The Migrant Health Agenda in the West Midlands

Results of a Local Scoping Exercise

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1. Foreword

The scale and diversity of migration into the West Midlands presents significant challenges for priorities in health, local government and social care. Our response to this changing policy environment, its complexity with respect to welfare entitlement, the needs of migrant communities in relation to language, cultural expectations and health needs has been varied. This report, *The Migrant Health Agenda in the West Midlands* represents the first attempt to identify how migration has impacted upon priorities for the health sector, on service planning, commissioning, and policy development and how organisations have responded to these challenges.

The report, written jointly by the Department of Health in the West Midlands and the West Midlands Strategic Migration Partnership has identified a number of common themes including the importance of strategic leadership at a senior level and a systematic approach to addressing the challenges; the scope for innovation and people centered design and commissioning of services; the need to learn from and share good practice; the unique contribution of Local Authorities and the voluntary sector to improved service delivery; the need for better access and awareness of health services; the need to target allocation of resources; the importance of the creation of dedicated teams to work with asylum seekers and the potential for routine health data systems to provide contemporary migration data.

Where areas lack political champions, strategic leadership and coordination or where there is limited understanding of the needs of migrant populations, then the health sector’s response is more likely to be confused, uncoordinated and will impact on migrants themselves and the staff who provide services.

Finally we are grateful to all the localities who responded to the questionnaire, for their honesty and frankness and their willingness to engage in this work. The findings from this report will be used to evolve future policy, stimulate action, encourage the roll out of good practice and to strengthen leadership on migrant health across the whole system.

The report serves as a legacy of the work undertaken by Primary Care Trusts to date, but more importantly identifies the need for professional leadership, as well as a continued specific focus on commissioning services for communities experiencing multiple disadvantages. The Government’s recent white paper *Equity and Excellence: Liberating the NHS* proposes a major change in the way services are to be commissioned in the future. With responsibility for commissioning healthcare transferring to GP consortia, the NHS Commissioning Board and the local authority.

We believe the learning, principles and approaches described in this report will continue to be relevant for those organisations and should be developed in the future.

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2. Background

Since the expansion of the European Union (EU) in 2004 the impact of migration has been experienced in all parts of the West Midlands. This is not a new phenomenon but a diversity and rapidity of migration presents a range of challenges across sectors. Whilst migration has traditionally affected the urban areas of the West Midlands, the EU enlargement resulted in a significant number of new arrivals from Eastern Europe coming to live and work in the more rural areas of the region. The dispersal of asylum seekers and refugee resettlement since 2000 in parts of the region has also led to the development of new communities and services to meet the changing needs of an increasingly diverse population. Other recent migrants include those who have come to the UK for family formation and settlement, foreign students, overseas visitors and undocumented migrants. Categories of new migrants are listed at Annex A.

Exact information on the scale of settlement and movement of refugees and migrant workers is not well known at present. There are a range of data sources, which currently provide a snapshot of new arrivals into a Local Authority area, such as the Department for Work and Pensions quarterly information on National Insurance Numbers issues for Foreign Nationals or the Workers Registration data for the A8 accession state nationals. Currently there are around 5200 asylum seekers being supported by the UK Border Agency within the Region, with additional numbers living with friends or relatives whilst their asylum claim is being considered.

In order to better understand the migrant health agenda in the West Midlands and to assess the impact or potential impact of migration on priorities at local, sub-national and national level, the Regional Public Health team developed a questionnaire to Directors of Public Health. The aims of the questionnaire were to better understand the position locally on the migrant health; to explore the impact of migration on primary care services and to look at how these changes might impact on planning, commissioning, policy and service delivery. The questionnaire was consulted on with the Regional Director of Public Health, the West Midlands Strategic Migration Partnership and with the Chair and members of the West Midlands Refugee, Asylum Seeker and Migrant Health Group. The questionnaire is included as Annex B. The questionnaire was issued in January 2010 and responses received from all 17 PCTs. On the whole the forms were completed by either Directors or Assistant Directors within Public Health, Public Health specialists, consultants, registrars or facilitators. Identified leads for migrant health are listed at Annex C. Where leads were not specified the Director of Public Health has been listed.

The questionnaire built on learning from the range of good work across the region over recent years in support of the migrant health and well-being agenda. Previous work has informed the questions asked. Unlike the Scoping Exercise undertaken in 2008, which focused on migrant workers and seeking to identify what could be achieved by the West Midlands Strategic Migration Partnership to add value to local work in this area, this scoping exercise sought to identify the impact of the migrant population on local issues around health and inequalities (i). The “Migration Matters” conference held in 2009 identified a number of areas requiring further work and investigation, including leadership and coordination, data provision and workforce development (ii). These areas were covered in the questionnaire.
The scoping work has received interest nationally and from other regions that are now looking to undertake a similar exercise. The results of this scoping exercise provide us with a current understanding of migrant health issues with examples of effective practice that should be shared and scaled up, as well as identifying areas for improvement. **Examples of good practice identified are summarised at Annex D.** This report summarises the responses and is an important step in further developing and supporting the migrant health agenda across the West Midlands. The major challenges and barriers to the delivery of the migrant health agenda include the lack of data on resident migrants and insufficient understanding of the complexity of the migrant population. Similarly the lack of information on the health needs and impact of specific migrant groups were identified as a challenge. Lack of leadership, strategy, coordination and information sharing on the migrant health agenda is evident. This is reflected in limited resource (e.g. staff time, capacity or expertise) available to develop the agenda and meet local needs. In the absence of a local strategy and plan, commissioning priorities are not being developed to reflect health needs of changing populations.

3. Leadership on Migrant Health in Localities

Responses showed that leadership on the migrant health agenda generally falls within Public Health, although five areas indicated that no one was responsible. Leadership in the other areas sat with either the Director of Public Health, Director of Health Improvement, Assistant Director or with a Public Health Consultant or Specialist.

**Consideration should be given to the level of representation within organisations and whether this reflects the lower priority given to migration priorities.** The responses may also reflect a bias to Public Health as the questionnaires were sent from the office of the RDPH to Directors of Public Health in the region. Responses indicated that the range of local activity addressing migrant health needs was not always clearly understood or visible. This was illustrated by some areas not identifying commissioned GP services or health teams for asylum seekers. **This should be explored further and it suggests a need for further discussions on commissioning such services, particularly in relation to the planned GP Consortia arrangements and in relation to the public health role of local authorities.**
Support was most notable as part of the health inequalities, health improvement and the health and well-being agenda, with senior leads identified within each of these categories. The Public Health intelligence team and other Public Health staff were also identified as supporting the agenda. Several areas identified support for this agenda was provided via equalities leads. Three areas indicated there was no additional support available for the migrant health agenda (these were shire locations) with two other areas uncertain as who else was supporting this agenda (urban areas). A small number of responses indicated a broad range of senior management support within the organisation alongside links to frontline community development work. A Travellers health service in one area was also identified as providing a supporting role on migrant health. Only one response referred to partnership working on this agenda with the local authority. This is an area that requires particular attention in the future particularly in the context of the proposed new Public Health Service where Local Authorities will lead on public health priorities.

4. Strategic Objectives on Migrant Health

Responses to this section focused on where the migrant health agenda sat in relation to inequalities such as equality of access, addressing health inequalities and understanding of new migrant populations. Five localities were unable to identify any specific objectives in relation to migrant priorities within their current plans.

The questionnaire aimed to enhance understanding of the complexity and location of migrant populations in local areas and to illustrate how localities were gaining this understanding. One area was prioritising the identification of people experiencing disadvantage within the migrant population, with another focused on migrants and specific policy priorities in mental health, women’s health and long term conditions e.g. HIV and TB. Work with specific new community groups, linked to community development approaches, was also identified as a key objective in understanding health needs and barriers to services.

Another area had identified specific priorities linked to reducing apparent health inequalities, increasing access to services and supporting employers to assess and respond to migrant workers needs.

Some areas indicated that a focus on offering equitable access to services to all within their local populations on the basis of need and not specifically their ethnicity was their priority. Others linked the migrant health agenda to the promotion of better quality in healthcare for migrant communities which focused on access, appropriateness, acceptability and equity. Action to address the wider determinants of health in partnership, combined with action to reduce social exclusion and support groups experiencing disadvantage were also seen to address the migrant health theme in some areas.

Support for the migrant health agenda through local strategy

The involvement of Local Strategic Partnerships (LSPs) in the migrant health agenda varies. Where the level of support was unknown, it may reflect the level of knowledge the respondent held on the LSPs current work programme and priorities. Three areas indicated that their LSP made no reference to migrant health. One area identified the Local Authority as taking a lead on migrant health agenda.

Some LSPs had health and well-being groups or partnerships where several linked the needs of migrant communities to the sustainable community strategy, with another having a newcomers (new migrant) section within their current business plan. Only one LSP had identified a specific local target related to migrant health and this reflected specific concerns on community cohesion. Another area had included migrant health within a local target linked to work on people in the local area getting along together.
Only three of the sustainable community strategies (SCSs) included any reference to migrant health, although their responses did not provide specific details. Where there was no specific reference to migrant health in the SCS, PCTs said that migrant health was picked up in other areas including reducing health inequalities, work on the impact of Unaccompanied Asylum Seeking Children, social exclusion and community cohesion priorities or in work on economic migrants.

Commissioning:

Only one area reported that specific services had been commissioned for the health needs of asylum seekers, refugees and the homeless, but even this response did not cover the broader range of migrant communities. Another area reported how actions to address specific health inequalities in their commissioning strategy is beginning to ensure migrant health needs are incorporated into specific services, e.g. school nursing service and maternity services specifications.

Joint Strategic Needs Assessment (JSNA):

The JSNA process is intended to assist in the meeting of current and future health needs of the resident population, improve health outcomes and assist in the reduction of health inequalities. Over half of respondents said that there was no reference to migrant health in their JSNA. Other JSNAs made reference to the presence of migrant populations but no specific priorities or needs were identified. Only two JSNAs included migrant health as a priority, one provided no further detail whereas the other related purely to the needs of the Polish Community. Nationally the Department of Health is developing a JSNA toolkit on migrant data. Considerable work is going on to improve the quality and availability of migration data. There are already plenty of data sources that give good enough estimates for most purposes, so it should be reasonably straightforward to give a solid quantitative basis to the JSNA. The toolkit will be available soon for localities to use.
5. Operational Impact of Migrant Health Priorities

Resource Allocation

The West Midlands is serving an increasingly diverse population; however there is limited information on what resource is allocated for migrant health priorities. Specific information was provided by three areas who commission asylum seeker health services. This appeared to cover the costs of specialist services only and did not reflect other activities which the PCT may be involved with in relation to the migrant health agenda e.g. Child and Adolescent Mental Health Services (CAMHS), sexual health, training or interpreting services. One area had a migrant health project funded via the Migration Impact Fund (MIF) (national funding); another provided information on the costs incurred through a Locally Enhanced Service (LES) arrangement to provide for patients who are asylum seekers. Finally in one area a Travellers’ Health Project was specifically funded to address traveller and migrant health needs in the county.

The majority of respondents were unable to identify any financial resources allocated to the migrant health agenda with one indicating that such data were not available. The absence of specific resource allocation may mask the cost impact of migrant health to PCTs e.g. Interpreting costs. Current analysis indicates that only basic costs for commissioned services are identifiable in some PCTs. A more detailed understanding of the ways in which services are commissioned for migrants is needed at PCT level, for example mental or sexual health services.

Services and Support

The responses under this heading varied considerably. Some localities were providing no specific services whilst others acknowledged the key role that the voluntary sector is playing. For the latter it is unclear whether the areas were actively commissioning these services.

Recognition is given to the need to gain a clearer picture of who is working with these new communities at a local level. Localities should consider how this information is being incorporated into commissioning frameworks.

One area had commissioned their Race Equality and Diversity Partnership to work with the wider BME community to identify health needs. A number of health inequality leads also indicated that work to increase support for the migrant health agenda was underway, and ways to enhance existing services to address the needs of ‘hard to reach communities’ would be explored. One PCT noted that work was underway to explore social marketing for lifestyle services which addressed the needs of migrant communities.

A number of respondents had specific services or Locally Enhanced Services arrangements in place to address the health needs of refugees and asylum seekers although a number were no longer used or were under review. Community Development Workers and interpreting services were seen in a few areas as being specifically relevant to delivery to migrant health work, and the clear links to a range of other Local Authority services such as housing and benefits advice were noted.
One area has a range of projects, in addition to their specialist asylum seeker health service, which address migrant groups. These included a project aimed at reducing infant mortality; a project providing practical and emotional support to Asian women and a number of projects focusing on HIV prevention, support, education and a wider sexual health focus. The Migration Impact Fund was being used in a number of areas to develop programmes with new communities. See Annex E.

Performance Monitoring

Performance monitoring of the migrant health agenda appears limited to those with specialist services for asylum seeker health, although only one respondent references this. In one area provision was managed via the contract monitoring forum with the provider services arm. References were made to ad hoc arrangements in relation to midwifery services by another area.

Some localities indicated that migrant health was performance managed as part of health inequality work. It was not clear that these approaches covered migrant health needs, specifically. In one area the Local Authority was seen to performance manage the migrant health agenda via its Overview and Scrutiny Committee. Four areas stated there was no performance monitoring function being undertaken on migrant health in their area.

In the absence of specific performance management for migrant health, consideration should be given to how the existing equalities framework could be utilised to identify the service use and outcomes for migrants the broad range of commissioned services. This should particularly be in areas where there would be an expectation of potential use by new migrants e.g. mental health, sexual health, TB services, maternity services.

Data

A wide range of data sources in relation to migrant health were identified. However no consistent pattern of use emerged with a lack of consistency and few similarities in approach evident. Office for National Statistics (ONS) population and migration data and National Insurance Numbers issues to foreign nationals were the most common information sources cited, followed by GP Registration data/Flag 4 (Flag 4s are codes which indicate an international in-migrant to England and Wales) and UK Border Agency (UKBA) dispersal information. It was interesting given the impact of migration from the enlarged European Union that only three PCTs identified the Workers Registration Scheme as a source of information. Similarly, it is interesting that only three of the seven areas of dispersal identified UKBA as a source of information on asylum seekers.

A small number of local areas were utilising a broad range of data sources from their Local Authority including school registration and housing authority data. Others were using information from specialist asylum seeker health practices, Port Health information and local intelligence from equalities forums, third sector organisations, MIF projects and community engagement information. Several localities made reference to relevant information in the JSNA which was mainly information on economic migrants. One area noted their Migrant Health Needs Assessment as a source of data.

A detailed knowledge of the current population is essential to inform the JSNA yet over half of respondents indicated that there was no reference to migrant health within their JSNA. In three JSNAs the presence of migrant populations was noted but with no specific priorities identified. One area indicated migrant health was a priority but this was for the Polish Community only.
There is almost universal acknowledgement that localities do not have a clear understanding of their local migrant populations and that data which may be available is often out of date. The need to have an agreed understanding of what we mean by migrants and the diversity of groups which might be covered by such definition makes data collection more difficult. The lack of application of routine data collection means it is difficult to establish robust baselines. All respondents agreed that a more detailed analysis of existing data was required. Three areas provided examples of how these data sources are being used to inform work on health outcomes for example.

Two of them had incorporated the data into new and emerging community plans, one had undertaken local needs assessment as part of work linked to the MIF and another had completed a Migrant health needs assessment. These examples of good practice should be widely shared.

Good commissioning needs to be underpinned by an evidence based approach, which demonstrates a clear understanding of the current and future health needs of the local population. The limited knowledge of local migrant populations presents a clear challenge to this agenda.

6. Engagement with Migrant Communities

How are areas using information from service users and providers to feed into the commissioning process? A number of respondents indicated that community engagement strategies ensure service user and community health needs are fed into the commissioning process. One locality included specific work with the Polish community. Several responses indicated that migrant health needs were not separately recorded within consultations and further work was required to ensure these specific needs were highlighted for commissioners. The MIF projects in two areas were identified as providing further engagement with migrant communities and also potential information which could inform commissioning intentions. One area has a specific New Communities
Forum which links to new migrant community organisations, the third sector and had engaged with commissioners of specific services in relation to migrant health needs. Another area commissioned work to understand the sexual health needs of asylum seekers and refugees within their area. Community development workers in another area are seen to provide an important level of information on migrant population and needs to commissioners in addition to engagement with the voluntary sector agencies providing advocacy for new migrants.

A number of PCTs indicated that there was no specific involvement with new communities and that further work on this agenda was required with their Local Authority. Given the focus within current Government policy on engaging communities, further consideration is required to identify what actions need to be taken to address these gaps.

How are PCTs Engaging with New Migrants to Develop Services?

Engagement with migrant communities mirrors the responses above. There is an assumption in many local areas that existing Black and Minority Ethnic (BME) or equalities leads and existing community engagement strategies cover the needs of new communities. In one area a New Communities Health Group was seen as an example of how health needs were being identified to inform commissioning. In some areas, BME specialist workers or Community Development Worker posts were being used to engage with new communities.

In a number of areas there was no clear engagement with new migrants, with some taking the view that existing strategies to reduce health inequality would address these needs. Finally, engaging with refugee/migrant advice organisations on the quality of health provision is noted in a few cases, complemented by a new community focused conference on mental health.
Inter-agency Working

A range of approaches exist to address the diversity of migrant health needs across a broad set of priorities e.g. children’s services; maternity services; community development; housing; employment; specialist language services; primary care and GP support and acute care.

Some areas are using community development workers to engage with new communities, e.g. tackling post natal depression amongst economic migrants. Some services are co-located to enable e.g. swift and easy referral to housing support and immigration matters. A number of respondents have contributed to various ‘Welcome to….’ information packs for new migrants that include information on health services in a given area or to highlight the development of the “Welcome to West Midlands” website for new migrants”. This is a new website with a wide range of information for new arrivals to the West Midlands available at www.welcometowestmidlands.org.uk. The site will provide links to seven local satellite sites.

Several areas were involved in the commissioning of interpreting and translation services, some jointly with their Local Authority. A number of localities were ensuring that the migrant health agenda is supported in work with pregnancy outreach posts, public patient involvement, health inequalities and breastfeeding support. Four respondents commissioned specific asylum seeker health services. One area had a BME Liaison Nurse to support individuals and communities to engage with the health service and preventative services.

There were a number of responses which indicated areas were unaware of any specific services working with migrant communities. Actions to scope the range of support and services being provided to migrant communities within local areas should be prioritised to inform the JSNA and commissioning agenda. It is unlikely that the shift to prevention and promoting well-being will be effective in areas where there is limited understanding and engagement with new and emerging migrant communities or those organisations which provide support and advocacy for them.

Involvement with Wider Networks on Migration

Several localities indicated active involvement with their BME communities, race equality and diversity partnership or their ethnic minority action partnership. It was suggested, by some, that further work exploring the links between the BME agenda and new migrants within existing community engagement strategies was required to ensure that new migrant communities are identified and their impact and needs realised. A small number indicated their engagement with wider networks on migration was conducted through links to the faith community.

In a small number of areas there is active involvement in inter-agency fora which consider new communities or refugee and asylum seeker issues. Several localities had incorporated the wider migrant health agenda in wider partnership work on new and emerging communities.

7. Assessing the Impact of Migrant Health at Local Level

Health impact assessments, which considered migrant health, had been undertaken in only three localities. One area had conducted a health needs assessment for Refugees and Asylum Seekers in 2007. The assessment highlighted needs under the broad categories of infectious diseases, mental health and haemoglobinopathies in addition to more detailed understanding of the age; country of origin; literacy rates and interpreting use for these communities. Individuals experience of accessing health care and further information on social needs, and those of women from these communities particularly was also gathered. No area had undertaken a health economic analysis. Two areas made reference to migration in equality impact assessments, although another plans to conduct a Health Equity Audit this year. An equality impact assessment is a way of systematically and thoroughly assessing, and consulting on, the effects that a proposed policy is
likely to have on people depending on their race, gender, disability, age, religion or belief, or sexual orientation. There are three pieces of legislation that require public bodies to undertake equality impact assessments:

• Race Relations (Amendment) Act 2000;
• Disability Discrimination Act 2005;
• Equality Act 2006.

Under the Race Relations (Amendment) Act 2000, Local Authorities are required to identify all of the functions, policies, plans and strategies which have a race equality dimension, and carry out an impact assessment against them. Where gaps and adverse impacts are found, action plans should be developed and included in service improvement plans.

Given this, the apparent lack of impact assessment work at local level is a real concern. **Immediate attention is required to ensure that the equalities agenda notes the distinctive challenges, which new migration brings to existing health targets.** Local areas should review the adequacy of existing equalities audits and consider whether the health needs of these new migrants can be adequately appraised within the existing BME category.

### 8. Training and Development

**Responses revealed limited training is available on the migrant health agenda within the region and where it exists, it is of an ad hoc nature.** Several areas suggested that existing equality and diversity training may cover relevant issues but provided no evidence in support of this. Further consideration is required on a broader range of the health, social and legal issues which affect new migrants and their health outcomes, as well as broader cultural understanding and more systematic training on the use and work with interpreters. This is an area requiring further examination. Some scoping of migrant health training needs is being undertaken in relation to midwives and health visitors in some localities. One area had commissioned training on a range of migrant health related issues including sexual health, female genital mutilation, legal rights and entitlements.

In a number of areas the MIF is being utilised to provide some training on migrant health. Further information is required on the content and intended audience of such this training.

**The majority of respondents had no specific training in place for staff working on migrant health with some suggestions that this has not been raised as an issue.**
9. Barriers to the Delivery of the Migrant Health Agenda

Significant barriers include:

PCTs indicated the major barriers to the delivery of migrant health agenda are the lack of data on resident migrants and insufficient understanding of the complexity of the migrant population. Similarly, the lack of information on the health needs and impact of specific migrant groups was identified as a major challenge. The lack of leadership, clear strategy, coordination and information sharing on the migrant health agenda within the PCTs is seen as a barrier. This is reflected in further concerns about the limited resource (e.g. staff time, capacity, or expertise) available to develop the agenda and meet needs. In the absence of a local strategy and plan, commissioning priorities are not being developed to reflect the health needs of changing populations.

Other barriers identified included:

• The unpredictability of the growth of migrant populations and the numbers of unaccompanied asylum seeking children in the care of some Local Authorities create difficulties in planning to meet migrant health needs;
• The current focus of commissioning and contracting processes do not enable providers to respond flexibly to constantly changing demographics of migration groups and diverse routes of migration;
• Destitution and its affect on the health seeking behaviour of those affected, e.g. increased use of walk-in provision;
• The need to support staff to develop new skills to work with and address the health needs of new communities in a coherent and timely fashion;
• Lack of knowledge regarding what services exist for new migrants in the area;
• The need for a clear definition of who is covered under the term “migration”;
• Difficulty in sustaining contact with migrant workers who are highly mobile, due to the availability of work, particularly those working on a seasonal, agricultural work;
• The need for more communication and engagement with organisations with well established links to migrant health information and who can provide feedback from migrant communities on their experience of using health services.

10. Most Scope for Strengthening Leadership on Migrant Health and suggested areas for Development

Partnership responses to address the migrant health agenda, in particular action or specific projects led from the LSP arrangements were the most common response. This is mirrored by comments on the need for an integrated response to migrant health. The role of partnerships in developing approaches to data collection and sharing on migrant populations and ensuring that migrant health becomes part of SCS were also noted.

• The development of a more detailed understanding of migrant health needs at a local level should be pursued;
• Further work with voluntary sector groups, who are providing services and support to these communities, was considered important and achievable in the short term. This should be coupled with improved data collection that highlights, for commissioners, the specific scale and type of issues which migration raises;
• Identifying a senior level champion at Board level;
• The need to regularly, and systematically, evaluate the effectiveness of all aspects of services for migrants and make better use of data to improve performance;
• Widespread use of health and equality impact assessments;
• Clarification of the asylum seeker dispersal process;
• Collaboration with the voluntary sector focused on delivery of desired outcomes;
• Annual agenda setting to clarify outcomes on this agenda, supported with appropriate resources;
• Developing sustainable and collaborative partnerships across the local economy;
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• Developing sustainable and collaborative partnerships across the local economy;
• Specific work to address sexual health and mental health needs;
• Further work with voluntary sector groups, who are providing services and support to these communities, was considered important and achievable in the short term. This should be coupled with improved data collection that highlights, for commissioners, the specific scale and type of issues which migration raises;
• Identifying a senior level champion at Board level;
• The need to regularly, and systematically, evaluate the effectiveness of all aspects of services for migrants and make better use of data to improve performance;
• Widespread use of health and equality impact assessments;
• Clarification of the asylum seeker dispersal process;
• Collaboration with the voluntary sector focused on delivery of desired outcomes;
• Annual agenda setting to clarify outcomes on this agenda, supported with appropriate resources;
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• Collaboration with the voluntary sector focused on delivery of desired outcomes;
• Annual agenda setting to clarify outcomes on this agenda, supported with appropriate resources;
11. Conclusion

It is evident that as people begin to move into the West Midlands with greater rapidity, that the impact of migration of all kinds will affect health in increasingly complex ways, posing new and more difficult challenges to health services. This scoping report highlights a range of emerging and existing good practice to tackle such challenges. The questionnaire responses also highlight a range of challenges and areas for further development. Not least is that any consideration of the relationship between migration and health is limited by the relative paucity of information that exists in the region. Unofficial and unrecorded migration poses another obstacle to understanding the real pace and potential impact of migration on health services.

The speed of migration, the numbers involved, and the fact that people are often moving from parts of the world with distinct health conditions carries with it implications for the health and health care of those who move and those that receive them. This impact is often compounded by culture, language and how people from different parts of the world perceive health. The socio-political context is important and migration can be less appreciated by receiving societies. This also has implications for the health sector.

The responses to the questionnaire reveal that there remain significant gaps in addressing the challenge of migration in a comprehensive way and one which considers ethical and public health issues alongside health care and health service provision. It is encouraging that since the scoping was completed, several localities have made further contact and with the authors initiated discussions on the migrant health agenda.

It is hoped that the findings from this impact assessment report will be instrumental in maintaining a focus on migration issues moving forward, in supporting localities in addressing the ongoing and emerging challenges and in enabling the necessary improvements to enhance local delivery.
12. ANNEX A - Categories of new migrants
see also www.wmleadersboard.gov.uk/migration-documents

Asylum Seekers:

An individual who has applied to the Home Office for protection under the United Nations Convention related to the protection of refugees (1951) and is waiting for a decision on their asylum case. These individuals and their dependents may request support from the UK Border Agency (UKBA) whilst their application for asylum is being considered. Asylum seekers are dispersed to the following locations within the West Midlands: Birmingham, Coventry, Dudley, Sandwell, Stoke-on-Trent, Walsall and Wolverhampton.

Refugees:

Refugee status is given to those who satisfy the criteria of the above UN Convention. Individuals might also be granted Humanitarian Protection or Discretionary leave to remain in the UK.

Refused (failed) asylum seekers:

• An asylum seeker whose claim for asylum has been fully and finally determined and who has been refused any form of leave to remain in the UK.
• A small number of individuals may qualify for Section 4 support from the UKBA.

Economic Migrants:

• This includes non EU – nationals with permission to enter the UK and work under the points based migration system (www.ukba.homeoffice.gov.uk/workingintheuk/)
• Individuals from the European Economic Area,
• Individuals from the A8 accession states which joined the EU in 2004 and who need to register for employment under the Workers Registration Scheme www.ukba.homeoffice.gov.uk/workingintheuk/eea/
• Individuals from Bulgaria and Romanian the A2 countries who still have restricted access to the UK Labour market.

Overseas Students are covered under the points based migration system.

Entry for Spouses and Family members:

A significant number of migrants enter the UK to rejoin family, for marriage or to join a spouse with UK Residency. (Spousal Visa applicants or Family reunion)

Undocumented Migrants:

This category includes individuals who have entered the country illegally without any documentation. It also includes those who have overstayed their previous entry visa or failed to renew their leave to stay in the UK.

Unaccompanied asylum seeking children:

A number of children arrive in the UK unaccompanied each year and enter the care of local authorities whilst their claim for asylum is considered.
## ANNEX B - Questionnaire

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>RESPONSE</th>
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<tbody>
<tr>
<td>1. Who is the senior lead for migrant health in your PCT?</td>
<td></td>
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<tr>
<td>2. What other staff directly support the migrant health agenda?</td>
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<tr>
<td>3. What are your migrant health strategic objectives?</td>
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<tr>
<td>4. What support for the migrant health agenda is provided by the Local Strategic Partnership?</td>
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<td>5. Is migrant health included in your Sustainable Community Strategy?</td>
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<tr>
<td>6. How is performance management of the migrant health agenda undertaken?</td>
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<tr>
<td>7. What level of resources did your PCT spend on migrant health in 2009/10? Where is your migrant health budget funded from?</td>
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<tr>
<td>8. Data on the migrant population:</td>
<td></td>
</tr>
<tr>
<td>i. What are your key data sources?</td>
<td></td>
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<tr>
<td>ii. Does the PCT have problems knowing the details of local needs?</td>
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<tr>
<td>9. Is migrant health a priority in your Joint Strategic Needs Assessment?</td>
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<tr>
<td>10. Is migrant health incorporated into commissioning plans and linked to world class commissioning?</td>
<td></td>
</tr>
<tr>
<td>11. How does the PCT ensure it is able to use the information collected from service users and providers as to what they need/want and commission on the basis of this? How does your PCT engage with migrants regarding developing services to meet their needs?</td>
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<tr>
<td>12. What services/support do you have in place for migrant health with the voluntary sector?</td>
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<tr>
<td>Question</td>
<td>Answer</td>
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<td>-------------------------------------------------------------------------</td>
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<tr>
<td>13. What services/support do you have in place for migrant health with</td>
<td></td>
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<tr>
<td>other agencies such as children’s services; maternity services;</td>
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<tr>
<td>community development workers; housing; employment; specialist</td>
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<tr>
<td>language services; specialised primary care support; targeted GP</td>
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<tr>
<td>support and NHS and Foundation Trusts etc.?</td>
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<tr>
<td>14. Have you undertaken any of the following in relation to migrant</td>
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<tr>
<td>health: i. health impact assessment ii. health economic analysis</td>
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<tr>
<td>iii. equality impact assessment?</td>
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<tr>
<td>15. Training and Development i. Has training or development been</td>
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<td>undertaken in relation to migrant health and who received the training?</td>
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<td>ii. Do key groups such as Health Visitors and midwives receive any</td>
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<td>training?</td>
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<td>16. Is your PCT involved in any wider migrant health networks e.g.</td>
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<td>Faith Groups?</td>
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<td>17. What are the top three barriers facing your PCT in delivering on</td>
<td>i.</td>
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<tr>
<td>the migrant health agenda?</td>
<td>ii.</td>
</tr>
<tr>
<td>i.</td>
<td>iii.</td>
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<tr>
<td>18. In which three areas is there most scope for strengthening local</td>
<td>i.</td>
</tr>
<tr>
<td>level leadership of migrant health?</td>
<td>ii.</td>
</tr>
<tr>
<td>i.</td>
<td>iii.</td>
</tr>
<tr>
<td>19. In which three areas is there most scope for strengthening regional</td>
<td>i.</td>
</tr>
<tr>
<td>level leadership of migrant health?</td>
<td>ii.</td>
</tr>
<tr>
<td>i.</td>
<td>iii.</td>
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</table>
20. In which three areas is there most scope for strengthening national level leadership of migrant health?

<table>
<thead>
<tr>
<th>i.</th>
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<tr>
<td>ii.</td>
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<td>iii.</td>
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</table>

21. Please make any other comments

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22. And finally, can you give us some details about yourself:

<table>
<thead>
<tr>
<th>Name:</th>
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<tbody>
<tr>
<td>PCT:</td>
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<tr>
<td>Job title:</td>
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<td>E mail:</td>
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<tr>
<td>Tel no:</td>
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<tr>
<td>Location</td>
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<td>--------------------------------</td>
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<tr>
<td>Birmingham East and North</td>
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<tr>
<td>Heart of Birmingham</td>
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<tr>
<td>South Birmingham</td>
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<tr>
<td>Coventry</td>
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<tr>
<td>Dudley</td>
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<tr>
<td>Herefordshire</td>
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<tr>
<td>North Staffordshire</td>
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<tr>
<td>Sandwell</td>
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<tr>
<td>Area</td>
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<td>-----------------------</td>
</tr>
<tr>
<td>Shropshire</td>
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<tr>
<td>Solihull</td>
</tr>
<tr>
<td>South Staffordshire</td>
</tr>
<tr>
<td>Stoke-on-Trent</td>
</tr>
<tr>
<td>Telford &amp; Wrekin</td>
</tr>
<tr>
<td>Walsall</td>
</tr>
<tr>
<td>Warwickshire</td>
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<tr>
<td>Wolverhampton</td>
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<tr>
<td>Worcestershire</td>
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</tbody>
</table>
The questionnaire identified a range of local good practice that should be shared more widely and replicated where possible. These include:

- The LSPs with specific local targets for migrant health;
- LES arrangements in place to address the health needs of refugees and asylum seekers;
- Walsall needs assessment (From Outside to Involvement) and Sandwell data analysis. Telford and Wrekin, Walsall and Warwickshire are examples of how data sources are being used to inform work on health outcomes. Warwickshire and Telford have incorporated data into community plans and Herefordshire has a migrant health needs assessment in place;
- A JSNA highlights the needs of the Polish Community in Shropshire;
- Specific services commissioned for the health needs of asylum seekers, refugees and the homeless;
- Actions to address specific health inequalities included in commissioning strategies to ensure migrant health needs are incorporated into specific services, e.g. school nursing and maternity services;
- Community health needs fed into the commissioning process
- Sandwell new communities’ health forum which links to new migrant community organisations, the voluntary sector and engages with commissioners of specific services in relation to migrant health needs;
- Commissioned work to understand the sexual health needs of asylum seekers and refugees;
- Coventry has a range of projects in addition to their specialist asylum seeker health service which address migrant groups. These include the MAMTA project aiming to reduce infant mortality, a project providing practical and emotional support to Asian women, and a number of projects focusing on HIV prevention, support, education and a wider sexual health focus
- Community development workers in place to engage with new communities, e.g. tackling postnatal depression amongst economic migrants in Worcestershire;
- Coventry's Meridian practice co-located with the Coventry Refugee Centre which enables easy referral of housing, support and immigration related issues;
- BME specialist workers / community development worker posts to engage with new communities, e.g. Worcestershire and Wolverhampton;
- Telford and Wrekin have commissioned their race equality and diversity partnership to work with the wider BME community to identify health needs;
- Migrant health agenda supported through work with pregnancy outreach posts, public patient involvement health inequalities and a breastfeeding coordinator;
- Commissioning of specific asylum seeker health services;
• Herefordshire Travellers’ Health Service Project delivers specific services to migrant workers, including a mobile service in a number of locations in the county;

• Telford and Wrekin has a BME liaison nurse to support individuals and communities to engage with the health service and preventative services;

• Health impact assessments undertaken in some areas;

• Warwickshire and Telford and Wrekin have included migration within equality impact assessments;

• Some scoping of migrant health training needs is being undertaken in relation to midwives and health visitors in Solihull;

• Coventry has commissioned training on a range of migrant health related issues e.g. sexual health, FGM and legal rights and entitlements;

• In a small number of areas there is active involvement in inter-agency forums which consider new communities or refugee and asylum seeker issues, e.g. Sandwell;

• Some of the shire areas have incorporated the migrant health agenda into wider partnership work on new and emerging communities, e.g. Warwickshire, Herefordshire & Worcestershire via the Migration and Integration into Rural Areas Project (MIRA).
ANNEX E – Migration Impact Fund

The Migration Impact Fund was announced in the February 2008 Green Paper “The Path to Citizenship” to manage the transitional impacts of migration and to promote innovative ways of managing the pressures on local services impacted by recent or ongoing growth in migrant population including new migrant groups. The projects funded demonstrated benefit to the community as a whole e.g. providing additional or specific resource to a service delivery to relieve pressures elsewhere thus supporting improved services to all; or encouraging increased and/or appropriate engagement with public services from particular groups so providing benefits to a wider society.

Projects funded all demonstrated:

- Evidence of need
- Impact on specific communities/group
- Wider community and service delivery benefits
- Succession/sustainability plans

A West Midlands evaluation panel considered all proposals and made the recommendations to Ministers for funding.

The Migration Impact Fund projects within this region have the potential to enhance the understanding of migrant populations in their given area. Such projects may develop links to new community groups, provide further detail on the numbers and complexity of migrant groups and identify new and emerging issues. For example a number of MIF projects have identify concerns about substance abuse and homelessness amongst groups of economic migrants.

Walsall – From Outside to Involvement. This project is a partnership between NHS Walsall, Walsall MBC and a number of voluntary sector agencies. The project aims to improve health and social care literacy in migrant communities, through awareness raising, provision of a drop in service and recruitment of volunteer outreach workers from migrant communities.

Migration and Integration in Rural Areas – Herefordshire and Worcestershire. The project includes specific work on support for a reconnect services for economic migrants with No Recourse to Public Funds. There is a mobile health unit for seasonal workers operating in Herefordshire; specific support for health visitors and ongoing work to raise awareness of how to access and register with GPs.

Women’s Healthy Lifestyles - Birmingham. This is a joint project between Birmingham City Council and the voluntary sector aimed to improve new migrant women’s health and lifestyle. The project is focusing on raising awareness of specific health issues and access to the health service, though a range of seminars; drop in provision and advice and guidance services. Specific work addressing FGM is also being commissioned through this project, aimed at education and awareness raising for specific communities where FGM is practiced.

Training on migrant rights and entitlements - Sandwell – Training on migrant rights and entitlements is being delivered across a range of sectors including health. The Protected Learning Time event on migrant health entitlements was held in March and drew together a large number of primary care practitioners to look at the issues and PCT’s response to delivery of health care to these communities. Further community engagement and health awareness activities with new communities are planned.
Warwickshire together - sustainable solutions for changing communities - Warwickshire - An equalities event which focused on new migrants was held on 16th March. The project also includes development of their translation and interpreting services and increased resources for independent advice to new migrants through Legal Advice Warwickshire.

Refugee and Migrant Centre - Wolverhampton – Facilitating Integration through improved advice and advocacy services from the Refugee and Migrant Centre; including specific work to assist GP registration; awareness of mental health and identification of emerging health issues linked to NRPF.

Welcome to the West Midlands website is an information portal designed to be used by new migrants and professionals working with them. It gives a broad overview of rights and entitlements to services and then links to 7 other Local Authority based websites which direct individuals to local services and contact information. The website will build on the existing Welcome to Birmingham site. There is a broad range of health information and entitlement information available on the site, which will be useful for frontline staff working with new migrant communities. The site went live in July 2010 and can be viewed at www.welcometowestmidlands.org.uk

The Migrant Health Agenda in the West Midlands: Results of a Scoping Exercise
13. References

i. www.wmro.org/displayResource.aspx/7325/
   West_Midlands_strategic_migration_partnership_Regional_migration_scoping_exercise_Summary_of_key_fin.html


iii. www.cabinetoffice.gov.uk/media/346571/inclusion-health.pdf


vi. www.welcometowestmidlands.org.uk

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