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Health & Wellbeing Board

Tuesday, 5th March, 2019
5.30 pm

AGENDA

Date Published: Date Not Specified
Harry Catherall, Chief Executive

BLACKBURN WITH DARWEN HEALTH AND WELLBEING BOARD
MINUTES OF A MEETING HELD ON TUESDAY, 11TH DECEMBER 2018

PRESENT:

Councillors	Mohammed Khan (Chair)
	Maureen Bateson
	Brian Taylor
Clinical Commissioning Group (CCG)	Roger Parr
Voluntary Sector	Vicky Shepherd
	Angela Allen
Council	Dominic Harrison
	Jayne Ivory
	Joanne Stewart
	Justine Westwell
	Anne Cunningham
	Laura Wharton
	Shirley Goodhew
Council Officers	Firoza Hafeji
Midland and Lancashire Commissioning Support Unit	Nicola Feeney

1. **Welcome and Apologies**

The Chair welcomed everyone to the meeting. Apologies were received on behalf of Cllr John Slater, Dr Penny Morris and Joe Slater.

2. **Minutes of the meeting held on 25th September 2018**

RESOLVED – That the minutes of the last meeting held on 25th September 2018 were agreed as an accurate record and were duly signed by the Chair.

3. **Declarations of Interest**

There were no declarations of interest received.

4. **Public Questions**

The Chair shared a letter received from Kate Davies OBE, Director of Health & Justice, Armed Forces and Sexual Assault Services Commissioning and Jackie Doyle-Price MP, Parliamentary under Secretary of State for Mental Health,

regarding data available for service planning for Veterans and the delivery of the Armed Forces Covenant.

It was noted that the letter was to ask that the Health and Wellbeing Board worked with Local Government to use the available veteran data, published in October 2018, to maximum effect, and that this is cascaded to the relevant bodies. A refreshment of Joint Strategic Needs Assessment criteria was requested, reflecting the recently updated alcohol, drugs and tobacco Commissioning Support Pack, to include this additional data; all of which should contribute to ensuring there is no disadvantage to veterans.

The Board heard that Angela Allen worked with veterans in Community Charity in Burnley.

After a lengthy discussion the Board felt that it was the Local Governments responsibility to support the veterans.

5. <u>Start Well Annual Update</u>

The Board received a presentation from Jayne Ivory, Director of Children's Services on the 'Start Well' annual update.

Jayne explained that in March 2018 the Children's Partnership Board explored which priorities should be adopted for 2018/19 and three broad priorities to focus on an increased number of health and wellbeing issues were adopted as:

1. Poverty & Neglect
2. Emotional Health & Wellbeing
3. Adverse Childhood Experiences

Early Help & Parenting will be included across the 3 new priorities which were shared as:

- Substantial growth in CAF cases
- Family Group Conferencing
- Caring Dads Programme
- Teen pregnancy and teen parent offer
- Recurrent proceedings work
- Development of the 'Local Family Offer'

Laura Wharton, Public Health Specialist shared the Adverse Childhood Experiences (ACE), Pennine Lancashire ACE Framework. The Board noted that ACE Awareness training will be rolled out to all the staff in schools from 2019.

Jayne explained that the new priority for 2018/19 was Neglect and explained that the BwD Neglect Strategy & Multi-agency Action Plan launched in October 2018. It was highlighted that nearly half of the children subject to Child Protection Plans are known to social care due to neglect. A multi-agency audit on the implementation of the action plan will be carried out to monitor progress across the partnership.

The Board heard that 21% of children in Blackburn with Darwen live in poverty, compared to 18.7% in the North West and 16.8% in England. Strategies to

support this were noted by the Board.

Challenges to deliver Start Well services were shared with the Board as:

- Child Poverty & Neglect (working and non-working families)
- Increased demand for statutory services and a rise generally across the sector
- Local prevalence of emotional health & wellbeing issues: domestic abuse, mental health, emotional wellbeing, self-harm & substance misuse
- Rising number of children & young people identified and assessed with Special Educational Needs & Disabilities
- Safeguarding challenges are increasing
- Continued national budget cuts to funding & policy changes

The Board heard that Children Services were working closely with schools to tackle the significant challenges. Joanne Stewart, Head of Early Help & Support highlighted that school readiness was also a substantial challenge which was a key focus for Children Centres, to ensure nursery children were ready for their transition into primary schools.

6. PAN Lancashire Health and Wellbeing Board

The Director of Public Health, Dominic Harrison, gave a verbal update on the PAN Lancashire Health and Wellbeing Board. It was noted that there would be a single Health and Wellbeing Board for Lancashire with five local area Health and Wellbeing partnerships reflecting the local area health economies across Lancashire.

It was agreed that Dominic would keep the Board updated on the progress.

7. Joint Commissioning and Better Care Fund Update

Roger Parr, Deputy Chief Executive/Chief Finance Officer summarised the Better Care Fund Update report which had been previously circulated with the agenda.

Roger highlighted that the purpose of the report was to:

- Provide Health and Wellbeing Board members with an overview of Better Care Fund performance reporting for Q2 2018/19
- Provide HWBB members with the BCF and iBCF Finance position at Q2 2018/19
- Provide HWBB members with feedback from the Local Learning Visit from the National BCF Team

The Health and Wellbeing Board members were recommended to:

- Note the BCF Q2 2018/19 finance position
- Note the BCF Q2 2018/19 performance metrics
- Note the feedback from the National BCF Team Local Learning Visit
- Note that due to the timing of the national returns and data reporting processes, the metrics described within this report relate to data from Q1 2018/19 and up to July 2018 of Q2.

RESOLVED - That the Health and Wellbeing Board noted the recommendations.

8. Joint Strategic Needs Assessment Summary Review

The Chair invited Anne Cunningham, Public Health Intelligence Specialist to present the Joint Strategic Needs Assessment Summary Review.

The Board were informed that the JSNA Summary Review is organised into four sections:

- Setting the Scene
- Start Well
- Live Well
- Age Well

The Board thanked Anne for the detailed report and suggested to include a summary with the report to highlight the key areas.

The Director of Public Health, Dominic Harrison, recommended for the Health and Wellbeing Board to:

- Approve the 2018 JSNA Summary Review as a key component of Blackburn with Darwen's Joint Strategic Needs Assessment;
- Grant permission for analysts to keep the web version of the JSNA Summary Review routinely updated as new data is released;
- Agree that the ISNA Leadership Group should have the delegated authority to approve additional self-standing chapters for inclusion in the JSNA, and to retire old material.

RESOLVED - That the Health and Wellbeing Board noted and approved the recommendations.

9. Action on Air Quality

The Director of Public Health, Dominic Harrison, presented the Action on Air Quality report which focused on reducing deaths and ill health caused by poor air quality in Blackburn with Darwen and across Lancashire and Cumbria.

Dominic highlighted that the purpose of the report was to:

- Provide an update on health related air quality both nationally and locally
- Provide information on recent work in Blackburn with Darwen and sub-regionally to improve air quality
- Outline next steps for action on air quality in both Blackburn with Darwen and sub-regionally.

The Board were updated on the Blackburn with Darwen Air Quality Management Area (AQMA) action priorities and Lancashire and Cumbria Air Quality priorities which included:

Blackburn with Darwen AQMA action priorities:

- Develop an action plan for Four Lane Ends junction AQMA
- Assess the impact of the new road at Blackamoor AQMA once more information is known about the layout and anticipated traffic flows
- Further monitoring to determine if some AQMAs can be revoked
- Close monitoring of the Moorgate Street/Livesey Branch Road and the

Accrington Road Toll Bar Junctions because they hover below level at which new AQMAs may need to be declared.

- Delivering the DfT's Access Fund project "CONNECTING East Lancashire" working with businesses, educational establishments, residents and commuters to raise awareness of travel options and the choices available, in additional to delivering interventions that address specific barriers to active travel.
- Emissions from factories, domestic and commercial bonfires, and also from stoves and fireplaces in smoke control areas are regulated to minimise emissions.

The Board members noted that the priorities for Lancashire and Cumbria Air Quality were captured in Appendix 2 of the report.

RESOLVED –

1) That the Board members noted the content of the report.

2) Considered what action the Health and Wellbeing Board and its constituent organisations may take to address and improve air quality.

10. <u>Health and Wealth Report</u>

The Director of Public Health, Dominic Harrison, presented the Health and Wealth report which was noted by the Board members.

The Chair reminded the Board that the date and time of the next Health and Wellbeing Board meeting was scheduled for 5th March 2019 at 5.30pm.

Signed……..

Chair of the meeting at which the Minutes were signed

Date……

DECLARATIONS OF INTEREST IN

ITEMS ON THIS AGENDA

Members attending a Council, Committee, Board or other meeting with a personal interest in a matter on the Agenda must disclose the existence and nature of the interest and, if it is a Disclosable Pecuniary Interest or an Other Interest under paragraph 16.1 of the Code of Conduct, should leave the meeting during discussion and voting on the item.

Members declaring an interest(s) should complete this form and hand it to the Democratic Services Officer at the commencement of the meeting and declare such an interest at the appropriate point on the agenda.

MEETING: **Health and Wellbeing Board**

DATE: **5th March 2019**

AGENDA ITEM NO.**:**

DESCRIPTION (BRIEF):

NATURE OF INTEREST:

DISCLOSABLE PECUNIARY/OTHER (delete as appropriate)

SIGNED :

PRINT NAME:

(Paragraphs 8 to 17 of the Code of Conduct for Members of the Council refer)

HEALTH AND WELLBEING BOARD

Health & Wellbeing Board

Start well | Live well | Age well

TO:	Health and Wellbeing Board
FROM:	Director of Public Health and Wellbeing
DATE:	5th March 2019

SUBJECT: Eat Well Move More Shape Up Strategy Year 2 Report

1. PURPOSE

To update on the progress made against the Eat Well Move More Shape Up strategic action plan during the second year of delivery.

To inform the Health & Wellbeing Board about the key priorities and opportunities for year three.

To highlight key issues impacting on effective delivery of the action plan in year three.

2. RECOMMENDATIONS FOR THE HEALTH & WELLBEING BOARD

That the Health and Wellbeing Board:

- Note the contents of the report.
- Note that physical inactivity and unhealthy weight remains a significant public health issue requiring ongoing senior level leadership and commitment to increasing physical activity levels, improving access to healthy and sustainable food and encouraging self-care from council, partners and stakeholders.
- Note the progress made to date by all partners and the key issues impacting on effective delivery of the action plan.
- Note the priorities and opportunities for Year 3 of the Eat Well Move More Shape Up Strategy.

2. BACKGROUND

Physical inactivity and unhealthy weight are major public health problems due to their association with serious chronic diseases and the costs to both the individuals and society as a whole. Levels of participation in physical activity nationally are currently very low in both children and adults. Nationally, over two thirds of the adult population are overweight or obese and data from the National Child Measurement Programme shows that 1 in 10 4-5 year olds and 1 in 4 10-11 year olds are obese.

The economic cost of unhealthy weight and physical inactivity is significant and with the increasing pressure on the health and social care system, prevention must be a priority. Obesity is a complex, but largely preventable condition which has serious, far reaching physical, psychological and social consequences that affects virtually all age and socioeconomic groups although some groups are affected more than others. Obesity impairs a person's wellbeing, quality of life and ability to earn.

Being physically active has benefits for mental health, quality of life and wellbeing and maintaining independent living in older age. Physical activity can help to play a role in reducing health and social inequalities and as a result of its wide reaching impact has been described as the 'best buy' in public health.

Local partners and stakeholders are committed to increasing the number of people of a healthy weight and increasing physical activity levels in Blackburn with Darwen (BwD). Public Health has provided the strategic leadership and co-ordination, and has a key role in leading the delivery of the Eat Well Move More Shape Up strategy to ensure senior level, multiagency ownership and co-ordinated local action. The three year strategy (2017-20) adopts a life course approach, aligned to the three Health and Wellbeing life stages of start well, live well and age well.

3. RATIONALE

The purpose of the BwD Eat Well Move More Shape Up Strategy is to provide a framework for action to increase the number of people with a healthy weight and to increase physical activity levels and ultimately increase healthy life expectancy. It draws upon local experience and knowledge, the dedicated health and social care workforce within the borough, a network of passionate volunteers and community groups and research evidence to improve the health and wellbeing of the residents of the Borough.

The three overall strategic objectives are:

- To improve access to healthy, affordable and sustainable food
- To increase physical activity levels
- To increase the number of children and adults of a healthy weight

The strategy provides an approach to health improvement which recognises the contributions that can be made across all sectors of our society. The national obesity and physical activity strategies are clear that it is not the sole responsibility of any one sector alone. It is important that stakeholders and partners work together to help reduce the prevalence of non-communicable diseases such as Type 2 Diabetes, coronary heart disease and stroke through a healthy lifestyle and co-ordinate and deliver interventions with local communities to ensure that they are effective in helping to improve healthy life expectancy in the Borough.

Key Progress During Year 2

Year two has seen a consolidation of existing partnerships and the engagement of new partners with the strategy. All partners involved in the delivery of the strategy share a sense of passion and pride in serving Blackburn with Darwen and its residents and share the common goals of improving health and wellbeing and helping to reducing the burden on local health care system and, in doing so, protecting precious resources.

Progress against the action plan continues, as can be seen in the Year 2 Annual Report (Appendix A), but with the acknowledgement that there is still much to do to have a significant impact on the population.

Headline achievements against each of the strands of the strategy are:

- BwD Food Alliance and Food Poverty Action plan development
- Together an Active Future Sport England Local Delivery Pilot work
- Signing of the East Lancashire Hospital Trust Healthy Weight Declaration

In engaging with all partners and stakeholders, including council and health leaders, Community, Voluntary and Faith sector organisations, the wider public sector, private business, and local communities themselves; the strategy demonstrates a joint commitment to work together to have

prevention as a priority in all that we do. This strategic approach that will enable us to make a significant difference to the health and wellbeing of the residents of Blackburn with Darwen.

Year 3 Priorities and Opportunities

The Year 3 annual report identifies in detail the priorities agreed by the steering group for the final year of delivery. Each sub group will continue to direct the delivery of the priorities and identify other opportunities for development and the steering group will continue to have oversight of overall progress. The steering group will continue to align the direction of the strategy with national policy and strategy including the recently released NHS Long Term Plan along with Pennine Lancashire ambitions and Blackburn with Darwen's locality priorities and work will also begin on planning for 2020 and beyond.

During 2019-20 Blackburn with Darwen is seeking to undertake a Whole System Healthy Weight Review across Pennine Lancashire. The development of a clear, concise Healthy Weight Route Map will provide a consistent approach for all partners and stakeholders to tackling unhealthy weight across Pennine Lancashire from policy development to frontline delivery of activity to support a healthy weight. Unhealthy weight remains everybody's business and requires a coordinated and sustained effort to ensure that the whole system is working together to create a step change in tackling unhealthy weight.

In support of this whole system review, Blackburn with Darwen has the opportunity to be one of five Childhood Obesity Trailblazer Programmes nationally. The Childhood Obesity Trailblazer Programme seeks innovative action to tackle childhood obesity at local level. The programme is funded by the Department of Health and Social Care and managed by the Local Government Association. It is intended to test the limits of existing powers and developing solutions to local obstacles aiming to enable ambitious local action and to achieve change at scale. Blackburn with Darwen is one of 13 Authorities selected to develop the expression of interest into a full submission. Successful Local Authorities will be informed in Summer and will undertake a three year programme funded by the Local Government Association, Public Health England and the Department of Health and Social Care.

A full analysis of the impact of the action plan on the high level indicators during the initial three years will take place at the end of Year 3. There is still acknowledgement that any significant impact from delivery of the action plan may take many years to come to fruition; however we may see some small steps towards long term health improvement of residents in Blackburn with Darwen.

5. KEY ISSUES

Tackling obesity requires a whole systems approach from all partners and stakeholders. Taking a population approach through policy change and development will have the greatest impact on obesity and not focussing on service delivery to a small number of people. Ongoing engagement with key partners and ensuring key contacts are maintained within services to maintain momentum in delivering against the action plan. The year on year cut in funding from central government to the Council and Clinical Commissioning Group (CCG) has led to reduced capacity to support the strategy. Whilst there remains widespread support for the strategy from senior leaders within both organisations, full engagement in supporting the steering group meetings and in the delivery of the action plan continues to be low priority.

Lack of understanding of the wider determinants affecting unhealthy weight can lead to a tendency to focus on one issue as the root cause e.g. hot food takeaways, rather than looking at the whole system and mechanisms involved e.g. poverty. Supporting the drive to ensure healthy weight is included in all policies is part of the Local Authority Declaration on Healthy Weight which was signed in April 2017 by both the Council and CCG. This intention to tackle unhealthy weight will

require further awareness of the complexities of unhealthy weight and how some of these issues can be tackled locally. Further work is planned during 2019 to raise awareness of the Healthy Weight Declaration and the need for a whole systems approach to tackling healthy weight for both elected members and senior managers across the statutory organisations to address this.

6. POLICY IMPLICATIONS

This strategy has been aligned to both local and national recommendations and guidelines for improving access to healthy and sustainable food, increasing physical activity levels and achieving a healthy weight and BwD's refreshed Health and Wellbeing strategy. The action plan has been developed in line with national policies and guidelines and local priorities as derived from the extensive consultation work undertaken.

The strategy and action plan take into account the strategies, frameworks and policies listed below:

- Public Health Outcomes Framework 2014-15 (Department of Health, 2014)
- Fair Society, Healthy Lives. A strategic review of health inequalities in England post 2010 (The Marmot Review, 2010)
- Blackburn with Darwen Joint Health and Wellbeing Strategy 2018-21
- BwD Planning for Health Supplementary Planning Document
- BwD Integrated Strategic Needs Assessment
- Food Active's Local Authority Declaration on Healthy Weight
- Prevention Is Better Than Cure (DHSC, 2018)
- The NHS Long Term Plan (NHS, 2019)

7. FINANCIAL IMPLICATIONS

There are no financial implications. The strategy and action plan will be delivered within existing partner agency budgets and the Department of Health Public Health Prevention grant.

8. LEGAL IMPLICATIONS

Transfer of public health from the NHS to local government and Public Health England (PHE) has introduced a significant extension of local government powers and duties and represents an opportunity to change focus from treating sickness to actively promoting health and wellbeing. Section 12 of the Health and Social Care Act inserts a new section 2B into the NHS Act 2006 to give each relevant local authority a new duty to take such steps as it considers appropriate to improve the health of the people in its area. This section also gives the Secretary of State a power to take steps to improve the health of the people of England and it gives examples of health improvement steps that either local authorities or the Secretary of State could take, including giving information, providing services or facilities to promote healthy living and providing incentives to live more healthily.

Local authorities have considerable discretion in how they choose to invest their grant to improve their population's health, although they have to have regard to the Public Health Outcomes Framework and should consider the extant evidence regarding public health measures.

9. RESOURCE IMPLICATIONS

The strategy and action plan will be delivered by strategic health and wellbeing board partners, with the council's Public Health team providing a leadership and co-ordination role.

10. EQUALITY AND HEALTH IMPLICATIONS

The Health Impact Assessment associated with the strategy has been reviewed and remains valid. Progress against the agreed action plan is being made to support health improvement for residents in Blackburn with Darwen.

11. CONSULTATIONS

Extensive consultation around the strategy took place during the 18 months preceding its adoption. An initial period of consultation and insight work took place during 2015 and involved a Start Well and Age Well consultation along with a commissioned consultation around the issue of food poverty in the borough. There was also an initial online public consultation in 2015 which had 201 responses.

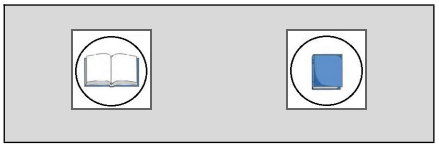
From this work the draft action plan was produced and further targeted consultation has taken place during 2016, particularly concentrated between May and September. The consultation has included the following:

- Public Online Consultation – 110 responses
- Health Professional Online Consultation – 27 responses
- Stakeholder Engagement event in June 2016 and face to face/email engagement with individual stakeholders
- Senior Policy Team briefings across all portfolios
- Quarterly Eat Well Move More Shape Up Steering Group meetings
- Primary School Catering Managers
- Clinical Commissioning Group Protected Learning Time event and Clinical Commissioning Group Operations Group
- Bangor Street Ladies group & Inter Madrassah Organisation Women 4 Women group
- Families Health & Wellbeing Consortium
- Older People's Forum and Age UK consultation
- Learning Disabilities Partnership Board
- Blackburn with Darwen Health and Wellbeing Board, Live Well Board and Children's Partnership Board

Intelligence gathered through the BwD Integrated Strategic Needs Assessment (ISNA) and subject specific ISNAs has also informed the action plan.

VERSION:	**1.2**

CONTACT OFFICER:	Beth Wolfenden
DATE:	8th February 2019
BACKGROUND PAPER:	Eat Well Move More Shape Up Strategy and Action Plan, Plan on a Page http://www.blackburn.gov.uk/Pages/Eat-Well-Shape-Up-Move-More-Strategy.aspx Health Impact Assessment Year 2 Annual Report http://www.blackburn.gov.uk/Health%20and%20well%20being%20board/EWMMSU-report.pdf



HEALTH AND WELLBEING BOARD

TO:	Health and Wellbeing Board
FROM:	Sayyed Osman, Director of Adult Services, Neighbourhoods and Community Protection, BwD LA Roger Parr, Deputy Chief Executive/ Chief Finance Officer
DATE:	5th March 2019

SUBJECT: Better Care Fund Update

1. PURPOSE

The purpose of this report is to:

- Provide Health and Wellbeing Board (HWBB) members with an overview of Better Care Fund (BCF) performance reporting for Q3 2018/19
- Provide HWBB members with the BCF Finance position at Q3 2018/19

2. RECOMMENDATIONS FOR THE HEALTH & WELLBEING BOARD

Health and Wellbeing Board members are recommended to:

- Note the BCF Q3 2018/19 finance position
- Note the BCF Q3 2018/19 performance metrics
- Note that due to the timing of the national returns and data reporting processes, the metrics described within this report relate to data up to November 2018 of Q3.

3. BACKGROUND

As outlined in previous reports, the Health and Wellbeing Board is accountable for the delivery of the Better Care Fund plan. The management of the plan is undertaken through Blackburn with Darwen joint commissioning arrangements.

The Blackburn with Darwen BCF plan for 2017/19 was approved on the 22nd January 2019, with an expectation that planned performance metrics are achieved as described. Quarterly reports have been submitted as per the national schedule, demonstrating the progress made against each scheme. The Q3 return was submitted on 25th January 2019 following sign off by Councillor Mohammed Khan. Due to the timing of the national returns and year end reporting processes, the metrics described within this report relate to data for Q3 2018/19.

4. RATIONALE

As outlined within previous reports to the HWBB, the case for integrated care as an approach is

well evidenced. Rising demand for services, coupled with the need to reduce public expenditure, provides a compelling argument for greater collaboration across health, care and the voluntary sector.

The Spending Review set out an ambitious plan such that by 2020, health and social care is integrated across the country. This is also reflected in the NHS Planning Guidance 2016/17-2020/21 Delivering the Forward View. The Better Care Fund remains a key policy driver to support integration of health and care services at a local level.

The NHS 10 Year Plan was published in January 2019 and sets out the vision for the NHS and partners to create an Integrated Care System by April 2021, through the bringing together of local organisations to deliver 'triple integration' of primary, specialist, physical and mental health services and health with social care. The ICS key role is working with Local Authorities at 'place' level, and through ICSs, commissioners will make shared decisions with providers on population health, service redesign and Long Term Plan implementation.

5. KEY ISSUES

5.1 BCF Pooled Budget 2018/19

The CCG minimum pooled budget requirement for 2018/19 is £11,381,000. The DCLG have confirmed the DFG capital allocation for 2018/19 at £1,739,476.

The 2018/19 allocations as above plus carry forward amounts from 2017/18 are analysed as:

- Spend on Social Care - £6,501,650 (48.0%)
- Spend on Health Care - £4,252,828 (31.4%)
- Spend on Integration - £2,191,698 (16.2%)
- Contingency - £600,000 (4.4%)

As previously reported, the BCF budget for 2018/19 has been reviewed following further joint planning across LA, CCG finance and social care leads and includes the following:

- Inflationary uplifts
- Capital allocation assigned to Integrated Neighbourhood Team estates
- The realignment of available monies to fund a reshaped Take Home and Settle service.
- Review of Community Voluntary and Faith Sector Funding (CVFS), as part of the wider joint Local Authority and CCG CVFS service delivery model, to procure a more integrated offer.
- Commissioning Transformation Lead - Integrated Care post in place since October 2018.
- The balance of BCF of £600,000, ordinarily held as a contingency, has been allocated to the LA in 2018/19 to meet social care demand and acuity pressures. Any further pressures or savings identified in year will be shared between the LA and CCG in accordance with the S75 agreement.

5.2 iBCF Pooled Fund 2018/19

Central Government consulted on the distribution of the Improved Better Care Fund as part of the Local Government Finance Settlement 2018/19. The spending review set out the expected available revenue for Local Government spending through to 2019/20 and the Core Spending Power information for Local Authorities has now been issued, including the proposed allocations of the Improved Better Care Fund.

Allocations in the Core Spending Power recognised that authorities have varying capacity to raise council tax (including that through the adult social care precept). Further allocations of the

Improved Better Care Fund have been made following the Spring Budget. For Blackburn with Darwen the total allocations of Improved Better Care Fund are:

	Original iBCF	Additional iBCF for Social care – Spring Budget	Total
2017/18	£717,301	£3,589,451	£4,306,752
2018/19	£3,714,497	£2,186,064	£5,900,561
2019/20	£6,257,725	£1,081,454	£7,339,179

Allocations will be paid directly to Local Authorities as Section 31 grant and Local Authorities must meet the conditions set out in the grant determination as part of locally agreed plans. The grant must be spent on adult social care and used for the purposes of:

- meeting adult social care needs (£4.0m allocation)
- reducing pressures in the NHS – including supporting more people to be discharged from hospital in a timely way as a means to avoid Delayed Transfers of Care (DToC) (£635k allocation).
- stabilising the social care provider market (£1.265m allocation)

Local Authority Section 151 Officers are required to certify use of the grant. Reporting on use of the iBCF is undertaken via the BCF quarterly returns. Local Authorities must pool the grant funding into the local Better Care Fund and work with CCG's and providers in line with the Better Care Fund Policy Framework and Planning Requirements 2017-19.

5.3 BCF 2018/19 Performance Metrics

Due to the timing of the national returns and year end reporting processes, the metrics described within this report relate to data up to November 2018.

- **Reduction in non-elective admissions**

There has been an increase (+20.8%) in emergency admissions during 2018/19 due to the intentional change in patient pathways affecting the 'zero day admissions' and activity through the Respiratory Assessment Unit (RAU) and Ambulatory and Emergency Care Unit (AECU). The fact that the number of patients accessing services through these pathways has increased represents a positive change, albeit one that that results in the overall number of reportable admissions going up. This was referenced as a risk, and referenced as an area of support need in the 18/19 Q2 submission which is also being reviewed locally by the Local Authority and CCG. Work continues to develop integrated working at a neighbourhood level across health, care and the voluntary sector, supporting people to avoid hospital admission and remain independent at home. Emergency admissions with a length of stay of 1 day or more are lower this year to date than in 2017/18 (-0.5%).

- **Rate of permanent admissions to residential care**

The 2018/19 target has been set at the same numerical target as the previous year which is 175 admissions (817.1 per 100,000 populations). Progress against the numerical target of 44 per quarter has shown a slight increase for quarters 1, 2 and 3 which is summarised below:

Quarter 1 – 56 admissions
Quarter 2 – 62 admissions
Quarter 3 – 26 admissions (up to November 2018 – this performance will be finalised in March 2019).

Rates of admissions to residential and nursing care within Blackburn with Darwen historically remain high relative to the national average. A number of factors contribute to this including demographic pressures and multiple long term conditions. Admissions to nursing care, for people with dementia and complex needs, continues to be an area of increasing demand. There continues to be a range of services in place to provide reablement in reach, dedicated social work support, assistive technology and access to therapy services to maximise the opportunity to return home. Extra care schemes are in place for people with both frailty and dementia needs.

- **Reablement**

The reablement target relates to the proportion of people (65 and over) who were still at home 91 days after discharge from hospital into Reablement and /or rehabilitation services. Quarter 3 performance against the target is on track at 89%. The Reablement service continues to expand the reablement offer across all of our integrated pathways. This involves supporting residents with increasingly complex needs onto the rehab programme. This process presents a challenge around maintaining outcomes across a wider cohort of residents with increasingly complex needs.

- **Delayed Transfers of Care (DToC) (delay days in hospital)**

Performance against target for Qtr. 3 2018/19 DToC is not on track and has lifted the total reported planned levels above plan. The increase in delayed transfers of care days reported is due to both NHS and social care delays. However, the cumulative position is showing a reduction in delayed days in comparison to the previous quarter.

This measure is typically subject to fluctuations in response to hospital pressures however the positive trajectory reflects several schemes which have been agreed to support the reduction in DToC and which are continuing to progress as planned:

- The enhanced Home First service and Discharge to Assess pathways are fully established and working well to support patients with more complex needs to return home from hospital and to enable a longer period of recovery outside of the hospital environment.

- The Reablement and Intermediate Care pathways and services are well established and can be seen to positively impact on patient flow.

- A system-wide approach from a range of organisations and services is in place to support the micro management of the delayed transfers of care position and long length of stay patients.

Additionally, there is significant work at hospital level to clearly identify and apportion DToC in line with current guidance. A series of improvement meetings are continuing to seek to address the current increase in demand and delays.

5.4 BCF Local Learning Visit

Blackburn with Darwen has participated in a Local Learning visit from the National BCF Team on Tuesday 9th October 2018. The visit offered an excellent opportunity to showcase our integrated care developments and the feedback we received was very positive. We continue to liaise with the team and at their request have submitted two case studies on 10th December 2018. We will continue to highlight our work on a regular basis with the national team.

6. POLICY IMPLICATIONS

The key policy drivers are outlined within the main body of this report and within previous BCF papers presented to HWBB members. Local areas are expected to fulfil these requirements. Any further impact due to changes in National Policy or planning guidance will be reported as they arise.

7. FINANCIAL IMPLICATIONS

No further financial implications have been identified for quarter 3. This report outlines the budget position at November 2018.

8. LEGAL IMPLICATIONS

Legal implications associated with the Better Care Fund governance and delivery have been presented to Health and Wellbeing Board members in previous reports. A Section 75 agreement is in place between the Local Authority and CCG which outlines risk sharing arrangements associated with the Better Care Fund and other funding streams aligned to integrated delivery locally.

9. RESOURCE IMPLICATIONS

Resource implications relating to the Better Care Fund plan have been considered and reported to Health and Wellbeing Board members as part of the initial plan submission.

10. EQUALITY AND HEALTH IMPLICATIONS

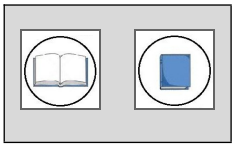
Equality and health implications relating to the Better Care Fund plan were considered and reported to Health and Wellbeing Board members prior to submission of the plan.
Equality Impact Assessments are ongoing as part of the development of all BCF and integrated care schemes, including new business cases, and are integral to service transformation plans.

11. CONSULTATIONS

The details of engagement and consultation with service providers, patients, service users and the public have been reported to Health and Wellbeing Board members throughout development of the local BCF plan.

VERSION:	**1.0**

CONTACT OFFICER:	Samantha Wallace-Jones
DATE:	6th February 2019
BACKGROUND PAPER:	



HEALTH AND WELLBEING BOARD

TO:	Health and Wellbeing Board
FROM:	Dominic Harrison, Director of Public Health
DATE:	5th March 2019

SUBJECT: Asylum Seekers and Refugees Health Needs Assessment

1. PURPOSE

To disseminate the finding of the Asylum Seeker and Refugee Health Needs Assessment (HNA).

2. RECOMMENDATIONS FOR THE HEALTH & WELLBEING BOARD

It is recommended that members of the Board;

- Note the recommendations made within the report
- Consider the way in which the recommendations may be used to inform and improve the health and wellbeing of asylum seekers and refugees in Blackburn with Darwen.

3. BACKGROUND

People seeking asylum and refugees are among some of the most vulnerable groups in society. Before arriving in the UK, they may have experienced violence, war, torture and may have been separated from, or even lost family members and friends. Almost universally, people seeking asylum will have experienced dangerous and difficult journeys to escape to safety. They frequently will have been separated from families and friends and may be bereaved. Arriving in an unfamiliar country, where they perhaps find it difficult to communicate and navigate the complex legal processes can be disorientating and disheartening.

There are up to 350 Asylum seekers in the town at any one time and an undetermined number of refugees.

4. RATIONALE

People seeking asylum and refugees may have considerable and varying health and social needs. Given their diverse backgrounds and experiences prior to entering the UK. Therefore, their social, economic and health needs cannot be addressed with a generic approach but should be considered within the context of an individualized, holistic model of care and service provision (Robertshaw, Dhesi, & Jones, 2017) A local Health Needs Assessment (HNA) adds to our understanding of these complexities and supports the development of appropriate support for this group.

This is the first HNA for asylum seekers and refugees conducted in Blackburn with Darwen. The purpose of the HNA was to identify local provision that is currently working well to support this group and understand any gaps that may be impacting negatively on the health and wellbeing and increasing vulnerabilities for this population.

1. KEY ISSUES

The HNA identified the following **key issues** for asylum seekers and refugees living in Blackburn with Darwen;

- Mental Health provision and access - unable to navigate the 'choose and book' system, lack of interpreters and reception staff at mental health services unaware of needs of ASR.
- Malnutrition and other associated dietary conditions due to limited cooking skills and lack of availability of familiar foods, also financial pressures
- Infections disease risks- incomplete vaccination schedules, also increased risk of Blood born viruses and other infections acquired during migration.
- Dentistry issues due to lack of interpreters at dentists and also poor knowledge on dental hygiene
- Exacerbation of chronic conditions due to migration and limited access to treatment due to lack of understanding of how to book appointments (choose and book letters not in native tongue)
- Women's health issues – Female Genital Mutilation, Rape, Pregnancy and Screening
- Lack of awareness on the rights of an ASR in Primary Care,
- Lack of awareness of ASR by healthcare staff (receptionist) could cause barriers to access
- Family members and friends acting as interpreters resulting in safeguarding concerns as often children doing this and also this use of translation leads to confidentiality and discloser issues.
- Impact of housing, childcare and employment on health

The report makes the following **recommendations**;

Mental Health

- Materials required in community languages,
- Trained mental health professionals facilitating support groups locally to break down barriers/stigma.

Physical Health

- Explore possibilities of specialist services of healthcare professionals.
- Possibilities of one lead General Practitioner (GP) practice in Blackburn and one in Darwen for ASR
- Ensure all GP's using the Public Health England migrant checklist at first GP appt.
- Dentist to have and use Language Line rather than relying on ASR bringing own interpreters.
- Prepare ASR on future planning for appointments and what to expect.

General Recommendations

- Training required for administration and front line health staff (GP's Dentists and Hospital) on the needs and rights of ASR.
- Translation services must be used by services and not encourage ASR's to use family or friends.
- Written communication to patients should be in native tongue.
- Targeted services for promoting healthy lifestyles should be used more e.g. Re Fresh.
- Development of community volunteer schemes for ASR's alongside peer ASR support programmes.

2. POLICY IMPLICATIONS

The findings of this health needs assessment should be taken into consideration when developing any policy that may directly or indirectly affect the health and wellbeing of ASR living in Blackburn

with Darwen.

7. FINANCIAL IMPLICATIONS

There are no direct financial implications of this paper.

8. LEGAL IMPLICATIONS

Under the Health and Social care Act 2012 Health and Wellbeing Boards have duty to undertake Joint Strategic Needs Assessment (JSNA) in relation to the health needs of the local population.

This health needs assessment will assist constituent organisations of the Board in their responsibilities under the Equality Act 2010 and in meeting Home Office requirements for ASRs.

9. RESOURCE IMPLICATIONS

There are no direct resource implications of this paper.

10. EQUALITY AND HEALTH IMPLICATIONS

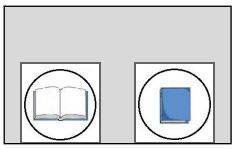
The recommendations made within the HNA seek to reduce the inequality gap faced by this population group. By ensuring the recommendations are addressed health and wellbeing outcomes for this group will be improved.

11. CONSULTATIONS

The needs assessment was carried out in consultation with asylum seekers and refugees living in Blackburn with Darwen and the agencies employed to support and represent them.

VERSION:	**Final**

CONTACT OFFICER:	Kerry Riley
DATE:	03.01.2019
BACKGROUND PAPER:	Blackburn With Darwen Asylum Seekers and Refugees Health Needs Assessment 2018



Blackburn with Darwen Asylum Seekers and Refugees Health Needs Assessment 2018

Wendi Shepherd

Specialty Registrar in Public Health,
Blackburn with Darwen Borough Council

ACKNOWLEDGEMENTS

Thank you to all the asylum seekers and refugees who shared their experiences. Particular thanks to all the members of the Blackburn with Darwen Asylum Support Multi-agency Forum (ASMAF), associated project workers, and volunteers who contributed time, knowledge, and expertise to this project.

EXECUTIVE SUMMARY

INTRODUCTION

Blackburn with Darwen (BwD) has recently been recognised as a City of Sanctuary for Asylum Seekers and Refugees (ASRs). There are up to 350 asylum seekers in the borough at any one time, and an unknown number of refugees who have chosen Blackburn as their home after being given Leave to Remain.

Globally, the number of ASRs and displaced people is rising each year due changing geo-political and environmental factors. There has been a slight downward trend of asylum applications across the EU and in the UK since 2015.

There has been no Health Needs Assessment (HNA) carried out previously for this group of individuals in BwD. This document seeks to identity the health needs of this unique group, map existing service provision, and make recommendations for local action to address the findings of this research.

METHODS

A qualitative approach was employed to identify the health needs of ASRs in BwD. The author spent time speaking to ASRs directly at local drop-in centres. Local staff and volunteers working with ASRs were interviewed to develop understanding and local context from information obtained from ASRs directly and via literature reviews. Ethnography was also employed where appropriate to do so. Data was gathered from February – May 2018 in Blackburn with Darwen.

FINDINGS

The health needs were identified during this research were:

- Mental health and wellbeing provision appropriate to the unique needs of ASRs requires development
- Dietary factors including malnutrition and dietary-associated conditions (physical and mental) due to limited cooking skills, local availability of familiar food, and financial pressures
- Infectious disease risk from conditions during migration and differing vaccination schedules in home countries
- Dentistry issues due to local access, language barriers, and lack of knowledge of dental hygiene
- Exacerbation of chronic conditions during migration
- Knowledge of women's health issues including FGM and rape
- Primary care awareness of the rights of ASRs in terms of access
- General awareness of ASR status in healthcare provision resulting in barriers to access
- Family members and community members being asked to provide translation services for healthcare resulting in confidentiality and disclosure concerns
- Impact of childcare, housing, and employment on health

RECOMMENDATIONS

The report recommends that local service providers should consider:

- Physical health:
  - Explore possibilities of creation of specialist services for ASRs; staffed by GP and healthcare professionals with an interest in, and knowledge of, ASR-specific conditions and needs.
  - Ensure PHE Migrant Health checklist (available on PHE website) utilised in all first GP appointments with ASRs
- Mental health:
  - Development of self-help materials in community languages
  - ASR-specific support groups facilitated by trained professionals
  - Specialist mental health services with staff skilled in the mental health needs of ASRs
- General recommendations:
  - Training and support for all health providers in the rights of, and health needs of, ASRs. This should particularly focus on front-line administrative staff (ie, receptionists) and clinical areas of high footfall (ie, maternity, A&E, GPs, practice nurses);
  - All services should ensure that only appropriate translation services are used – children and families should not be used for this purpose. There should be active monitoring and response to issues regarding translation services by all healthcare providers;
  - Access to official translation services to be made available to non-NHS healthcare providers;
  - Written communication from service to be offered in community languages (or provided automatically if noted in patient demographic information);
  - Review of referral pathways into areas of high use by ASRs to ensure that potential barriers to access are reduced/removed;
  - Promote healthy lifestyles to ASRs via targeted interventions using existing agencies (ie, Re:Fresh) and community projects.
  - Education – specifically around English language and life skills
  - Information for ASRs about local services and their individual rights
  - Transition support once given Leave to Remain
  - Improved information sharing between partner organisations
  - Development of volunteering schemes for ASRs
  - Support for ASR project volunteers and workers

Given the transient nature of ASRs, it is suggested that this document is reviewed at regular intervals to ensure that the health needs outlined above are still relevant to the local ASR population.

LIST OF FIGURES

LIST OF ABBREVIATIONS AND ACRONYMS

ARC	Asylum & Refugee Community [BwD-based Project]
AS	Asylum Seeker
ASMAF	Asylum Support Multi-agency Forum
ASR	Asylum Seekers & Refugees
BBV	Blood-borne Virus
BwD	Blackburn with Darwen
BwDBC	Blackburn with Darwen Borough Council
CCG	Clinical Commissioning Group
CGL	Change Grow Live
DARE	Darwen Asylum & Refugee Enterprise
DWP	Department of Work & Pensions
EIA	Equality Impact Assessment
ESOL	English for Speakers of Other Languages

FGM	Female Genital Mutilation
HMO	Hous(e/ing) of Multiple Occupation
HO	Home Office
IAC	Initial Accommodation Centre
IDP	Internally Displaced Person/People
IRC	International Red Cross
LGBTQ+	Lesbian, Gay, Bisexual, Transgendered & Questioning
MLCSU	Midlands and Lancashire Commissioning Support Unit
MSF	Medicins Sans Frontiers (Doctors without Borders)
NCD	Non-communicable Disease
NGO	Non-Governmental Organisation
PSED	Public Sector Equality Duty
PTSD	Post-traumatic Stress Disorder
UC24	Urgent Care 24
UNHCR	United Nations High Commission for Refugees
WIT	Wellbeing Inclusion Team

CONTENTS

INTRODUCTION

Asylum seekers and refugees (ASRs) are a varied and diverse group of people who come from a wide range of backgrounds. While there have always been ASRs, recent global conditions have significantly increased numbers due to conflict (such as Syria, Democratic Republic of Congo, and South Sudan); systematic persecution (Rohingya Muslims in Myanmar); poor humanitarian conditions (Yemen); and human rights violations (globally). The UN estimates that there are currently in excess of 65.6million people around the world who were forcibly displaced in 2016 (United Nations, 2017) – roughly the same as the total population of the whole of the UK.

There has been no previous Health Needs Assessments (HNA) for this unique group of people carried out locally. In 2018, BwD was recognised as a "City of Sanctuary"[1] for ASRs – it is timely therefore to provide information on the health needs of the local ASRs in 2018 and document the local service provision to support these needs in BwD.

[1] City of Sanctuary is a national initiative to create towns and cities that welcome people in need of safety.

Further details can be found at www.cityofsanctuary.org.

AIMS & OBJECTIVES

The aims and objectives of this health needs assessment are:

AIMS

The aim of this report is to provide information to relevant stakeholders around the health needs of asylum seekers living in BwD. This information will assist in formulating a set of recommendations to inform future work to improve the health and wellbeing of ASRs within the Borough by outlining potential interventions that may help to improve outcomes for individuals.

NB: This Health Needs Assessment does not directly relate to economic migrants. However, some of the issues discussed may apply.

OBJECTIVES

1. Conduct a literature review to identify the health and wellbeing needs of ASRs and to identify evidence-based interventions targeted to meet such needs;
2. Report on the regional (North West) and local services available to ASRs;
3. Identify and analyse the met and unmet needs of ASRs within BwD;
4. Formulate recommendations to meet the needs of ASRs based on information obtained.

BACKGROUND INFORMATION

When considering the health needs of ASRs, it is important to be aware of several key over-arching themes that are likely to affect all ASRs - regardless of country of origin or the reason for their asylum claim.

Firstly, ASRs are a vulnerable group. They have all had (diverse) experiences that have led them to seek asylum away from their home. Many have left their families and friends and may be bereaved. Many have relied on people smugglers and extreme transport conditions to escape to safety. Arriving in an unfamiliar country, where they perhaps find it difficult to communicate and navigate the complex legal processes, can be disorientating and disheartening.

Secondly, by virtue of being in a new country, ASRs are isolated from their culture, language, and support networks. Being classed as an asylum seeker – and hence not being able to work – may further increase isolation at the individual level.

Finally, while these individuals share the experience of being an asylum seeker, they are not a homogenous group. Different individuals will have different needs based on existing health conditions, country of origin, age, gender, sexual orientation, religion, social norms, and other factors. Any HNA for this group needs to consider these unique needs at the individual level, alongside any shared needs of ASRs. A "one size fits all" approach to provision of health and social care services for people seeking asylum and refugees is likely to be insufficient.

ASYLUM PROCESS IN UK

The asylum process in the UK is complex and lengthy with several opportunities for appeal by rejected asylum seekers. In the UK, the process of asylum is regulated by international, European and UK laws. It aims to last up to six months. However, the process is frequently lengthier at present. A flowchart detailing the current asylum process is provided in Appendix 2.

KEY DEFINITIONS

It is important to clarify terminology around ASRs to avoid potential confusion. While the terms "asylum seeker" and "refugee" are sometimes used interchangeably in popular media and daily discourse, there are clear distinctions between the groups – both in terms of their legal status and public services entitlements – which impact on their needs.

For the purposes of this document, the following definitions will be used throughout:

- An **asylum seeker** is a person who has asked the UK Government for refugee status and is awaiting a decision on their application (original application or appeal decision).
- A **refugee** is a person who 'owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country' (United Nations, 2010). In UK terms, this is an asylum seeker who has been awarded refugee status by the UK Government. Refugees can also be fleeing poverty, famine, war, or natural disaster.

Therefore, all asylum seekers are refugees, but not all refugees are asylum seekers. If an asylum claim is rejected, then the asylum seeker is known as a **failed asylum seeker**. It is important to note that most asylum claims are rejected with only 27% of applications being given leave to remain after all appeals options are exhausted:

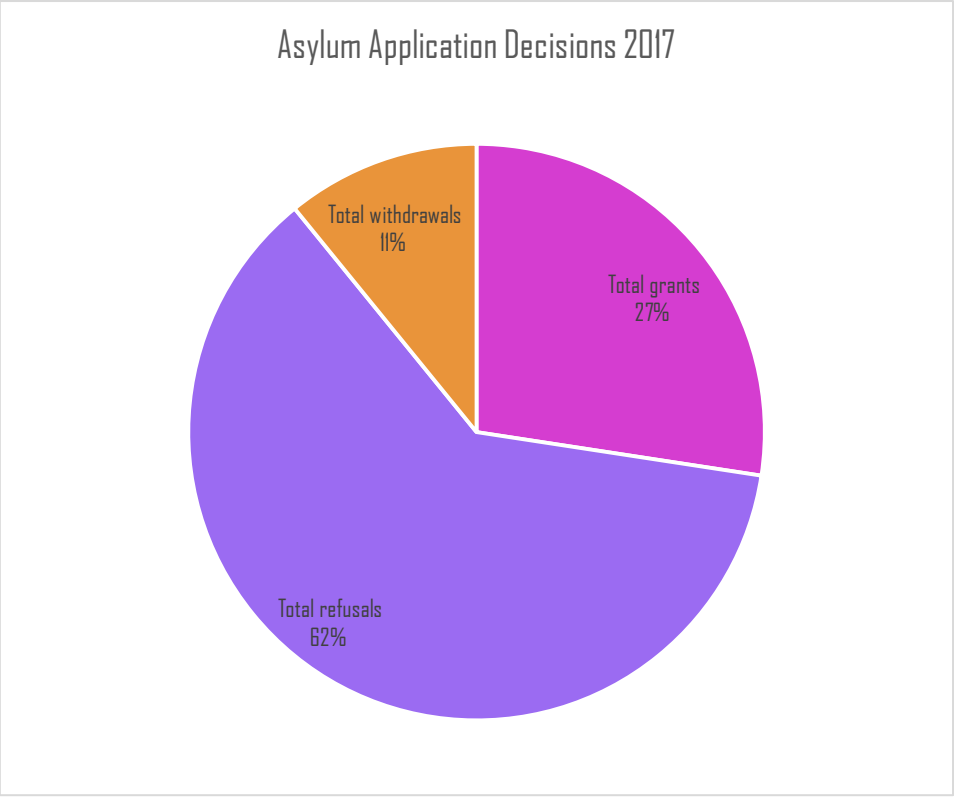


Figure 1 - Asylum Application Decisions, 2017 ***(UK Home Office, 2018)***

Rather than risk formal deportation, many who are not given leave to remain may become undocumented residents – a hidden number whose health needs also need consideration.

In addition to the above, there is a third category of ASRs in the UK – **resettled refugees**. Resettled refugees are admitted to the country via dedicated resettlement programmes such as the Gateway Programme or Syrian Vulnerable Persons scheme with their legal status of refugee being secured before their arrival in the country. BwD does not host any resettled refugees at this time but we have agreed to host unaccompanied asylum seeker children.

ENTITLEMENTS OF ASYLUM SEEKERS & REFUGEES

As soon as someone is given "Leave to Remain" status by the UK Government, they are entitled to the same state support and public service access as any other UK national. This includes education, health care, social care, housing, and full welfare support.

While someone is an asylum seeker, they are entitled to free healthcare (primary, secondary, acute and mental health). Dispersal housing is supported by the Home Office (HO) and a small welfare payment is available. This is currently £37.75 per week per individual (£35.59 per week if awaiting appeal decision). There is also access to some education (primary and secondary, children only) and some additional maternity support (UK Goverment, 2018).

If an asylum application is refused and there are no further appeal options, or the individual does not wish to appeal, then they are able to access primary and emergency care for free while they remain in the country. Secondary (ie, hospital or specialist) treatment is only available at a charge to the individual. No charges are payable if secondary treatment commenced before the outcome of their asylum application was given. There is no recourse to any additional public support. Failed asylum seekers are offered two options: either to voluntarily return to their home country (a resettlement grant is available to assist with this); or to be forcibly removed from the UK.

ASYLUM & MIGRATION STATISTICS

The information below provides details of the global, national, regional (North West England), and local (BwD) context with regards to ASR numbers and trends.

GLOBAL CONTEXT

The number of ASRs has risen by approximately 10 million to 27 million global ASRs in 2016 (from 18 million in 1997). This represents only part of the scale of displacement as the total displaced people over the same period has risen from 32 million to 66 million with the majority of the rise being in people who are "internally displaced persons" (IDPs) – in other words, still resident in their home

country but having to live away from their usual place of residence. 0.9% of the global population is believed to be internally displaced or an ASR (2016 figures, United Nations, 2017).

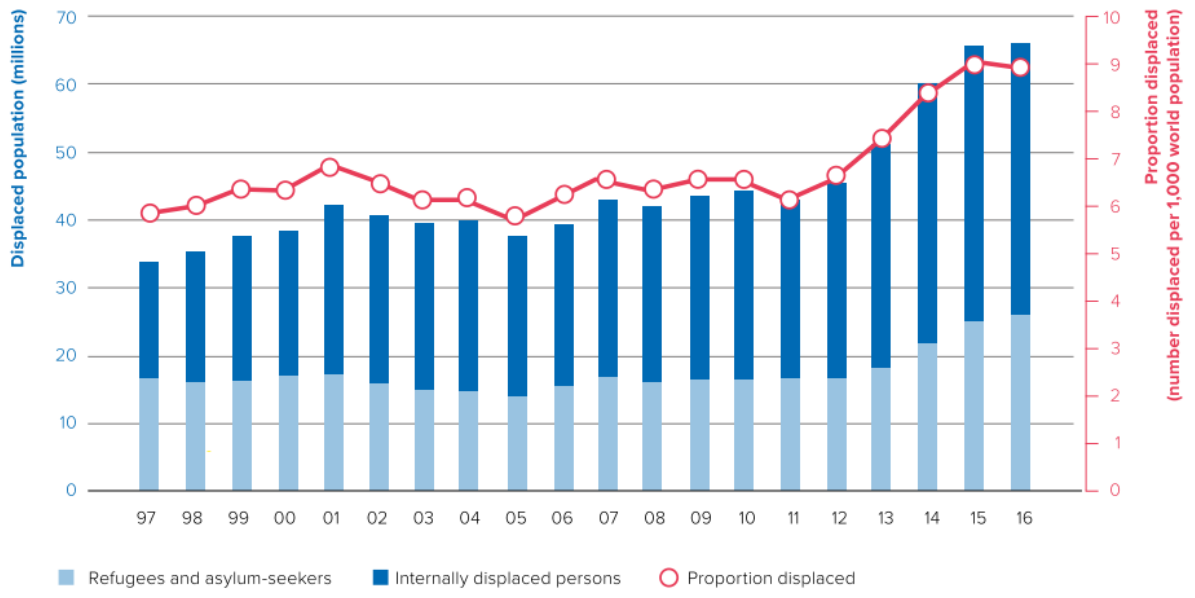


Figure 2- Trend of Global Displacement 1997 – 2016 ***(United Nations, 2017)***

The latest figures from the EU Asylum Office show a downward trend of asylum claims across the EU in 2017 and the first 4 months of 2018. 728,470 applications were logged across the EU in 2017 (a 44% reduction on the previous year) with the majority of applications being for Germany, Italy and France (European Asylum Support Office, 2018). Turkey, Uganda, and Pakistan are the top 3 ASR host countries globally with over 5million ASRs in 2017 (UNHCR, 2018).

Global co-ordination efforts to support ASRs (and IDPs) are championed by several key global NGOs such as UNCHR, MSF, and IRC. These agencies provide front-line medical and support services in conflict areas, establish refugee camps, lobby for the rights of ASRs, and work supranationally to co-ordinate support efforts.

NATIONAL CONTEXT

Monitoring of the numbers of ASRs nationally is carried out by the Home Office (HO). Information on total numbers of ASRs nationally are not known as people are only counted when they make an official application to Leave to Remain. Information on the total number of successful applications gives a proxy for the number of refugees but, like other UK citizens, once they have leave to remain, their movements are not routinely monitored and any emigration, or death, is counted as general UK

population movement so this figure is not robust. The graph below shows the total number of asylum applications in the UK per year since 2013.

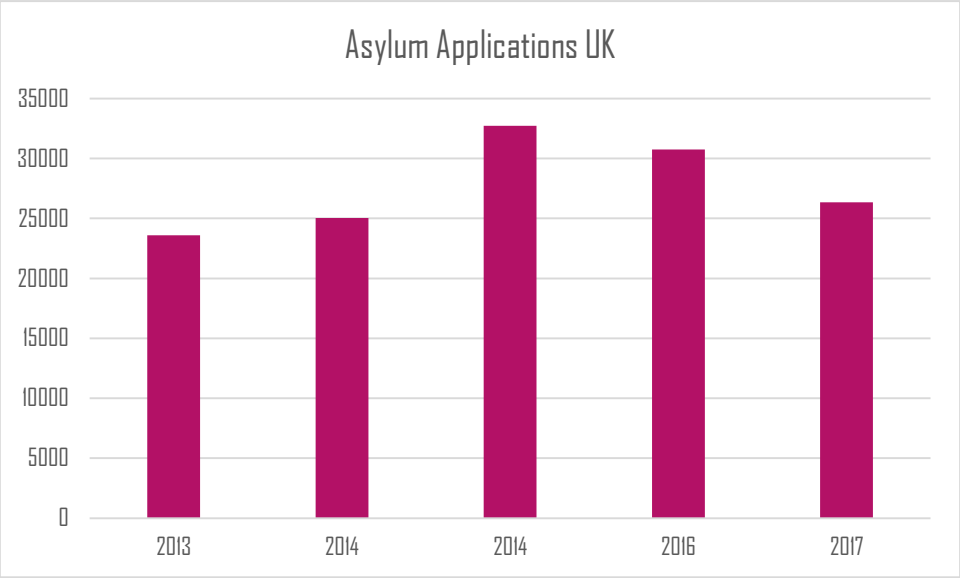


Figure 3- Asylum Applications to UK (2013 – 2017) ***(British Refugee Council, 2017)***

The UK has less asylum applications per 10,000 resident population than the EU average with 6 per 10,000 in UK compared to 25 per 10,000 across EU based on 2017 figures (House of Commons Library, 2018).

Initial asylum applications are screened (usually at airports or the Asylum Intake Unit in Croydon) to take preliminary information, assess need, and transfer the individual to a regional Initial Accommodation Centre (IAC). If, under international convention, the UK is not the appropriate country for a claim for asylum to be processed, individuals may be removed from the country at this point.

REGIONAL CONTEXT

Once an individual has lodged an asylum claim, they are sent to a regional IAC. In the North West, this is in Liverpool. At the IAC, ASs are provided with accommodation in a housing block (with their own kitchens), and receive nurse-led medical triage (provided by Urgent Care 24 - UC24[2]) with GP support available "out of centre" if it is required. There is not a full health screen at the IAC or at any

[2] UC24 is a social enterprise healthcare provider who provide services across Merseyside. Further details can be found at www.urgentcare24.com.

other point in the asylum seeker process (bar GP registration). An ASs will stay at the IAC until dispersal accommodation can be found.

The asylum seeker trends in the North West are shown below:

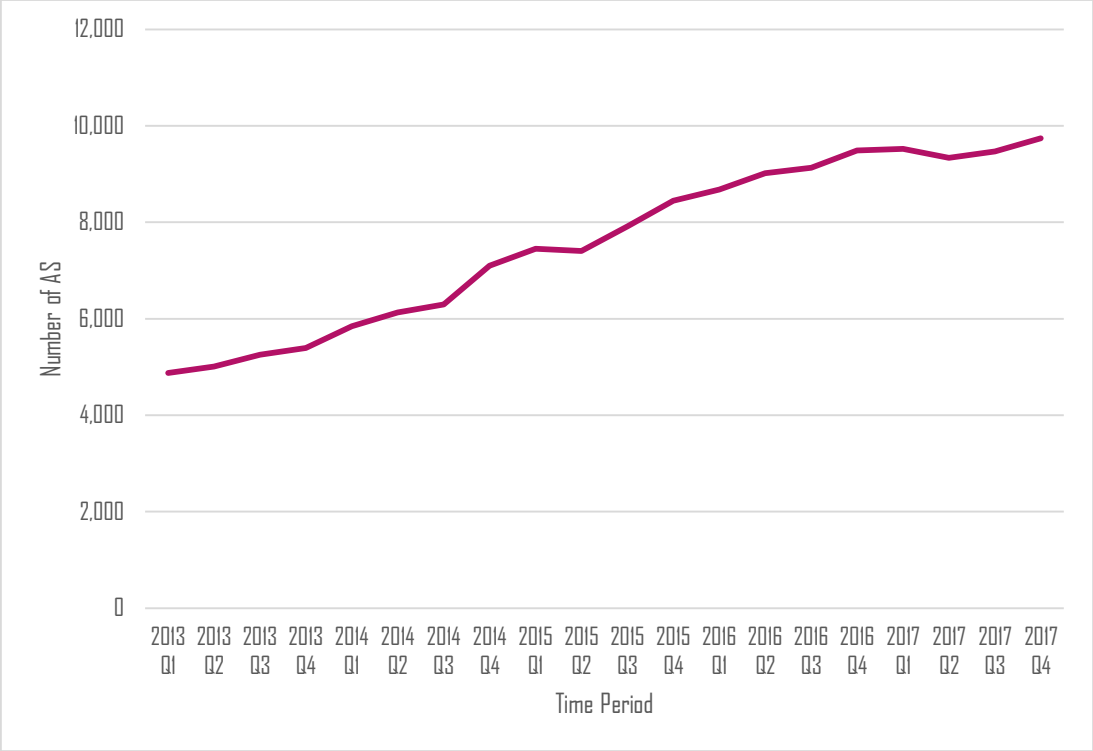


Figure 4 - NW England Total Claims for Section 95 2013 – 2017 ***(Office of National Statistics, 2018)***

The North West has traditionally hosted significantly more asylum seekers than other regions. In Q4 2017, the North West hosted 9,739 ASs in receipt of Section 95 support[3], while the South East (excluding London) hosted 598.

LOCAL CONTEXT

The issues around knowledge of the local ASR population mirrors those outlined at the regional and national level. As core asylum seeker provision (housing, introduction to area etc) is provided by SERCO under contract from the HO (COMPASS contract), no local statutory provider receives official

[3] Section 95 refers to Government support provided to asylum seekers who are awaiting the outcome of their claim for asylum. It is referred to in this manner as it is legally provided for under Section 95 of the Immigration and Asylum Act 1999.

information about ASs in the area at any one time, their personal demographics (age, gender, health status etc), or where they are living. Support agencies are aware of who is accessing their services but not every ASR will engage with services. BwD workers believe that the majority of current (June 2018) ASRs in BwD are from Pakistan, Nigeria, and Iraq with lower numbers of Afghani, Syrian, Palestinian, and Sudensese. The country of origin of ASRs frequently changes based on geopolitical circumstances.

Officially, BwD has a cap on the number of AS that will be placed in the borough at any one time (currently limited to 350). This equates to approx. 1:400 AS:BwD population which is approximately half the national average for a local authority area (1:200). Exact numbers of ASs in the area are provided monthly to BwDBC by the Home Office via the Regional Strategic Migration Partnership (RSMP).

Local agencies only become officially notified of the identity of ASs when they are given Leave to Remain (and, therefore, notice to quit their SERCO accommodation). At this point, they are only entitled to SERCO housing for a further 4 weeks and then the local authority has a statutory duty to provide housing options advice.

The trend analysis of BwD ASs receiving Section 95 support (ie, who have claimed asylum but not received a decision) is below:

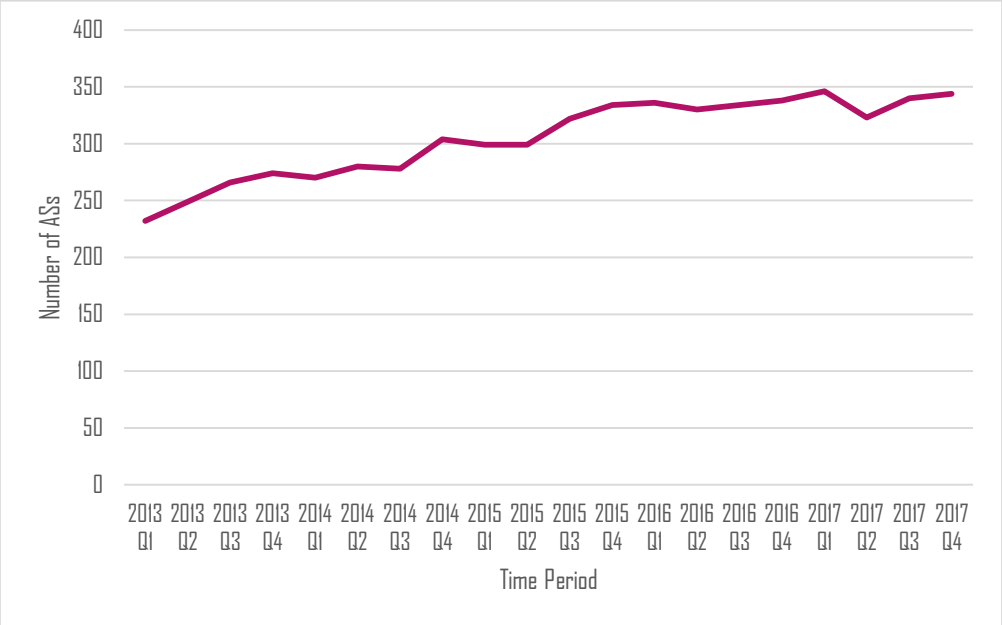


Figure 5- BwD: Total Individuals Supported Under Section 95 2013 - 2017*(Office of National Statistics, 2018)*

The experience of local agencies within BwD highlights that the majority of people who receive Leave to Remain status often stay and settle in Blackburn but when and if they decide to move away,

Department of Work and Pensions (DWP) are the only agency who would be aware of their immigration status.

METHODS

To ensure as much relevant information was captured as possible, this Health Needs Assessment used a range of different methods:

1. Data from various sources was analysed to draw a national and local picture of the asylum seeker and refugee situation;
2. A detailed literature search of the evidence was carried out to review the existing knowledge around the needs of asylum seekers as well as evidence-based interventions designed to meet such needs;
3. Evidence from interviews with key stakeholders and local ASRs was gathered to gain information on the current services available and the experiences and the challenges faced by both providers and asylum seekers within the BwD area. A list of stakeholders consulted can be found in Appendix 3;
4. Insights gained from ethnography and author observations during the production of this document have also been included where appropriate.

All data was gathered between February and May 2018.

CURRENT SERVICE PROVISION

As detailed in the Background Information, ASRs (until status changes to "failed asylum seeker"), are eligible to access NHS provision including GPs, hospital services (inpatient and outpatient), maternity services, and mental health services. ASRs are assisted with local GP registration by SERCO as part of their introduction to the area support. ASRs are signposted to the nearest GP to their accommodation.

Co-ordination, referral, and signposting between agencies (bar the NHS and statutory providers) is generally on an informal basis. The ASMAF supports networking between local ASR staff and organisations. A working group between BwDBC and the CCG has been established to drive improvement in statutory support for ASRs.

To understand the wider support available to ASRs outside of NHS provision, a service mapping exercise was carried out with members of ASMAF in May 2018. The purpose of the service mapping was to document all voluntary and statutory provision (outside of core NHS) that exists locally to support ASRs. Services encompass housing support, health, drop-in, and advisory/advocacy.

HOUSING SUPPORT

For ASs, housing support (on arrival into area from the IAC) is provided by **SERCO**. SERCO manage and maintain 93 properties ranging from single-person provision to family accommodation across the borough. Once a positive decision has been made, then the person has 28 days to vacate their SERCO housing. At this point, responsibility for housing transfers to the local authority **(BwDBC Housing Dept)** who have a small selection of properties available to support ASRs on a short-term basis. There is a duty for the local authority to find housing for vulnerable households (disabilities, children etc).

Alternative housing support providers for ASRs (for those who do not receive Leave to Remain or for whom there is no vulnerability) include **Salvation Army**, **NightSafe**, and **Foyer** plus other houses of multiple occupation (HMOs) in the borough. Most ASRs accessing this accommodation are single males.

HEALTH

Additional support for health needs (outside of NHS) is provided by the voluntary sector - mostly under public health commissioned services.

The **CGL Wellbeing Inclusion Team** (WIT) are available at drop-in centres and through appointments. Health Care Assistants offer screening for infectious diseases, basic health checks, complementary healthcare (auricular acupuncture) and referral to other services.

Further screening is provided at the drop-in centres for latent **TB Screening** (NHS commissioned service), and **HIV Advice & Support Service** (provided by Renaissance). Both services provide initial screening plus on-going clinical support and/or supported referral to secondary care services as needed.

In addition to the drop-in services below, voluntary sector wellbeing support is provided by **Action Factory** who run an arts programmes for ASRs in the borough. **Lancashire Mind** are also able to provide support and signpost as needed.

DROP-IN/SUPPORT CENTRES

There are three main drop-in services for ASRs located in BwD – two located in Blackburn, and one in Darwen. All of these services are provided by the voluntary sector.

Both the **Darwen Asylum & Refugee Enterprise (DARE)** and Blackburn **Asylum & Refugee Community (ARC)** provide a range of services including weekly drop-in, English language classes, and advocacy/advice. ARC has also commenced a Job Club (with volunteer opportunity service being developed) for ASRs with Leave to Remain. Service users self-refer into both ARC and DARE. Both centres run from church premises and act as a "hub" for other services who make use of the facilities to support ASRs – effectively acting as a "one-stop shop" on drop-in days.

The **YMCA New Beginnings/Champion Group** is a Big Lottery-funded initiative that promotes peer-support within ASR communities across the borough. The primary focus of the group is the development of Community Champions who identify and support ASRs within their local communities. They also provide a monthly drop-in session where they host guest speakers on a range of ASR issues.

EDUCATION

Statutory education is provided for ASRs of school-age (5 to 16 years). Access and support into schools locally is currently facilitated by the **New Arrivals Team** (local authority funded) but this service will be ending in July 2018 and there are no plans to replace this support. There is no recourse to financial support for formal education – including English language classes – for new ASRs over school-age. ASRs over 16 who have been awaiting an asylum decision from the HO for longer than 6

months are eligible to access education provision (including higher and further education) on the same terms as "home" students (Asylum Information Database, 2018).

Princes Trust offer short-courses and mentoring for all young people which are open to ASRs aged 16-25years with appropriate language skills.

ADVISORY/ADVOCACY

There are a wide range of general and special interest organisations that offer advice and advocacy to ASRs. For individuals, these include:

- **City Heart (Liverpool)** – trafficking support (based in Liverpool but provides support in BwD if needed)
- **Red Cross –** international family tracing and reunion service (FRTA) and travel assistance for official asylum related appointments
- **Lancashire LGBT** – although their experience is that ASRs prefer to access LGBT+ support out of area (mainly Manchester) due to fear of persecution within the community
- Legal aid solicitors

More generally, and not usually providing advice/advocacy to individuals but acting on a collective basis, there is:

- **North West Strategic Migration Partnership**
- **Migrant Help**
- **Asylum Matters** (hosted by City of Sanctuary UK)
- **Refugee Action**
- **Healthwatch BwD**
- **Children's Society**
- **Lancashire Constabulary** (Prevent Team and Early Intervention Teams)

CONTROLLING MIGRATION FUND

BwDBC has been successful in securing funding from the Department for Housing, Communities and Local Government for a discreet project – **Integrating Refugees and Migrants in BwD**. This funding (from 2017 – 2019) allows the provision of temporary housing for ASRs who have been given Leave to Remain to enable them to apply for, and access, benefits and longer-term housing. The funding also provides resources to ARC and DARE to deliver Job Club and English language classes for local ASRs.

FINDINGS

The findings discussed here have been developed following interviews with ASR workers, and ASRs attending drop-in projects in the borough. The findings below represent key themes that emerged from these interviews and observations, supported (where possible) with other sources of evidence.

COMMON HEALTH NEEDS OF ASRS

MENTAL HEALTH & WELLBEING

Mental health emerged as one of the key themes throughout the consultation exercise with both workers and ASRs raising it as a health need. This is to be expected given that there is a higher prevalence of mental health conditions within the ASR population compared to the general population (Fazel, Wheeler and Danesh, 2005). Post-traumatic stress disorder (PTSD) is most commonly diagnosed within the first year of arrival with anxiety and depression prevalence increasing 5 years post-resettlement (Giacco, Laxhman and Priebe, 2018).

Pre-UK experiences play an important role in the mental health and wellbeing of ASRs in BwD. Bereavement, traumatic experiences that caused the need to seek asylum (such as conflict, torture, and threats), and experiences *en route* to safety lay the foundations for PTSD with suggestions that over 30% of ASRs suffer with PTSD as a result of these factors (Chey *et al.*, 2009). Isolation from usual support networks, delayed culture shock, boredom (as unable to work or study until given Leave to Remain), financial pressures, and feeling of lack of control over their personal situation as an ASR appear to both compound PTSD as well as lead to later on-set anxiety and/or depression. Estimations of the prevalence of suicide and self-harm in ASRs suggest that this is over twice the rate seen in the general population (Cohen, 2008). Anxiety in ASRs arising from communication with the HO was a recurring theme in discussions with

Daniel* approached a local drop-in service following a call from the Home Office about his application. As the case workers at the drop-in were all with other clients, he was asked to wait to be seen. In his heightened anxiety, he thought the delay meant that the drop-in service was working with the Home Office.

Rather than wait to see a case worker, Daniel went back home and took an overdose of medication which resulted in seizures, respiratory arrest and hospital admission.

(*All case studies in this document are real examples but names and other identifiable details have been changed to protect the individuals concerned)

BwD workers.

A recent survey by Healthwatch Blackburn with Darwen (2018) suggests that 18% of local ASRs have accessed mental health provision but this is not a representative sample and literature, with local anecdotal evidence, suggests demand is likely to be significantly higher than this. Several local ASRs reported being wary about mental health services due to fear and/or stigma of mental health issues. There may also be issues about the appropriateness of talking therapies as treatment for those who are not confident English speakers and the need for service providers to truly understand the unique issues affecting ASRs.

FOOD, POVERTY, & MALNUTRITION

There are a range of issues around food for ASRs in BwD – some of which are unique to the area, and some that are reflective of the experiences of ASRs across the country. Broad key themes for all ASRs are:

- **Malnutrition** from an inadequate diet (through not eating enough and/or eating poor quality food);
- Development of **dietary-associated conditions** (diabetes, rickets, scurvy etc.); and
- **Mental health conditions** arising from inadequate nutrition, and stress and anxiety of experiencing food poverty.

Locally, cooking skills of ASRs appear poor (especially single men as, culturally, they may not have undertaken cooking in their home country). One worker reported that she had had to show a young male ASR how to make a bowl of cereal. Compounding this is limited cooking facilities being provided in AS accommodation (no SERCO property has a microwave as standard) which reduces the food that can be prepared if ASs do not have cooking skills; together with individuals having to adjust to different types of food, ingredients, and cooking techniques than they may have grown up with.

The limited financial resource that individuals are provided with by the HO restricts their dietary options due to their proximity to food sources (especially cheap, healthy and, in some cases, halal) and limitations on opportunities to travel to seek better quality/value. Economies of scale mean that those in families or other extended networks who pool resources may be able to experience a better quality diet than those who are alone. Additionally, many families are not aware that they are eligible for free school meals as an AS until supported to apply for this by workers.

INFECTIOUS DISEASES

ASRs are at a higher risk of infectious diseases than the general population – partially due to living conditions before/during migration (Eiset and Wejse, 2017). Other contributing factors are ASRs coming from areas with different endemic disease and differing vaccination schedules globally. Children may also become ASRs during a vaccination programme and so may not have received their full doses of common vaccines.

There is no routine screening for blood-borne viruses (BBV) or TB as part of the asylum application process but all attendees of local drop-in centres are encouraged to attend for testing with both ARC and DARE hosting TB, HIV, and BBV screening services on a regular basis. Public Health England (PHE) recommend that infectious diseases are considered by medical practitioners when patients present with ill health.

Sexually Transmitted Infections (STIs) were not raised as a specific issue by local ASRs or workers but PHE suggests that STI screening should be an essential part of the management of migrant health, appropriate to individual circumstances (Public Health England, 2018).

NON-COMMUNICABLE DISEASES

Non-communicable diseases (NCDs) are a major contributor to the health needs of ASRs. There are 2 main NCD fields that are particularly pertinent to ASRs:

- **Dental health** – there is significant dental decay and lack of awareness of dental hygiene amongst the local ASR community. ASRs are entitled to the same dentistry access as the general population – free of charge - but a lack of translation services available in local dentistry practices often prevents attendance. There are reports of ASRs being turned away from dentists where they are not able to provide their own interpreter as dentists do not routinely use Language Line.
- **Chronic conditions** may not have been treated, monitored, or managed during the migration process due to access to healthcare facilities and medication, and a lack of perception of urgency of care by the individual themselves. This can lead to a deterioration of an existing condition which may have long-term health consequences. NCDs account for 80% of the global burden of disease with the prevalence of NCDs in ASRs from some areas being very high (30% - 50%) (Amara and Aljunid, 2014).

WOMEN'S HEALTH

Women's Health was raised by both workers and ASRs themselves. This is not surprising given that in the UK "asylum-seeking women are three times more likely to die in childbirth and up to four times more likely to experience postnatal depression than the general population because of a complex combination of physical, psychological, educational, monetary and language problems" (Asif, Baugh and Jones, 2015). The issues raised below in the "Access to Health Services" section apply equally to obstetrics and gynaecology services. Specific issues to women's health include:

Female genital mutilation (FGM) – while illegal in the UK and condoned internationally, women from some areas are likely to have undergone this either in their home country, or, for younger women/girls, illegally while in the UK. This process risks psychological trauma and a range of long-term physical health effects – for example, urinary and vaginal functioning, and infection (World Health Organization, 2018). Awareness of FGM has increased in recent years but this should form a key part of health professional's knowledge around ASR health.

While acknowledged that this is not exclusively a female issue, it is possible ASRs have experienced **rape and sexual violence**. Research by the Refugee Council suggests that approximately 44% of ASRs are directly affected by this – either in their home country, or en route to safety (Refugee Council, 2012). This can lead to psychological and physical trauma, both short- and long-term.

Women's Health providers need to be sensitive to the **translational needs** that ASRs may have. ASRs locally reported very young (<10 years) children acting as translators during complex gynaecology and obstetrics appointments – a practice that can affect the patient through removal of their dignity and confidentiality, as well as affecting the child psychologically too who may be exposed to information about their mother's health that they, nor the mother, would want them to know. Similar reports in maternity settings – ante-natal, post-natal, and during labour - were received from ASRs and workers.

ACCESS TO HEALTH SERVICES

Access to healthcare was a clear issue for both ASRs and workers. Workers were keen to praise SERCO for the additional work that they had undertaken in ensuring that GP registrations were happening for all ASRs with a recent survey by Healthwatch suggesting that 94% of local ASRs are registered with a GP (Healthwatch Blackburn with Darwen, 2018). This was a change in practice by SERCO following concerns raised by members of ASMAF that ASRs were not supported in the GP registration process. Workers remain concerned that, should there be a change of HO contract, this support may stop as it is not a service that SERCO are currently contracted to provide. There are also concerns that ASRs are

Ibrahim had a history of epilepsy and was running low on his medication (an urgent medical issue). He attended his GPs with his children where he had completed his registration paperwork the week before. He was told by the receptionist that, as he had not completed the GP registration process, he was not able to see a doctor. This distressed Ibrahim who believed that this would mean he would have potentially life-threatening seizures. The receptionist informed him that he would need to attend A&E to get his medication (lack of medication being neither an accident, nor an emergency – GPs, nurse prescribers, and pharmacists are both able to assist with this issue).

Ibrahim did not understand the system, nor spoke good enough English, to be able to debate this point with the receptionist. Coincidentally, a local ASR worker happened to be in the waiting area who was able to advocate for Ibrahim which resulted in his being able to get his medication that day from that practice.

not being made aware of the need to attend GP registration appointments (usually with a practice nurse) and so there is an assumption that they are registered when, in practice, they have only completed half the process.

Lack of awareness – by ASRs of the NHS system, and by healthcare providers of the needs of ASRs – was at the crux of many issues around access. Workers reported that, particularly in referrals to secondary care, providers were not aware of ASR status and so had made no provision for extended appointments (due to complex issues), or translation services (via Language Line). In many instances, these were not resolved at appointment either with family members acting as translators in direct contradiction with patient confidentiality rights. Additionally, there is currently no provision for health records from UC24 assessments at the IAC to be made available to local GPs which results in GPs having to duplicate medical histories, tests, and screenings that may have been already undertaken.

Awareness (or lack of) of NHS services available, particularly at anything other than primary care level, results in ASRs being disempowered to request access to services. This lack of knowledge appears to be an ongoing issue as it was documented locally in 2016 (Bairstow and Altham, 2016).

Length of appointments to deal with complex issues in primary care were also raised as an issue with ASRs feeling that appointments were rushed. This may be due to cultural differences about

the role of primary care physicians and the nature of appointments, but also due to additional pressures put on short appointment times by need for external translation services (Language Line).

Confusion arising from recent changes to policy around charging overseas visitors for NHS treatment (from which ASRs are exempt) compounded barriers to access at all levels – usually at the reception/booking-in area of NHS services. ASRs reported receiving letters from the NHS demanding payment for services to which they were legally entitled. This caused anxiety as the ASRs thought that they had accessed services correctly and were in possession of the correct paperwork detailing their exemption status. Fear of these charges has deterred use of NHS provision by local ASRs.

Other barriers to healthcare are the cost of transport for appointments – particularly those that take place outside of the borough (East Lancashire Hospital Trust provides some services in Burnley and other East Lancashire locations). A hospital shuttle bus is available between hospital sites but this was not well-known in the local community. In some instances, local drop-in centres support ASRs to attend hospital appointments but this is not always possible due to limited resources.

OTHER FACTORS FOR CONSIDERATION

RISK-TAKING BEHAVIOURS

Anecdotal information from workers suggests that ASRs are more likely to engage in risk-taking behaviours (such as smoking and drug-use) than the general population. The reasons for this are likely to be acculturation and as a coping mechanism for underlying mental health issues (as detailed above). Workers also reported that there was a lack of knowledge about the dangers of these risky-behaviours amongst ASRs.

LANGUAGE

Language remains a key issue for ASRs in navigating the NHS system, and other support services. Locally, providers are commissioned to use Language Line in all NHS appointments (bar dentistry) with non-English speakers. In practice, this is not always happening leading to potential privacy and dignity concerns (see "Women's Health"). Many ASRs spoke about this which suggests that the issue is quite widespread. This may be due to a pre-appointment lack of communication between providers of the translation needs of the individual. There were also reports that official translation services themselves may not recognise the variety of dialects within a language and therefore be inaccurately translating if the ASR and translator are speaking different dialects.

In non-NHS settings, confidentiality and consent is potentially an even bigger issue with commissioned services operating at a grassroots level in open community buildings and with no access to Language Line. This results in other service users being used to provide unofficial translation with an additional lack of privacy from the physical setting in which services are operating. This risks ASRs not fully disclosing information to workers because of the setting. Additionally, although unlikely, there is a risk that translators may be withholding information between service users and workers, or imprecisely translating which could impact on clinical treatment/advice given.

Health-related letters and forms are often only available in English which requires support from workers or the wider community to understand. This raises the same issues as above. It should be noted that literacy levels are also not as high as in the UK in many parts of the world (particularly for females) so even if someone speaks English, it should not be assumed that they are able to read the language.

English language learning opportunities for AS compound these language issues. At present, there is no access to Government-supported formal English for Speakers of Other Languages (ESOL) for ASs until they have been awaiting an asylum decision for 6-months (see "Education" above). There are informal English classes available through the drop-in centres. If an AS wishes to undertake formal ESOL learning, they will be required to pay tuition fees until they are granted Leave to Remain (at which point courses are free). There is also very limited provision of ESOL classes in the borough.

Mohammad developed a growth on the back of his head. He presented to the GP who referred him to secondary care where he received an operation to remove the growth. Two weeks after this operation, he received a copy of a letter that the consultant had written to his GP informing him of the benign pathology result.

Mohammad did not have the English language skills to understand the letter. He came to ARC in visible distress thinking that the letter meant that he had been given a terminal diagnosis. Workers were able to explain to him that the letter was good news.

HOUSING

Housing plays a large role in the health of ASRs. In their country of origin, and particularly en route to the UK, ASRs are likely to experience over-crowding and lack of sanitation, making them more susceptible to the health issues outlined above.

The transition from AS to refugee also causes issues around housing. Single men may find that they are housed in HMOs or with voluntary providers. There is also the risk of exposure to risk-taking behaviours such as drugs/alcohol with anecdotal reports that some single male refugees choose to be homeless or sofa-surf as alternatives.

Refugees are able to choose where they live in the borough by registering with the Choice Based Lettings Scheme (known as Be-with-Us) and bid for properties. However, there is limited housing stock and high demand. This may mean a move away from their existing support networks, schools, etc and lead to social isolation and associated mental health and wellbeing effects.

Private rental accommodation also causes issues for refugees when they move away from local authority housing provision. This is primarily due to the financial burden of landlords requiring hefty deposits, application fees, and upfront rent – problems that are not unique to the refugee community. More worryingly was reports from refugees that they had had applications for housing with private landlords declined as they were not viewed as having appropriate "Right to Rent" status due to their Leave to Remain not being permanent. The HO guidance is clear that refugees with Leave to Remain do have a right to rent (Home Office, 2016) but tenants may not know about their legal rights. There may be a lack of knowledge by letting agents and landlords too.

CHILDCARE

Childcare in relation to health-needs is frequently overlooked by providers. For ASRs, particularly recent arrivals, are less likely than the general population to have support networks that are able to provide childcare support. This can create additional worry for patients and may result in patients not attending for treatment if childcare is unavailable.

EMPLOYMENT & FINANCE

Employment is an issue for ASRs. As previously detailed, ASs are unable to work until they are granted Leave to Remain, a process that can take years from arrival to the UK. During this time the lack of employment places families under financial hardship and risks deskilling individuals. Once Leave to Remain is granted, there can be complications regarding transfer of overseas qualifications (paperwork for which may have been lost en route to the UK or remain in the country of origin). There

can also be significant costs for recognition of overseas training by professional bodies, or exam fees to prove English language competence.

Often refugees experience poor terms and conditions when they seek work with national reports of pay below the minimum wage, lack of sick pay and holiday pay, zero-hours contracts with no job certainty etc. It is likely this is due to both exploitative employers and a lack of awareness of UK employment law and individual rights by refugees.

There is an additional risk of ASRs being victims of modern slavery and trafficking – frequently under the auspices of repaying a "debt" accrued from travel arrangements from their country of origin. The UN believes that approximately 77% of ASRs travelling via boat across the Mediterranean are victims of trafficking and/or slavery (International Organisation for Migration (IOM), 2017). Slavery and trafficking can result in significant psychological distress and physical trauma. The same survey (International Organisation for Migration (IOM), 2017) suggests that 2.1% of the same group of ASRs have experienced organ trafficking and the medical needs arising from these practices are likely to be great so it is important that workers are aware that it is a possibility that ASRs have experienced this.

Debt was a concern for ASRs in BwD – partly due to low funds received until they are given Leave to Remain, but also due to increased expenditure on leaving SERCO properties and inability to work (see above).

Haya, a single mother from Syria, needed to attend hospital for a day case procedure and arranged childcare support for the day via a local neighbour. A DARE volunteer went to collect Haya from the hospital that evening where she was informed that Haya was not medically well enough to return home. The DARE volunteer explained that Haya had a daughter she needed to look after but the ward staff were unable to offer any support or suggestions on how the issue could be resolved. The ward staff informed the DARE worker that Haya should have been told that she may need to stay overnight and should have made appropriate arrangements. It is not known if this information was provided to Haya who, lacking in English skills, did not understand or if this information was not given.

The DARE volunteer was able to liaise with social services and the neighbour on behalf of Haya to arrange extended childcare provision for the duration of Haya's hospital stay.

PUBLIC SECTOR EQUALITY DUTY (PSED)

All publicly funded organisations are required to meet certain mandated legal

duties in accordance with the PSED outlined in the Equality Act 2010 when making decisions that affect patients and/or employees. Support for the local Clinical Commissioning Group (CCG) in ensuring it fulfils its responsibilities is provided by the Equality & Inclusion Team at Midlands and Lancashire Commissioning Support Unit (MLCSU). MLCSU recently updated its training packages for both GPs and CCGs around ASRs. An Equality Impact Risk Assessment toolkit (which includes ASRs) and guidance has also recently been updated.

BwDBC and BwDCCG currently comply with PSED via Equality Impact Assessments (EIAs) for all decision-making processes to identify potential impacts, especially for groups with protected characteristics and other vulnerable groups.

LIMITATIONS OF HNA

There are significant limitations to this HNA which require discussion.

- First and foremost, only ASRs who are accessing services were contacted. This means that the results are not truly reflective of the BwD ASR population as we are unable to comment on the health needs of those who are not as engaged with provision. Their needs may be very similar to those discussed above, or they may be very different.
- Children were not directly contacted about their experiences as part of this study. The drop-in centres operate during school-hours and therefore, 5-16 year olds were not around to participate.

It is suggested that efforts be made to understand the health needs of these two groups specifically.

Sufficient English language was required by ASRs to participate in sharing their experiences – this is likely to indicate either high educational level and/or being in the UK for a significant amount of time.

There are at least 350 ASRs in BwD. This research was only able to consult with a small proportion of these. Workers gave a broader view of issues affecting the wider community but this health needs assessment should not be taken to be statistically representative of the whole ASR population.

As discussed in the "Background Information", the countries of origin – and demographics - of ASRs changes frequently dependent on geopolitical and global environmental factors. The majority of the issues outlined in this document will be applicable regardless of country of origin or reason for seeking asylum. Due diligence should be applied if this document is used to inform service delivery to ensure that the needs of current ASRs remain the same as detailed above.

RECOMMENDATIONS

The information in this document provides a snapshot of the health needs of ASRs in BwD during early 2018. Recommendations below serve to provide suggestions of potential solutions to tackle these current problems for the benefit of existing, and future, ASRs in BwD. Fundamentally, actions should be targeted on ensuring the reduction of health inequalities experienced by ASRs.

It is crucial that addressing the health needs of ASRs encompasses a whole-systems approach. This required active engagement with, and ownership of, actions by all ASR stakeholders across the statutory and voluntary sectors including ASMAF members, social services, NHS providers, and health service commissioners. Robertshaw, Dhesi and Jones (2017) advocate the following areas as essential features of a health-system that is ASR-centered but this could be applied to any ASR-centered service:

Figure 6 - Features of ASR-centered Healthcare*(Robertshaw, Dhesi and Jones, 2017)*

PRIMARY CARE RECOMMENDATIONS

As primary care is often the first, and main, contact that ASRs have with healthcare, the following recommendations may help to address some of the issues outlined above:

- Explore possibilities of creation of specialist services for ASRs; staffed by GP and healthcare professionals with an interest in, and knowledge of, ASR-specific conditions and needs.
- Ensure PHE Migrant Health checklist (available on PHE website) utilised in all first GP appointments with ASRs

MENTAL HEALTH RECOMMENDATIONS

Given the issues around language barriers and the prevalence of mental health conditions in ASRs, this is an area that needs clear focus. Options to consider include:

- Development of self-help materials in community languages
- ASR-specific support groups facilitated by trained professionals
- Specialist mental health services with staff skilled in the mental health needs of ASRs

GENERAL HEALTH RECOMMENDATIONS

The recommendations here transgress individual healthcare services:

- Training and support for all health providers in the rights of, and health needs of, ASRs. This should particularly focus on front-line administrative staff (ie, receptionists) and clinical areas of high footfall (ie, maternity, A&E, GPs, practice nurses);
- All services should ensure that only appropriate translation services are used – children and families should not be used for this purpose. There should be active monitoring and response to issues regarding translation services by all healthcare providers;
- Access to official translation services to be made available to non-NHS healthcare providers;
- Written communication from service to be offered in community languages (or provided automatically if noted in patient demographic information);
- Review of referral pathways into areas of high use by ASRs to ensure that potential barriers to access are reduced/removed;
- Promote healthy lifestyles to ASRs via targeted interventions using existing agencies (ie, Re:Fresh) and community projects.

OTHER FACTORS

EDUCATION

Free English language education would significantly reduce some of the issues around access to health services, isolation, and anxiety experienced by local ASRs. This would also assist with wider community integration and ensure that they are have the skills required for employment once a decision is made on their asylum applications.

Life skills education would also assist in increasing individual confidence as well as helping to address some of the issues outlined in this HNA such as risk-taking behaviours and cookery skills. This may also help foster increase social links within the community and reduce social isolation.

INFORMATION FOR ASRS

ASRs were not aware of a lot of services available to them, nor their legal rights in key areas. A web-portal for BwD ASRs containing this information, in a variety of community languages (via online web-page translation tools), could be developed and easily updated by ASMAF members. Printed copies could given to ASs by SERCO as part of their induction to the area.

Formal transition support for refugees leaving SERCO housing who have been given Leave to Remain would be beneficial. This could include basic information on how to pay bills, how to change utility suppliers, access to schools, registration at a new GPs etc as the UK systems are likely to be significantly different from those experienced to date.

OTHER RECOMMENDATIONS

Information sharing between organisations needs to be addressed in order that all agencies are able to proactively provide assistance to ASRs. This is a national issue but BwD should continue efforts to find local solutions and lobby for national change.

Volunteering opportunities for ASRs is already being explored by ARC and DARE as part of the Controlling Migration funding. This could be further developed, in conjunction with the local Council for Voluntary Services (Community CVS) to ensure that opportunities exist for ASRs to volunteer in the wider community. There are well-documented benefits of volunteering to the individual in terms of physical health and mental wellbeing; as well as benefits to organisations that provide volunteer opportunities. Additionally, experience of work environments within the BwD area may improve employment prospects for ASRs once they have Leave to Remain. Volunteering is also being explored as part of the new Integrated Neighbourhood Teams across the Pennine Lancashire area – it would be timely to ensure that ASRs are considered as part of this development from the outset.

This report only provides information about those individuals who are accessing some ASR services. ASMAF and partners need to consider mechanisms by which they can offer support to ASRs who are disengaged from services at present.

Support for ASRs in BwD would not be possible without the relentless hard work and dedication of an army of workers and volunteers. Literature suggests that these workers and volunteers are frequently exposed to distressing situations that can impact on mental wellbeing (Griffiths *et al.*, 2003). Ensuring that these individuals receive adequate professional support is vital to maintaining ASR care and support.

Finally, given the transient nature of ASRs, it is suggested that this document is reviewed at regular intervals to ensure that the health needs outlined above are still relevant to the local ASR population.

REFERENCES

- Amara, A. H. and Aljunid, S. M. (2014) 'Noncommunicable diseases among urban refugees and asylum-seekers in developing countries: A neglected health care need', *Globalization and Health*. Globalization and Health, 10(1), pp. 1–14. doi: 10.1186/1744-8603-10-24.
- Asif, S., Baugh, A. and Jones, N. W. (2015) 'The obstetric care of asylum seekers and refugee women in the UK', *The Obstetrician & Gynaecologist*, 17(4), pp. 223–231. doi: 10.1111/tog.12224.
- Asylum Information Database (2018) *Asylum in Europe UK Country Report*. Available at: http://www.asylumineurope.org/reports/country/united-kingdom (Accessed: 20 June 2018).
- Bairstow, Y. and Altham, J. (2016) *HIV testing within a community setting in Blackburn with Darwen*
- British Refugee Council (2017) *Asylum statistics Annual Trends*, *British Refugee Council*. http://www.refugeecouncil.org.uk/assets/0003/6286/Asylum_Statistics_Annual_Trends_Nov_2015.pdf.
- Chey, T. *et al.* (2009) 'Association of Torture and Other Potentially Traumatic Events With Mental Health Outcomes Among Populations Exposed to Mass Conflict and Displacement', *JAMA*, 302(5).
- Cohen, J. (2008) 'Safe in our hands?: A study of suicide and self-harm in asylum seekers', *Journal of Forensic and Legal Medicine*, 15(4), pp. 235–244. doi: 10.1016/j.jflm.2007.11.001.
- Eiset, A. H. and Wejse, C. (2017) 'Review of infectious diseases in refugees and asylum seekers—current status and going forward', *Public Health Reviews*. Public Health Reviews, 38(1), pp. 1–16. doi: 10.1186/s40985-017-0065-4.
- European Asylum Support Office (2018) *Asylum Trends in EU+*. Available at: https://www.easo.europa.eu/overview-situation-asylum-eu-2017 (Accessed: 19 June 2018).
- Fazel, M., Wheeler, M. and Danesh, J. (2005) 'Prevalence of serious mental disorder in 7000 refugees resettled in western countries: A systematic review', *The Lancet*, 365(9467), pp. 1309–14. doi: 10.1016/S0140-6736(05)61027-6.
- Giacco, D., Laxhman, N. and Priebe, S. (2018) 'Prevalence of and risk factors for mental disorders in refugees', *Seminars in Cell and Developmental Biology*. Elsevier Ltd, 77, pp. 144–152. doi: 10.1016/j.semcdb.2017.11.030.
- Griffiths, R. *et al.* (2003) 'Operation safe haven: The needs of nurses caring for refugees', *International Journal of Nursing Practice*, 9(3), pp. 183–190. doi: 10.1046/j.1440-172X.2003.00422.x.
- Healthwatch Blackburn with Darwen (2018) *Asylum Seeker & Refugee Community Report*.
- Home Office (2016) 'Right to Rent : a User Guide', (December). Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/573057/6_1193_HO_NH_Right-to-Rent-Guidance.pdf.
- House of Commons Library (2018) *Asylum statistics*. Available at: https://researchbriefings.parliament.uk/ResearchBriefing/Summary/SN01403#fullreport.
- International Organisation for Migration (IOM) (2017) 'Flow Monitoring Surveys: The Human Trafficking and Other Exploitative Practices Indication Survey Analysis on Adults and Children on the Mediterranean Routes Compared', (October).

- Office of National Statistics (2018) *Immigration Statistics*. Available at: https://www.gov.uk/government/statistics/immigration-statistics-october-to-december-2017 (Accessed: 18 June 2018).
- Public Health England (2018) *Assessing new patients from overseas: migrant health guide*. Available at: https://www.gov.uk/guidance/assessing-new-patients-from-overseas-migrant-health-guide (Accessed: 21 June 2018).
- Refugee Council (2012) *The Experiences of Refugee Women in the UK*.
- Robertshaw, L., Dhesi, S. and Jones, L. L. (2017) 'Challenges and facilitators for health professionals providing primary healthcare for refugees and asylum seekers in high-income countries: A systematic review and thematic synthesis of qualitative research', *BMJ Open*. Institute for Applied Health Research, University of Birmingham, Birmingham, United Kingdom: BMJ Publishing Group, 7(8). doi: 10.1136/bmjopen-2017-015981.
- UK Goverment (2018) *Asylum Support Guidance*. Available at: https://www.gov.uk/browse/visas-immigration/asylum (Accessed: 18 June 2018).
- UK Home Office (2018) *Asylum Seeker Statistics 2017*. Available at: https://www.gov.uk/government/publications/immigration-statistics-year-ending-march-2018/how-many-people-do-we-grant-asylum-or-protection-to (Accessed: 18 June 2018).
- UNHCR (2018) *Figures at a Glance*. Available at: http://www.unhcr.org/uk/figures-at-a-glance.html (Accessed: 19 June 2018).
- United Nations (2010) *The Convention Relating to the Status of Stateless Persons*. doi: 10.1093/iclqaj/10.2.255.
- United Nations (2017) 'Forced Displacement - Trends At a Glance'. Available at: http://www.unhcr.org/5943e8a34.pdf.
- World Health Organization (2018) *Female Genital Mutilation*. Available at: http://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation (Accessed: 21 June 2018).

APPENDICES

APPENDIX 1 – LITERATURE SEARCH CRITERIA

A literature review was undertaken using SCOPUS to support the development of this HNA. SCOPUS was selected to reflect that health needs of ASRs are broader than the focus of more clinically orientated databases such as MEDLINE. The search criteria are detailed below:

1. 2007 to present = **35,867 document results**

   "Asylum seeker*" OR "refugee*" OR "migrant*"

   AND

   "health need" OR "health" OR "medicine" OR "medical"

   OR

   "mental health" OR "stress" OR "depression" OR "post traumatic stress" OR "PTSD" OR "anxiety" OR "isolation"

   OR

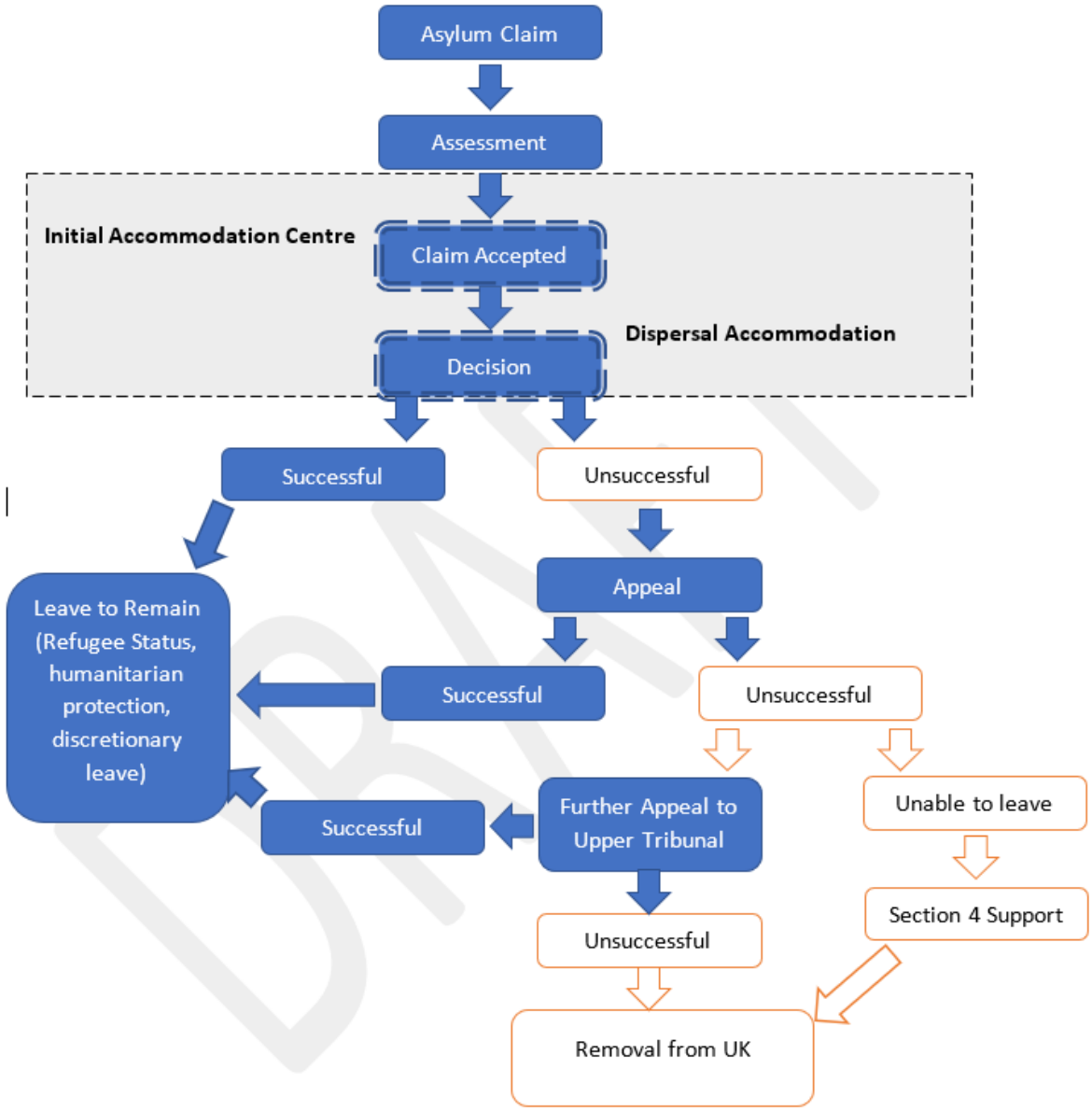
   "physical health" OR "communicable disease" OR "infection*" OR "chronic disease"

   OR

   "social" OR "access" OR "integration" OR "culture" OR "housing*" OR "education*" OR "care"

2. Only UK and English language articles = **4718 document results**
3. Restrict to social sciences, medicine, nursing, immunology, health professions, multidisciplinary, and dentistry = **4136 document results**
4. Restrict to articles, book chapters and conference notes **= 3406 document results**
5. Limit to 2010 onwards (change in govt and national policy) = **2555 document results**
6. Sort on relevance. Review abstract and title of **top 250 results = 115 results**
7. Review of full text of documents = **85 results**

APPENDIX 2 – FLOW CHART OF THE PROCESS OF CLAIMING ASYLUM IN THE UK (2018)



APPENDIX 3 – LIST OF STAKEHOLDERS CONSULTED

The following stakeholder organisations were consulted with directly to inform this health needs assessment:

- Action Factory
- Asylum Matters
- Blackburn Asylum & Refugee Community (ARC)
- Blackburn with Darwen Borough Council (Public Health & Housing Teams)
- Blackburn with Darwen Clinical Commissioning Group
- Blackburn YMCA New Beginnings Project
- British Red Cross Refugee Services (Lancashire)
- Change, Grow, Live (CGL) Wellbeing Inclusion Team
- City of Sanctuary
- Darwen Asylum and Refugee Enterprise (DARE)
- Darwen United Reformed Churches
- Lancashire LGBT
- Midlands and Lancashire Commissioning Support Unit
- North West Regional Strategic Migration Partnership
- Princes Trust
- Renaissance HIV Rapid Testing Service

In addition, the Blackburn ASMAF distribution list have received regular updates about this piece of work via email and at meetings. All members have been invited to comment on the development of the project and the final piece of work.

Asylum seekers and refugees were approached directly at both ARC and DARE. The purpose of the project and confidentiality was explained to them prior to soliciting their views about their health and experiences of healthcare.

HEALTH AND WELLBEING BOARD

TO:	Health and Wellbeing Board
FROM:	Jayne Ivory – Director of Children's Services
DATE:	5th March 2019

SUBJECT: SEND Stocktake event feedback

1. PURPOSE

To provide an update on the findings of the SEND Stocktake event which took place in November 2018.

2. RECOMMENDATIONS FOR THE HEALTH & WELLBEING BOARD

It is recommended that the content of this report and identified key actions are noted and endorsed.

3. BACKGROUND

The purpose of the stocktake event was to bring together key leaders and decision makers as a strategic partnership to reflect on the effectiveness of the local area SEND offer, including the implementation of the SEND Strategy and governance arrangements across the network. It was also designed to strengthen readiness for the future Local Area SEND Ofsted Inspection and enable agreed priorities and next steps.

4. RATIONALE

Thirty-five partner colleagues from the range of health services, the CCG, schools, Children's Services, Adult Services and parent/carer representatives attended the event in November. The event was co-hosted by the Director of Children's services and Iain Fletcher, Head of Corporate Business at NHS Blackburn with Darwen CCG.

A revolving workshop approach was used to allow all attendees to contribute their views and opinions on three key themes:

1. The SEND Strategy Implementation Action Plan
2. Data collection and analysis
3. Partnership Governance arrangements

5. KEY ISSUES

Ahead of moving into workshops participants were asked to consider to what degree they felt that the SEND strategy had been embedded within their organisation, service or setting. This discussion revealed that whilst information may have been shared with teams there was more work to be done to ensure that all leaders, managers and staff understood the strategy and embedding it into day to day delivery.

<u>Theme 1: SEND Strategy Implementation Action Plan (see appendix A – SEND Implementation Action Plan on a Page)</u>

Participants were asked to consider:

- *does the plan included the right key priority actions as identified in the SEND strategy?*
- *Is there anything else that should be in the plan?*
- *how does your service contribute to the action plan?*
- *ideas for practical solutions to help support progressing the plan*.

The consensus of feedback from all groups was that the right priorities had been identified, however two areas for improvement were identified:

- Improved communications and collaborative working across the partnership
- address gaps in data, understanding and dissemination across the partnership to better support strategic decision making

Theme 2: Data collection and analysis

Some of the data currently collected by the local area was shared at the session. Participants were then asked to consider:

- *Where are there gaps in our data?*
- *What other data is collected?*
- *Are we using data to identify needs and gaps accurately*?

The discussion in the workshop identified a number of improvements that should be made to how the partnership currently shares and uses data, these being:

- The partnership needs to develop a shared data set that collects the same kinds of information – currently data held by Children's Services includes demographics of children and young people and types of need routinely compared with regional and national trends whilst health data is orientated on service demand.
- Data that is available to the partnership needs to be shared regularly with an analysis of what it means to support improved understanding
- Data needs to be used to inform strategic planning, decision making and joint commissioning particularly in relation to key transition points.

Theme 3: Partnership and Governance (see appendix B)

The current hierarchy structure was shared with participants; they were asked to consider the following points;

- *Is the governance structure right?*
- *Is the membership of these groups right?*
- *What other decision making groups are there?*
- *Can we determine the impact of our current arrangements?*
- *Does the current structure drive the SEND agenda forward at both an individual organisation level and as a partnership?*

Feedback from discussion was:

- Whilst the governance reporting hierarchy is clear on paper, it is not understood by all partner organisations. The levels of decision making felt complicated to many participants and they were unclear about who sat on each group and if all the right people were included in the membership of each group. A review of the terms of reference and membership of these groups would be a beneficial action to take forward to ensure sufficient representation at meetings and to clarify the purpose of each group. This information then should be shared across the partnership.
- Greater transparency perhaps in the form of published meeting papers, or post meeting briefing updates from each of the key meetings would communicate key decisions with SEND partners and share strategic thinking

Recommendations

- That the Strategy implementation action plan is updated to include new actions identified through the workshops. –
- That a review of the membership of each of the key decision making groups (Implementation Group, SEND Board and Joint Commissioning Group is reviewed to ensure the best possible representation and that there are clear communications from these meetings that are circulated.)
- To review the terms of reference of each meeting and share new refreshed documents with wider partners
- That a series of SEND strategy briefing sessions are planned to share the strategy, action plan and the governance structure.

6. POLICY IMPLICATIONS
None.

7. FINANCIAL IMPLICATIONS
None

8. LEGAL IMPLICATIONS
The key actions identified will support the Local Area to continue to improve its compliance with key statutory requirements and legislation pertaining to the SEND agenda.

9. RESOURCE IMPLICATIONS
None

10. EQUALITY AND HEALTH IMPLICATIONS
The key actions identified will support the Local area to continue to improve its compliance with key statutory requirements and legislation pertaining to the equality and inclusion agenda.

11. CONSULTATIONS
35 decision makers from across the local area partnership attended and contributed to the event.

VERSION:	**2.0**

CONTACT OFFICER:	Joanne Stewart, Head of Service – Early Help & Support
DATE:	11th February 2019
BACKGROUND PAPER:	Appendix A_SEND Implementation Plar Appendix B_Governance Struc