British Red Cross

St George's University of London

VCSE health & wellbeing alliance

Delivering with dignity

A framework for strengthening commissioning and provision of healthcare services for people seeking asylum

#Deliveringwithdignity
@RedCrossPolicy

Acknowledgements

The peer researchers: Isra Al-Sharabi, Niloha Rangel and Acha Joseph.

The St George's Hospital Migrant Health Research Group: Anna Deal, Katy Mackey, Sally Hargreaves, Jess Carter, Felicity Knights and Stephanie Fisher.

The British Red Cross project group: Lois Davies, Emma Cookson, Leo Bryant, Simone Currie, Lucy Fisher, Tamara Manuel, Tom Cottam, Morgan Mead, Daisy Vaughan-Liñero and Jen Anderson.

The working group who provided invaluable insights: Norfolk & Waveney ICB, West Yorkshire ICB, Lancashire & Cumbria ICB, West Yorkshire ICB , Cheshire & Merseyside ICB, Hampshire &Isle of Wight ICB, Inclusion healthcare CIC, ASHA, Respond Integrated Refugee Health Service, University College London Hospital, Walsall Council, Stoke City Council, Hampshire County Council, Dr Samuel Duncan, Dr Laura Oakes, Dr Aisha Malik.

The 60 workshop participants who generously contributed their time, expertise and experiences with us.

The voluntary and community organisations who kindly supported this work: Southwark Refugee Communities Forum, ASHA Stoke-on-Trent and the VOICES Network.

The Health and Wellbeing Alliance who made this work possible with crucial guidance from colleagues working in government agencies and departments: Fatima Wurie (OHID, DHSC), Faye Mitchell-Charman (OHID, DHSC), Olivia Falgayrac-Jones (NHSE), Mark Smith (NHSE), Nicola Gitsham (NHSE), Cathie Railton (OHID, DHSC) and colleagues at the Home Office.

Published August 2024

Design: Ross McLeod, graphics.coop

For media requests, please contact: press@redcross.org.uk

For more information on the policy recommendations and research, or to get in touch about where this framework has been useful to you, please contact: advocacy@redcross.org.uk

Contents

Glossary

Co-production

Working with people with relevant lived experience to produce a specific collective outcome. Power sharing, collaboration and interdependency are centralised in this approach. People with lived experience are supported to work together with mutual responsibilities and expectations. Successful co-production builds on people's existing capabilities and ensures they can participate in ways that recognise their value.[1] Co-design refers to a similar but distinct creative process, where people with lived experience work in partnership with healthcare providers to improve services or develop interventions.[2]

Contingency accommodation

Accommodation sites opened by the Home Office in response to the backlog in unprocessed asylum claims and the rise in the asylum-seeking population, mostly from 2019 onwards.[3] These are often repurposed hotels, hostels or former military barracks nearly always offering shared rooms and catering.

Community leaders

The term 'community leader' will be used here to refer to people leading or involved in voluntary, community and social enterprise groups that support people seeking asylum. They often identify as a member of the community that their organisation serves.

Dispersal accommodation

Accommodation to which people seeking asylum can be moved after qualifying for Section 95 support. The location of this accommodation, which is usually flats and shared houses, is allocated on a no-choice basis by the Home Office.

Healthcare professional

Any individual working in the healthcare sector, including both clinical and non-clinical staff, such as receptionists and practice managers.

Healthcare provider

A medical professional or an organisation that provides healthcare services. Examples of healthcare providers include doctors, nurses, therapists, pharmacists, hospitals, GP practices and other healthcare centres.[4]

Inclusion health groups

Inclusion health groups include people who are socially excluded and experience multiple, intersecting risk factors for poor health. This includes vulnerable migrants, people who experience homelessness, drug and alcohol dependence, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery.[5]

Initial accommodation

The term 'initial accommodation' is used to refer to the first accommodation that people seeking asylum are placed in by the Home Office while in receipt of asylum support. This does not include contingency accommodation, which is referred to above.

Large-scale sites

This refers to large-scale accommodation provided by the Home Office which aims to provide 'more appropriate, cost-effective accommodation options around the country'.[6] These are often former military sites and are designed to accommodate large numbers of people seeking asylum in a contained site.

Locally enhanced service

A specific primary care service commissioned by an Integrated Care Board (ICB) outside of national GP contracts to meet local population needs and priorities.[7] Locally enhanced services pay GP practices incentives for providing this specific service or service improvement, usually per GP appointment carried out.

Peer researchers

People with lived experience of seeking asylum in the UK who worked on this research to co-design research tools; develop, conduct and analyse roundtable discussions and workshops; and develop and draft the framework.

Person seeking asylum

Someone who has left their country of origin to seek protection in another country. A person seeking asylum has applied for refugee status but their claim has not yet been determined.[8] The British Red Cross uses language that reflects the preferences of people with lived experience of seeking asylum, seeing the person first, before their often temporary situation or status.

Refugee

Someone who has been forced to flee conflict or persecution and has crossed an international border to seek safety. They have had their claim for asylum accepted by the government and have permission to stay in the UK.[9]

Trauma-informed care

Trauma-informed practice is an approach to health and care interventions that is grounded in an understanding of the impact trauma exposure can have on individuals. It aims to avoid re-traumatisation and to improve patients' ability to feel safe or develop trusting relationships with health and care services.[10]

Workshop participants

The term 'workshop participants' or 'participants' refers to the 60 individuals who participated in this research as community leaders and people with lived experience of the asylum system across three workshops. More details on workshop methods and participants can be found in section 4.1 and a detailed overview of findings from the workshops in section 4.2.

Working group

The term 'working group' refers to the 19 individuals who consented to be a part of the working group that guided framework development throughout the research. These individuals included ICB representatives such as inclusion health leads, local authority public health representatives and clinical professionals such as nurse specialists. As part of the research, two roundtable discussions were held with the working group. Those who participated in this session will sometimes be referred to as 'attendees'. Further information on attendees in the working group and roundtable discussions can be found in section 4.1.3 and an overview of findings from the roundtable discussions in section 4.2.2.

Acronyms

A&E	Accident and Emergency Care
AASC	Asylum Accommodation and Support Services Contract
DHSC	The Department for Health and Social Care
GP	General Practitioner
ICB	Integrated Care Board
ICS	Integrated Care System
NHS	UK National Health Service
NHSE	National Health Service England
OHID	Office for Health Improvement and Disparities
PCN	Primary Care Network
UK	The United Kingdom
UKHSA	The UK Health and Security Agency
VCSE	Voluntary, Community and Social Enterprise

Introduction

The number of people seeking asylum in the UK has been rapidly increasing in the last few years, mostly due to a backlog in the processing of asylum cases.[11] In December 2023, 128,786 people were waiting for a decision or appeal on their asylum claim in the UK.[12,13] As the UK's largest independent provider of services for people seeking asylum, the British Red Cross has used its three-year membership with the VCSE Health and Wellbeing Alliance[a] to investigate barriers to healthcare access for refugees and people seeking asylum in England.[14,15] This research has built on a wealth of literature showing that people seeking asylum often have complex health needs and face significant barriers to accessing healthcare.[16,17]

NHSE's inclusion health framework[18] and All Our Health (Office for Health Improvement and Disparities)[19] provide guidance on healthcare provision for inclusion health groups. Doctors of the World UK have published a toolkit for commissioners of primary care for people seeking asylum in contingency and initial accommodation settings.[20] While these have made important contributions to practice and understanding, there is currently no national framework for providing and commissioning healthcare for people in the asylum system, despite their specific needs and circumstances.

Between September 2023 and April 2024, the British Red Cross commissioned the Migrant Health Research Group at St George's Hospital, University of London, to address this gap. The research brought together a diverse range of experts including those with lived experience of seeking asylum, academic researchers and those directly involved in providing and commissioning healthcare services.

Our research aimed to explore the following questions:

1. What are the specific challenges associated with commissioning healthcare services for people seeking asylum and how can Integrated Care Systems (ICSs) and healthcare professionals be supported to achieve good practice?
2. Drawing insights from a scoping review of previous or existing interventions and the healthcare experiences of people seeking asylum, what would good practice for improving access to healthcare for people seeking asylum look like and how can this be achieved?

Leveraging lessons and insights from the scoping review, the experts designed a framework of good practice for a) strengthening commissioning and provision of healthcare for people seeking asylum in England at a local level and b) policy making to better enable this at a national level. This is referred to throughout this report as 'the Framework'.

This report contains the Framework in Section 2. The Framework is preceded by an outline of the urgent case for action in Section 1 and followed in Section 3 with links to resources and case studies from the scoping review which may help practitioners to implement the recommendations in the Framework. Section 4 provides a detailed description of the research methodology and the research findings from which the recommendations in the Framework were derived. This sets out in detail the valuable insights from people with lived experience of seeking asylum.

[a] The Voluntary, Community and Social Enterprise (VCSE) Health and Wellbeing Alliance (HW Alliance) is a partnership between NHS England (NHSE), the Department of Health and Social Care (DHSC), the UK Health Security Agency (UKHSA) and 18 VCSE members that represent groups who share protected characteristics or experience health inequalities.

1. The case for action

This section sets out the current context and why change is needed.

1.1 Barriers to access

People seeking asylum in England face significant barriers to accessing timely, quality, and appropriate healthcare.[21] Limited English proficiency can lead to unmet language support needs, such as difficulties accessing interpreters.[22] In addition, differences between the NHS and healthcare systems in someone's home country can complicate navigation and foster uncertainty about entitlements. Destitution is widespread among people in the asylum system.[23] This has far-reaching health impacts: preventing people from leading a healthy life; purchasing basic necessities such as clothing; restricting their ability to travel to medical appointments;[24] and increasing their likelihood of experiencing digital exclusion.[25] The high risk of digital exclusion among people seeking asylum can create and exacerbate barriers to healthcare, particularly in an increasingly digitalised healthcare landscape.[26]

These challenges faced by people seeking asylum and the resulting impact on an already stretched health and care system[27] are being compounded the backlog in processing asylum applications. By the end of 2023, pending asylum claims exceeded 125,000,[28] marking a 20 per cent decrease from the end of 2022 and a 237 per cent rise since the end of 2018.[29] In 2014, nine in ten applications received an initial decision within six months; by 2022, this dropped to just over one in ten. Over the past years there has been an increase in contingency[30,31] resulting in new challenges in healthcare provision for local areas due to limited funding for health and the dissemination of information about the numbers and needs of residents.[32,33,34] Despite being designed for short stays of up to 35 days,[35] some individuals had stayed in contingency accommodation for one to two years.[36] The negative consequences of long stays in contingency accommodation and large-scale sites, such as the impact on mental health and vulnerability to contracting infectious diseases, are well documented.[37,38,39]

Providers of contingency accommodation are not contractually obligated to provide clothing,[40] often leaving residents without access to clean changes of clothes.[41] This heightens the risk of infectious diseases like scabies spreading among residents.[42] Not everyone seeking asylum resides in Home Office accommodation; the healthcare needs of those who do not must also be carefully considered.

At the time of writing, the new government has committed to ending hotel use within the year, and has announced the closure of the Bibby Stockholm in January. However, there are learnings in this report that can be implemented to ensure access to healthcare as these changes take place and provide a blueprint for an asylum system that includes timely, accessible, good quality and cost effective healthcare.

1.2 ICSs and ICBs: roles and responsibilities in healthcare provision for people seeking asylum

Existing in various forms since 2016 and made statutory by the Health and Care Act 2022, Integrated Care Systems (ICSs) aim to improve health outcomes by encouraging collaboration across the NHS, local authorities and other local stakeholders.[43,44] There are currently 42 ICSs in England.[45] ICSs are comprised of Integrated Care Boards (ICBs) and Integrated Care Partnerships (ICPs), each made up of representatives from NHS Trusts and Foundation Trusts, local authorities, general practice, public health, social care and housing services, and voluntary, community and social enterprise (VCSE) organisations.

Tackling health inequalities is one of the statutory duties of an ICS as defined in the Health and Care Act.[46,47] NHS England (NHSE) also prioritise action to reduce healthcare inequalities through their CORE20PLUS5 approach.[48] NHSE's inclusion health framework from 2023 made it a requirement for each ICB to have a named inclusion health lead.[49] The inclusion health lead is responsible for driving action to reduce health inequalities amongst health inclusion groups in the area.

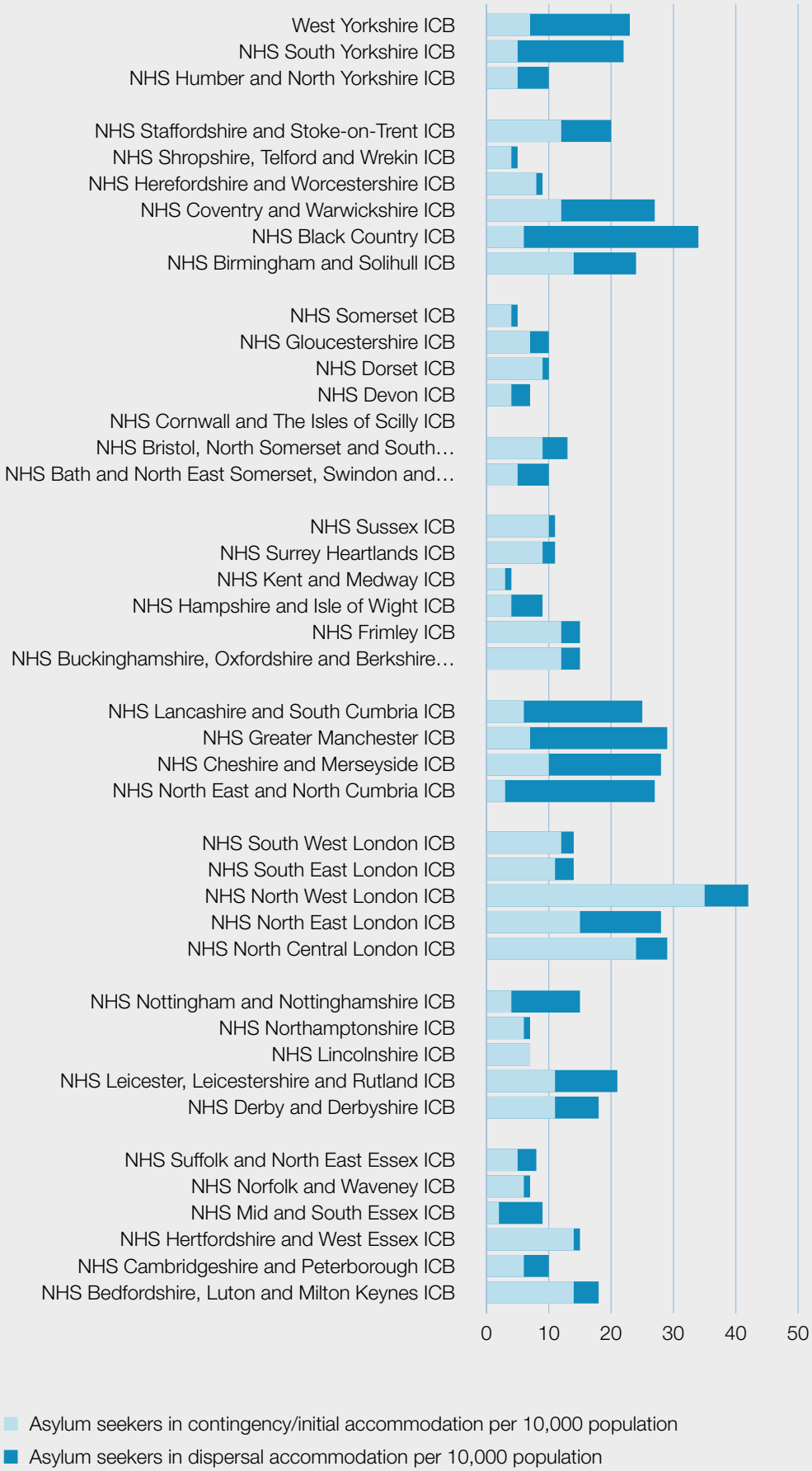
Within ICSs, ICBs have statutory and delegated responsibilities for managing the NHS budget for their area and commissioning healthcare services for the population within their footprints – except services to detained settings and some specialised services whose responsibility remains with NHSE. Local authorities and ICBs are expected to work together to provide and commission healthcare services as part of the ICS structure, mandated by the Health and Care Act.[50] While local authority representatives may be part of ICBs and wider ICS structures, the responsibilities of local authorities and ICBs/ICSs differ.

In the Health and Social Care Act 2012, local authorities were assigned the responsibility for improving the health of their local population, which includes people seeking asylum, and for some specific public health services, such as sexual health clinics, through their Public Health teams.[51]

Improving health outcomes and healthcare access for people seeking asylum in the local areas falls directly within the ICB and ICS remit, as part of a broader responsibility to tackle health inequalities and planning local inclusion health strategies.[52] NHSE's inclusion health framework[53] specifically highlights that services commissioned for these inclusion health groups may need to be specialised and allow for additional time and support. Responsible for commissioning primary care, ICBs are also responsible for providing initial health assessments for people seeking asylum on their arrival into the ICS area.[54] Since 2020/21, NHSE has contributed to ICBs' costs supporting individuals in contingency accommodation to access GP services and receive initial health assessments.[55] This funding has varied year on year due to the growing number of individuals in contingency accommodation.[56]

While healthcare provisions for people seeking asylum have historically been more relevant to specific local areas in England, the increased dispersal of people seeking asylum across the country and the establishment of asylum accommodation in new areas have broadened the applicability and responsibility of commissioning healthcare for people seeking asylum to all ICBs in the country. Figure 1 illustrates this, showing the number of people living in initial or contingency and dispersal accommodation per 10,000 population in each of the 42 ICSs as of September 2023.[57]

Figure 1. People seeking asylum per 10,000 population in dispersal and initial accommodation by ICB area, September 2023 data.[58]



2. The Framework

This section sets out five pillars of good practice and recommendations to support stakeholders on implementation.

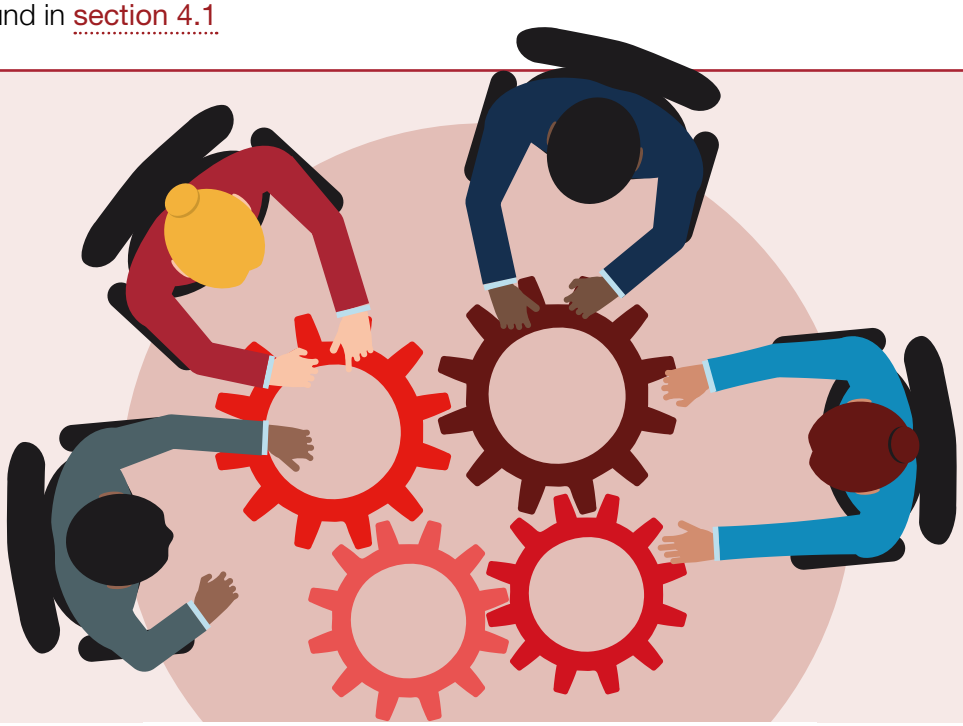
2.1 Research method summary

The following framework of good practice for strengthening commissioning and provision of healthcare services for people seeking asylum emerged from the research. The research methods, outlined below, were underpinned by the principles of co-production. From inception, three peer researchers with lived experience of seeking asylum were recruited to form part of the research team. They played a pivotal role in designing and driving each stage of the research. In collaboration with the rest of the research team, the peer researchers co-designed the research tools and approach; ran workshops; supported in conducting a scoping review; co-designed the framework; and contributed to the write-up of the research.

The research had four main strands:

1. A scoping review of interventions, initiatives or projects, mostly in England, that have sought to improve access to healthcare for people seeking asylum. This enabled the identification of existing themes and recommendations concerning good practice strategies.
2. Three two-hour workshops conducted with 60 community leaders and people seeking asylum or recently granted refugee status, to gather perspectives on, and experiences relating to, the themes and recommendations identified in phase one. The workshops were conducted in-person in London and Stoke-on-Trent.
3. 23 online informal 30-minute interviews with 32 England-based professionals working in healthcare provision for people seeking asylum, including ICB commissioners, policymakers, inclusion health specialists and healthcare professionals. Of these, 19 elected to form a working group of professionals to further contribute to the research.
4. Two online hour-long roundtable discussions with the working group. During these sessions, attendees refined the recommendations, inputted on the challenges around commissioning services, and developed ideas for the framework of good practice.

More detail on the research methods used and the approach to recruitment and analysis can be found in section 4.1



2.2 Introduction to the Framework's five pillars

The framework uses five pillars of good practice to thematically categorise recommendations across three different 'levels' of the health and asylum systems: commissioning of services, service provision, and national policy. These pillars were identified across the interviews and roundtable discussions with the working group, as well as through workshops with people with lived experience of seeking asylum and representatives from community groups who support them.

The recommendations within the five pillars are intended to support stakeholders to enable the provision of timely, good quality, accessible and cost-effective healthcare services for people seeking asylum. There is notable alignment with the five principles of NHSE's inclusion health framework.[59] These areas of alignment are highlighted in the pillar descriptions below. In section 2.3, there are detailed recommendations under each pillar.

1. Working in partnership

The importance of cross-sector collaboration in improving healthcare provision for people seeking asylum was a major finding of the literature review and was reiterated during roundtable discussions of the working group. Roundtable discussions highlighted how multidisciplinary and cross-sector working can optimise limited resource allocation, reduce duplication, and promote the proactive provision of holistic services delivered by a range of actors.

Implementing or improving cross-sector and multidisciplinary approaches across all three levels could include:

- Setting up strategic and multidisciplinary working groups specific to healthcare provision and wellbeing support for people seeking asylum.
- Ensuring national-local collaboration and definition of strategic responsibilities through communication channels between the Home Office, NHSE and ICSs.

Recommendations for implementing this pillar of good practice specific to different stakeholders can be found in section 2.3. These recommendations particularly relate to Principle 1 of NHSE's inclusion health framework: *Commit to action on inclusion health*, including the need to identify named leads at ICB and ICS level and to establish cross-sector strategic partnerships between NHS bodies, local authorities, VCSE organisations and wider partners. They equally relate to Principle 4: *Deliver integrated and accessible services for inclusion health*, including the need to commission specialist services and work with both VCSE and wider partners to fund and sustain provision for inclusion health.

Resources and case studies to guide cross-sector working in healthcare provision for people seeking asylum can be found in section 3.

> "It's really frustrating seeing duplication of work. It is coming from different silos of funding and thinking back to that inclusion health approach of one encounter when you can do lots of different things. So, for example, vaccination is often funded separately. If you could do those vaccinations at the same time as other things, it would make it a much more efficient model and better use of funding"
>
> **Healthcare professional, roundtable two**

2. Upskilling the workforce

A need for specialised training for healthcare professionals to support them in understanding the entitlements, specific needs and circumstances of people seeking asylum was highlighted both in lived experience workshops and roundtable discussions with the working group.

Specialised training, including trauma-informed care and working with interpreters, improves the ability of mainstream services to provide accessible, culturally competent and trauma-informed care[60] and increases the confidence of those delivering these services. It also reduces the risk of causing unintended harm, such as triggering traumatic experiences or unfairly denying access.

Upskilling the workforce to provide good quality and effective healthcare for people seeking asylum could include:

- Ensuring all healthcare staff, both clinical and non-clinical, are aware of the healthcare entitlements of people seeking asylum.
- Prioritising the training of healthcare staff at GP practices on trauma-informed care, working with interpreters in areas where significant numbers of people seeking asylum live, and training staff working in asylum accommodation on trauma-informed care and cultural competency.

Recommendations specific to different stakeholders for training the healthcare workforce can be found in section 2.3. These recommendations particularly relate to Principle 3 of NHSE's inclusion health framework: *Develop the workforce for inclusion health*, including the need to ensure that training on inclusion health is accessible to all staff and that frontline staff have the skills required to deliver compassionate care with cultural competence.

Resources and case studies to guide the implementation of this pillar can be found in section 3.

> "There are pockets of excellence around the country and people do things differently … Ability and capacity and expertise can help support rather than focusing on which service delivers which bit of the care"
>
> **Healthcare provider, roundtable two**

3. Valuing lived experience

The literature review, workshops and roundtable discussions consistently highlighted the vital role of the VCSE sector and the importance of seeking lived experience perspectives when designing services. Workshop participants frequently mentioned the role of VCSEs in increasing trust in healthcare. VCSEs can also contribute to improving the access, experience and outcomes of healthcare by advocating for the communities they serve. Strengthening engagement with both VCSEs and individuals with lived experience of seeking asylum will support commissioners and providers to ensure services are appropriate and sensitive to the specific needs of this population.

This could include:

- Facilitating the involvement of VCSEs by bringing them into conversations and establishing robust collaborations around healthcare provision, particularly in strategic working groups.
- Actively promoting the inclusion of people with relevant lived experience in all aspects of healthcare design and delivery, for example through co-production boards or patient participation groups.

Recommendations for engaging with VCSEs and lived experience partners for specific stakeholders can be found in section 2.3. These recommendations particularly relate to Principle 1 of NHSE's inclusion health framework: *Commit to action on inclusion health*, including the need to hear and respond to the voices of people with lived experience. They equally relate to Principle 2: *Understand the characteristics and needs of people in inclusion health groups*, including the need to take a coordinated and consistent approach to understanding the needs of inclusion health groups.

Resources and case studies to guide the implementation of this pillar can be found in section 3.

> "Communication and being able to say what you want to say [to health care workers] is really important"
>
> **Workshop two participant**

4. Maximising data for action

Roundtable discussions with the working group and literature review findings highlighted the importance of collecting, acting on and sharing disaggregated data to identify local needs and priorities. The working group stressed the value of evaluating past initiatives, projects or models of care and disseminating these online, even in the absence of formal evaluations, to establish an evidence base for effective healthcare provision for people seeking asylum.

Strategies for gathering data to understand local needs could include:

- Including people seeking asylum as a disaggregated group in any relevant local evaluations of healthcare provision or strategic plans, such as Joint Strategic Needs Assessments or Joint Health and Wellbeing Strategies.
- Improving the speed and effectiveness of data sharing on people seeking asylum relevant to planning healthcare services, particularly in the context of new asylum accommodation sites being opened and the movement of individuals between accommodation sites. This should always be done with data protection in mind.
- Evaluating and sharing outcomes of healthcare initiatives for people seeking asylum.

Recommendations specific to different stakeholders for ensuring good practice in collecting, sharing and acting on data can be found in section 2.3 These recommendations particularly relate to Principle 2 of NHSE's inclusion health framework: *Understand the characteristics and needs of people in inclusion health groups*, including the need to improve methods of collecting routine data. They equally relate to Principle 5: *Demonstrate impact and improvement through action on inclusion health*, including the need to include people with lived experience in evaluation work.

Resources and case studies to guide the implementation of this pillar can be found in section 3.

> "Coaches have certainly turned up at 7:30 on a Saturday morning in the middle of nowhere and dropped 300 people in a hotel, and then we arrived Monday morning to try and respond to that, and we can't … We didn't know whether the people had been in the country 20 minutes, or they'd been in six months. So invariably what we were doing was doubling up on work that we knew was more likely to have been conducted elsewhere, which is then putting additional unnecessary pressure on systems"
>
> ICB representative, roundtable two

5. Strengthening pathways to care

Ensuring there are effective pathways that support people seeking asylum to navigate the health system and guide them to the healthcare services that they need was a central theme across all research findings. Both workshop participants and the working group emphasised the need for effective initial health assessments, education on using the NHS, and specialised services to fill gaps to ensure equity in access. Ensuring accessible pathways into mental healthcare and dental care services consistently emerged as top priorities for improvement.

Strategies for strengthening pathways into healthcare could include:

- Ensuring an initial health assessment is given to every individual within ten days of claiming asylum. This should provide an opportunity for healthcare providers to do an extensive check of an individual's health and wellbeing needs and to set them up to be able to use the NHS independently.
- Improving education on the NHS system throughout an individual's journey through the asylum system, with particular emphasis on those in shared accommodation, such as initial and contingency accommodation, and large-scale sites.
- Commissioning and delivering specific, tailored services for people seeking asylum, to support the care provided by mainstream NHS services, according to local needs.

The working group emphasised a need to find the right balance on a local level between uplifting mainstream NHS services and commissioning specific, tailored services for people seeking asylum to ensure accessible pathways into care.

Recommendations for different stakeholders to guide the implementation of this pillar can be found in section 2.3 These recommendations particularly relate to Principle 4 of NHSE's inclusion health framework: *Deliver integrated and accessible services for inclusion health*, including the need to commission specialist services and work with both VCSE and wider partners to fund and sustain provision for inclusion health.

Resources and case studies on uplifting mainstream NHS services and providing tailored services, such as initial health assessments, can be found in section 3.

> "We come as blind people and we want you to open our eyes to the things that we don't yet know"
>
> **Workshop participant, London**

2.3 Framework recommendations

Commissioning and regional level: ICBs, local authorities and other regional stakeholders

> **"Now that there has been a lot of dispersal into the community in and around our area and the funding that was attached to the hotels is not attached to people in the community, in individual houses [dispersed accommodation], whilst their cases are being considered. So, from our perspective that funding has dropped. And in some ways, it was easier to focus services on this population when they were all in one place."**
>
> **ICB representative**

ICSs are responsible for planning local inclusion health strategies, including those tailored to people seeking asylum. This section highlights strategies for ICBs and local authorities to work together under the ICS structure to implement the five pillars of good practice.

1 Pillar 1: Working in partnership

i. Establish an ICS-level working group to plan healthcare strategies, inform commissioning decisions and monitor delivery for people seeking asylum across ICB and local authority areas. Include representatives from public health teams, local authority housing and education teams, local VCSEs, safeguarding teams, inclusion health leads and people with relevant lived experience.

ii. Depending on local needs, consider implementing strategic working groups at multiple geographical levels, for example covering specific asylum accommodation sites, at local authority or ICB areas or a wider regional level. (See section 3.1.7 for resources on cross-sector working and strategic groups.)

iii. Ensure that each ICB designates a named lead responsible for monitoring and driving the improvement of healthcare provision for refugees and people seeking asylum. This could be the existing health inclusion lead or another member of staff working in a relevant area. Local authorities should also have a named lead for healthcare for refugees and people seeking asylum within their public health team.

iv. Work with GP practices and PCNs to put commissioning agreements (such as locally enhanced services) in place at an ICB level that cover asylum accommodation sites (such as initial and contingency accommodations and large-scale sites) and reflect the extra time and resources required for these to work effectively.

v. Map local VCSE groups serving people seeking asylum and the services they provide. It is key for ICBs and local authorities to be aware of the VCSEs in their local area and the services they provide to be able to best support them, benefit from their expertise, and avoid duplication of effort. This could include involving them in working groups and delivery plans.

vi. Support and provide accessible funding and training opportunities for VCSEs that provide social support, healthcare, and volunteering opportunities for people seeking asylum.

vii. Partner with VCSEs to provide screening opportunities (such as infectious disease, diabetes and cervical cancer screening), preventative health education in trusted community settings and clothing (to mitigate the spread of infectious disease) according to locally identified needs. (See section 3.1.8 for resources and case studies around working with VCSEs.)

viii. Collaborate within and across ICB areas to map and potentially 'pool' available funding from different sectors that could be used to provide healthcare initiatives for people seeking asylum.

2 Pillar 2: Upskilling the workforce

i. Actively encourage all PCNs and GP practices within the local area to sign up for the Safe Surgeries scheme by Doctors of the World and instigate regular evaluation of this scheme at an ICB, local authority and practice level, depending on local needs. This could involve 'mystery shopper' style evaluations, such as the case study from Haringey Council highlighted in section 3.2. ICBs and local authorities could publish running statistics on the number of Safe Surgeries in their area to encourage further sign-up.

ii. Work with healthcare providers to develop and provide training initiatives on 1) trauma-informed care and 2) working with interpreters for healthcare professionals. For example, ICBs could commission expert external training providers to provide specific training to relevant healthcare providers in their area, or tailored training courses developed using existing resources. (See section 3.1.3 for further resources around training the healthcare workforce.)

3 Pillar 3: Valuing lived experience

i. Actively collaborate with key local VCSEs and people with relevant lived experience in the design of local services provided for people seeking asylum. This could include setting up co-production boards for refugees and people seeking asylum to ensure lived experience voices can contribute to the planning of local healthcare provision, and including VCSEs in strategic working groups. (Resources for working with VCSEs and people with lived experience can be found in section 3.1.8.)

ii. Create or support opportunities for people with lived experience of the asylum system to train as peer support, community champions or health navigators. (See section 3.1.8. for resources on working with lived experience partners.)

4 Pillar 4: Maximising data for action

i. Monitor and evaluate healthcare provision for people seeking asylum in each local authority area under the ICB. ICBs should view this as a regular evaluation activity, as some local authority areas may need more support from their ICB and different approaches may be needed. (See section 3.1.9 for resources on evaluation and data collection.)

   This should include:

   - Evaluations to check that an effective system is in place to permanently register residents at all asylum accommodations in the ICB area with a local GP practice.
   - Evaluations of current initial health assessment provision in the ICB area to confirm that initial health assessments are received by all people seeking asylum within 10 days of arriving in the UK.
   - A specific evaluation for any large-scale sites within the ICB area to define the amount and type of healthcare outreach required for the site, as this may be significantly more than at initial or contingency sites, depending on population size and ability to access local NHS facilities.

ii. Include disaggregated data on people seeking asylum in any local Joint Strategic Needs Assessments, Joint Health and Wellbeing Strategies and Inclusion Health Strategies, or any other population health-related evaluations at an ICB or local authority level.

iii. Where possible, evaluate any specific interventions or projects to improve healthcare for people seeking asylum and make a summary publicly available, to contribute to the evidence base on what works well and to help in future planning of services nationally.

iv. Collate data on the cost of primary care health services being provided for people seeking asylum in the ICB area, and the current resource gap to achieving good practice. This should be published and shared with the Home Office and NHSE to build a national picture of resources required to provide an adequate and equitable level of primary healthcare provision for people seeking asylum and to help NHSE in defining resource distribution.

5 Pillar 5: Strengthening pathways into care

i. Where a gap is identified in existing pathways, ensure a system is put in place to permanently register all people seeking asylum with a local GP practice, including those in initial and contingency accommodation and large-scale sites. It may be more challenging to ensure GP registration in rural areas; areas with GP practices that are already heavily overloaded; or those less accustomed to receiving refugees and people seeking asylum.[61,62] In these areas, separate commissioning agreements, such as locally enhanced services, may be useful to support local GP practices with the extra resources required.

ii. Commission good-quality and accessible healthcare services for people seeking asylum in the ICB area, which should include the following:

- At least one clinical healthcare point of contact in every initial and contingency accommodation site within the ICB area, visiting at least three times a week. They should have the ability to escalate cases to relevant local services where needed.
- Initial health assessments for all people seeking asylum in the ICB area, either in the format of outreach into asylum accommodation sites or within mainstream healthcare services (usually a GP practice), depending on existing local structures. Initial health assessments are the responsibility of ICBs to commission[63] and NHSE provides a contribution to ICBs towards the costs of these assessments.[64] Existing guidelines around the contents of initial health assessments should be followed (more details can be found in section 3.1.1). Appointments must be at least 30 minutes long to allow for essential screening, triage and data collection. Interpreters are essential and trauma-informed care principles should always be followed.

iii. Commissioning healthcare services for people seeking asylum should also consider specific healthcare needs, such as dental, maternity, sexual and mental healthcare, and could include:

- Tailored dental care, such as outreach dental screening events in collaboration with local VCSEs or specially commissioned services from local dentists. See section 3.1.6 for case studies and resources on dental care provision.
- Social prescribers for low-level mental health needs and isolation. This could involve expanding the area covered by existing social prescribers to include asylum accommodation sites or specifically commissioning social prescribing for people seeking asylum in an ICB area. Social prescribers should link people seeking asylum to existing local VCSEs, activities and education or could set up specific activities for people seeking asylum, such as football teams. (See section 3.1.5 for more resources on mental health and wellbeing and section 3.1.8 for working with VCSE groups.)
- Prioritising catch-up vaccination and communication for residents in shared accommodation should be considered a key priority to avoid infectious disease outbreaks.[65] UKHSA have produced a guide to outbreak management in short-term accommodation, which outlines the responsibilities of ICBs, local authorities and accommodation providers.[66] Substantial outreach into asylum accommodation sites may be needed to increase trust around vaccination, and should take into account existing recommendations for communication strategies and increasing trust in vaccinations among people seeking asylum in outbreak situations.[67,68] Collaborating with VCSEs and people with lived experience to design and deliver outreach and communication strategies around vaccination has been shown to have a positive impact on vaccine confidence, particularly during COVID-19 vaccine roll-outs,[69,70] and is highly recommended.[71,72]

Provision level: PCNs, Trusts, GP practices, hospitals and healthcare professionals

"When I arrived, no one told me about the GP for two months and I didn't know where to go until I called A&E."

Workshop participant, London

Primary care networks (PCNs), secondary care trusts and healthcare professionals are generally the main providers of healthcare on an operational level and often have direct contact with people seeking asylum. They have a duty to provide an equitable and adequate level of care to everyone in their area, including people seeking asylum. This section highlights strategies and approaches for PCNs, secondary care trusts, GP clinics and other healthcare professionals who work on an operational level to implement the five pillars of good practice.

1 Pillar 1: Working in partnership

i. Appoint a champion for healthcare for people seeking asylum among both the clinical and non-clinical teams in GP practices and relevant secondary care sites (particularly urgent treatment centres and A&E departments). This individual should be responsible for ensuring topics around healthcare for people seeking asylum are included in internal audits and training and that opportunities for collaboration with the ICB, local authority or local VCSEs are followed up on.

ii. Select representatives to regularly attend any relevant strategic working groups run by the local authority or ICB. For example, in a GP practice, this representative could be the selected champion for healthcare for people seeking asylum, as recommended above.

iii. Partner with local VCSE groups to provide outreach services in the community, such as screening, vaccination and emotional or wellbeing support. (See section 3.1.8 for resources and case studies around collaborations with VCSEs.)

iv. Actively advocate for needs in terms of funding and resources with local authorities and ICBs. This could be needed on the GP practice level, at a secondary care site or more widely, such as at the secondary care trust or PCN level.

2 Pillar 2: Upskilling the workforce

i. Use existing resources to upskill healthcare professionals working with people seeking asylum on 1) trauma-informed care and 2) working with interpreters (see section 3.1.3 for existing resources for training the workforce). This should include both clinical and non-clinical staff, such as receptionists.

ii. Follow recommendations from local ICBs and local authorities to implement Safe Surgeries training from Doctors of the World in GP practices, taking a whole-team approach to include both clinical and non-clinical staff. Some aspects of this training package may also be relevant and could be implemented in specific secondary care sites, such as urgent treatment centres and A&E departments.

3 Pillar 3: Valuing lived experience

i. Actively encourage people seeking asylum to join existing GP practice-level, PCN-level or secondary care trust feedback groups, such as patient participation groups at GP practices. This should be encouraged through collaboration with local VCSEs for people seeking asylum or through advertising opportunities in a range of languages.

4 Pillar 4: Maximising data for action

i. Collect, analyse and publish data on the healthcare needs of people seeking asylum collected as part of standard practice, such as the prevalence of infectious and non-communicable diseases collected from screening in initial health assessments.

ii. Ensure medical records are consistently coded in GP practices according to existing frameworks (e.g. Systematized Nomenclature of Medicine Clinical Terms (SNOMED) codes for the clinical software EMIS). Particular emphasis should be put on coding information from a patient's initial health assessment, such as country of origin and existing health conditions, to ensure health workers have access to the information they need in subsequent visits and to initiate the correct health pathways.

iii. Ensure that data from initial health assessments done outside of a patient's GP practice (for example, by a specialist or mobile health team) is rapidly transferred to their registered GP's system and includes their NHS number. This may involve some follow-up but is key to ensure resources are not wasted and patient trust is not damaged by duplication of tests or vaccinations, for example.

iv. Ensure that the NHS Spine has been checked before registering a new patient, to identify whether a demographic record and NHS number already exist, and avoid the duplication of records.

v. Ensure data recorded on patients includes interpretation needs and languages spoken, existing healthcare conditions and prescriptions required, and disabilities or digital barriers that may affect access. NHSE has created a patient questionnaire in 29 languages that could be used for this purpose.[73] Consistently recorded patient data will help GP practices to understand needs at both a patient and practice level and allow more detailed analyses of needs to be done.

vi. Regularly evaluate practice progress on healthcare provision for people seeking asylum, including awareness and education of staff around entitlements, and culturally competent and trauma-informed care. For example, Doctors of the World have created Quality Improvement Project resources for practices to easily incorporate Safe Surgeries evaluation into their existing audit process, highlighted in the section 3.1.3.

5 Pillar 5: Strengthening pathways into care

i. Ensure all people seeking asylum are permanently registered with a local GP practice, even those in large-scale accommodation that may have some level of internal healthcare provision. It is important to remember that under the NHSE general medical services contract,[74] GP practices do not have the right to decline patient registration based on race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition.[75] Ensuring universal registration may require coordination on a PCN level, in collaboration with the local authority and ICB, to consider local capacity and advocate for additional resources where required.

ii. Ensure there is access to interpreters and translated resources across the patient pathway, with particular emphasis on improving the availability of interpretation services during the registration process, appointment booking system and initial health assessments. All patient information sheets, questionnaires or guidance should be given to patients in their native language where possible. (See section 3.1.8 for resources on managing language barriers and section 3.1.4 for translated patient resources on navigating the NHS system.)

iii. Screen for mental health needs using the NHS's 'making every contact count' approach[76] and triage individuals to an appropriate level of services. Given the likelihood of trauma among people seeking asylum, screening should be conducted in a trauma-informed manner (see section 3.1.3.for resources on following trauma-informed care principles).

iv. Connect people identified as having low-level mental health needs with local VCSEs that can provide social activities and wellbeing support (see section 3.1.8 for resources to guide collaborating with VCSEs).

v. Put specific considerations in place for the provision of initial health assessments, including:

- Initial health assessments should be provided by health care teams specialised in migrant or refugee health, where possible, due to the expertise and training required. They could be done by a variety of healthcare staff (such as nurses and healthcare assistants) and do not necessarily need to be the responsibility of a GP. The healthcare staff undertaking these assessments must receive training in working with interpreters and trauma-informed care (see section 3.1.3 for existing training resources).
- Longer initial health assessment appointments provide an essential time to explain and provide resources on how to use the NHS. GP practices with residents registered from shared accommodation settings should consider having a supply of printed resources explaining the NHS system in different languages (see section 3.1.4 for translated resources on navigating the NHS for patients).

The Home Office

"I'm constantly horrified by the fact that … we could have someone on a cancer pathway just disappear overnight and we don't know where they've gone. We could have someone who's just had a TB test who disappeared overnight and we don't know where they've gone … If a person registered with the GP with exactly the same name, the same date of birth, spelt the same, then the records will catch up. However, that doesn't always happen."

ICB representative

The Home Office has a statutory duty to provide accommodation to people seeking asylum who would otherwise be destitute, with a stated commitment to safeguarding their health, safety and wellbeing.[77] Accommodation provision is outsourced to four private companies under the Asylum Accommodation and Support Contract (AASC): CTM, Serco, Clearsprings Ready Homes and Mears.[78] The AASC details[79] the training programme for staff working in asylum accommodation to ensure the safety and security of residents, including in mental health first aid and cultural competency.[80] The Home Office has committed to timely data sharing, to enable effective collaboration between accommodation providers and local authorities.[81] However, findings from roundtable discussions with the working group suggest that this not yet happening consistently in practice.

Given its commitments to safeguarding people seeking asylum, the Home Office plays a key role in supporting ICBs and local authorities to uphold the pillars of good practice. Recommendations for how the Home Office can strengthen this support are detailed below.

1 Pillar 1: Working in partnership

i. Identify a named contact in every ICB to serve as a primary point of communication. Ideally, this individual should be the named lead for refugee and asylum health.

ii. Work closely with local ICBs and local authorities to plan new locations for asylum accommodation, considering local advice on the resources likely to be available in terms of healthcare provision at proposed sites. This includes giving ICBs and local authority public health teams sufficient notice before new accommodation sites are opened, per recommendations by the Independent Chief Inspector of Borders and Immigration in 2021.[82]

iii. Work with NHSE to agree on a standardised user journey to ensure the systematic offer of an initial health assessment within ten days of an individual arriving in the UK.

iv. Allocate at least one room in every initial and contingency accommodation site as a confidential, clinical space; this could be an unused bedroom if no other space is available. This will require close collaboration with accommodation providers and the visiting health team (see section 3.1.7 for resources to guide cross-sector collaboration).

2 Pillar 2: Upskilling the workforce

i. Ensure that the contracted asylum accommodation providers provide training for staff on health entitlements, health navigation and mental health first aid (see section 3.1.3 for relevant training resources).

ii. Ensure that commissioned accommodation providers understand their responsibility to work with the local public health sector, including ICBs, local authority public health teams and healthcare professionals, to ensure residents can both access appropriate healthcare and also feedback on their experience of doing so. This is likely to include supporting outreach teams to access shared accommodation sites to provide care.

3 Pillar 3: Valuing lived experience

i. Consult people with lived experience of seeking asylum to inform the production and dissemination of accessible, informative and translated information on health care entitlements that should be provided to all new arrivals. This should include guidance on how to obtain health services, such as how to register for a GP service.

ii. Consult with people with lived experience of the asylum process when setting asylum support rates to ensure healthcare access needs are actively considered.

4 Pillar 4: Maximising data for action

i. Proactively share data on a routine basis with relevant ICB and local authority representatives. Data sharing should:

- Include regular updates on how many people are residing in local Home Office-managed accommodations.
- Focus on new arrivals of people seeking asylum, including the numbers of potential arrivals to an area as well as the locations and additional demographic information to assist with planning healthcare services and understanding needs.

NHS England

"As a commissioner, you tend to do what is a must-do from NHSE. If it's presented as good practice or not compulsory, it will go to the bottom of the pile."

ICB representative

NHSE has a duty to reduce inequalities in healthcare access, experience and outcomes nationally, as stated in the NHS Long Term Plan.[83] To fulfil this duty, NHSE should support local systems to produce joint forward plans that will enable improvement, ensure accountability, mobilise expert networks, support monitoring, and drive transformation.[84] Based on findings from the research, the following recommendations will enable NHSE to support ICBs and local authorities to implement good practices.

1 Pillar 1: Working in partnership

i. Officially define where the strategic responsibility lies for different aspects of providing and commissioning care for people seeking asylum. This includes initial health assessments, data collection and transfer of data on dispersal, mental healthcare provision and dental care.

ii. Build upon the NHSE inclusion health framework to establish greater clarity of minimum expectations and 'what good looks like' specific to healthcare provision for people seeking asylum for different bodies such as ICBs, PCNs and secondary care trusts.[85] These should aim to establish a level of consistency in provision across and between areas while allowing for local flexibility dependent on existing services.

iii. In collaboration with ICBs and local authorities, analyse current costs and define the funding and resources needed to provide the minimum expectations in healthcare for people seeking asylum.

iv. Work towards designating funding to local bodies in a sustainable, holistic manner and ensure this is equitable across the country. Funding should be provided as a general 'pot' for healthcare provision for people seeking asylum, based on the minimum budget required (see recommendation iii above). Funding provision must move away from small 'pots' for specific services, which encourages working in silos and results in small-scale, unsustainable services being developed and abandoned when funding ends.

v. Support ICBs to put locally enhanced services into place for healthcare provision for people seeking asylum, such as initial health assessments, primary care provision and mental health services. This will allow ICBs to better support local GP practices to provide primary care services for people seeking asylum.

vi. Work with the Home Office to agree on a standardised user journey to ensure the systematic offer of an initial health assessment within ten days of an individual arriving in the UK.

2.4 Conclusions

The development of the Framework was a collaborative effort involving a diverse range of stakeholders, including community leaders, people with lived experience of the asylum system, healthcare professionals, inclusion health specialists, ICB commissioners and policymakers. This collective expertise yielded a comprehensive set of practical recommendations to support stakeholders to improve the accessibility and quality of healthcare for the people seeking asylum in their communities. These recommendations apply across both health and asylum sectors and, in doing so, point to the need for deeper collaboration between the two in order to meet essential health needs.

People seeking asylum encounter unique healthcare challenges, shaped by their experiences before, during and after migration. They encounter multiple, intersecting barriers to healthcare access upon arrival to the UK and while in the asylum system. These include a lack of information about and understanding of the NHS, leading to difficulties navigating the health system and uncertainties about their entitlements; experiences of destitution restricting the ability to travel to appointments; digital exclusion resulting in exclusion from rapidly digitalising services; and language barriers that impede communication and understanding from staff in the health system.

Substantial gaps in provision and policy create and exacerbate these barriers, making it harder for people seeking asylum to access appropriate healthcare when they need it. Significant work is needed to mitigate these barriers for successful outcomes of national health equality initiatives such as NHSE's inclusion health framework and CORE20PLUS5 to be realised. These barriers not only impact the healthcare access, experiences and outcomes for people seeking asylum but also exacerbate system pressures, as obstacles in accessing primary care services increase preventable demands on emergency care.

While challenges persist, there are notable pockets of excellence that have been achieved in the provision of healthcare for people seeking asylum and other inclusion health groups across England. The case studies and resources showcased in section 3 offer inspiration and guidance for stakeholders working in this field. Throughout this research, the emphasis has been to leverage these pockets, encouraging healthcare providers and commissioners to 'borrow with pride'.

At a national level, concerted efforts are needed to address systemic gaps and enable healthcare commissioners and providers to succeed in meeting the challenge of equitable healthcare provision at scale. There is a gap in official guidance for what good looks like for the health system to deliver timely, appropriate healthcare to people seeking asylum. Local systems require effective resourcing to deliver these standards, and actors working within the Home Office must work closely in partnership with the health system locally and nationally.

The Framework offers a structured approach to delivering an inclusive healthcare system for people seeking asylum, offering practical recommendations and strategies for implementation. By implementing the recommendations and drawing inspiration from the showcased case studies and resources that follow, stakeholders can play an active role in reducing the inequalities in healthcare access, experiences and outcomes faced by a population with unique vulnerabilities.

3. Existing resources to support implementation

This section contains links to case studies and other resources that workshop participants and working group members identified as good practice. They are listed here to support the implementation of the Framework's recommendations at a local level, encouraging stakeholders to 'borrow with pride'.

Structure of section three

3.1 lists nine topics with links to relevant case studies and resources:

1. Initial Health Assessments
2. Specialised service models of primary care
3. Uplifting mainstream primary services for people seeking asylum
4. Enabling people seeking asylum to navigate the health system
5. Provision of mental health care services
6. Provision of dental health care services
7. Cross-sector collaboration
8. Utilising lived experience and the VCSE sector
9. Data collection

3.2 provides a table including further case studies gathered as part of this research and identifies their relevance to six topics:

1. Overcoming language barriers
2. Supporting health navigation
3. Providing mental health services
4. Providing dental care
5. Multi-agency approaches to delivering services
6. Providing suitable training for healthcare professionals

3.1 Case studies and resources across nine elements of service delivery

Initial health assessments

Based on the findings of this research, specialised providers are recommended to provide outreach and initial health assessments. This ensures the best quality of service for people seeking asylum, as seen in the case study highlighted below. Specialised services are often best placed to consider the complex needs and requirements around initial health assessments, such as trauma-informed care and infectious disease screening. However, the commissioning of initial health assessments varies depending on the local context.

CASE STUDY 1: RESPOND: a pilot service delivering specialised initial health assessments in north-central London

Respond is an integrated refugee health service hosted by the Hospital for Tropical Diseases and the Children and Young People's division at University College London Hospital. The Respond initial health assessment pilot ran October 2021 to March 2023 and saw approximately 1500 people. Encounters were nurse-led, one-hour and based in the community (either in asylum accommodation sites or local GP practices). They included an initial health discussion, care planning, onward referral and medical input as needed. Assessments were holistic and included a review of physical, dental, mental, sexual and women's health as well as social, educational, safeguarding and developmental needs (for children). Infection screening (including for parasites) was undertaken for everyone. Appointments were available to all adults and children seeking asylum and living in temporary Home Office accommodation in Camden, Islington, Haringey and Barnet. Respond continues to offer full holistic health assessments and/or infectious diseases screening. Complex case support is also available via the Respond Advice and Guidance multi-disciplinary team (MDT) meeting. For more information email uclh.respondmailbox@nhs.net or see: https://www.uclh.nhs.uk/our-services/find-service/tropical-and-infectious-diseases/respond-integrated-refugee-health-service

A large number of resources exist nationally that set out the recommended content of initial health assessments:

- OHID's migrant health guide to assessing new patients from overseas: https://www.gov.uk/guidance/assessing-new-patients-from-overseas-migrant-health-guide
- BMJ article 'Initial health assessments for newly arrived migrants, refugees, and asylum seekers', which gives guidance on the recommended content of an initial health assessment: https://www.bmj.com/content/377/bmj-2021-068821
- Catch-up vaccination guidelines from the UK Health Security Agency (UKHSA): https://www.gov.uk/government/publications/vaccination-of-individuals-with-uncertain-or-incomplete-immunisation-status
- Guidelines from UKHSA on the management of children with incomplete screening status: https://www.gov.uk/government/publications/screening-of-individuals-with-uncertain-or-incomplete-screening-status
- A patient questionnaire resource published by NHSE, translated into 29 languages, that can be used by healthcare professionals during initial health assessments: https://www.england.nhs.uk/publication/meeting-the-initial-health-needs-of-vulnerable-migrants-translated-health-guidance-and-patient-questionnaire-for-newly-arrived-migrants-in-the-uk/#heading-2

Specialised models of primary care for people seeking asylum

While the decision on whether to provide a specialised model of primary care for people seeking asylum or to integrate them within mainstream NHS services is usually context and resource-dependant, the findings of this research suggest that specialised primary care services can provide high-quality care which effectively meets the often-complex needs of people seeking asylum. Two 'good practice' case studies of bespoke models of primary care are outlined below.

CASE STUDY 2: A specialised primary care practice in Leicester for people seeking asylum

The Assist practice in Leicester, part of the Inclusion Healthcare Social Enterprise Community Interest Company, is a specialised primary care centre specifically designed for people seeking asylum. As of 2024, the practice has around 1,400 registered patients seeking (or refused) asylum.

Assist gives new patients a 45-minute initial health assessment appointment, and subsequently all registered patients are given a minimum of 15 minutes per appointment (increased to 30 minutes if the patient requires an interpreter). Staff at the practice are experienced in working with clients with additional needs and undergo regular and bespoke training on the asylum-seeking process, including HC2 forms (which enable support with health costs) and the process after receiving an asylum decision. Assist approaches healthcare holistically, educating patients on the NHS system at their initial health assessment and providing booklets with information about VCSE groups and social activities in the local area. Assist also supports patients' transition into mainstream GP practices if they are granted refugee status.

https://www.assistpractice.co.uk

CASE STUDY 3: A social enterprise in West Yorkshire providing two specialised inclusion health GP practices in Leeds and Bradford

Bevan is a social enterprise established in 2011 that provide health and wellbeing services for inclusion health groups facing barriers to accessing care. Bevan operates across West Yorkshire and its patients include people who are homeless or in insecure housing, seeking asylum or refugees. They currently run two specialised GP practices in Leeds and Bradford. Bevan has a nurse-led migrant health team, who is often the first point of contact with a medical professional in the UK for people seeking asylum. Their service includes initial health assessments, mental health screening and education on using NHS services. They also run child wellbeing workshops and drop-in sessions with social prescribers. Bevan has also recently produced a translated animated guide to navigating the NHS for people seeking asylum.

https://wearebevan.co.uk

Below are further online resources to guide the running or creation of bespoke primary care services:

- A compilation of case studies of good practice from the Equality and Human Rights Commission:[86] https://www.equalityhumanrights.com/sites/default/files/case-studies-healthcare-and-service-providers-facilitating-access-to-healthcare-for-people-seeking-asylum.pdf
- A list of funding resources available for health inequalities initiatives: https://www.hfma.org.uk/publications/resources-and-funding-reduce-health-inequalities

Uplifting mainstream primary services

In addition to providing specialised services for people seeking asylum, uplifting mainstream NHS services to provide appropriate care that is sensitive to the needs of this group is essential. This may be particularly important in areas where there are fewer people seeking asylum, or bespoke healthcare services do not already exist. The Safe Surgeries initiative from Doctors of the World is highlighted below as a case study of good practice.

CASE STUDY 4: Doctors of the World Safe Surgeries initiative

Doctors of the World Safe Surgeries is a network of GP practices committed to tackling barriers that prevent access to primary care and to promoting the health of everyone in their community – regardless of their nationality or immigration status. Doctors of the World provides resources to support practice staff, including toolkits, training resources, simple guides to NHS entitlement and translated patient-facing posters. The organisation has also created a toolkit for commissioners which explains the benefits of implementing Safe Surgeries in their local area.

A wealth of resources exist to guide the training of both clinical and non-clinical staff and the uplifting of mainstream NHS services:

- Doctors of the World resources:
  Safe Surgeries toolkit: https://www.doctorsoftheworld.org.uk/safesurgeries/safe-surgeries-toolkit
  Training resources: https://www.doctorsoftheworld.org.uk/what-we-stand-for/supporting-medics/training
  Toolkit for commissioners: https://www.doctorsoftheworld.org.uk/safesurgeries/safe-surgeries-toolkit/
- BMA guidelines on managing language barriers:
  https://www.bma.org.uk/advice-and-support/ethics/refugees-overseas-visitors-and-vulnerable-migrants/refugee-and-asylum-seeker-patient-health-toolkit/managing-language-barriers-for-refugees-and-asylum-seekers
- NHSE guidelines for commissioning interpreters and translators in primary care: https://www.england.nhs.uk/wp-content/uploads/2018/09/guidance-for-commissioners-interpreting-and-translation-services-in-primary-care.pdf
- All Our Health e-learning programmes from NHSE:
  Vulnerability and Trauma Informed Practice Session: https://portal.e-lfh.org.uk/Component/Details/748874
  Inclusion Health Session: https://portal.e-lfh.org.uk/Component/Details/688646
- Trauma Foundation South West provides bespoke training courses on trauma-informed care, including training for mental health professionals on working with interpreters and for interpreters on working in the mental health sector: https://www.tfsw.co.uk/training
- A trauma-informed practice toolkit from NHS Scotland: https://www.gov.scot/publications/trauma-informed-practice-toolkit-scotland

Enabling health navigation and accessibility

The importance of educating people seeking asylum on navigating the NHS was a key finding of this research. Based on current and previous examples of good practice, this can be done through specialist NHS teams, health navigators or social prescribers, in initial health assessments or mainstream primary care or through VCSE groups – or preferably a combination of these, depending on the local context.

CASE STUDY 5: NHS navigation assistance through the Asylum Seeker and Refugee Health Team, Stoke-on-Trent

The Asylum Seeker and Refugee Health Team of the Midlands Partnership University NHS Foundation Trust in Stoke-on-Trent introduces people seeking asylum and refugees to NHS services when they arrive in the area. The team provides practical help and advice to meet the health needs of people applying for asylum as well as refugees who have been granted permission to stay in the UK and choose to remain in Stoke-on-Trent. They also help people who have been refused asylum, many of whom are homeless and destitute with no recourse to public funds. The team offer an open access service to assist people seeking asylum to access a GP, dentist and sexual health services; to help complete HC2 forms; to signpost to other agencies according to needs; and to translate information about the NHS. The service also operates many health promotion activities relating to emotional needs, sexual health and physical health, working in partnership with the local Sexual Health Team.

Several translated resources exist that can be used in a range of settings to explain the NHS system to people seeking asylum and to make services more accessible:

- NHSE guidance on health and how to use the NHS, translated into 29 languages: https://www.england.nhs.uk/publication/meeting-the-initial-health-needs-of-vulnerable-migrants-translated-health-guidance-and-patient-questionnaire-for-newly-arrived-migrants-in-the-uk
- Doctors of the World translated leaflets, including 'How the NHS works' infographic and leaflets on healthcare entitlements: https://www.doctorsoftheworld.org.uk/translated-health-information/?_gr=navigating-the-nhs-and-right-to-healthcare
- An animated guide on YouTube, 'How to navigate the NHS for Refugees and Asylum Seekers' by Bevan Healthcare, with subtitles in 17 languages: https://www.youtube.com/watch?v=FrVH5eQP1m4&ab_channel=BevanCIC
- Health resources in other languages (NHS collection of resources for specific conditions): https://www.nhs.uk/about-us/health-information-in-other-languages
- Resources from the Refugee Council including: 'Guide to using the GP'; communication cards containing useful translated words and phrases for service users; and 'Which NHS service do I need?' poster mapping out different NHS services in a range of languages: https://www.refugeecouncil.org.uk/get-support/services/therapeutic-wellbeing-resources

Mental healthcare provision

This research and a considerable amount of previous literature show that mental health services for people seeking asylum are paramount to ensuring their health and wellbeing. Mental health services for people seeking asylum must consider their specific cultural and language needs. Mainstream services may not always be appropriate. Several national organisations, such as the Refugee Council and the Helen Bamber Foundation, provide specialised mental health services. Many examples of good practice involve collaborations between these organisations and local NHS services, such as the case study below from south-east London.

CASE STUDY 6: A specialist mental health offer in South East London

Collaboration with the Refugee Council, the South London and Maudsley (SLaM) NHS mental health service and the Guy's and St Thomas' Health Inclusion Team has been a key part of providing mental health care and counselling services to people seeking asylum since 2015. From June 2022, the South East London ICB funded a one-year pilot project delivered by the Refugee Council to provide 12 counselling sessions to those in contingency accommodations when referred by GPs. Sessions aim to deal with the first stages of trauma and stabilisation, rather than unpacking major trauma while individuals are still in shared, temporary accommodations. Alongside this, SLaM was funded to provide an advanced mental health practitioner for one year, focused on providing mental health services for those in Initial Accommodation sites, in collaboration with the Refugee Council counsellor.

There are numerous resources focused on mental healthcare provision, therapy and wellbeing for people seeking asylum that could be useful for planning or commissioning services:

- Wellbeing guides in 35 languages from Doctors of the World: https://www.doctorsoftheworld.org.uk/translated-health-information/?_gr=wellbeing-guidance
- A detailed Mental Health and Psychosocial Support Directory for Refugees and Migrants in London[87] from Kings College London: https://www.kcl.ac.uk/research/mhpss-directory
- Mental health information from the Royal College of Psychiatrists translated into 26 different languages: https://www.rcpsych.ac.uk/mental-health/translations
- E-learning modules on effective therapeutic support for health professionals and translated videos with exercises to help with stress and trauma from Solace: solace-uk.org.uk
- The Helen Bamber Foundation has a range of guidelines and resources focused on mental health provision for vulnerable migrants and victims of trafficking: https://www.helenbamber.org/resources
- Barnardo's has a mental health offer for people seeking asylum: https://www.barnardos.org.uk/get-support/services/asylum-seeker-mental-health-and-wellbeing-project
- A collection of audio resources for anxiety, trauma, sleeping difficulties and other mental wellbeing areas, specifically designed for refugees and translated into a range of languages, from youth counselling charity Off the Record: https://www.talkofftherecord.org/croydon/refugee-support
- Translated resources for young people seeking asylum and the professionals supporting them in both education and community settings: https://uktraumacouncil.org/resources/childhood-trauma-migration-asylum

Dental care provision

This research identified dental care as a key unmet need for people seeking asylum and has recommended an increased focus on commissioning and providing accessible dental care for this group. This could either be in the form of outreach into VCSE groups or asylum accommodation sites, or through uplifting mainstream NHS dental services, depending on the local context.

CASE STUDY 7: Dental Wellness Trust pilot scheme for children seeking asylum

Respond, the inclusion health service based at University College London Hospital mentioned above, has worked in collaboration with the Dental Wellness Trust to provide outreach dental services to asylum-seeking and refugee children in North-Central London. As well as actively signposting to both routine and urgent NHS dental services, asylum-seeking and refugee children were supported to access pop up clinics run by the Dental Wellness Trust both at their clinical home site and in asylum seeker accommodation.

Some resources exist to guide the provision of dental care for people seeking asylum, including:

- The dental care section of OHID's migrant health guide: https://www.gov.uk/guidance/dental-health-migrant-health-guide and OHID's model for oral healthcare for refugees and people seeking asylum: https://www.gov.uk/government/publications/oral-healthcare-model-for-asylum-seekers-and-refugees
- Dentaid runs dental health clinics across the UK in collaboration with local partners and is open to new project enquiries: https://www.dentaid.org/refugees-and-asylum-seekers/
- The Dental Wellness Trust is a London-based charity that has previously collaborated with partners to provide dental services for asylum-seeking children: https://www.dentalwellnesstrust.org/about

Establishing strong cross-sector relationships and strategic ownership

Strong cross-sector and multi-disciplinary relationships in local areas have emerged as a key pillar of good practice in healthcare provision for people seeking asylum. This includes strategic working groups focused on people seeking asylum at different operational levels, strong ICB-local authority-healthcare provider collaborations, and the inclusion of the VCSE sector in strategic decision-making. One case study demonstrating the strength of using cross-sector collaboration to react to rapidly opened contingency hotels, from Norfolk and Waveney, is highlighted below.

CASE STUDY 8: A multi-agency response to provide healthcare for contingency hotels in Norfolk and Waveney

In Norfolk and Waveney, four hotels recently opened to accommodate people seeking asylum. A multi-agency response was set up by the ICB to provide healthcare for those arriving. The operational locality-focused group included district councils; police; mental health, public health and primary care teams; and the ambulance service. The ICB worked particularly closely with the People from Abroad Team, a social work team located in Norfolk County Council who support people seeking asylum and other vulnerable migrants arriving in Norfolk. The ICB funded an enhanced healthcare offer of support for GP practices through a locally enhanced service. This covered all inclusion health groups, including people seeking asylum and refugees. The service provides the education and training needed to effectively care for people seeking asylum within primary care.

There are resources available that may be useful to guide cross-sector collaboration for healthcare provision, including:

- The Health Foundation's evidence scan on 'Cross-sector working to support large-scale change': https://www.health.org.uk/sites/default/files/CrossSectorWorkingToSupportLargeScaleChange.pdf
- NHSE's inclusion health framework: https://www.england.nhs.uk/long-read/a-national-framework-for-nhs-action-on-inclusion-health/#roles-and-responsibilities

Utilising the expertise of the VCSE sector and including lived experience voices

A key finding emphasised in both lived experience workshops and roundtable discussions was the importance of integrating the VCSE sector and lived experience voices in decisions around healthcare planning and commissioning for people seeking asylum. VCSE groups often hold the trust of asylum-seeking communities in their area, provide key wellbeing support, and signpost individuals into relevant healthcare services. There are many examples from across the country of VCSEs collaborating with NHS services to provide healthcare or healthcare advice in community settings, such as in the case study from Stoke-on-Trent highlighted below.

CASE STUDY 9: ASHA in Stoke-on-Trent

ASHA is a voluntary, collaborative enterprise based in Stoke-on-Trent, Staffordshire. It serves the local asylum seeking and refugee communities. On average, their services are accessed by 600 people each week and range from legal advice to English lessons to destitution and wellbeing support. They also run digital skills workshops and give guidance on how to access online NHS and GP services. ASHA has a long history of multi-disciplinary collaboration with external organisations such as the NHS, bringing people seeking asylum the services they need in a place they trust. This includes a recent collaboration with University Hospital of North Midlands to run outreach breast and bowel cancer screening and education events. They also work closely with mental health charities locally and run an initial mental health screening and triage for their users, with emotional support provided in-house for those with low-level need.

A wealth of resources to support the integration of VCSE groups and people with lived experience into decision-making in healthcare can be found below:

- NHSE's 'framework for addressing practical barriers to integration of VCSE organisations in integrated care systems', which includes a series of case studies: https://www.england.nhs.uk/long-read/a-framework-for-addressing-practical-barriers-to-integration-of-vcse-organisations-in-integrated-care-systems
- A report by the King's Fund entitled 'Actions to support partnership': https://www.kingsfund.org.uk/insight-and-analysis/reports/actions-to-support-partnership
- E3M's toolkit for commissioners 'from procurement to partnership': https://e3m.org.uk/from-procurement-to-partnership-a-practical-toolkit-for-commissioners
- A report from the VCSE Health and Wellbeing Alliance on 'Making better use of voluntary sector data and intelligence in health service planning': https://files.constantcontact.com/ca3da02a001/53fdcebd-64b2-4a2d-b103-a0d2760b1328.pdf
- Health and Social Care Alliance Scotland's guide to engaging people with lived experience: https://www.alliance-scotland.org.uk/blog/news/new-report-engaging-people-with-lived-experience/#expanded
- The Mental Health Foundation Scotland's report 'Voices and visibility: the inclusion of refugees and asylum seekers in decision-making processes': https://www.mentalhealth.org.uk/sites/default/files/2022-07/MHF-Scotland-Voices-and-Visibility-Report.pdf

Data for action and evaluating healthcare provision

This research has highlighted the importance of data collection to drive initiatives aimed at enhancing the health and wellbeing of people seeking asylum. Beyond capturing demographic and health-related data at the local level, information should also be gathered on existing services within the ICS area. Moreover, healthcare services commissioned for people seeking asylum should be continuously evaluated to ensure they are meeting their needs.

CASE STUDY 10: 'Mystery shopping' in north London to evaluate Safe Surgeries

In 2022, Healthwatch Haringey and Haringey Welcome partnered with the NHS, Haringey Council and Doctors of the World to find out how many Haringey GPs would accept a patient without ID. They also evaluated how many surgeries provided help with completing the registration form, such as interpreting or translating the form into a community language or offering help from staff who could speak the patient's language. The results of the evaluation found that 20 out of 37 (54 per cent) of practices visited in-person stated that they required proof of address and ID, despite NHSE guidance stating that the lack of this is not grounds to refuse patient registration.

https://www.healthwatchharingey.org.uk/report/2023-05-16/barriers-gp-registration-haringey

Resources to assist commissioners and healthcare providers to effectively collect and use data and evaluate existing services can be found below:

- NHSE's guidance on using data and analysis to enable effective decision-making in ICSs: https://www.england.nhs.uk/long-read/building-an-ics-intelligence-function
- The VCSE Inclusion Health Audit Tool: https://www.inclusion-health.org
- The Public Health Outcomes Framework from Public Health England: https://fingertips.phe.org.uk/profile/public-health-outcomes-framework
- Doctors of the World's quality improvement project toolkits for evaluating Safe Surgeries practices: https://www.doctorsoftheworld.org.uk/safesurgeries/safe-surgeries-qi-project-for-gp-trainees

3.2 Table of case studies

The table below is offered as a resource for healthcare professionals seeking examples of previous initiatives that have helped to overcome barriers to accessing healthcare for people seeking asylum. It lists the case studies included in the literature review and identifies their application to six common themes.

Link to project or contact	Location	Description	Language barriers	Health navigation	Mental health	Dental care	Multi-agency working	Training healthcare professionals
Refugee Council's Therapeutic IAHC Communication Card	England	The Refugee Council's therapeutic IAHC Communication Card is a double-sided card with useful vocabulary and phrases with translations. It can be used to speed up and clarify communication about health problems with doctors, nurses and reception staff, in the hospital, with people who work in supporting organisations and with members of the public. It is currently translated into five languages: Albanian, Arabic, Dari, Farsi and Tigrinya.	✔	✔	✔		✔	
British Red Cross-Helen Bamber Foundation project	England	A pilot partnership between the British Red Cross and the Helen Bamber Foundation that aims to increase access to trauma-focused interventions for those fleeing conflict (particularly the conflict in Ukraine), trafficking, torture and other forms of human cruelty, and who find themselves in locations where they have little access to much-needed mental health treatments.	✔	✔	✔		✔	
Doctors of the World Safe Surgeries (see case study 4 in section 3.1.3)	England	Doctors of the World Safe Surgeries is a network of GP practices committed to tackling barriers that prevent access to primary care and to promoting the health of everyone in their community – regardless of their nationality or immigration status. Doctors of the World provides resources to support practice staff, including toolkits, training resources, simple guides to NHS entitlement and translated patient-facing posters. The organisation has also created a toolkit for commissioners which explains the benefits of implementing Safe Surgeries in their local area.	✔	✔	✔		✔	✔
ReSTORE programme	South Yorkshire	The ReSTORE programme provides support, training, orientation, recruitment and education for refugees and people seeking asylum with nursing qualifications who are living in South Yorkshire, supporting them to complete exams required to practice nursing/midwifery in the UK. The programme aims to support a healthcare workforce that is more inclusive and understands the needs of people seeking asylum.	✔	✔	✔		✔	

Link to project or contact	Location	Description	Language barriers	Health navigation	Mental health	Dental care	Multi-agency working	Training healthcare professionals
Bevan Healthcare (See case study 3 in section 3.1.2)	West Yorkshire	Bevan are commissioned by the West Yorkshire ICB to run two specialist primary care general practices in Bradford and Leeds for people seeking asylum, alongside proactive outreach services into initial accommodation centres across the majority of West Yorkshire's place-based partnerships. Their health and wellbeing centre has also been used to deliver mental health support and a range of socioeconomic and educational projects to support wider wellbeing. They have also produced translated resources on healthcare entitlements and how to use the NHS.	✔	✔	✔		✔	
HARP (Health for Asylum Seekers and Refugees) project	Yorkshire	HARP is a three-year project that began on 1 September 2018, delivered by the Refugee Council, to improve the physical and mental health of people seeking asylum and refugees and reduce health inequalities. It mainly serves those living in contingency accommodation in Wakefield, Hull, Sheffield and Rotherham and provides weekly health drop-in sessions in contingency hotels; health access workshops; support accessing interpreters and specific healthcare services; and mental health and wellbeing triage. A range of video resources were also created as part of the HARP project. The HARP project has been evaluated by the University of Bradford.	✔	✔	✔		✔	✔
Newcastle 'Health Access' card	Newcastle	Professional representatives and refugees and people seeking asylum in Newcastle co-produced a folded, pocket-sized 'Health Access' card that was distributed to a number of key providers in healthcare and third-sector organisations. The cards are available in facilities commonly accessed by members of these communities (such as GP practice waiting areas and community centres) and were also shared with professional staff in a number of organisations to be given out in person. This card was evaluated qualitatively by Newcastle University and Newcastle City Council.	✔	✔	✔		✔	
Healthcare provision in contingency accommodation	Hounslow	The ICB Borough Team in Hounslow, alongside Little Park Surgery in Feltham, have worked in collaboration to co-design, deliver at pace, and continually evaluate a new model of delivering outreach healthcare for people seeking asylum residing in short-term hotel accommodation. The ICB and the local practices worked together to design a model of on-site care delivery in the hotels, to build trust and rapport with the residents and to support them with immediate and necessary healthcare needs. As a result, A&E attendances from the hotel were brought down by more than 60 per cent.	✔	✔	✔	✔		

Link to project or contact	Location	Description	Language barriers	Health navigation	Mental health	Dental care	Multi-agency working	Training healthcare professionals
Respond-Dental Wellness Trust pilot scheme (see case study 7 in section 3.1.6)	London	Respond, an inclusion health service based at University College London Hospital (UCLH), has collaborated with the Dental Wellness Trust (DWT), to provide outreach dental services to asylum seeking and refugee children in IA sites. Active signposting to NHS dental services was provided, as well as direct referrals into DWT asylum seeking and refugee children clinics at either the Greenwall Dental practice or via outreach dental work in IA sites. During just one half-day clinical session for the Respond cohort, the DWT team were able to provide 86 procedures.				✔	✔	
UK Chagas Hub	London	The UK Chagas Hub is a collaboration of healthcare professionals, researchers, advocates, and members of the Latin American community to tackle Chagas disease in the UK. Their activities include raising awareness of Chagas disease, improving clinical services for those with Chagas and running community-based screening events. A recent pilot study of community screening by the UK Chagas Hub in Lambeth and Southwark screened 258 Latin American migrants at community events in 2021/22. The overall seroprevalence was 23 per cent and this short pilot study doubled the number of patients with Chagas disease linked into mainstream care nationally. They have also developed a range of resources for healthcare professionals and translated information leaflets.	✔	✔	✔	✔	✔	
Healthwatch Haringey 'Mystery shopping' (See case study 10 in section 3.1.9)	North London	In 2022, Healthwatch Haringey and Haringey Welcome partnered with the NHS, Haringey Council and Doctors of the World to find out how many Haringey GPs would accept a patient without ID. They also evaluated how many surgeries provided help with completing the registration form, such as interpreting or translating the form into a community language or offering help from staff who could speak the patient's language. The results of the evaluation found that 20 out of 37 (54 per cent) of practices visited in person stated that they required proof of address and ID.	✔	✔	✔	✔	✔	
RESPOND (See case study 1 in section 3.1.1)	North London	RESPOND is an integrated, co-designed health system providing services for refugees and people seeking asylum, run by University College London Hospitals NHS Foundation Trust. RESPOND's Outreach Assessment Service was commissioned by the North Central London ICB as a pilot project and has carried out initial health assessments (IHAs) for more than 1,400 people seeking asylum in initial accommodation centres in the area. RESPOND's initial health assessments are holistic and seek to identify and address unmet physical, mental, dental and social health needs.	✔	✔	✔	✔	✔	

Link to project or contact	Location	Description	Language barriers	Health navigation	Mental health	Dental care	Multi-agency working	Training healthcare professionals
SRCF Polio Vaccine Outreach	South London	In response to concerns around poliovirus being found in London sewers, Southwark Refugee Communities Forum (SRCF) ran a set of outreach activities aiming to share information about poliovirus and increase polio booster vaccine uptake among refugee and migrant communities in Southwark, south London. Over 500 parents from a wide range of refugee and migrant communities were reached through engagement and educational activities.	✔		✔		✔	
Guy's & St Thomas's Health Inclusion Team (See case study 6 in section 3.1.5)	South London	The Guy's & St Thomas' Health Inclusion Team (HIT) provide health assessments in initial and contingency accommodation centres across south-east London, commissioned by South East London ICB. This includes a partnership with South London and Maudsley (SLaM) and the Refugee Council to provide counselling sessions to those identified as needing mental health support. The HIT also hold a twice-weekly primary care clinic specifically for people seeking asylum or refugees who are struggling to access primary care at a GP practice in Lambeth.	✔		✔		✔	
Merton Healthcare's education programme on health navigation	South London	In south-west London, nurses, community workers, GPs and others have worked together to develop a programme that supports migrant communities, resulting in a reduction in their use of accident and emergency services. The programme included setting up community education sessions, six-week courses, and bilingual advocacy and interpretation services. Its success relied heavily on the team getting to know local communities, working in partnership and making time to develop trust.		✔			✔	
Over-the-counter vouchers in Lambeth	South London	In 2004, a scheme was trialled and evaluated in Lambeth, South London, offering pharmacy vouchers to people seeking asylum and refugees presenting with minor illnesses, to remove pressure from local GP services. The vouchers were given out by nurses or support officers and could be exchanged for free over-the-counter medication at participating pharmacies. In the trial, a total of 200 vouchers were distributed to 184 individuals over a five-month period for complaints such as headache, muscle pain, hay fever and indigestion, with only two clients referred directly to the GP.		✔			✔	
Aymara Social Enterprise	South London	Aymara is a social enterprise project founded in 2020 with the aim of reducing inequalities through an integrated approach to the health and wellbeing of migrants, refugees and people seeking asylum. Aymara provides support in response to a need for efficient, culturally specific healthcare and community services. Their work mainly focuses on education on HIV prevention in Latin American communities, including information sessions on PrEP and outreach-based HIV testing days.		✔			✔	

Link to project or contact	Location	Description	Language barriers	Health navigation	Mental health	Dental care	Multi-agency working	Training healthcare professionals
The Haven Clinic	Bristol, North Somerset and South Gloucestershire	The Haven is a specialist primary healthcare service for people seeking asylum and refugees in Bristol, North Somerset and South Gloucestershire. The Haven offers holistic initial health assessments, medical management of existing healthcare conditions, screening and information on how to use the NHS. They have expertise in trauma-informed care and can signpost or triage on to services such as counselling and wellbeing support organisations.	✔	✔			✔	✔
A system response to welcoming displaced people in Somerset	Somerset	Somerset has taken a multi-agency, tactical approach to work together as a system to provide healthcare for those in contingency accommodation. Multi-agency tactical meetings were set up to bring together partners from Health, VCSE, local authority representatives, police and the Home Office, which allowed the prevention of two sites being set up in unsuitable areas, with limited access to healthcare and provision of alternative sites based on local recommendations. Six Welcome Hubs were opened across Somerset in collaboration with VCSE groups, which provide health and wellbeing support as well as wider support for people seeking asylum. Clinical space was arranged within contingency hotels to support health provision and on-site initial health assessments provided by Taunton Vale Healthcare. Collaborations with other local services such as Open Mental Health and the Somerset-Wide Integration Sexual Health service (SWISH) have provided further, specific healthcare services to those living in contingency hotels.		✔	✔		✔	
The Trauma Foundation South West	South West England	The Trauma Foundation South West, which provides support for those who have suffered torture, oppression or war, provides free, long-term psychotherapy and counselling to highly traumatised refugees and people seeking asylum. They also provide specialist training, supervision and consultancy to agencies and individuals who work with traumatised people, including training for mental health professionals on working with interpreters and training for interpreters on working in the mental health sector.	✔		✔		✔	✔

Link to project or contact	Location	Description	Language barriers	Health navigation	Mental health	Dental care	Multi-agency working	Training healthcare professionals
Crawley 'Access to Primary Care' group	West Sussex	Local Community Networks (LCNs) have been developed across West Sussex to provide the forums to enable multi-agency partners to work together. A local community network 'Access to Primary Care' subgroup in Crawley was formed to raise awareness among residents and frontline GP surgery staff around barriers to accessing and registering with GP practices for local health inclusion groups. This group has worked on multiple projects, including developing an instructional leaflet for the NHS App in several languages, removing GP referral criteria for the county Wellbeing service and providing a flyer for residents seeking asylum, giving contacts and information on their rights to healthcare. The LCN group was paused in 2022 and the work is now being led by ABC GP Federation.	✔	✔			✔	
The Assist Practice (See case study 2 in section 3.1.2)	Leicester	The Assist practice in Leicester is a GP practice specifically for people seeking asylum, commissioned by Leicester, Leicestershire and Rutland ICB. Healthcare provision is specifically designed to serve the needs of people seeking asylum and interpreters are always available. Additional services provided at the practice have included midwife and health visitor appointments, mental health support, access to psychological therapies and advice clinics from the British Red Cross.	✔	✔	✔	✔	✔	
ASHA (See case study 9 in section 3.1.8)	North Staffordshire	ASHA is a collaborative enterprise based in Stoke-on-Trent that serves the local refugee communities and people seeking asylum. Their services include legal advice, destitution support, English lessons and wellbeing support. They also run digital skills workshops and give guidance on how to access online NHS and GP services. ASHA has recently collaborated with the University Hospitals of North Midlands (UHNM) to run outreach breast and bowel cancer screening and education events. They also work closely with mental health charities locally and run an initial mental health screening and triage for their users, with emotional support provided in-house for those with low-level needs.	✔	✔	✔		✔	
Wakefield's Ukrainian Health Integration Service	Wakefield	The service included the adaptation of the Refugee Council's Integration Star Model (ISM) which tracks self-reported improvements in integration to life in the UK. This framework was used when visiting refugees from Ukraine and identified the integration needs of individuals and families. The service focused on health and wellbeing and utilised the Making Every Contact Count approach to consider aspects including registering for a GP; referrals to TB screening; vaccination services; support accessing prescriptions; and referrals to mental health, sexual health or dental services.	✔	✔			✔	

Link to project or contact	Location	Description	Language barriers	Health navigation	Mental health	Dental care	Multi-agency working	Training healthcare professionals
Wakefield roving health model for vaccination	Wakefield	The Wakefield partnership developed a multi-faceted outreach model to achieve maximum vaccination participation among local health inclusion groups. The model comprised a communications and engagement approach, resource distribution, vaccine hesitancy education and training, and pop-up vaccination clinics delivered in community settings by a mobile team. Overall, 4,246 vaccines were given at 135 clinics across 33 venues. Third-party champions estimate that 80 per cent of those vaccinated would never have been vaccinated without this approach.					✔	
Specialist child health and wellbeing support team in Derbyshire	Derbyshire	To help support children from families seeking asylum, Derbyshire Council and the NHS have funded a specialist team to provide both support for health and wellbeing and wider social support. It was established in the summer of 2021 and provided a door-to-door service to assess health needs, check vaccination records and meet immediate needs through nurses with qualifications in prescribing.		✔			✔	
MPFT Asylum Seeker and Refugee Health Team (See case study 5 in section 3.1.4)	Stoke-on-Trent	The Asylum Seeker and Refugee Health Team is a team from the Midlands Partnership University NHS Foundation Trust, responsible for introducing people seeking asylum and refugees recently arrived into Stoke-on-Trent to NHS services. The team provides practical help and advice to meet the health needs of asylum applicants and refugees who have been granted permission to stay in the UK, and who choose to remain in Stoke-on-Trent. They also help people whose asylum claims were unsuccessful, many of whom are homeless and destitute with no recourse to public funds. The service also operates many health promotion activities in relation to emotional needs, sexual health and physical health, working in partnership with the Sexual Health Team.		✔			✔	
Norfolk and Waveney multi-agency response (See case study 8 in section 3.1.7)	Norfolk and Waveney	In response to the opening of new contingency accommodation sites in Norfolk and Waveney, the Norfolk County Council's People from Abroad Team supported GP registration for new arrivals and undertook initial health triage on arrival, holistic health assessments and ongoing complex case management. Norfolk and Waveney ICB funded an enhanced health care offer of support from GP practices through a health inclusion Locally Commissioned Service (LCS), allowing GP practices to sign up to varying levels of support depending on need. A newly formed Asylum and Migration Partnership Board was formed to support multi-agency collaboration and mental health and wellbeing support, and activities were set up through partnerships with local VCSE groups.					✔	

Link to project or contact	Location	Description	Language barriers	Health navigation	Mental health	Dental care	Multi-agency working	Training healthcare professionals
The British Red Cross Health Access project	Cardiff	The British Red Cross Health Access project, commissioned by the Cardiff and Vale University Health Board, supports people seeking asylum in initial accommodation and people seeking asylum, refugees and other vulnerable migrants who have been assigned to dispersal accommodation in Cardiff and need to register or are registered at a GP practice. The support focuses on providing information, adequate accommodation, protection and safeguarding; registering with a GP; and accessing dental care, optometrists, pharmacies and other health services, including statutory, community and mental health support. The project was mainly based at the Cardiff and Vale Health Inclusion Service (CAVHIS), which operates within the Cardiff Royal Infirmary. Eight NHS GP surgeries were also involved in the project, which ran from 2021 to 2023 and has been evaluated by the British Red Cross.		✔			✔	

4. Research methods and findings

This section details the research findings and methods from which the Framework was developed.

4.1 Research methods

The research had four main strands outlined below. Combined, the insight from these four strands directly shaped the pillars and recommendations for improving healthcare commissioning and provision for people seeking asylum.

1. A scoping review of existing interventions, initiatives or projects, mostly in England, that have sought to improve access to healthcare for people seeking asylum. This enabled the identification of existing themes and recommendations concerning good practice strategies.
2. Three two-hour workshops. These were conducted with 60 community leaders, refugees who had recently been granted status and people seeking asylum. The workshops gathered perspectives and experiences relating to the themes and recommendations identified in phase one. The workshops were conducted in-person in London and Stoke-on-Trent.
3. 23 online informal 30-minute interviews with 32 England-based individuals working in healthcare provision for people seeking asylum, including ICB commissioners, policymakers, inclusion health specialists and healthcare professionals. Of these, 19 elected to be part of a working group to further contribute to the research.
4. Two online hour-long roundtable discussions with the working group. During these sessions, attendees refined the recommendations, inputted on the challenges around commissioning services, and developed ideas for the framework of good practice.

Co-production

Before the research commenced, three peer researchers were recruited through the VOICES Network[b] and the St George's Hospital Migrant Health Research Group. They were chosen for their lived experience of seeking asylum in the UK, their interest in working towards health equality and, as far as possible, to represent a diversity of genders, races, ages, nationalities, and cultural identities, to achieve a spread of knowledge and perspectives in the team.

As part of building a reciprocal relationship, peer researchers were asked how they would like to be valued and compensated for their time. They were all paid for their work in line with the NIHR Involve guidelines.[88] Depending on their preferences, they either received this money in shopping vouchers or payment through a payroll system.

As peer researchers were based in different parts of the UK, weekly meetings to discuss research progress were held online. There were also two main in-person meetings: a four-hour 'brainstorming' meeting in December during which plans for lived experience workshops were created, and a meeting in February following the second lived experience workshop to discuss emerging findings. To support the peer researchers to collaborate as meaningfully as possible, two training sessions were held, one on literature reviews and one on qualitative research methods.

The peer researchers contributed to every stage of the research. The peer researchers and researchers at St George's worked as a team throughout the project, with regular input from the British Red Cross project lead. This approach was anchored in the Red Cross' co-production principles of equality and power sharing, inclusion and diversity, creativity and accessibility, and reciprocity.[89]

Peer researchers' involvement in the design and implementation of the workshops with those with lived experience was imperative, to ensure an appropriate environment was created for participants with experience of seeking asylum. Peer researchers also substantially contributed to the analysis and interpretation of the results and development of the research output and framework. At the end of the data collection period, peer researchers were asked for their

[b] The VOICES Network is a nationwide programme supported by the British Red Cross which provides people with refugee and asylum-seeking backgrounds with a platform to share the challenges they face and raise those issues with decision-makers.

preferences about how they would like to contribute to the writing of the report. As a result, one peer researcher was directly involved in writing and reviewing the report and recommendations, and the two remaining peer researchers chose to provide feedback on the report and recommendations as it was being written.

Scoping literature review

The first stage of the research involved conducting a scoping literature review of existing evidence on interventions, initiatives or projects, mostly in England, that have sought to improve access to healthcare for people seeking asylum. Previous literature suggesting models or frameworks of good practice for healthcare provision for people seeking asylum were also included. Individuals working in healthcare provision or commissioning for people seeking asylum were also approached directly to provide examples of good practice.

The focus was on the English context but particularly pertinent or outstanding examples from other similar healthcare settings were also included where it was felt they were relevant to the framework development. The research team identified the overarching themes emerging from the literature, collating good practice strategies for improving healthcare provision for people seeking asylum on a local level. This process took place via online meetings. From the themes arising from discussions around the literature gathered, the team created a draft framework of good practice incorporating key principles of improving healthcare provision across different settings.

A total of 77 pieces of literature were included in the literature review, of which the majority were grey literature, such as reports from VCSE, NHS or government websites, case studies shared by stakeholders and news reports.

Roundtable discussions and the working group

Individuals working in commissioning, planning or providing healthcare to people seeking asylum were invited to participate in the research. This included leads for health inequalities, inclusion health and primary care within ICBs; commissioners; members of local authority public health teams; and clinical professionals including a nurse, paramedic and GP, who all specialised in providing care to people seeking asylum. Existing contacts working in relevant positions were contacted and further potential participants were identified through a snowballing approach.

Preliminary engagement and unstructured 'interviews'

Professionals involved in providing or commissioning healthcare for people seeking asylum who expressed interest in the research were invited for a preliminary, informal 30-minute interview with the research team. In total 23 informal online interviews were run with 32 individuals representing a range of organisations and roles. In these interview discussions, participants were informed about the research aims and opportunities to join a working group to contribute further. The interviewed participants were also asked for case studies of good practice from their local area and their views on key priorities in terms of providing a good quality healthcare service to people seeking asylum. Notes were made from all interviews and an informal analysis of these contributed to developing topic guides for roundtable discussions and to gathering preliminary concepts for the framework.

Working group set-up and roundtable discussions

All individuals who had expressed interest in being part of a working group for the research, either in preliminary interviews or over email, were sent a 'term of reference' for the planned working group. This document contained more information about the research and what to expect from being part of the working group. In total, 19 individuals confirmed their participation in the working group. The working group was offered the opportunity to take part in two online roundtable discussions to drive the direction of the framework development.

Across both roundtable discussions, the majority of attendees were either ICB representatives (mostly inclusion health or health inequalities leads and commissioners) or clinicians providing healthcare to people seeking asylum. All attendees were working in England and they represented a wide range of geographic areas within the country. The major areas represented were London, north-west England and south and south-east England.

A topic guide was created for both roundtable discussions, driven by research findings so far: preliminary findings from workshops with those with lived experience; informal interviews with people working in providing or commissioning healthcare for people seeking asylum; and the literature review. The first roundtable discussion focused on participants' views on priorities in terms of healthcare content in different asylum

settings and models of care. The second roundtable discussion moved on to cover views around systemic level good practice, including strategic partnerships, data requirements and challenges such as funding.

At the beginning of each roundtable discussion, a short slide set was presented by the research team to summarise the research aims and progress so far, and to summarise the questions from the topic guide for the discussion. Both roundtable discussions were held on Microsoft Teams, recorded and transcribed. Key concepts and quotes from the transcripts were analysed using descriptive analysis techniques and the results were summarised, and the themes and views raised in these discussions were key drivers in the formation and structure of the recommendations arising from the research.

Table 1. Demographics of participants attending roundtable discussions

	Roundtable discussion 1	Roundtable discussion 2	Total unique attendees
Total number of attendees	13	10	15
Role or organisation represented			
ICB	5	4	6
Local authority	1	1	1
Healthcare provider	5	4	6
Other	2	1	2
Area of Country			
London	3	2	4
Northwest	3	2	4
Midlands	2	2	2
Yorkshire	1	1	1
South and Southeast	4	3	4

Workshops with people with lived experience of the asylum system and community leaders

From January to February 2024, two workshops were held with people with lived experience of the asylum system and one with community leaders working with migrant groups. During these sessions, the draft framework was presented and feedback was sought. Participants' experiences of accessing (or not) healthcare services were also heard. These workshops aimed to generate expert insights on what good practice for improving access to healthcare would look like from the point of view of people seeking asylum themselves, ensuring the framework is relevant and reflects the needs of the target population. The method and materials for these sessions were developed collaboratively with peer researchers and the British Red Cross project lead.

Demographics of participants

A total of 60 people participated across three workshops. This included 30 people who took part in a 'community leaders' workshop. These participants represented communities with large proportions of people seeking asylum and community organisations working directly with people seeking asylum. The community leaders were often members of the societies they serve and may or may not have had lived experience of seeking asylum themselves. A further 30 participants took part in two 'lived experience' workshops held specifically for people currently seeking asylum, or who had recently received a decision on their asylum case (in the last two years). In these lived experience workshops, 15 participants took part in London and 15 in Stoke-on-Trent.

Table 2. Demographics of workshop participants

	Community leaders workshop	Lived experience workshop: London	Lived experience workshop: Stoke-on-Trent	Total
Total number	**30**	**15**	**15**	**60**
Gender				
Women	20	7	5	32
Men	7	8	10	25
Not stated / Unknown / Other	3	0	0	3
Region of origin[c]				
African region	10	3	5	18
Region of the Americas	3	0	0	3
South-East Asian Region	2	0	1	3
European Region	1	0	0	1
Eastern Mediterranean Region	5	12	8	25
Western Pacific Region	0	0	1	1
Unknown/not stated	9	0	0	9
Role or representation				
NGO/community group	19	0	0	19
Individuals with lived asylum experience	3	15	15	33
Other migrant community	8	0	0	8
Language of participation				
English	28	5	14	47
Arabic	2	10	1	13

Overall, the gender distribution was fairly even; 32 participants (53 per cent) identified as women. Across the three workshops, most participants originated from either the Eastern Mediterranean region (42 per cent) or the African region (30 per cent). In terms of language, 47 participants (78 per cent) took part in the workshops in English and 13 (22 per cent) in Arabic.

Community leaders workshop

In January 2024, the first workshop was held with 30 participants from VCSE organisations who work with or represent communities with a high proportion of people seeking asylum, many of whom have previously sought asylum themselves. The aim was to gain an overarching perspective of the needs and views of asylum-seeking communities. This workshop was part of a wider community event organised by the research team and participants were recruited through the research team's existing networks.

As part of a broader 'ideas café', one table was dedicated to this research. Five groups of between six and seven participants contributed. Participants were presented with the draft framework and asked to identify from the framework their top three priorities for healthcare access and provision across the journey through the asylum system. Each participant 'voted' for their top three priorities either by using stickers or marking with a pen. Participants were then invited to add new ideas to the framework or add to/modify existing ideas.

[c] World Health Organization regions

Workshops with people with lived experience of seeking asylum

Two workshops were held with people who are currently going through the asylum system and those who have recently (in the last two years) gained refugee status through the asylum route.

The first of these workshops was held in Southwark, with participants recruited through the Southwark Refugee Communities Forum. There were 15 attendees. Participants were split across three tables based on language spoken (one table was conducted in English, and two in Arabic).

The second workshop was held with people seeking asylum in Stoke-on-Trent, who were recruited through ASHA, a VCSE group that supports refugee communities in Staffordshire. There were 15 attendees. Participants were split across three tables based on the language spoken (one table was run with the possibility of Arabic translation for those who needed it). In both workshops, tables were facilitated by one to two members of the research team.

In both workshops, the draft framework was shared to aid discussion on identifying key priorities for improving healthcare access and experiences for people seeking asylum. Participants were asked to identify from the framework shown to them their top three priorities for healthcare provision across the journey through the asylum system. Each participant 'voted' using stickers or by marking with a pen. Following this, participants were invited to share their experiences of seeking healthcare in England and to add new ideas/priorities to the framework either verbally or using sticky notes. The facilitators explained the activities to their group, read out any information on charts in the appropriate language and made notes from the group in English.

4.2 Research findings

Findings from workshops

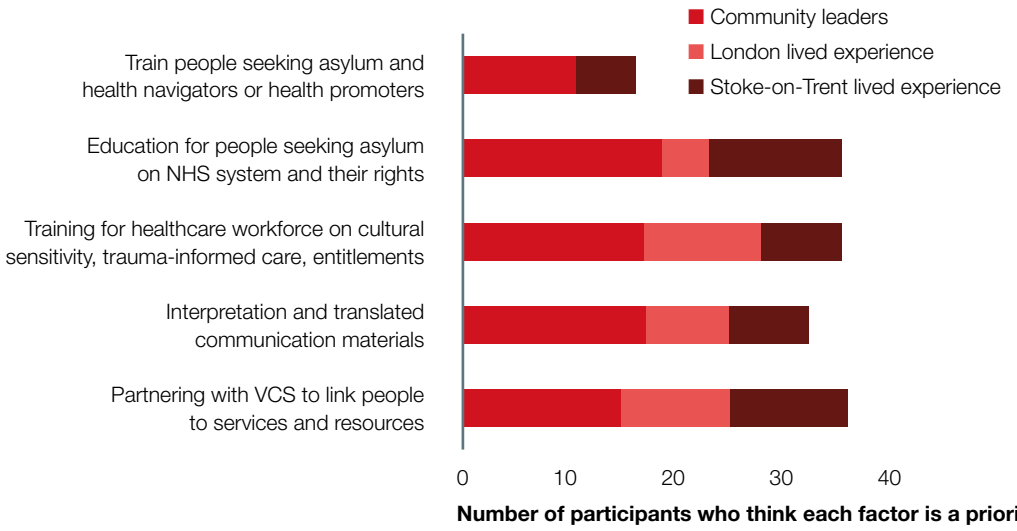
In total, 60 people participated across three workshops to discuss what good practice looks like in healthcare provision for people seeking asylum. The first workshop was held in London with community leaders, who mostly represented communities and VCSEs with large proportions of people seeking asylum. The subsequent two workshops, one in London and one in Stoke-on-Trent, were held with people currently seeking asylum and individuals who had received a decision on their asylum claim within the past two years.

During the workshops, participants were presented with a draft framework, developed from the scoping review of case studies and resources. They were asked to identify their top three priorities for improving access to and experiences of healthcare across the journey through the asylum system. Each participant 'voted' for their top three priorities, either by using stickers or marking them with a pen (for more on this, see section 4.1.4).

Participant priorities to improve access to healthcare

Across three workshops, healthcare sector partnerships with VCSEs were the top priority among participants for improving access to healthcare for people seeking asylum. This was followed closely by 1) providing people seeking asylum with education on the NHS system and their rights, and 2) training for healthcare professionals on cultural sensitivity, trauma-informed care and healthcare entitlements for people seeking asylum.

Figure 2. Priorities to ensure accessibility of healthcare for people seeking asylum across three workshops



The training of healthcare professionals on the specific needs, circumstances, and entitlements of people seeking asylum was also noted by participants as an important priority. Multiple participants mentioned discriminatory experiences with reception staff at GP practices, particularly for those who struggled more with communicating in English. Reports of healthcare professionals across all settings denying access to services due to a lack of awareness of entitlements were common, particularly when registering with a GP practice or accessing prescription medication at the pharmacy.

The majority of workshop participants spoke about the importance of being able to communicate well with healthcare professionals, particularly reception staff. Several reported difficulties in booking appointments as a result of communication issues. This was usually driven by interpretation not being available at reception or when phoning a practice.

> **"Communication and being able to say what you want to say is really important."**
>
> Workshop participant, London

The difficulty of communicating symptoms precisely and understanding medical terminology used by healthcare professionals was occasionally brought up as an issue. Accordingly, many stressed the importance of interpretation and translated communication materials being made available.

Participants reported how differences between the NHS and health systems in their home countries caused confusion and difficulties in understanding how to navigate the health system. Commonly cited examples of confusion around expectations of the NHS included frustration at not being able to access timely services through GP practices in an emergency, significant wait times in A&E, and frustration with GP practices not following up with them automatically after initial appointments. One participant described how they had been waiting two years for staff at their GP practice to follow up with them regarding test results, likely due to not understanding that negative test results are often not proactively shared with patients in the NHS:

"The staff [at the GP practice] take advantage of people who don't know the system. I waited two years for some simple test results [from a GP appointment]."
Workshop participant, London

This emphasises the importance of expectation management and education on how the NHS works. Individuals having a lack of knowledge and understanding of the NHS can result in additional pressure on the health system. For example, some participants shared they had often used A&E for non-urgent issues, as it was the only way they knew to access healthcare.

Support from accommodation staff and VCSEs was brought up as crucial in bridging this knowledge gap, particularly immediately after the arrival of people seeking asylum, before they have had time to learn about the NHS system. Most workshop participants also felt that charities had played an important role in supporting their wider wellbeing, offering housing advice and social support, and relieving isolation and stress.

"Charities are the only ones who actually provide help, without them we would receive nothing."
Workshop participant, London

"[Volunteering with community groups] invites us into society."
Workshop participant, Stoke-on-Trent

However, as described by the participant below, many participants agreed that in the long term, they preferred to be supported to find information and education on how to navigate the NHS independently, so that they could become independent once moved to dispersed accommodation or after gaining refugee status.

"In hotels, they do everything for us, they register us and book appointments, and when we go to dispersal accommodations we can't do anything. We want them to teach us not only to do it for us."
Workshop participant, Stoke-on-Trent

"[The] first step [to good health] is finding NHS information."
Workshop participant, London

The quality and availability of support to access healthcare varied significantly between participants, often dependent on the level of connection between the VCSEs supporting them and local health systems, as well as the knowledge of accommodation staff. This underscores the critical need for accessible, clear and consistent information and education about the NHS system from the outset of an individual's journey through the asylum system.

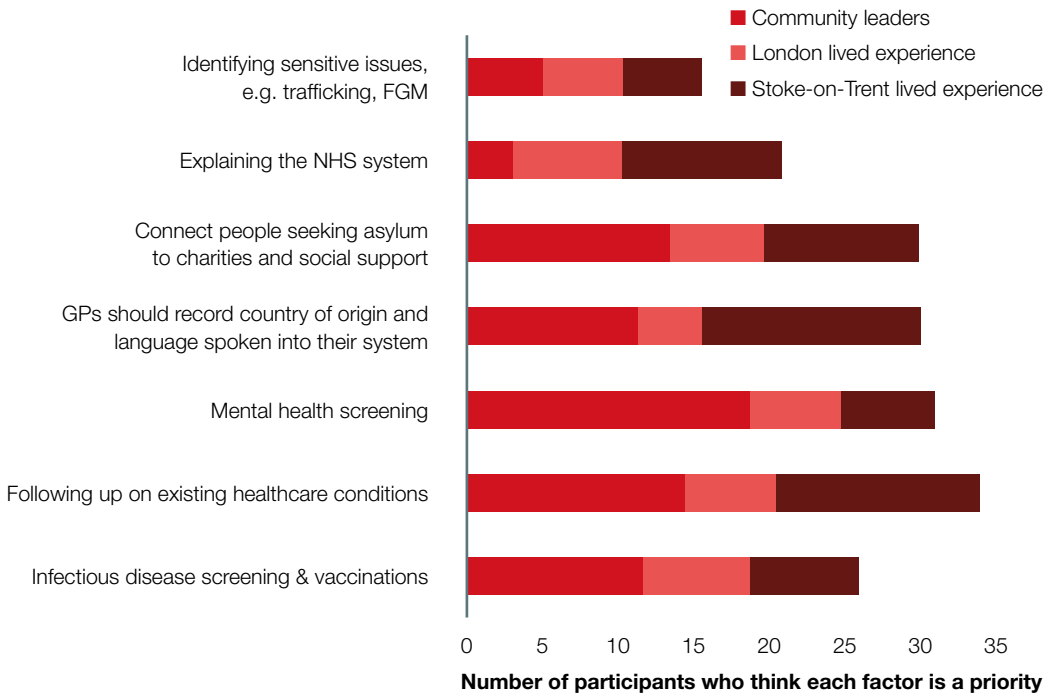
> **"When I arrived, no one told me about the GP for two months and I didn't know where to go until I called A&E."**
>
> Workshop participant, London

Participant priorities for healthcare provision

Upon entering the asylum system, every individual should receive an initial health assessment. Most workshop participants had been offered an initial health assessment but a few stated that they had not. Some participants who had not been given an initial health assessment talked about having to find out about and register with a GP practice through other routes, such as attending A&E.

Participants discussed the importance of being supported to register with a GP practice during initial health assessments, as well as the appointments being an important moment to follow up on existing conditions and offer mental health screening. Healthcare professionals recording interpretation needs and doing infectious disease screening were also highlighted as priorities during this first appointment.

Figure 3. Workshop participants' priorities in initial health assessments



Participants emphasised the importance of using the first contact point an individual has with the healthcare system to give information on the NHS and connect them to local community groups and support. This is usually the initial health assessment but may not always be. This can support people seeking asylum to overcome barriers to healthcare access as they progress in their journey through the asylum system and gain a sense of independence and agency around using the NHS.

> **"Access to community services is really important, people need to be supported and encouraged to connect."**
>
> **Workshop participant, London**

> **"Signposting people to local charities and support groups is really important to make sure healthcare is accessed."**
>
> **Workshop participant, London**

Of the 31 participants who gave a response, 25 said they would prefer initial health assessments to be done in the form of outreach into their accommodation, rather than at a local GP practice. The reasons given included not yet knowing the NHS system, transport difficulties, and mobility issues for some (for example, older people or those with disabilities).

"When you have your first appointment [initial health assessment] it should be with a nurse in the hotel because you don't understand the system yet."

Workshop participant, London

Figure 4. Workshop participants' priorities in contingency and initial accommodation settings

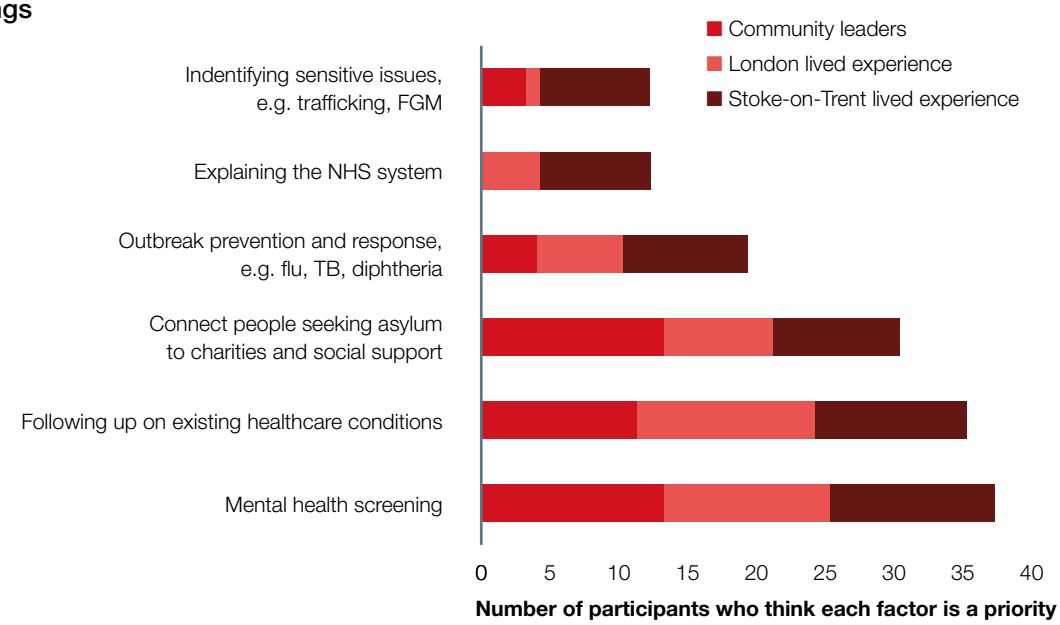
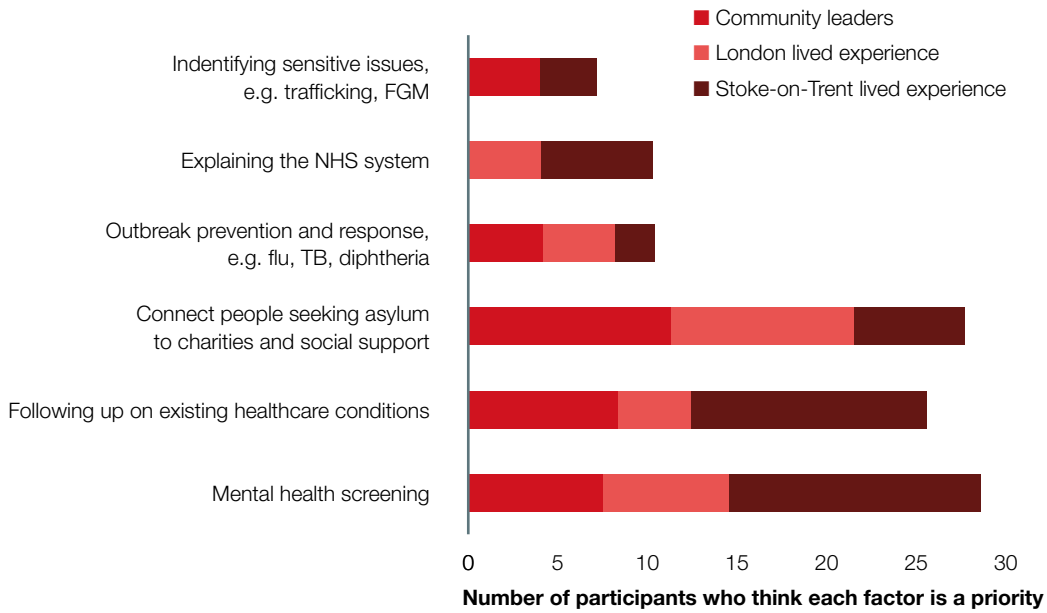


Figure 5. Workshop participants' priorities in dispersal accommodation



Participants emphasised the continued need for mental health screening and support throughout their journey through the asylum system, and the importance of linking people with VCSEs and social support. Most felt this was not happening well enough currently. Participants frequently brought up the mental health impact of the living conditions in a range of different asylum accommodation settings and shared stories reflecting significant unmet mental healthcare needs both for themselves and others. One participant shared how a young adult in their contingency accommodation received no mental health support following two suicide attempts:

> **"There were two suicide attempts by a 21-year-old at the hotel. He was taken to the hospital but quickly brought back [each time] with no help."**
> **Workshop participant, London**

This highlights a critical need for increased mental health support in shared accommodations. Participants emphasised the role that VCSEs and simple social activities in shared accommodation settings can play in reducing stress and isolation as well as providing a sense of community and purpose.

> **"Activities like excursions can really improve our mental health by giving a distraction and opportunity to relieve stress from the situation."**
> **Workshop participant, London**

In the discussion, some participants also mentioned long-term challenges around accessing dental care, with many practices not accepting new NHS patients and significant waits for treatment, which caused ongoing issues to become more serious, reflected in the quote below.

> **"Dental care is a big problem, the dentists don't have any space in Stoke. I had two teeth problems and it took so long they had to remove them."**
> **Workshop participant, Stoke-on-Trent**

After feedback from the first workshop, the importance of ongoing education on how the NHS system works was added to the list of priorities put together by participants in subsequent workshops. Ensuring people have a good understanding of the NHS and setting expectations of what the NHS can offer during stays in shared accommodation sites (while individuals are in the same place and often have some level of support) also emerged during subsequent workshops as a priority.

> **"We come as blind people and we want you to open our eyes to the things that we don't yet know."**
> **Workshop participant, London**

In particular, nearly all participants emphasised the importance of ensuring all individuals know how to independently register with a GP practice before being moved to dispersal accommodation or receiving a decision on their asylum case.

> **"It's much easier in hotels when you have a nurse [who does outreach visits], then when you leave [the hotel] you're on your own."**
> **Workshop participant, London**

In one workshop, participants reported chickenpox and scabies outbreaks in the contingency accommodation in which many of them were living. They expressed their frustration regarding the lack of communication around the outbreaks and felt that more efforts should have been made to protect their health. Further, participants in this workshop expressed hesitation about accepting vaccination due to the lack of communication and sensitisation around outbreaks and information on vaccinations. For them, this was a key area for improvement.

> **"There was a chickenpox outbreak in [participant's hotel name], and no one told us about it. There should have been signs and messages, people should have been separated."**
> **Workshop participant, London**

> **"I haven't taken any vaccines since arriving in the hotel, I'm too scared. They need to tell us the benefits and the negatives very clearly because people turn to rumours more easily than to truth."**
> **Workshop participant, London**

Several participants discussed how misinformation or rumours around vaccination were spreading more in shared accommodation settings, compared with official information, which was viewed as inaccessible.

Findings from roundtable discussions with the working group

Two roundtable discussions were held with 15 members of the working group. Most attendees were either ICB representatives (mostly inclusion health or health inequalities leads and commissioners) or clinicians who frequently provide healthcare to people seeking asylum.

Challenges in planning and commissioning healthcare for people seeking asylum

In roundtable discussions, attendees frequently raised concerns about the lack of clarity around strategic responsibility and expectations for different areas of service planning and provision for people seeking asylum. As a result, many felt it was unclear what level of healthcare provision they were expected to provide for people seeking asylum in their local area. In the context of competing priorities and limited funding, some participants suggested this lack of official guidance on expectations made it difficult to make the case for improving healthcare provision locally for people seeking asylum. They emphasised the need for strong leadership and a standardised national approach with the ability for context-dependent local adaptation.

> **"[Roles and responsibilities are] just so blurred that, you know, things are really falling through the cracks."**
>
> **Healthcare professional**

> **"As a commissioner, you tend to do what is a must-do from NHSE. If it's presented as good practice or not compulsory, it will go to the bottom of the pile."**
>
> **ICB representative**

Accessing adequate and sustainable funding was frequently brought up as another major challenge to commissioning a good quality of healthcare for people seeking asylum.

> **"We can only do as much as the budget we've got, which is probably minimal in some areas."**
>
> **ICB representative**

More specifically, one attendee shared a concern that changes in funding models for initial and contingency accommodation, combined with fewer large-scale arrivals, had resulted in effective funding cuts in their local area for specialist services. This was despite the increasing number of people seeking asylum locally across all accommodation settings. This has led to a rise in unmet healthcare needs.

> **"Local GP practices have been declining to register [people seeking asylum] because of the complexity of their needs… [Additional pockets of funding have] kind of stopped because the arrivals now en masse have stopped. It's kind of constant movement [of people seeking asylum] now. So, we're not getting that funding anymore, but the list size keeps on going up."**
>
> **Healthcare professional**

The challenges arising from funding being split into small, uncoordinated 'pots' for different accommodation settings, healthcare services or conditions were also discussed. Attendees shared how this often leads to many specialised healthcare services being planned and delivered 'in silos' and usually only on a short-term basis. Several attendees emphasised the lack of efficiency arising from this, often leading to duplication of effort and waste of resources.

"It's really frustrating seeing duplication of work. It is coming from different silos of funding and thinking back to that inclusion health approach of, you know, one encounter when you can do lots of different things. So, for example, vaccination is often funded separately. If you could do those vaccinations at the same time as other things, it would make it a much more efficient model and better use of funding."
Healthcare professional

"Now that there has been a lot of dispersal into the community in and around our area and the funding that was attached to the hotels is not attached to people in the community, in individual houses [dispersed accommodation], whilst their cases are being considered. So, from our perspective that funding has dropped. And in some ways, it was easier to focus services on this population when they were all in one place."
ICB representative

Beyond funding, attendees frequently highlighted competing priorities and capacity constraints in the NHS and primary care systems – from the availability of GP appointments to lack of housing – as key barriers to providing good practice in healthcare service provision for people seeking asylum.

"The money is not the issue, it's capacity. We've got significant housing growth across our patch anyway. And the issues with regards to struggling to recruit into general practice are only amplified by the fact that we've then got a population that have got very specific healthcare needs. They may well be healthcare needs that are new to our clinical [staff] and providers in the area. So, they're trying to wrap their head around that whilst they've got a rapidly increasing population anyway."
ICB representative

Ensuring adequate funding and capacity in the health system to meet the needs of the population as a whole, as well as the specific needs of people seeking asylum, is crucial.

System-level collaboration and data sharing

Roundtable attendees underscored the importance of cross-sector collaboration and improved data sharing. Given that the wide-reaching responsibility for supporting health services for those seeking asylum sits across many sectors and levels, attendees stressed the need to improve coordination to reduce duplication of effort. The frequent relocation of people seeking asylum poses a real risk that they may fall through the gaps in the health system, especially when they lack an understanding of the system or the language skills to correct this. Attendees felt that continuity of care needed significant improvement for these reasons, as reflected in the quote below.

"I'm constantly horrified by the fact that … we could have someone on a cancer pathway just disappear overnight and we don't know where they've gone. We could have someone who's just had a TB test who disappeared overnight and we don't know where they've gone … If a person registered with the GP with exactly the same name, the same date of birth, spelt the same, then the records will catch up. However, that doesn't always happen."
ICB representative

The importance of positive working relationships with the Home Office and the challenges arising from the lack of this and a lack of information-sharing on arrivals were also emphasised. Multiple ICB and healthcare professionals shared experiences of not being able to provide proactive services to people seeking asylum in their area due to a lack of advanced notification of arrivals or basic information on those arriving.

"Quite literally everything hinges on that relationship [between ICBs and the Home Office] … it's very difficult to negotiate and maintain good practice in that space."
ICB representative

"Coaches have certainly turned up at 7:30 on a Saturday morning in the middle of nowhere and dropped 300 people in a hotel, and then we arrived Monday morning to try and respond to that, and we can't … We didn't know whether the people had been in the country 20 minutes, or they'd been in six months. So invariably what we were doing was doubling up on work that we knew was more likely to have been conducted elsewhere, which is then putting additional unnecessary pressure on systems."

ICB representative

Improved systemic coordination and information sharing emerged as a key area for improvement. Attendees felt that this could substantially enhance the quality and promptness of the health support that ICBs and healthcare providers could deliver to people seeking asylum.

Good practice: healthcare provision for people seeking asylum

Attendees reflected on the many examples of good practices in providing healthcare services for people seeking asylum. They highlighted 'pockets of excellence' but also stressed that these were often driven by a few highly motivated individuals or organisations, rather than being the norm.

The importance of developing a cross-sector, holistic approach was raised by several attendees, who emphasised the need to draw on existing local resources, particularly VCSEs.

"There are pockets of excellence around the country and people do things differently … Having a holistic view is really important because you can't look at health without physical health, without mental health and the social situation. Ability and capacity and the expertise can help support rather than focusing on which service delivers which bit of the care."

Healthcare professional

As a step towards achieving a holistic approach, attendees highlighted the important role that the VCSE sector plays in supporting the health and wellbeing of people seeking asylum. Specific roles mentioned included providing peer support, education on how to navigate the NHS, signposting to other services, acting as an advocate, and supporting practices overwhelmed with demand.

"What people really appreciate is being listened to and having that time, which is often taken up by healthcare providers [i.e. healthcare providers don't always have time], but perhaps with trained peer support, it may be more financially viable."

Healthcare professional

In addition to cross-sector collaboration, several attendees mentioned the need for a flexible approach to healthcare provision for people seeking asylum, which considers local context. Specifically, roundtable attendees discussed the need for specialist, tailored services to provide the specific health expertise that is required and relieve some pressure from mainstream primary and secondary care. They also shared a preference for specialist services to provide initial health assessments particularly but noted that this role often falls to mainstream NHS services, who may have more limited oversight and resources, and as a result, need additional training and support.

"When we're working in inclusion health, you often have that tension of acknowledging the specialism that's required, and also being able to support mainstream services where it's appropriate to kind of pick up the rest."

ICB representative

In terms of specific provisions, attendees wanted to see the provision of better information and education for people seeking asylum to help them navigate the NHS, including how to access mental health support and dental care, right from the beginning of their journey.

"There's a big concern that there's a number of asylum seekers who are not accessing healthcare because they're not being signposted and we do a lot of that education around accessing healthcare appropriately as they come into the service … You know, part of it is education for people to be able to move on into mainstream practices."

ICB representative

"What we noticed locally was that … we were experiencing a lot of mental health issues around asylum seekers once they've gained their leave to remain because there wasn't enough support for them while they're in the asylum process."

Healthcare professional

These findings mirrored what was shared by community leaders and people with lived experience of seeking asylum in the other workshops, who also emphasised the need for a holistic, cross-sector approach to healthcare, particularly drawing on the strengths of VCSEs.

5. References

1 Involve (2018) *Co-production*.

2 Robert, G. et al. (2022) *Co-producing and co-designing*. Cambridge University Press.

3 House of Commons Library (2023) *Asylum accommodation: hotels, vessels and large-scale sites*.

4 NHS Data Model and Dictionary, *Health Care Provider*. Available at: https://www.datadictionary.nhs.uk/nhs_business_definitions/health_care_provider.html

5 NHSE (2023) *Inclusion health groups*. Available at: https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/what-are-healthcare-inequalities/inclusion-health-groups

6 The Home Office (2023) *Accommodation sites factsheet – April 2023*.

7 NHSE (2023) *Local enhanced service commissioning through GP contracts*.

8 UK Parliament (2022) *Refugees and asylum-seekers: UK policy*. Available at: https://lordslibrary.parliament.uk/refugees-and-asylum-seekers-uk-policy

9 British Red Cross, *Facts about refugees and asylum seekers*. Available at: https://www.redcross.org.uk/about-us/what-we-do/how-we-support-refugees/find-out-about-refugees

10 Office for Health Improvement and Disparities (2022) *Working definition of trauma-informed practice*.

11 Morris, M. (2024) *The asylum backlog: Job done?*

12 The Home Office (2023) *Immigration system statistics, year ending December 2023*.

13 The Home Office (2023) *Asylum and Resettlement – Asylum applications awaiting a decision. Year ending September 2023*.

14 British Red Cross (2023) *Offline and isolated: how digital exclusion impacts access to healthcare for people seeking asylum in England*.

15 British Red Cross (2021) *VCSE health and wellbeing alliance*. Available at: https://www.redcross.org.uk/about-us/what-we-do/we-speak-up-for-change/vcse-health-and-wellbeing-alliance#Mental-health

16 World Health Organization (2022) *Refugee and migrant health*. Available at: https://www.who.int/news-room/fact-sheets/detail/refugee-and-migrant-health

17 BMA (2023) *Refugee and asylum seeker patient health toolkit: unique health challenges for refugees and asylum seekers*.

18 NHSE (2021) *A national framework for NHS – action on inclusion health*.

19 Office for Health Improvement and Disparities (2021) *Inclusion Health: applying All Our Health*.

20 Doctors of the World UK (2023) *TOOLKIT FOR PRIMARY CARE COMMISSIONERS & PROVIDERS: Access to healthcare for people seeking asylum in initial and contingency accommodation*.

21 British Journal of General Practice (2019) *Access to primary health care or asylum seekers and refugees: a qualitative study of service user experiences in the UK*. Available at: https://bjgp.org/content/69/685/e537

22 Healthwatch (2022) *Lost for words. Healthwatch Evidence on how language barriers contribute to health inequalities*.

23 British Red Cross (2021) *Steps to preventing destitution in the asylum system*.

24 Refugee Council (2021) *A policy note on barriers experienced by refugees and people seeking asylum when accessing health services*.

25 British Red Cross (2023) *Offline and isolated: how digital exclusion impacts access to healthcare for people seeking asylum in England*.

26 Ibid.

27 British Journal of General Practice (2019) *Access to primary health care or asylum seekers and refugees: a qualitative study of service user experiences in the UK*. Available at: https://bjgp.org/content/69/685/e537

28 Home Office (2024) *How many people do we grant protection to? National Statistics*.

29 The Home Office (2023) *Immigration system statistics, year ending December 2023*.

30 Doctors of the World UK (2022) *Asylum seeking children housed in initial accommodation centres (IACs) and contingency accommodation across England: A briefing on safeguarding, healthcare and education provision*.

[31] House of Commons Library (2023) *Asylum accommodation: hotels, vessels and large-scale sites*.

[32] Ibid.

[33] Independent Chief Inspector of Borders and Immigration (2022) *An inspection of contingency asylum accommodation*.

[34] Independent Chief Inspector of Borders and Immigration (2021) *An inspection of contingency asylum accommodation: HMIP report on Penally Camp and Napier Barracks*.

[35] Doctors of the World UK (2022) *Asylum seeking children housed in initial accommodation centres (IACs) and contingency accommodation across England: A briefing on safeguarding, healthcare and education provision*.

[36] Deal, A., Hargreaves, S. & Lau, K. (2023) Southwark's JSNA: *The Health & Wellbeing of Asylum Seekers and Refugees in Southwark*.

[37] Doctors of the World UK (2022) *Asylum seeking children housed in initial accommodation centres (IACs) and contingency accommodation across England: A briefing on safeguarding, healthcare and education provision*.

[38] Doctors of the World UK (2022) *"They just left me": Asylum seekers, health, and access to healthcare in initial and contingency accommodation*.

[39] UKHSA (2022) *Diphtheria: cases among asylum seekers in England, health protection report (data to 25 November 2022)*.

[40] UK Parliament, *Asylum Accommodation and Support: Schedule 2*. Available at: https://data.parliament.uk/DepositedPapers/Files/DEP2018-1112/AASC_-_Schedule_2_-_Statement_of_Requirements.pdf

[41] Migrant Voice (2023 *No Rest, No Security: Report into the experiences of asylum seekers in hotels*. Available at: https://www.migrantvoice.org/img/upload/No_rest,_no_security._Report_into_the_experiences_of_asylum_seekers_in_hotels_-_Migrant_Voice_2023_.pdf

[42] Hansard (2022) *Hotel Asylum Accommodation: Local Authority Consultation*. Available at: https://hansard.parliament.uk/Lords/2022-11-24/debates/107387B3-2651-401E-826F-92C8FFC613F0/HotelAsylumAccommodationLocalAuthorityConsultation

[43] NHSE (2022) *What are integrated care systems?* Available at: https://www.england.nhs.uk/integratedcare/what-is-integrated-care

[44] UK Government (2022) *Health and Care Act 2022*.

[45] NHSE (2022) *What are integrated care systems?* Available at: https://www.england.nhs.uk/integratedcare/what-is-integrated-care

[46] UK Government (2022) *Health and Care Act 2022*.

[47] Government, UK. *National Health Service Act 2006*.

[48] NHSE (2023) *Core20PLUS5 (adults) – an approach to reducing healthcare inequalities*.

[49] NHSE (2021) *A national framework for NHS – action on inclusion health*.

[50] Department of Health (2011) *Joint Strategic Needs Assessments and joint health and wellbeing strategies explained: Commissioning for populations*.

[51] NHSE (2021) *A national framework for NHS – action on inclusion health*.

[52] House of Commons Library (2014) *Local authorities' public health responsibilities (England)*.

[53] NHSE (2021) *A national framework for NHS – action on inclusion health*.

[54] Ibid.

[55] NHSE (2019) *Allocations for 2019/20 to 2023/24*. Available at: https://www.england.nhs.uk/allocations/previous/allocations-for-2019-20-to-2023-24/

[56] NHSE (2022) *2022/23 Guidance and funding process for supporting additional commissioning costs for primary care services to destitute asylum seekers in contingency accommodation (hotels)*.

[57] The Home Office (2023) *Asylum seekers in receipt of support detailed datasets, year ending September 2023*.

[58] Ibid.

[59] NHSE (2021) *A national framework for NHS – action on inclusion health*.

[60] Office for Health Improvement and Disparities (2022) *Working definition of trauma-informed practice*.

[61] House of Commons Library (2023) *Asylum accommodation: hotels, vessels and large-scale sites*.

[62] Independent Chief Inspector of Borders and Immigration (2022) *An inspection of contingency asylum accommodation*.

[63] NHSE (2021) *A national framework for NHS – action on inclusion health*.

[64] Doctors of the World UK (2023) *TOOLKIT FOR PRIMARY CARE COMMISSIONERS & PROVIDERS: Access to healthcare for people seeking asylum in initial and contingency accommodation*.

[65] de Valliere, S. et al. (2011) 'Comparison of two strategies to prevent varicella outbreaks in housing facilities for asylum seekers', *International Journal of Infectious Diseases*, 15, pp. 716–721.

[66] UKHSA (2023) *Outbreak management in short term asylum seeker accommodation*.

[67] Deal, A. et al. (2021) 'Strategies and action points to ensure equitable uptake of COVID-19 vaccinations: A national qualitative interview study to explore the views of undocumented migrants, asylum seekers, and refugees', *Journal of Migration and Health*, 100050

[68] Deal, A. et al. (2023) 'Precarity, agency and trust: vaccination decision-making in the context of the UK asylum system', *European Journal of Public Health*, 33, ckad160. 443

[69] Tjilos, M. et al. (2023) '"Community members have more impact on their neighbors than celebrities": leveraging community partnerships to build COVID-19 vaccine confidence', *BMC Public Health*, 23, pp. 350

[70] Syed, U. et al. (2023) 'The role of faith-based organizations in improving vaccination confidence & addressing vaccination disparities to help improve vaccine uptake: a systematic review', *Vaccines*, 11, pp. 449

[71] Deal, A. et al. (2021) 'Strategies and action points to ensure equitable uptake of COVID-19 vaccinations: A national qualitative interview study to explore the views of undocumented migrants, asylum seekers, and refugees', *Journal of Migration and Health*, 100050

[72] Crawshaw, A. F. et al. (2021) 'What must be done to tackle vaccine hesitancy and barriers to COVID-19 vaccination in migrants?', *Journal of Travel Medicine*, 28.

[73] NHSE (2023) *Meeting the initial health needs of vulnerable migrants – translated health guidance and patient questionnaire for newly arrived migrants in the UK*.

[74] NHSE (2019) *Standard General Medical Services Contract 2019*.

[75] BMA (2022) *Patient registration*. Available at: https://www.bma.org.uk/advice-and-support/gp-practices/managing-your-practice-list/patient-registration

[76] Public Health England (2016) *Making Every Contact Count (MECC): Consensus statement*.

[77] The Home Office (2022) *Asylum support contracts safeguarding framework*.

[78] Kerr, M. (2023) *Asylum accommodation contracts: The next chapter for hotels*.

[79] UK Parliament, *Asylum Accommodation and Support: Schedule 2*. Available at: https://data.parliament.uk/DepositedPapers/Files/DEP2018-1112/AASC_-_Schedule_2_-_Statement_of_Requirements.pdf

[80] The Home Office (2022) *Asylum support contracts safeguarding framework*.

[81] The Home Office (2022) *Asylum support contracts safeguarding framework*.

[82] Independent Chief Inspector of Borders and Immigration (2020) *An inspection of UK Refugee Resettlement Schemes (November 2019-May 2020)*. London.

[83] NHS, *NHS Long Term Plan*. Available at: https://www.longtermplan.nhs.uk/

[84] NHSE (2021) *A national framework for NHS – action on inclusion health*.

[85] Ibid.

[86] Equality and Human Rights Commission (2019) *Case studies: healthcare and service providers facilitating access to healthcare for people seeking asylum*. Available at: https://www.equalityhumanrights.com/sites/default/files/case-studies-healthcare-and-service-providers-facilitating-access-to-healthcare-for-people-seeking-asylum.pdf

[87] Kings College London (2022) *Mental Health and Psychosocial Support (MHPSS) Directory for Refugees and Migrants in London*.

[88] NIHR (2022) *Payment guidance for researchers and professionals*. Available at: https://www.nihr.ac.uk/documents/payment-guidance-for-researchers-and-professionals/27392

[89] British Red Cross, *British Red Cross' approach to creating the conditions and measuring progress in Amplifying, Valuing and Acting Upon Lived Experience*.

For more information
redcross.org.uk
@RedCrossPolicy

August 2024