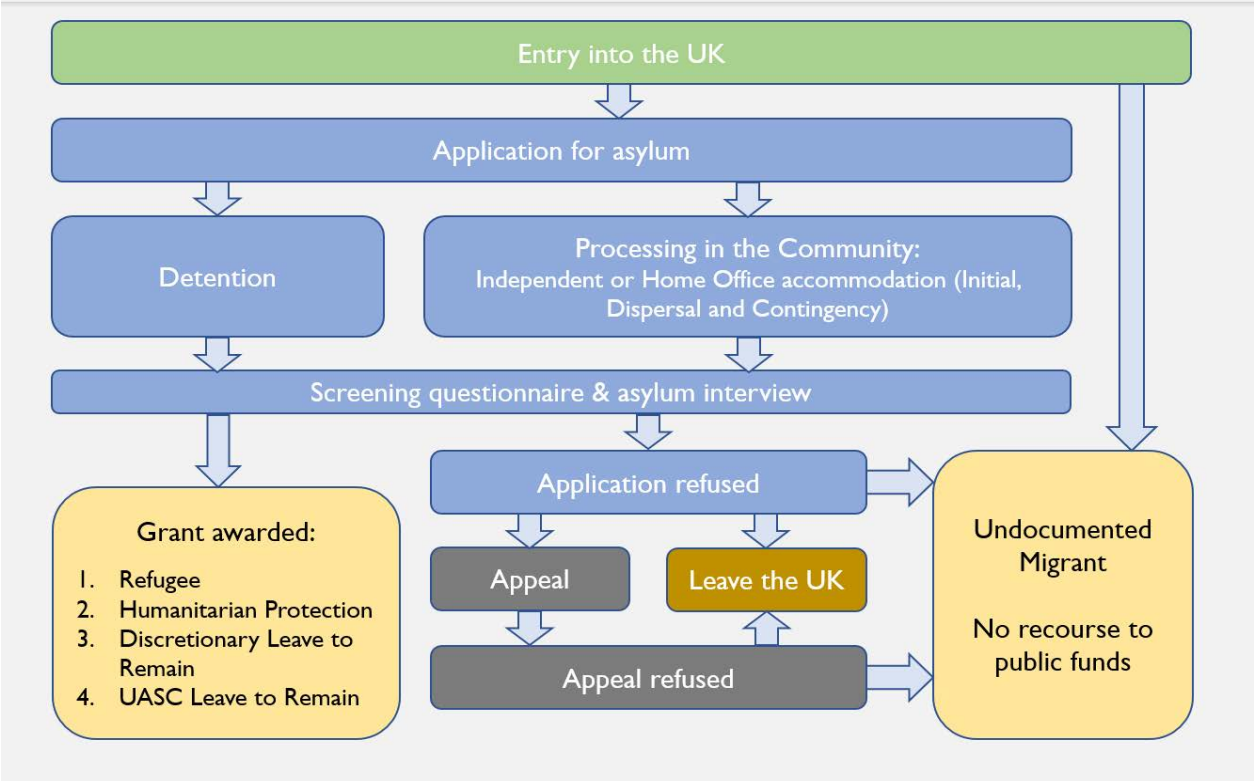
It is important to note that people's journey within the asylum system is not linear. They can move in and out at different points multiple times, the anxiety of which impacts on their health and wellbeing and ability to access services. Destitute asylum applicants who have been accepted as eligible for support are housed in regions throughout the UK on a 'no choice' basis.

During the COVID-19 pandemic, the number of people within the asylum system has risen. The Home Office temporarily ceased ending asylum support for those whose claims had been either granted or refused, to ensure people were not made homeless during lockdown and were able to follow social distancing guidelines. Contingency accommodation has included the use of hotels, housing of multiple occupancy (HMO) and

[9] Assessing new patients from overseas: migrant health guide - GOV.UK (www.gov.uk)

former barracks. The use of which has been a temporary measure which HO have advised is under constant review. Accommodation moves for those with Leave to Remain resumed from September 2020.

The asylum system in the UK is briefly described in Slide 2 below:



There are approximately 64,000 people in Home Office accommodation. The majority are in shared housing and about 10,000 are in hotel accommodation. There are currently approximately 9500 people housed in contingency accommodation across England. Supported by Deloitte, HO plan to move all people out of hotel contingency and into dispersed accommodation between March and June 2021 under a scheme called 'Operation Oak'. The use of barrack accommodation will continue until at least the autumn.

2.4 Cessations of support and evictions

Following a review of the pause on evictions at the start of the pandemic in March 2020 and a period of engagement with local authorities, HO have confirmed that they will begin to resume cessations of support including evictions from asylum accommodation for people who have been granted status. People who have been granted status receive 28 day move on notice letters.

For people who have been refused asylum HO announced on 23rd April 2021 that they are starting the review of cases of people on section 95 asylum support. This process will lead to cessations of section 95 support for people who no longer have pending asylum claims (refused asylum seekers). Those discontinuations were going to start immediately with a 21 calendar days grace period before the eviction can start.

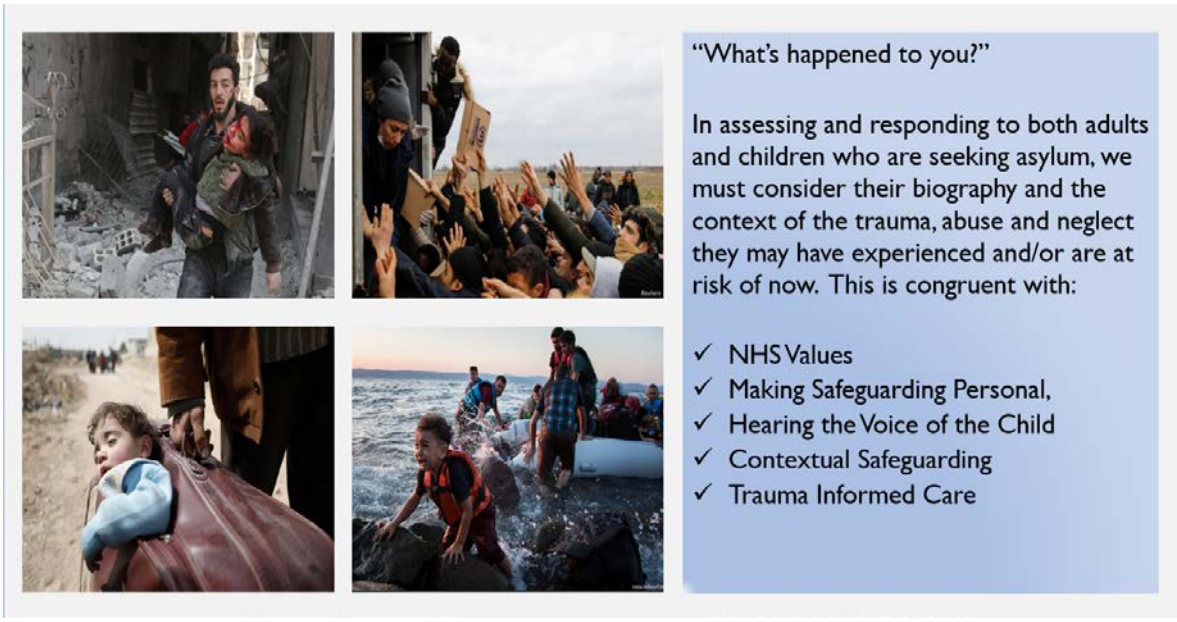
3 Pre, during & post migration impacts on health

3.1 Premigration

It is helpful for NHS organisations, their workforce and partners to understand the pre-migration context of people seeking asylum in order to effectively meet their care and support responsibilities. Many people have experienced significant trauma, abuse and neglect both prior and during their journey particularly those coming from conflict zones or countries intolerant to their characteristics. They may suffer from a broad range of chronic physical and mental health conditions[10] often related to ill treatment, socio-economic and environmental factors.

To understand the life story of the person can provide the capacity to humanise 'patients' or 'asylum seekers' as it allows staff to see beyond the diagnosis or presentation. It supports staff to understand the person being cared for in the context of their past and it may also help to understand behaviours that they observe in the present[11]:

Slide 3 Approach to assessment and response



This approach acknowledges people seeking asylum are not a homogeneous population and is also key to Trauma Informed Care and Cultural Competence discussed in Section 4.22 of this paper. It is also important to recognise the remarkable resilience and agency of many people seeking asylum and need to not 'pathologize' this population.

Due to the experiences many people seeking asylum experience common health needs pre and during migration can include:

[10] https://www.bma.org.uk/advice-and-support/ethics/refugees-overseas-visitors-and-vulnerable-migrants/refugee-and-asylum-seeker-patient-health-toolkit

[11] McKeown J, Clarke A, Repper J (2006) Life story work in health and social care: systemic literature review. Journal of Advanced Nursing. 55, 2, 237-247.

Slide 4 Common Health Needs Before and During Migration

- PTSD
- Anxiety & depression and other mental disorders
- Sexually transmitted infections
- Female genital mutilation
- Communicable diseases
- Pregnancy following rape
- Non-communicable diseases
- Malnutrition
- Musculoskeletal complaints
- Oral disease
- Physical and/or Learning Disability
- Incomplete medical/ immunisation history
- Untreated health needs
- COVID-19

Post migration context

It is in this destination stage of the migration process that often the cumulative effects of health influences during the prior stages of migration surface for people seeking asylum and it is this post-arrival period in which mental health is in most danger of decline[12].

Slide 5 Typical issues for people seeking asylum post migration

Post-migration stress and fear significantly influences the emotional well-being, and often provides a risk similar to or greater than war-related trauma:

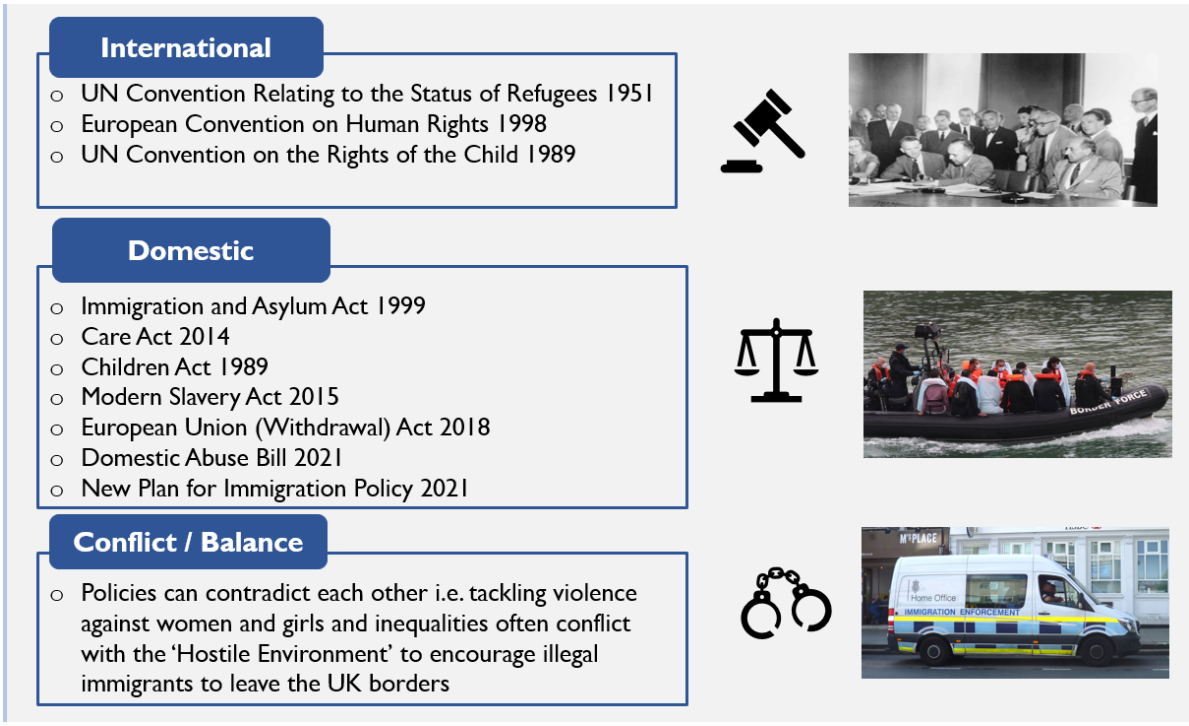
- Loss of identity and status
- Fear for family back home & with them
- Vulnerability to exploitation & risk
- Lack of support
- New culture language & integration
- Racism, discrimination, negative rhetoric
- Poverty & poor housing
- Long asylum process
- Uncertainty fear of deportation
- Navigating healthcare system
- Every contact 'not' counting – repeating traumatic history
- Difficult access to primary care
- COVID-19
- Trust - key barrier – highlighted through vaccine roll out
- NHS Overseas Charging Regulations

"I just try as much as possible not to get sick, I know you can't prevent it, but if I had pain, I would never go [to the doctor], I can't call the ambulance or anything. I would never have done that because of the fear"

[12] Kirmayer, L.J., Narasiah, L., Munoz, M., Rashid, M., Ryder, A.G., Guzder, J., Hassan, G., Rousseau, C. and Pottie, K., 2011. Common mental health problems in immigrants and refugees: general approach in primary care. *Cmaj*, *183*(12), pp.E959-E967.

3.1.1 International and domestic laws/ policies

Slide 6 Range of international and domestic laws that the UK is a signatory to and other key frameworks



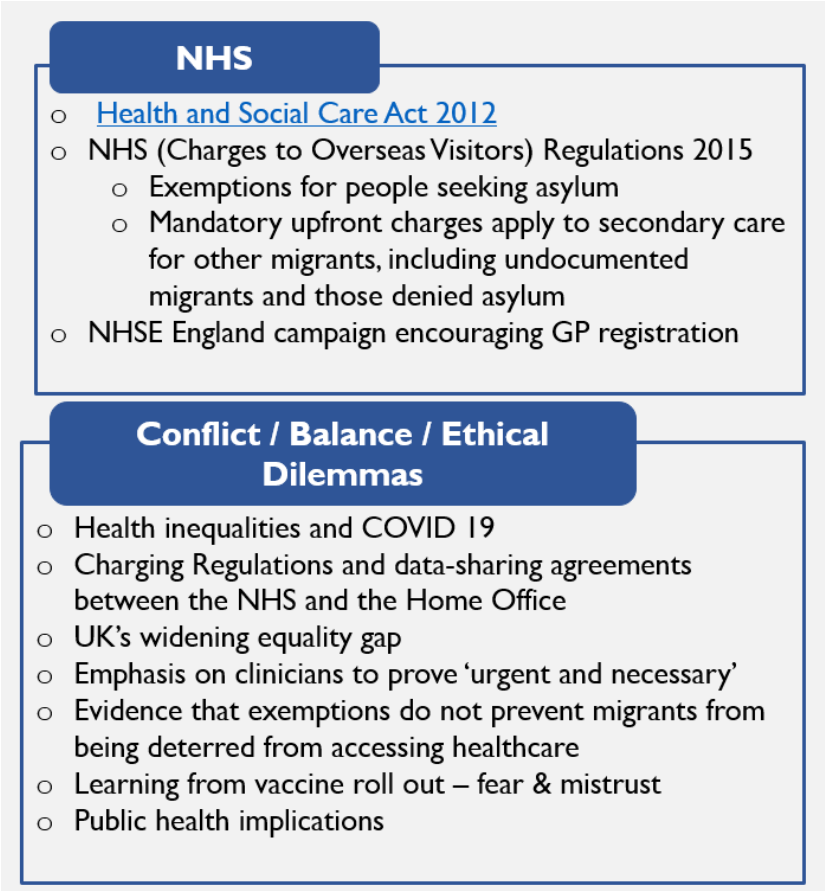
Migration is a highly political issue and the related laws and policies can cause tension between human rights and the rights of the state to control its borders. Domestic legislation sets out safeguarding responsibilities for all adults with care and support needs in the Care Act 2014 and all children up to 18 years in the Children Act 1989 irrespective of their immigration status. Building on this, the Modern Slavery Act 2015 offers protections to adults and children who are victims of trafficking and slavery either within the UK or arriving in the UK. The debate continues about the protections in the Domestic Abuse Bill, which recently received Royal Assent, for migrants who are experiencing domestic abuse.

Children have specific rights within the Children Act and unaccompanied asylum-seeking children are considered Looked After Children with the statutory duties and protections that offers.

The Immigration Act 2020 and previous Acts can create hostile environments for 'illegal' immigrants to encourage them to leave or deter entry to the UK and often create further vulnerabilities from a health and safeguarding perspective. With the Health and Social Care Act 2012 all healthcare is free to people seeking asylum. However mandatory upfront charges apply to secondary care for other migrants, including undocumented migrants and those denied asylum. This charging system brought in the sharing of people's information by the NHS with HO and has reduced people's trust in the health services and willingness to engage with it, often resulting in people presenting to health services much later in their illness/ crisis or in some circumstances not at all. The disproportionate impact of the COVID-19 deaths among people from migrant backgrounds as both NHS employees and community members during the pandemic has further exacerbated this mistrust. Some

migrants are exempt from charges; however, a lack of understanding of the rules and difficulties in proving exemption can create confusion for people on their rights and they can be wrongly denied or charged for health care[13] [14]

Slide 7 Key NHS frameworks



3.1.2 Trauma

Many people have suffered physical and psychological trauma of conflict, torture, rape, slavery and the disappearance or killing of loved ones[15] which has led them to seek asylum. People seeking asylum are not a homogeneous population, they come from different countries and cultures and have had experiences that rely on responses that are person centred in their approach and are both trauma and culturally informed.

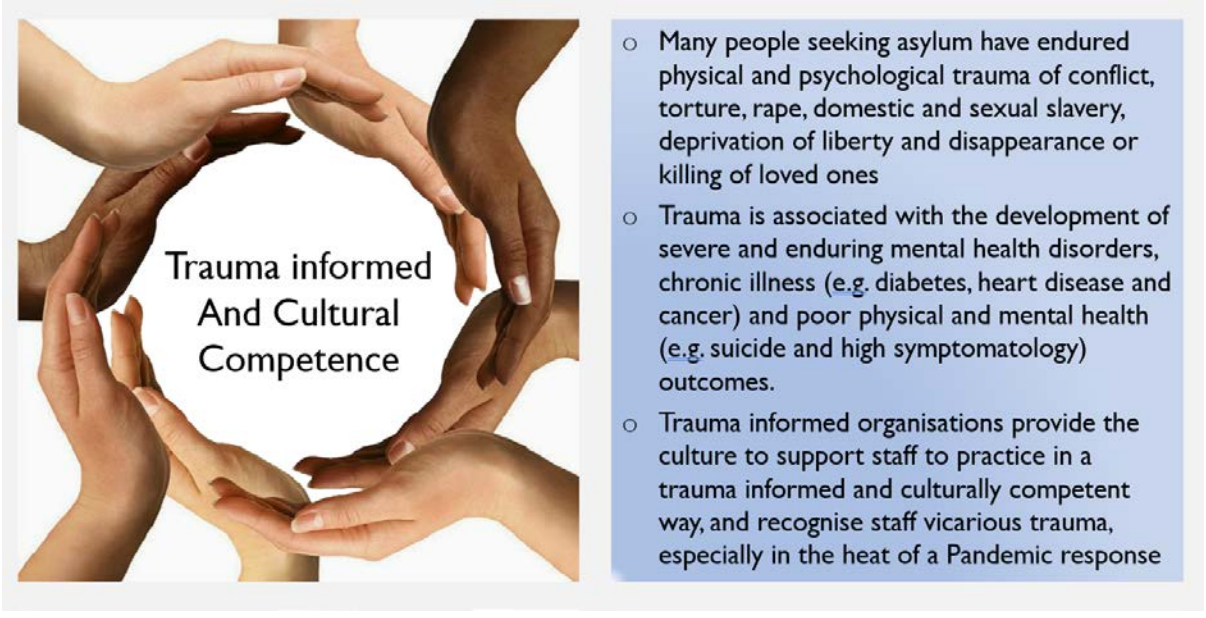
[13] Weller, S.J., Crosby, L.J., Turnbull, E.R., Burns, R., Miller, A., Jones, L. and Aldridge, R.W., 2019. The negative health effects of hostile environment policies on migrants: A cross-sectional service evaluation of humanitarian healthcare provision in the UK. *Welcome open research*, *4*.
[14] Stevens, A.J., 2020. How can we meet the health needs of child refugees, asylum seekers and undocumented migrants? *Archives of disease in childhood*, *105*(2), pp.191-196.
[15] McKnight, P., Goodwin, L. and Kenyon, S., 2019. A systematic review of asylum-seeking women's views and experiences of UK maternity care. *Midwifery*, *77*, pp.16-23.

People seeking asylum have described feeling stereotyped and discriminated against because of their immigration status in Home Office and healthcare settings[16][17] . Staff have reported anxiety about what is involved in caring for them, around culture, traumatic experiences, complex safeguarding and working with interpreters.

Health research in this area calls for culturally competent services and the need to recognise the trauma that people seeking asylum have likely experienced. There can also be cultural stigmas attached to areas of health care such as mental health[18]. Not all staff need to be experts in trauma but supported to recognise trauma, enquire sensitively, refer to trauma-specific support and for organisations to work collaboratively to prioritise emotional and physical safety of patients and the workforce. It is also important that immigration and health services recognise how the act of talking about past trauma, especially when subject to repeat assessments, may significantly re-traumatise people.

Cultural competence does not have a universally agreed definition although frequently cited work by Camphina-Bacote[19] defines it as a process which requires the professional to continuously attempt to gain the ability to give effective care while taking in to account the patients specific cultural needs, behaviours and beliefs. Cultural competence has benefits extending beyond the experiences of asylum seekers to other patients and for the diverse health and care workforce.

Slide 8 Trauma and culturally informed practice



For staff to work in a way that recognises trauma and is culturally competent, the organisations they work for must demonstrate such values and culture beginning at Board

[16] O'Donnell, C.A., Higgins, M., Chauhan, R. and Mullen, K., 2007. " They think we're OK and we know we're not". A qualitative study of asylum seekers' access, knowledge and views to health care in the UK. *BMC Health Services Research*, *7*(1), pp.1-11.
[17] Stevens, A.J., 2020. How can we meet the health needs of child refugees, asylum seekers and undocumented migrants? *Archives of disease in childhood*, *105*(2), pp.191-196.
[18] https://www.unhcr.org/uk/a-journey-towards-safety-a-report-on-the-experiences-of-eritrean-refugees.html
[19] Camphina-Bacote, J., 2002. The process of cultural competence in the delivery of healthcare services: A model of care. *Journal of transcultural nursing*, *13*(3), pp.181-184.

level. Trauma un-informed organisations can be toxic for staff, many of whom have lived through their own traumatic experiences[20], this is particularly true in relation to the trauma and vicarious trauma experienced by NHS staff and the public over Covid-19.

4 Common health needs of people seeking asylum

There is a growing body of research which evidences how people seeking asylum travel to the UK from different countries and cultures and will have different experiences that may affect their health[21]. Once in the UK they face many challenges in navigating their way through an unfamiliar culture, limited/ no social support and face racial discrimination, all of which negatively impact on their health and wellbeing[22]. The Faculty for Homeless and Inclusion Health discuss health needs within their 2018 standards for providers and commissioners document[23].

Table 1 Common health needs of people seeking asylum

- **Communicable diseases** – Often associated with the incidence of certain diseases from their country of origin or ones they have travelled through. The most common ones include cholera, typhoid, fungal infections, scabies, meningococcal disease, influenza, measles, varicella, diphtheria, hepatitis A, B, C and E, HIV, malaria, measles and tuberculosis (TB).
- **Incomplete immunisation history** which may be due to low immunisation rates in the country of origin, interruption of vaccine schedules during transit and lack of records of immunisation status.
- **Non-communicable diseases** where complications can arise due to not been diagnosed or diagnosed but poorly managed, e.g. cardiovascular diseases (like heart attacks and stroke), cancers, chronic respiratory diseases (such as chronic obstructive pulmonary disease and asthma) and diabetes.
- **Malnutrition** as a result of food insecurity.
- **Obesity** postmigration due to the introduction of refined foods to their diet.
- **Musculoskeletal problems** as a consequence of physical stress endured during the migration journey, injuries from torture or violence, or malnutrition.
- **Oral disease** – as a result of poor diet or lack of access to dental care.
- **Sexually transmitted infections** as asylum seekers may have been raped or forced into commercial sex work pre-arrival or post-arrival in England.
- **Adolescent pregnancy** due to limited sexual health awareness and low rates of contraception use.
- **Female genital mutilation (FGM)** which is common in some African and Middle Eastern countries and is associated with a range of complications including transmission of blood borne viruses (BBVs), urinary tract infections, psychological problems, infertility and adverse obstetric outcomes.

People seeking asylum often require prompt access to health care services to address their immediate health needs and ensure appropriate referrals are made. Integration

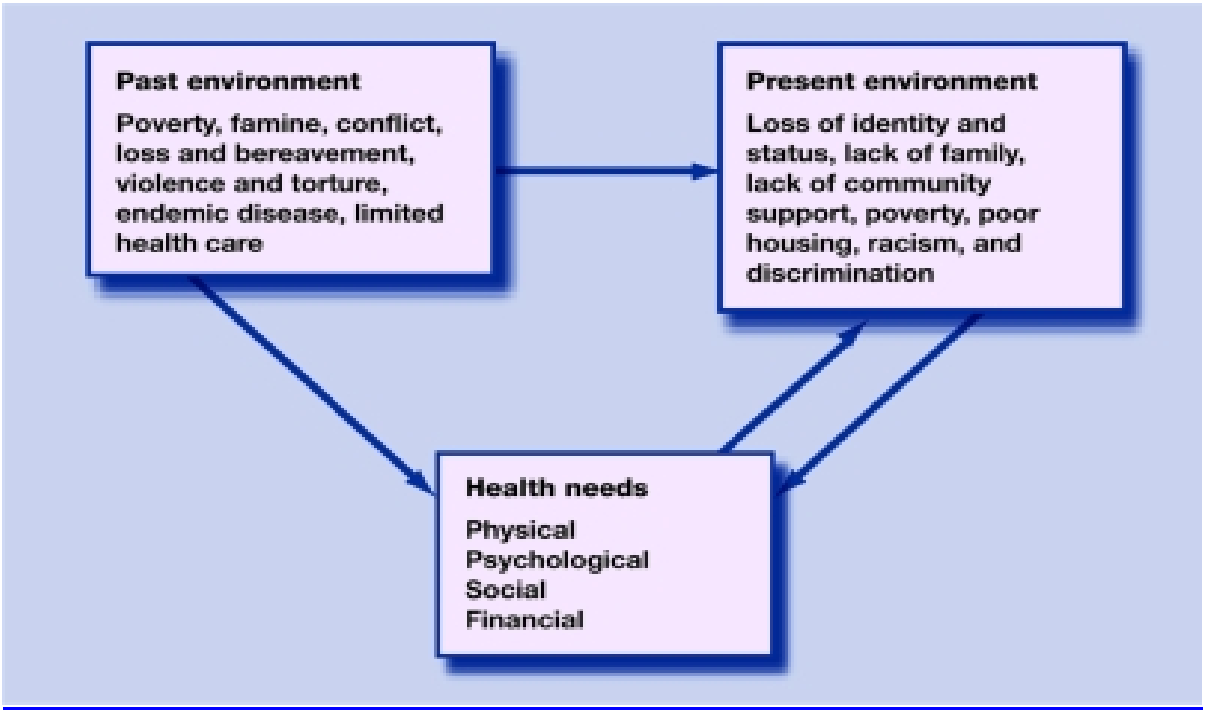
[20] Bloom, S.L., 2006. Organizational stress as a barrier to trauma-sensitive change and system transformation. *Alexandria, VA: National Technical Assistance Centre for State Mental Health Planning Publications and Reports*.
[21] Burnett, A. and Peel, M., 2001. Asylum seekers and refugees in Britain: Health needs of asylum seekers and refugees. *BMJ: British Medical Journal*, *322*(7285), p.544.
[22] Stevens, A.J., 2020. How can we meet the health needs of child refugees, asylum seekers and undocumented migrants? *Archives of disease in childhood*, *105*(2), pp.191-196
[23] https://www.pathway.org.uk/wp-content/uploads/Version-3.1-Standards-2018-Final.pdf

support that focuses on employment, language, and community, all of which are key determinants of health participation, is also important.

Safeguarding issues (See Section 5.9) can be complex and are often inextricably linked to health needs (See slide 9 below). There are also high rates of physical illness and disease resulting in poly-morbidity, cancer and neurological injuries/diseases[24]. Several studies have reported a high prevalence of non-specific and somatic presentations a result of psychosocial distress[25]. People seeking asylum have arrived from areas where they may have experienced significant trauma including poverty, torture, sexual violence and Female Genital Mutilation (FGM), they are also a high-risk group to be victims and survivors of trafficking and modern slavery. There is also significant risk of re-victimisation and exploitation once individuals and/or families have arrived in the host country due to their complex vulnerabilities.

People seeking asylum may also have additional needs such as pregnancy, disabilities and/ or they may be children.

Slide 9 Model of health effects of forced migration and refugee status (Taylor, K 2009)[26]



The implications for pregnant women seeking asylum are particularly acute due to the additional physical and emotional demands of pregnancy. Women frequently present to maternity services late in pregnancy with sexual and emotional trauma, infectious diseases

[24] Müller, M., Khamis, D., Srivastava, D., Exadaktylos, A.K. and Pfortmueller, C.A., 2018, April. Understanding refugees' health. In *Seminars in neurology* (Vol. 38, No. 02, pp. 152-162). Thieme Medical Publishers.
[25] Taylor, K (2009) Asylum seekers, refugees, and the politics of access to health care: a UK perspective Br J Gen Pract. 2009 Oct 1; 59(567): 765–772.

and underlying health conditions[26]. This is multifactorial in nature with influencing factors including the effects of limited English language proficiency, lack of awareness of the services, lack of understanding of the purpose of the services, income barriers, the presence of female genital mutilation (FGM), factors associated with differences between the maternity care systems of their countries of origin and the UK, arrival in the UK late in the pregnancy, frequent relocations after arrival, the poor reputations of antenatal services in specific communities perceptions of regarding antenatal care as a facet of medicalisation of childbirth and fear/ mistrust of authorities[27].

Pregnant women seeking asylum are at high risk of suffering maternal morbidity and mortality[28] [29]. Although the number of pregnant women accessing maternity care in the UK is unclear, recent Home Office statistics suggest that around 20–25% of all UK asylum applications are for women of childbearing age (15–49 years as defined by the World Health Organisation)[30]. The trauma that women have faced prior to entering the UK and the complexities of the immigration and benefits system create an increased vulnerability for women to be exploited; often suffering as victims of modern slavery and or human trafficking.

The end of the asylum process has also been recognised as a key safeguarding risk point. People with granted asylum are given 28 days to find alternative accommodation and those that are refused 21 days, leading to risks of exploitation relating to their pending destitution.

5 Meeting the health, wellbeing and safeguarding needs – key findings from scope

The scope was undertaken using a variety of information that included feedback from Health, Home Office and the Voluntary Community Social Enterprise Sector (VCSE) at a national, regional and local level. Lived experience was sought non-directly from frontline staff via health and the VCSE sector. The key themes of findings identified below, and subsequent recommendations apply across all areas of the country.

5.1 System leadership, housing, and health

5.1.1 System leadership

The scope identified that limited joined up systems leadership, lack of data sharing, clarity of access to healthcare pathways, backlog in asylum applications, compromised access to services, disruption in continuity of care and risks of homelessness when asylum decisions are granted, pre-date the virus, and need addressing by the NHS and Home Office.

[26] Asif, S., Baugh, A. and Jones, N.W., 2015. The obstetric care of asylum seekers and refugee women in the UK. *The Obstetrician & Gynaecologist*, *17*(4), pp.223-231.
[27] Higginbottom, G.M.A., Evans, C., Morgan, M., Bharj, K.K., Eldridge, J. and Hussain, B., 2019. Experience of and access to maternity care in the UK by immigrant women: a narrative synthesis systematic review. *BMJ open*, *9*(12), p.e029478.
[28] Knight, M., Bunch, K., Vousden, N., Morris, E., Simpson, N., Gale, C., O'Brien, P., Quigley, M., Brocklehurst, P. and Kurinczuk, J.J., 2020. Characteristics and outcomes of pregnant women admitted to hospital with confirmed SARS-CoV-2 infection in UK: national population based cohort study. *bmj*, *369*.
[29] https://www.nice.org.uk/guidance/CG110/chapter/1-Guidance#pregnant-women-who-are-recent-migrants-asylum
[30] Immigration statistics, year ending September 2020 - GOV.UK (www.gov.uk)

Through the early findings of this scope, at a national level, there has been recent commitment from both NHSEI and HO to improve systems leadership through a jointly chaired national steering group.

5.1.2 Housing

The pandemic and use of contingency accommodation has resulted in further negative impact to an already stretched system and has been seen across the country. Repeated moves of people and a 'gridlock' of initial accommodation (IA) to dispersal, has resulted in a health and housing system that is not in alignment.

The scope highlighted significant concerns regarding the standard and safety of some accommodation. 'Operation Oak' aims to move supported people from hotels and other contingency accommodation into longer term safe, secure 'Dispersed Accommodation' that meet Asylum Accommodation and Support Services Contract (AASC) standards. It is a complex process and has significant impact on the system, particularly if not coordinated between HO, Health, Local Authorities, Police and other statutory and VCSE.

A recent example where converted office blocks that were housing up to 125-150 women and children (victims of sex-trafficking) only became known to the CCG and healthcare services during COVID19 vaccine planning. The women and children will need rapid access to a wide range of health support which will have significant impact on the local health and wider system, which needs careful planning and coordination.

Many areas also made refence to the risks to people of destitution at the end of the process as cited above.

Slide 10 Accommodation issues

Accommodation & support:

- COVID impacts –System gridlock - use of contingency housing, hotels & barracks, repeated moves
- Accommodation substandard, poorly maintained and, at times, unsafe – issues with COVID safety
- Support via Housing Providers and Migration Help inconsistent
- Genders housed together, families with single adults
- Lack of safe sleep space
- Repeated moves, Increased risk of exploitation and safeguarding adults & children risks
- Destitution and food insecurity

Health impact:

- Systems not aligned – data sharing limited
- Challenge in planning and response, uncertainty of numbers and needs impacted by limited collaboration
- GPs not able to cope with demand
- Direct negative impact of housing on health - accidental injury, childhood development, mental health
- COVID-19 impacts – further reduced access to healthcare

"My client who is a survivor of trafficking was kept in initial accommodation with her young son. The accommodation was unsuitable for a baby, and the hostel was full of single men, some of whom would roam outside her room in the corridor at night, causing her to feel profoundly unsafe. She described sleeping on the bed with her toddler child huddled up with the light on as she was too frightened to turn it off. The food was unsuitable for a young child (nor was there a provision for her to heat up formula or obtain fruit, vegetables or healthy food for the child's diet)."

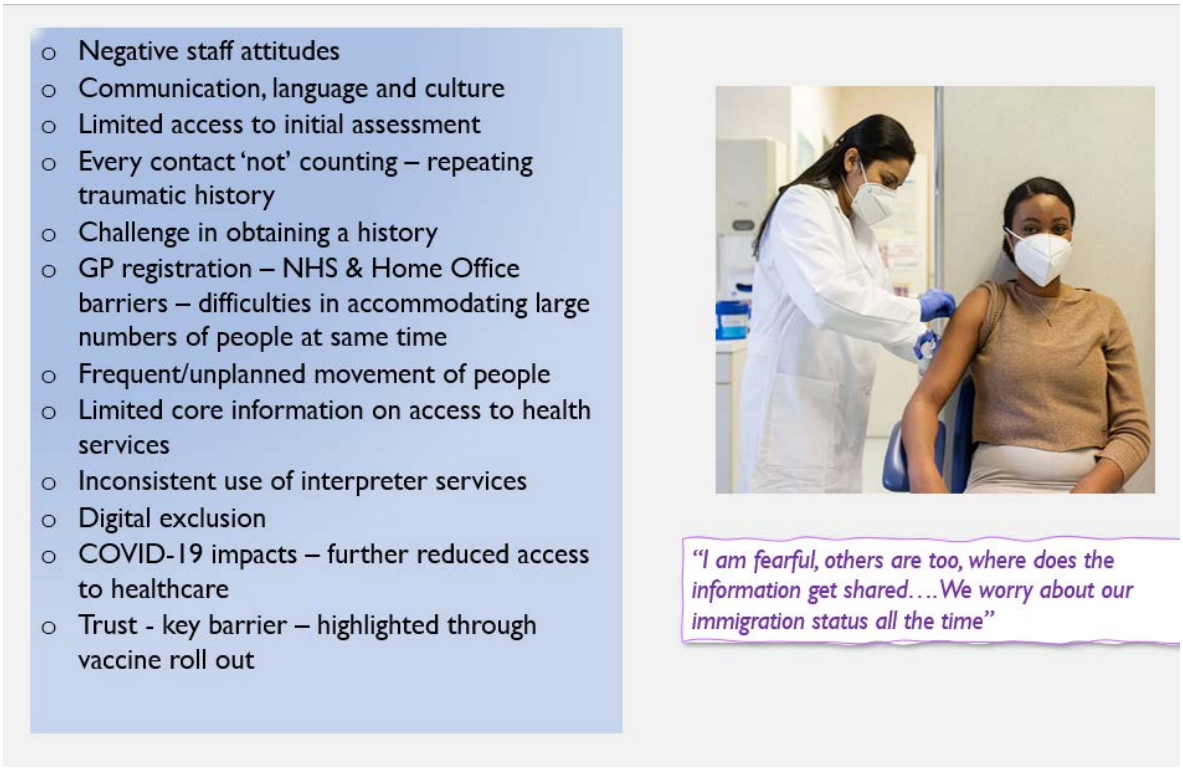
5.1.3 Data sharing

All regions identified concerns in relation to lack of access to consistent and accurate demographic and individual data for people seeking asylum. This inhibited their ability to not only plan and deliver vital health services, but also meet health, wellbeing and safeguarding needs at an individual as well as public health level. Most areas reported lack of systemised agreed sharing of data and significant time spent trying to resolve the issues.

5.2 Barriers to meeting health needs

Many areas fed back the importance of an awareness that authority figures may have a very different meaning for people seeking asylum (it may be authority figures that killed their family, cooperated with traffickers, abused and tortured them) so expecting respect and compliance in engaging with the healthcare system may present some significant challenges.

Slide 11 Examples of barriers to accessing healthcare



5.2.1 Initial health assessment and screening

Pre-pandemic initial healthcare assessments and screening were commissioned for people new to the asylum system coming through initial accommodation. However, this is not commissioned consistently across the asylum process and once the system became gridlocked it resulted in a significant proportion of people with highly complex needs not being offered tailored assessment and support. People seeking asylum often have no documented medical history and benefit from an initial assessment by a 'Gateway' or similar service to address immediate health and safeguarding needs, assist with prompt

GP registration and provide advice about other services such as pharmacists, dentists, hospitals and sexual health[31]. Some may offer screening for infectious diseases and vaccination prior to full GP registration in order to meet the individual's needs, support mainstream care in responding and protection of the wider public.

The scope found that there were some areas who were delivering comprehensive initial health assessments, screening for infectious diseases, handheld records and sharing of health information, including those individuals and families being moved to other accommodation nationally. However, this was not consistent, and many local areas have had to develop assessment tools, sometimes with no experience of migrant health, placing additional pressure on the systems to stand up the assessments with very little notice.

National accessible evidenced based asylum health guidance relating to individual and public health are needed to support all regions to ensure people have a personalised initial assessment and have immediate, often complex, needs addressed. Information then needs to follow the individual to ensure things are not missed and/ or subject to unnecessary duplication. Guidance would also provide an evidence base for new entrant screening within the assessment. All of which would have health benefits to the individual, protect the health of the wider public and arguably financially cost less to the wider NHS as prevents escalation and repetition.

It is important that healthcare practitioners also note that people rarely disclosure on first assessment/ meeting and disclosures re traumatic experiences such as sexual abuse, exploitation and Female Genital Mutilation are often made months after people have settled.

5.2.2 GP Registration

Whilst initial assessments are vital to understand immediate health needs and medical history they cannot cater for the short, medium to long term as people are likely to develop new health needs over the months and years that follow the assessment date. In the usual system, pre-pandemic, people were not being registered with GPs whilst in the IA as they would usually have only been there for a few weeks before moving onto dispersed accommodation. Although as the National Audit Office identified[32] delays in IA were common pre pandemic. Once the system became gridlocked and people were not moving on from initial IA settings, areas saw increasing use of contingency housing and, the need for registration became paramount. , However, for lots of people support and understanding of rights to GP registration was very limited with one area reporting significant impacts on people health due to delayed care.

GPs reported challenges in responding to the often-complex needs of people seeking asylum with no prior history and or templates in the electronic patient record to support assessment. Additionally, many areas reported capacity issues in registering what could sometimes be up to one hundred people with little or no planning. Short-notice transfers were also a theme across the country making the management of healthcare and follow-

[31] Feldman, R., 2006. Primary health care for refugees and asylum seekers: a review of the literature and a framework for services. *Public health*, *120*(9), pp.809-816.
[32] https://www.nao.org.uk/wp-content/uploads/2020/07/Asylum-accommodation-and-support.pdf

up very difficult. There were numerous cases reported of people with latent and active TB, that had been diagnosed but were still transferred out to other areas.

New patient registration guidance is clear that everyone in England may register and consult with GP free of charge and that immigration status or ability to provide documentation does not undermine this right. The issue of low GP registration rates amongst inclusion health groups, including the asylum-seeking population, is a key priority for NHS England and NHS Improvement (NHSEI). Alongside other initiatives, NHSEI have recently launched a campaign, to empower everyone in England to exercise their right to Primary Care and for Primary Care clinical and non-clinical staff to remove barriers to patient access. HO have been supporting this work, giving cards to all residents and recently sending direct instructions to Housing Providers to support GP registration.

The scope highlighted other key issues preventing registration included limited support to register, lack of information and barriers such as negative staff attitudes in GP Practices. HO have clarified that Housing providers are contracted to signpost GP registration and in the case of those with vulnerabilities, to assist in registration. HO have agreed to look at ways of clarifying and strengthening these expectations.

5.2.3 Digital Exclusion

Digital exclusion was key barrier identified throughout the scope as substantially limiting the support available to people that is crucially important to health, wellbeing and safeguarding. Lack of Wi-Fi in private spaces in initial, dispersal and contingency accommodation was of concern as accessing healthcare, whether a GP, secondary care or a therapy appointment needs privacy. Other barriers included lack of IT skills and digital paranoia.

There is a clear and strong relationship between groups that are digitally excluded and those at greater risk of poor health, with digital inclusion being a key priority of the NHS Long-Term Plan[33]. The COVID 19 pandemic and subsequent NHS response and expansion of remote pathways has resulted in further digital exclusion for many people seeking asylum.

5.2.4 Language Barriers

Many regions and stakeholders fed back that people often expressed anxiety and frustration about their inability to access healthcare services due to language barriers. There were reports of family members being used as interpreters leading to concerns about coercion and cultural factors affecting women and children's' access to health care. Where remote consultations were taking place, there were reports of GPs being unwilling or unable to use interpreters for telephone consultations. Many areas reported people feeling unable to request for an interpreter if they did not feel understood. Whilst there was some feedback that this has improved during the last few months as practices learn to use new systems, it is still often a barrier. Additional clinical time required to consult using interpreters can be significant especially for practices receiving large numbers of non-English speaking people housed within the asylum system.

[33] https://www.longtermplan.nhs.uk/

5.3 COVID 19

The COVID-19 pandemic has had a major impact on health and health inequalities in the UK.

The scope found that people seeking asylum living in initial and contingency accommodation often had limited ability to social distance and faced increased risk of contracting COVID-19. They were also more likely to experience adverse health impacts of lockdown restrictions as they are at higher risk of untreated health needs, chronic disease and of experiencing mental distress; anxiety, depression and PTSD, which could be exacerbated by their housing situation, restriction of movement and extended periods of uncertainty pertaining to the outcome of their asylum claim during the COVID-19 pandemic.

Housing was often reported to be cramped, people did not have consistent access to masks and there was limited capacity to respond to outbreaks. Access to both lateral flow and PCR testing was also often difficult. All areas reported barriers for people in engaging with contact tracing activities and accessing the COVID-19 vaccination.

Targeted action is currently in place to ensure that people seeking asylum have the same opportunity to access the COVID-19 vaccine as the rest of the population. However, lack of data sharing systems and limited GP registration continue to impede progress in many areas. There are also growing concerns regarding understanding of uptake rates in some populations and for those that do not currently appear in the data such as people seeking asylum and undocumented migrants and subsequent impacts on a third wave. Lack of trust of where data is shared has also been identified as a key issue, stopping people coming forward, particularly for people who have had their asylum claim refused and have become 'undocumented migrants'.

The Health Foundation's Covid-19 Impact Enquiry Team[34] has reviewed emerging evidence on long COVID and have found that the impacts of long COVID differ by age, gender and pre-existing health status. There is also a clear social gradient in the experience of long COVID with the prevalence being higher (2.16% of the total population) in the most deprived areas compared to that in the least deprived areas (1.41%)[35]. As evidence and treatment pathways further develop it will be important to ensure equitable access for people seeking asylum. There is already potential digital exclusion emerging relating to the 'Your Covid Recovery' rehab service only being available online.

5.4 Mental health

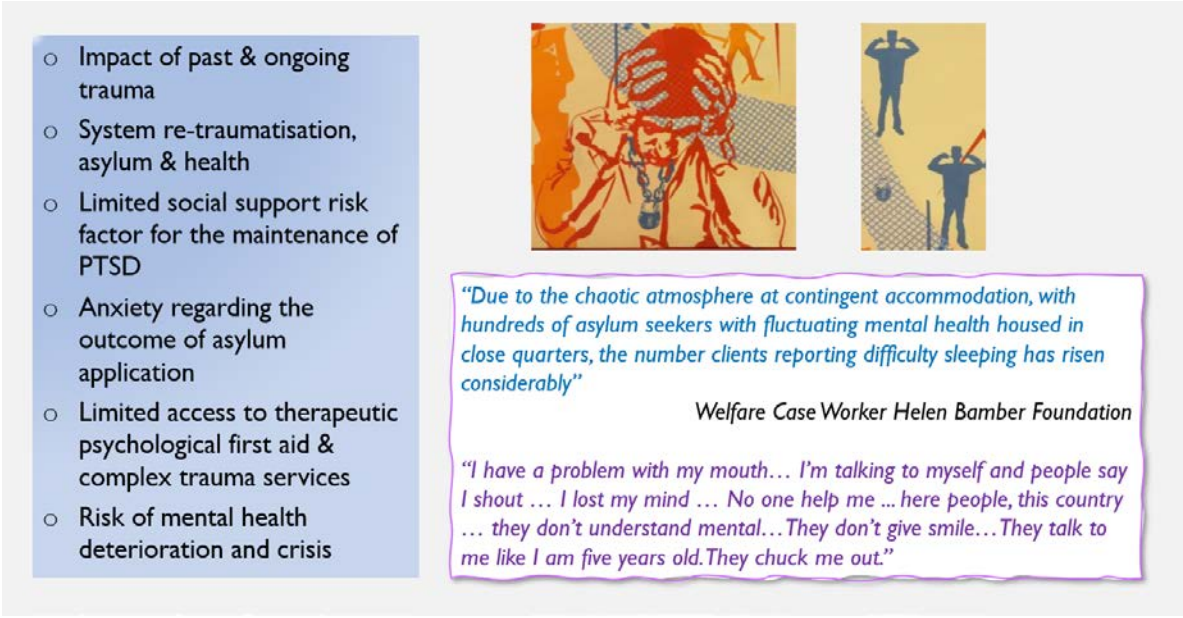
The mental health needs of people seeking asylum, including children and Unaccompanied Asylum-Seeking Children (UASC), living in shared accommodation are extremely nuanced and require a targeted approach. People commonly report anxiety,

[34] https://www.health.org.uk/what-we-do/a-healthier-uk-population/mobilising-action-for-healthy-lives/covid-19-impact-inquiry/call-for-evidence
[35] https://www.health.org.uk/news-and-comment/blogs/what-might-long-covid-mean-for-the-nations-health

depression, PTSD and suicidal ideation with UASC being at higher risk of mental illness than those with one or more parents[36].

In terms of cultural competency there is a need to understand mental health and grief within a cultural competency framework as many people experience overwhelming grief, loss and separation from family and friends[37].

Slide 12 Mental health key issues



The scope found that the use of contingency accommodation often had an additional negative effect on mental health. Conditions were often described as cramped, residents having little to no finances/independence (contingency accommodation is often full board), limited to no access to the internet or means of communicating with a support network, high prevalence of trauma, limited/disrupted access to health services, high levels of anxiety regarding the outcome of their asylum application and no foreseeable end point.

Mental health needs of residents were often not being met and the type or quality of accommodation was further exacerbating it, particularly in hotels and barracks, with mental health deterioration and crisis needs being high. Access to fresh air, exercise and activities are basic to wellbeing and were reported to not always being available. Living in close contact with people from diverse backgrounds with diverging cultural and religious beliefs, no common language, and deteriorating health were also often reported leading to feeling unsafe, conflict, isolation, and poor mental health.

Many areas raised concerns that many people seeking asylum find the asylum process and particularly the interview re-traumatising. There were also reports of a significant mental health impact of the long delays in asylum application decision making, with people

[36] Humphris, R. and Bradby, H., 2017. Health status of refugees and asylum seekers in Europe. In *Oxford Research Encyclopedia of Global Public Health*.
[37] Campbell, M.R., Mann, K.D., Moffatt, S., Dave, M. and Pearce, M.S., 2018. Social determinants of emotional well-being in new refugees in the UK. *Public health*, *164*, pp.72-81.

often speaking about the hopelessness that results from living in limbo on their mental health.

For children there were reports of very limited social interaction with peers and education, both of which are vital to improving and maintaining mental health.

Doctors of The World shared that 52% of residents supported during hotel outreach in London reported having a mental health issue, and every week at least one resident had attempted or threatened suicide[38].

Many areas reported lack of access to psychologically trauma informed first aid and interventions with the NHS Criteria to access Improving Access to Psychological Therapies (IAPT) services often not aligning with needs.

As risk factors to mental health are often outside the remit of health policy there is also the need for cross government work on prevention rather than just an enhanced or bespoke mental health offer. The Department of Health and Social Care (DHSC), NHSEI, PHE, HO and Refugee Council have recently established a Mental Health Forum in order to respond to such issues. The housing/ asylum impacts on mental health were agreed to be a priority objective to address alongside clarification of what is available in terms of mental health care in mainstream health services, wellbeing services and are they fit for purpose for this client group.

5.5 Maternal health

Earlier this year, the National Maternity Safeguarding Network (NMSN) held a deep dive into the needs of pregnant women and mothers seeking asylum. Maternity Action[39] highlighted the difficulties women often face whilst on their journey to the UK and through the asylum system and that they are likely to have endured the physical and psychological trauma of conflict, torture, deprivation of liberty, the disappearance or killing of their family and friends, rape, sexual and domestic slavery[40]. The NMSN also reflected that changes to immigration law and access to healthcare for other migrants were significantly effecting trust in services and what support is offered and available. The NMSN discussed the intricacies of supporting such vulnerable women who often have complex trauma, may not speak English, are socially isolated and fearful of accessing health services.

The NMSM identified the need for psychoeducation for unplanned pregnancy and birth controls to new arrival women who are often at risk of exploitation and lack information alongside better reproductive health outreach.

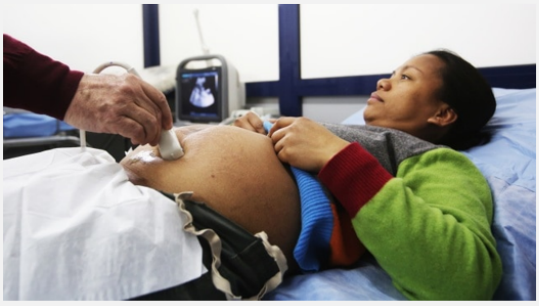
The NMSN reported some positive local resolutions, such as building a rapport with workers where women are housed but many shared their frustrations about women being moved multiple times, often late in their pregnancy alongside poor information sharing between

[38] https://www.doctorsoftheworld.org.uk/wp-content/uploads/2020/11/Letter-on-the-use-of-MoD-sites-as-accommodation_26.11.2020.pdf
[39] https://maternityaction.org.uk/
[40] Kalt, A., Hossain, M., Kiss, L. and Zimmerman, C., 2013. Asylum seekers, violence and health: a systematic review of research in high-income host countries. *American journal of public health*, *103*(3), pp.e30-e42.

health and the housing providers. Examples were given from across England of women who have had five or more moves in their pregnancy and some as late as 38 weeks, travelling for hours from London to places such as Scotland or Wales.

The NMSM have recommended that HO Health Care Needs Dispersal Policy[41] needs to consider a holistic assessment of risk, involving health and social care when making decisions to move women late in pregnancy or early postpartum. There also needs to be a process in place whereby other agencies can escalate safeguarding concerns to HO where a move to another area would not be in the best interests of that mother and child. Each move will have an impact on the continuity of that pregnant mothers' maternity care, on her ability to build support networks and ultimately the preparation for the birth of her baby.

Slide 13 Key issues for maternal health



"They were saying they're taking me to Birmingham. I had no one in Birmingham. I don't know anyone at all in Birmingham. I was like Oh God, where are they taking me?"

"The Home Office put me in detention centre so I could not attend my appointments. There were no maternity services there for me for the 2 months I was there. I was offered appointments but they were cancelled at short notice without anyone telling me why."

Fair et al., 2020

- Vulnerabilities of women & families who often have complex trauma
- Pregnancy as a result of rape
- Further impact of housing & poverty
- Delayed access to and change of Midwifery care
- Maternity Policy
- Perinatal mental health
- Further trauma, isolation, fear & uncertainty
- Increased vulnerability
- Safeguarding and health continuity when moving around the country

A recent Serious Case Review of Baby T[42], a child born to a Vietnamese woman seeking asylum, highlighted similarities of the concerns raised by the Network. There are a number of recommendations in that case review for HO, which the network would welcome, particularly the ask that HO publicise information about their safeguarding role/ arrangements and how local health and social care practitioners can best engage with those Home Office safeguarding services.

The Greater London Authority (GLA) highlighted several urgent issues pertaining to support for new mothers particularly in contingency hotel accommodation. These included urgent safeguarding issues concerning safe sleeping provision for babies. Their list of concerns included cots, moses baskets, maternity pads and sterilising equipment not being provided. There is also a need for culturally sensitive post-natal parental classes to

[41] new_Healthcare_Needs_and_Pregnancy_Dispersal_Policy_EXTERNAL_v3_0.pdf (publishing.service.gov.uk)
[42] https://www.redbridgescp.org.uk/wp-content/uploads/2016/04/Redbridge-LSCB-SCR-Baby-T-Report-Final-14-01-2020.pdf

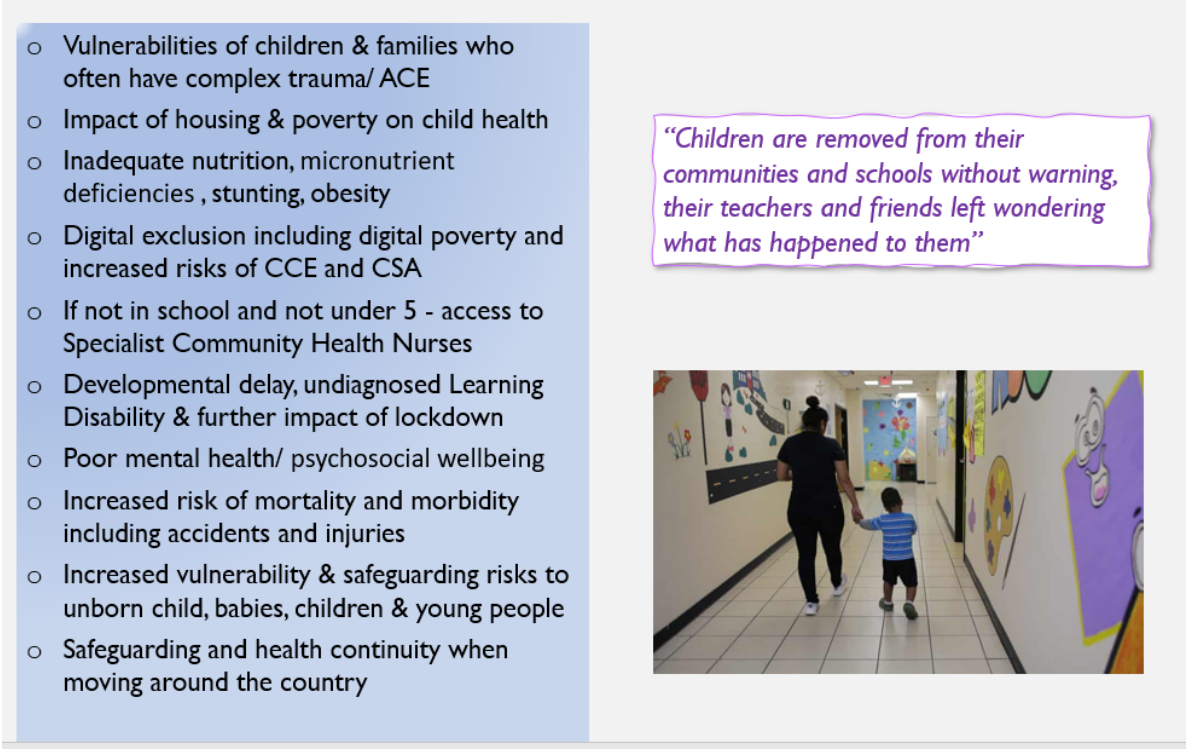
share host culture childcare approach which can be different from what the mother is familiar with due to cultural differences.

5.6 Children, young persons' and family health

The COVID-19 pandemic has upended the lives of families around the world. Parental stress and mental health problems have risen posing serious risks to children and young people's (CYP) development and wellbeing, putting them at risk of depression and anxiety themselves (from 1 in 9 in 2017 to 1 in 6 in 2020)[43].

CYP seeking asylum already have significant health, wellbeing and safeguarding vulnerabilities due to the their pre and post, migration experiences and the scope has highlighted that the impact of the pandemic has further exacerbated these.

Slide 14 Key issues related to children and families



All regions reported that support systems for CYP and their families seeking asylum have been profoundly disrupted. Many Health Visitors were redeployed into the frontline COVID-19 response during the first wave. Those who remained reported that their work with families was considerably affected by very high caseloads and the barriers created by social distancing measures. Many expressed concerns about their ability to monitor CYP's development, wellbeing and safeguarding needs.

Significant concerns were also expressed regarding lack of safe play, sleep and outside space for CYP particularly in contingency housing. Direct health conditions being

[43] https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2020-wave-1-follow-up

undiagnosed and untreated, inadequate nutrition provision for under 5s, missed immunisations, delayed presentations and lack of knowledge/barriers to accessing health care with effect on health and increased risk of mortality and morbidity including accidents and injuries.

Health issues were reported to be significantly exacerbated by short notice transfers and many CYP not being in nursery or school.

Young people aged 18-25 years have reported being harassed and intimidated within accommodation by older men. The scope also highlighted the need for support to engage with meaningful activities, advice on how to stay safe, and how to report safeguarding issues.

Lack of data sharing was found to be a critical safeguarding issue. One area reported being notified of a new baby living in hotel accommodation following hospital discharge but had no direct route to ascertain whether there were other children in the hotel who required health assessment. After investigating with several local GP practices and requesting information from hotel staff, the team were denied access to this information. When the team did gain access to the hotel, they made 38 referrals to specialist services on behalf of the first 20 children they met, encountering issues such as rickets, dental problems and diabetes. If major treatable health issues such as stunting and obesity, persistent micronutrient deficiencies, neurodevelopmental disorders or serious mental health conditions go unrecognised, children may suffer potentially lifelong consequences, such as early-onset non-communicable diseases with early mortality, impaired cognitive development, or longstanding mental health problems such as PTSD and depression.

In recent months areas have fed back some improvement in contingency accommodation, with the numbers of families reducing. However, most areas are still reporting concerns regarding quality and safety of accommodation, movement of CYP and safeguarding risks.

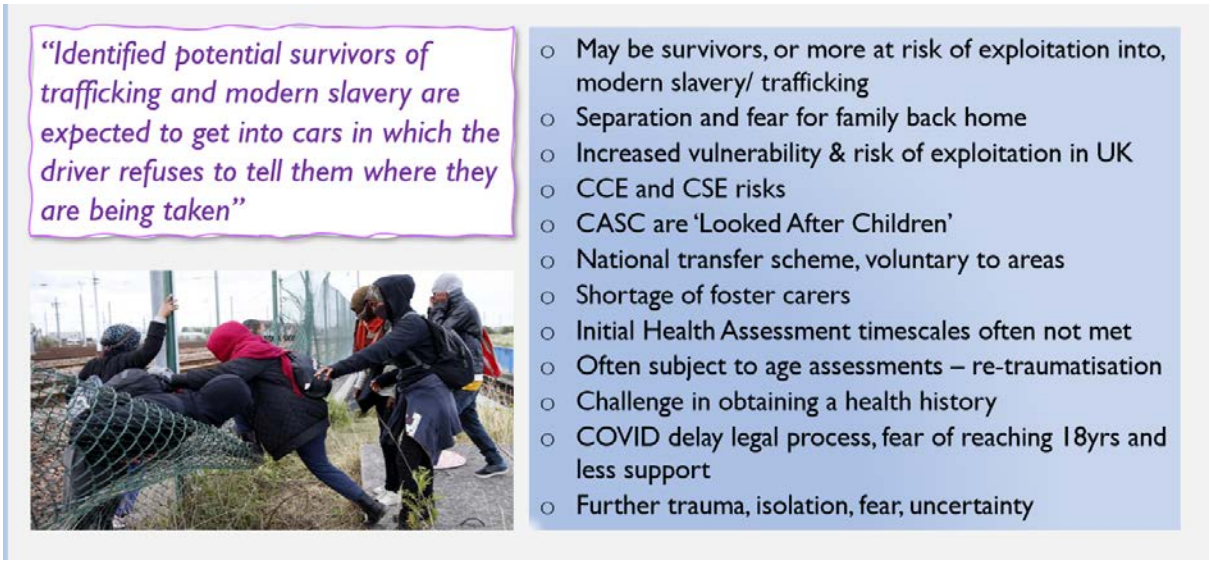
5.7 Unaccompanied asylum-seeking children

According to Home Office statistics, 2,868 unaccompanied children seeking asylum (UASC) applied for asylum in 2020. Many have fled conflict, war and persecution and have experienced multiple loss in their family, country of origin and on route to the UK. Some UASC may also have experienced violence and exploitation on their journey by adults including officials. They may have come from a country where they have or would have been forced to fight as a child soldier if they remained.

UASC do not enter asylum accommodation provision, instead they become ‘Looked After Children’ under the responsibility of the local authority where they arrive.

The scope identified that all regions had concerns regarding the health wellbeing and safeguarding of UASC.

Slide 15 Key issues relating to UASC



UASC often arrive highly traumatised, distrustful of officials, anxious to connect with people they know here, access housing and education. It is essential that practitioners have a child-centred, trauma-informed approach to build trust, understand UASC's needs, and engage them in safe, meaningful activities while accessing legal advice, housing and mainstream education. They are among the most vulnerable children in the country, often demonstrating high rates of trauma, physical and sexual abuse and unmet physical and mental health needs, requiring intensive, integrated support and health services to optimise engagement and physical health, mental health and social outcomes[44].

UASC who have arrived in the UK on their own have often faced delays in receiving an asylum decision as the Home Office system for interviewing children largely ground to a halt last March, resulting in a "devastating emotional impact".

Stakeholders reported working with UASC who had been child soldiers, were survivors, or potential victims, of modern slavery/ trafficking (including county lines, criminal exploitation and CSA) and gave examples of contextual safeguarding issues within the current National Transfer Scheme. Placement moves, lack of carers or support with similar language and culture, lack of consistency and ability to form trusting relationships were all reported as significant concerns. One case was highlighted in March whereby a young woman ran away from a taxi in Kent that came to take her to her foster carer in Leeds. Her whereabouts became unknown and concerns for her welfare were significant due to her increased vulnerability & risk of exploitation.

5.7.1 Initial health assessments

Initial Health Assessments are a legal requirement which are a key element of the safeguarding process for 'Looked After Children' and are supposed to be undertaken within twenty days of registration with a Local Authority but it was reported that this

[44] Armitage, A., Cohen, J., Eisen, S., Heys, M. and Ward, A., 2020. P06 Baseline characteristics and physical, sexual and emotional health needs of a cohort of unaccompanied asylum-seeking children presenting to a london borough. *Archives of Disease in Childhood*, *105*(Suppl 1), pp.A172-A172.

deadline is rarely met. Research suggests[45] that, despite guidance from government, NHS, the Royal College of Paediatrics and Child Health (RCPCH), that service providers feel clinically and emotionally ill-equipped to respond to the needs of this group.

5.7.2 Age assessment

There is a wide range of evidence that the age assessment process can be inconsistent and inaccurate. In 2019, in a statement on age assessment of UASC, the World Medical Association stated that medical age assessment should only be carried out in exceptional circumstances and only after all non-medical methods have been exhausted.

There were several reports during the scope from across the country of UASC being subject to age assessment and being moved in and out and then back in again of the child and adult process due to age dispute. The impacts being significant to their health including increased trauma for the UASC and increasing mistrust of healthcare services.

It is essential that UASC health needs are identified and required interventions facilitated including specialist support/treatment required. Specific health needs pathways need to be in place whereby the role of schools and further education needs to be a key consideration.

5.7.3 Suicide

Since presenting initial findings of the scope to the Safeguarding Adults National Network in March 2021 the authors have become aware of a letter from Da'aro Youth Project (DYP) in London that was recently sent to the Children's Commissioner referring to deaths by suicide of eight teenagers from Eritrea and Ethiopia, in the UK since 2016. All of whom died whilst being UASC and were either children in the care system or care-leavers at the time of their deaths.

Four deaths were reported in the Guardian newspaper [46]and another death led to a serious case review. Six coroner's inquests have taken place relating to these deaths, with two inquests still outstanding. One of the authors of this paper contacted DYP who relayed concerns that many of the young people had no family members in the UK to advocate for them after their deaths and that several inquests were held with no witnesses present and no family representation. DYP fed back that at one inquest they attended it only lasted half an hour and did not include a statement from the young person's social worker.

DYP has raised doubts as to whether the inquests have provided any useful instruction as to how such deaths can be prevented in the future. People seeking asylum have higher rates of mental health conditions that carry an increased risk of suicide but there is no accurate available data on suicide amongst this group in the UK. There is currently no provision for coroners to record the status of asylum seeker, UASC or any other immigration status on their returns to the Office of National Statistics[47].

[45] Stevens, A.J., 2020. How can we meet the health needs of child refugees, asylum seekers and undocumented migrants?. *Archives of disease in childhood*, *105*(2), pp.191-196.
[46] https://www.theguardian.com/uk-news/2018/jun/17/suicides-raise-alarm-about-uk-treatment-ofchild-refugees-eritrean and https://www.theguardian.com/uk-news/2019/sep/17/teenage-refugeewas-fourth-of-friendship-group-to-kill-himself

[47] Cohen, J., Katona, C. and Bhugra, D., 2020. National data on suicide must include ethnicity.

DYP report to knowing some information about those who have died that includes; some young people were still awaiting the outcome of asylum applications and were worried about a negative decision; some had experienced age disputes that had found them to be adults before they were later brought back into the care system as children and some had difficulties with post-traumatic stress and with misuse of drugs and alcohol. DYP believe that there are connecting factors between the young people who have died and has asked that the Children's Commissioner undertake an urgent inquiry into the deaths of the eight persons listed, and to gather further information on the wider issue of the mental health needs of UASC in care and care-leavers.

5.8 Disability

Persons with disabilities, either physical or intellectual, are often targeted for sexual exploitation and are more likely to experience involuntary detention with a higher risk of exposure to torture or inhuman and degrading treatment in institutions[48]. The UN High Commissioner for Refugees estimates 7-10% of forcibly displaced people are disabled but there is little empirical data to test estimates[49].

Slide 16 – Key Issues in Relation to Disability

People seeking asylum who are disabled are likely to experience further barriers[50] whilst in the UK. They may have difficulties in providing coherent or credible accounts of their disabilities and may be accustomed to hiding their disability. This makes identification, provision of support and reasonable adjustment challenging. Very few disability organisations work with people seeking asylum as a specific focus, this may be due to simply not getting many contacts/referrals. Agencies who do support this area feedback the complexity of trauma and lack of education makes it particularly challenging to establish learning disability.

[48] Brown, H., 2002. *Safeguarding adults and children with disabilities against abuse*. Council of Europe.
[49] Crock, M., Ernst, C. and Ao, R.M., 2012. Where disability and displacement intersect: Asylum seekers and refugees with disabilities. *International Journal of Refugee Law*, *24*(4), pp.735-764.
[50] Yeo, R., 2017. 'Disabled asylum seekers?… They don't really exist': The marginalisation of disabled asylum seekers in the UK and why it matters.

5.9 Safeguarding

Throughout the scoping exercise significant contextual safeguarding issues were identified. There were many safeguarding concerns ranging from domestic and sexual abuse, Female Genital Mutilation, breast binding, forced marriage, witchcraft and all forms of exploitation including slavery and trafficking.

Lack of data sharing and understanding of where people were housed, including children, raised concerns regarding increased risks of exploitation and re-trafficking. Destitution and food insecurity were also identified as leading to vulnerable people to more likely to seek support elsewhere. The 'Hear us' report from the Sisters Not Strangers coalition noted women seeking asylum being stuck in abuse or exploitation during the pandemic, leaving them at high risk from unscrupulous people and of grooming and exploitation[51].

Lack of gender segregation was also reported as a significant issue, presenting a high risk of abuse to vulnerable people including children. Accommodation providers often responded by separating floors for women, men and families but this then often impacted on capacity should it result in a floor with many empty rooms and large numbers of people requiring accommodation.

Refugee Council highlighted the importance of recognising the transitional safeguarding issues that people face when they move between the asylum and mainstream systems.

There are key transitions when people are greatest risk and include:

- Turning 18 and leaving care and going back into the asylum system;
- Move from initial accommodation to dispersal accommodation;
- Destitution into section 4 accommodation;
- Asylum to detention;
- Detention and bail into the community.

Designated safeguarding and children in care professionals for children and equivalent roles for adults can and do proactively offer support and advice to organisations working with people seeking asylum and facilitate partnership working via the statutory Safeguarding Adults Boards and Children's Safeguarding Partnerships.

The Designated Doctor and Named GP for Children are key to providing medical advice and system leadership in the NHS and the wider Safeguarding Partnership in safeguarding the welfare of children seeking asylum. The statutory guidance for safeguarding children sets out the requirement for Designated Nurses and Doctors to be employed in provider and commissioning organisations across each local health economy.

Both unaccompanied and accompanied children are supported by Designated Doctors and Nurses for children with roles and competencies for professionals are set out in the Intercollegiate Document[52]. Although the role of the Designated Professional in health is highlighted in the Care and Support Statutory Guidance for Safeguarding Adults, there are

[51] Helen Bamber Foundation 2021 briefing paper:
Welfare, maternity and asylum support hotels
[52] https://www.rcpch.ac.uk/sites/default/files/2019-08/safeguarding_cyp_-_roles_and_competencies_for_paediatricians_-_august_2019_0.pdf

no roles set out in the guidance for medical leadership, yet the rationale for having Designated Doctor roles to safeguard children applies to safeguarding adults. The Intercollegiate Document relating to adults[53] sets out roles and competence for the Designated Professional and Named GP but makes no provision for a Designated Doctor.

As unaccompanied and accompanied asylum seeking children will become adults, it would be beneficial for Designated Doctors for Children to transition their care to Designated Doctors for adults. In addition, complex vulnerability means asylum seekers are highly likely to have care and support needs regardless of whether these needs are being met, these adults may also be the parents of children requiring a health and partnership response. Safeguarding Adults Boards are key in seeking assurance from local systems on the welfare of adults seeking asylum but do not benefit from the strategic expertise of a Designated Doctor role to work with existing Designated Professional roles. This medical role would arguably benefit the NHS and partnership response to safeguarding and in reducing inequalities.

5.10 Workforce

The personal and emotional impact of the COVID-19 pandemic on staff wellbeing both in the short and longer term should not be underestimated. There are strong indications that the pressures and experiences of the last year are leading to increased stress, exhaustion and burnout[54].

Slide 17 Key Issues Related to Workforce

- Personal & professional emotional toll of pandemic
- Access to mental health & wellbeing offers
- Impact of vicarious trauma on frontline staff
- Access to trauma informed resilience based supervision
- Training to support knowledge and skills for asylum seeker health
- Recognition of support for non-front line/strategic roles in managing the system response to asylum seeking population needs
- Specialist safeguarding support

[53] https://www.rcn.org.uk/professional-development/publications/pub-007069
[54] https://www.kingsfund.org.uk/publications/health-social-care-select-committee-inquiry-workforce-burnout

The scope identified that Health, housing and wider support staff such as the VCSE sector have demonstrated remarkable resilience and dedication to deliver the best possible care for people seeking asylum in what has been very difficult circumstances. However there were also worrying reports of high levels of stress and vicarious trauma amongst staff working in this sector and vicarious trauma.

Managerial support for staff wellbeing and access to trauma informed resilience-based supervision and systems across health, housing and volunteer services is paramount. Training is available, but sporadic and joint training to support knowledge and skills for asylum seeker health needs to be accessible.

Delivering person-centred care which considers cultural and religious requirements of all patients is congruent with culturally competent practice. For the workforce to be supported to practice in a trauma informed and culturally competent way, at an organisational level a framework of values and standards should be developed to put these values in to action. By combining cultural competence and trauma informed systems, values, supervision and training between Board and floor, professional practice can develop, supported by organisational and wider system commitments in this area.

Beyond the formal health, housing and care workforce, better use should also be made of broader support available by embracing the contributions of voluntary and community sector organisations. In partnership with HO, it would be useful also to explore the possibility of providing more opportunities for people seeking asylum to become peer support volunteers.

6 Recommendations

Key recommendations for the ASHSG, SAAN and NSSG are:

System Leadership:

1. To establish a UK Asylum Seeker Health Steering Group (ASHSG) jointly chaired by Department Health Social Care (DHSC) and HO, ensuring lived experience voices, NHSEI, PHE, VCSE and Ministry of Housing Communities and Local Government (MHCLG) are represented (ASHSG to consider whether membership should include all of the UK).
2. ASHSG to agree key workstreams/ pathways from this report and recommendations to address key systems issues and barriers.
3. ASHSG to clarify roles and responsibilities of all key partners i.e. Housing Providers, Integrated Care Systems (ICS) and Strategic Migration Partnerships.
4. NHSEI & PHE to facilitate provision of migration health single point of contact in each ICS that aligns to other key roles i.e. inclusion health & safeguarding.
5. ASHSG to monitor impacts of housing policy on health and safeguarding; to assure systems leadership is in place throughout Operation Oak, future housing policies and Immigration plans and to ensure necessary actions are put in place to keep people safe wherever possible.
6. NHSEI, PHE and Home Office to establish national data sharing agreements in order to meet the health, wellbeing and safeguarding needs of people and wider public health protection. Recognising the need for a firewall to ensure no data flow from the NHS to HO, for the purposes of immigration enforcement.

7. NHSEI, PHE and Home Office to raise awareness of support and healthcare available for people seeking asylum, ensuring accessible fit for purpose resources that build trust in services by making it clear their health data will not be shared with Home Office.
8. ASHSG to explore need for national data sharing agreements in order to meet the health, wellbeing and safeguarding needs of people and wider public health protection.
9. ASHSG to consider wider implications on health, wellbeing and safeguarding for all 'vulnerable migrants'

Access to Healthcare:

1. NHSEI to recommend provision of initial assessment by local NHS services to all people new to the asylum system whether they come through Initial Accommodation Centres or not.
2. Housing providers to proactively support all people to undertake initial assessment, monitoring uptake and escalating barriers to steering group.
3. NHSEI to facilitate the review of guidance and templates for initial health assessment (including new entrant screening), electronic alignment to wider patient records and consider reinstating handheld records.
4. ASHSG to agree clear planning processes for health and asylum housing and transfers to ensure capacity and coordination of services.
5. Housing providers to proactively support all people to register with a GP in contingency, initial and dispersal accommodation, escalating barriers to steering group.

6. NHSEI and Home Office to agree a standard and clearly defined route to permanent GP registration and health access, clarifying key roles and responsibilities and mechanisms to monitor and escalate issues such as short notice transfers as necessary.
7. NHSEI to facilitate the development of GP electronic record templates for people seeking asylum, electronic alignment to initial health assessment and wider patient records.
8. NHSEI and Home Office to review and improve health induction information given to people seeking asylum ensuring it is available in accessible formats. Comprehensive information to include rights to and how to use; NHS services; safeguarding self and family; prescription medication and COVID-19 information, vaccination and testing services.
9. NHSEI to ensure plans are put in place to gain a better understanding of digital exclusion within this population and facilitate mitigating actions to level-up health outcomes across these groups.
10. NHSEI to reiterate to all regions the recent government guidance stipulates that a professional interpreter should always be offered. NHS England and Improvement to monitor adherence to the guidance, providing support and taking appropriate action when necessary.
11. ASHSG to consider the collection of systematic data on the uptake/availability of interpreters.

Covid-19:

1. NHSEI, PHE and Home Office to ensure robust COVID-19 public health procedures and data sharing arrangements are in place alongside published clarity of where and how information is shared for all vulnerable migrants included 'undocumented'. Reiterating commitment to maintaining firewalls to prevent information from being shared for immigration enforcement purposes.

Mental Health:

1. ASHSG to consider frameworks for all organisations to develop a Trauma Informed Approach that blend with Cultural Competence.
2. ASHSG to continue commitment to obtain funding for access to therapeutic psychological first aid - national pilot.
3. ASHSG to consider the development of national supportive programmes that improve mental wellbeing such as volunteer schemes and community champions who have experience of migration and can help bridge gaps

Maternal Health:

1. NHSEI and Home Office to review current Healthcare Needs and Pregnancy Dispersal Policy and agree governance frameworks relating to risk management, safeguarding and escalation processes that hold the system to account.
2. NHSEI and Home Office to agree a standard and clearly defined direct referral route to Midwifery services for pregnant women.

Children, young people and family health:

1. NHSEI and Home Office to work closely together to share vital data, ensuring those CYP and families who need additional support receive appropriate, timely, and culturally sensitive help.
2. PHE and Home Office to agree a standard and clearly defined direct referral route to Health Visiting and School Nursing services for all CYP. Health Visitors getting information about transfers in and out for families with under 5s.
3. The ASHSG to advocate for the need for guaranteed schools and nursery access for all CYP.
4. Home Office to ensure housing providers dedicate welfare staff focused on monitoring and ensuring the welfare of young people.
5. Home Office to ensure where full board minimum nutrition provision to be facilitated and monitored for all CYP.

UASC:

1. ASHSG to agree clear planning and provision for UASC to ensure safeguarding, capacity and coordination of services to optimise health and social outcomes.
2. Local Authorities to proactively support all UASC to have initial assessment completed within twenty days and to register with a GP, monitoring performance and escalating barriers to steering group.

3. NSSG to consider recommending a specific annual health assessment and remuneration for GP practices to ensure care leavers including UASC continue to have longer, appropriate appointments post 18 years old.
4. NSSG to consider extending statutory assessments beyond 18 years old as recommended in RCPCH state of child health review of Promoting the health of Looked After Children.
5. NHSEI and Home Office to consider age assessments processes that are supported by an expert panel with relevant clinical expertise.
6. Local Authorities to ensure all work for care leavers around education, housing, finances, social needs, health and mental health includes UASC with appropriate adaptations to meet their individual needs.
7. NHSEI, Home Office and Local Authorities to facilitate access to specialist training provision in meeting needs of UASC.
8. To review data collection systems for this group for greater understanding of need to inform policy and safeguarding needs.
9. To make provision for coroners to record immigration status on cases of suicide
10. NSSG to review concerns regarding deaths by suicide of UASCs and determine if further action is required.

Disability:

1. Training to be accessible for professionals in disabilities specifically related to people seeking asylum.
2. ASHSG to consider improved data collection around immigration status and disability in order to understand the need.

Safeguarding:

1. NSSG to consider Designated Doctor roles for safeguarding adults in parity with those for children.
2. NHSEI and Home Office to develop revised safeguarding policies and procedures to mitigate transitional safeguarding risks for people in the asylum system.

Workforce:

1. To scope, develop and provide training and supervision for staff responding to the needs of people seeking asylum which includes trauma informed practice and cultural competence.
2. Where accommodation requirements are subcontracted (such as with hotel accommodation) these minimum training requirements should form part of the sub contact agreement and apply to staff employed by the sub-contractor.
3. ASHSG to embrace and develop the contributions of voluntary and community sector organisations and also explore the possibility of providing more opportunities for people seeking asylum to become peer support volunteers.

7 Conclusion

The complexities involved in understanding and meeting the needs of people seeking asylum are clearly demonstrated within this scope and can not be underestimated. The NHS has faced, and continues to face, its biggest challenge brought by the pandemic both in terms of its workforce and how it meets the health needs of the nation. The recommendations in this report relating to people seeking asylum are made to align with the values and goals of the NHS Long Term Plan and recognising strengthening health as a common good. The recommendations are made while acknowledging the pressures on all services and the need for partnership working across all sectors to seek and make improvements.

6 Appendix 1 Template Used to Scope Regions

Question	Please describe any relevant detail in response to question	Any strengths, weaknesses, opportunities or threats?
Regional Strategic Leadership, Partnerships and Systems		
Please describe the regional strategic leadership in relation to client group e.g. at an ICS, CCG and/ or Strategic Migration partnership level.		
Please describe the communication channels within the partnership.		
Please describe the relevant regional and local partnership working with key organisations i.e. HO, Housing Providers, LAs and Third Sector Organisations? Are there clear roles and responsibilities between the different agencies?		
What systems are in place with HO and Housing Providers to ensure Healthcare and relevant Safeguarding Partnerships are involved in the planning and get notified of new accommodation/ contingency hotels being set up in your local areas?		

What are the arrangements for notification of new asylum seeker arrivals to the area in initial accommodation and in dispersal areas?		
Do you have arrangements in place to meet Infection Prevention Control measures i.e. PPE, COVID testing and vaccination in initial accommodation and in dispersal areas?		
Primary Care Inclusion Healthcare Models		
How are the primary health care healthcare needs commissioned for this client group in your region? e.g. Do you have inclusion health teams and if so, what is then the mainstream General Practice role?		
What are the arrangements for interpreting and translation services in NHS Services?		
Healthcare in Initial Accommodation		
For people in 'Initial Accommodation' which organisation provides initial health assessment (whether that be in an Initial Accommodation Centre or 'pop up' Accommodation such as hotels)? What role/s currently undertake the assessments?		
Does your region have a template for initial health assessments? (please attach if so)		

Do you feel these initial health assessments are undertaken effectively? Are these initial assessments shared with patients themselves in a handheld record for example? (If yes please attach example if possible). If not, why not? Are these initial assessments shared elsewhere for example with the registering GP Practice and if so how? If not, why not?		
Access to Primary Care Services		
What are arrangements for access/ referring to GP services for people in initial accommodation and in dispersal areas?		
Do your local practices have templates for new patient registrations specific to this population?		
Access to other NHS Services		
What are the arrangements for access/ referring to new entrant screening i.e. TB and HIV testing		
What are the arrangements for access/ referring to mental health services?		

What are arrangements for access/ referring to maternity services in initial accommodation and in dispersal areas?		
What are the arrangements for access/ referring to sexual health services including pregnancy testing?		
Children		
What are the arrangements for children to access school/ education?		
Do you have any specific concerns relating to meeting the health needs of children?		
Housing and Social Support		
Do you have any concerns regarding housing and social support that impacts on the health, wellbeing and safeguarding needs of this population?		
Training		
For healthcare staff including GPs what are the training arrangements to ensure good practice in meeting the **healthcare needs of people seeking asylum** your area? What healthcare training/ guidance is available for other agencies involved in meeting the meeting the health and safeguarding needs for people seeking asylum?		
Key Concerns		

What are the key healthcare concerns for people seeking asylum?		
What are the key safeguarding concerns for people seeking asylum?		
Any other concerns or comments you have regarding meeting the health and safeguarding needs for people seeking asylum you would like to share? Any opportunities you feel are being missed to promote health wellbeing for people seeking asylum?		