Primary health care services for refugees, asylum-seekers and vulnerable migrants in Oxford city

A study on the experiences of service users and service providers

Produced on behalf of Refugee Resource (Oxford)
by Jane Shackman and Fiona Gell

A Healthwatch Oxfordshire Project Fund Report, September 2016

Asylum Welcome
Oxford, Oxfordshire

Refugee Resource

healthwatch
Oxfordshire

Photos: Refugee Resource

Introduction by Healthwatch Oxfordshire

Healthwatch Oxfordshire is an independent organisation, established under the Health and Care Act 2012. It exists to find out about people's experiences of publicly funded health and social care, and to use that information to bring about improvements to these services in its local area. It gives the people of Oxfordshire a powerful voice in shaping decisions affecting vital services.

In 2014-2015, Healthwatch Oxfordshire set aside £25,000 a year to fund projects which would enable community groups and community based organisations to undertake small scale service evaluation projects with particular groups of service users. The aim of these studies is to gather intelligence about people's experience of care, particularly from seldom heard groups, and to produce reports which shed light on those users' experiences of services. Where appropriate, these reports contain recommendations from participants, or from the report authors, about how such services might be improved. They are also a means to celebrate examples of excellent care.

The views and opinions expressed in this report are those of the participants in the study, and of Refugee Resource. Healthwatch Oxfordshire will ensure that local providers and commissioners receive the report, and that they are alerted to the recommendations this group has made, and to the experiences the project participants describe. We will also follow up with those commissioners and providers on a regular basis, over time, in order to see what changes they make as a result. Finally we will report to the report authors, through our website and via the local media, on actions taken by providers and commissioners to deliver the report's recommendations.

Rosalind Pearce - Executive Director

healthwatch Oxfordshire

Acknowledgements

Sincere thanks go to members of the project reference group - Maxine Myatt (project manager), Maggie Dent (OCCG Equality and Access Manager), Kanika Lang (Healthwatch Oxfordshire), Mary Beth Oakley and Kate Smart (Asylum Welcome) and Sanda Kyu (refugee community) – who provided both strategic and detailed practical support throughout the project.

Thanks also to Kate Hood (director), staff, mentors, interpreters and clients at Refugee Resource, Kate Smart (director), staff and volunteers at Asylum Welcome, and the staff and volunteers from other voluntary sector organisations who patiently answered our questions.

We thank the many refugees, asylum seekers and migrants who willingly and openly shared with us their positive experiences of good services they had received, as well as their ideas for overcoming some of the challenges in the hope of improving things for others in the future. We are extremely grateful to the staff of Refugee Resource, Asylum Welcome and Connections Floating Support for facilitating access to their clients for us despite their heavy workloads.

We also express much appreciation to the primary health care professionals who completed questionnaires and took part in face-to-face or phone interviews despite their incredibly busy work schedules.

We thank Healthwatch Oxfordshire for funding and supporting this project.

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Acronyms and terminology

BME – Black and Minority Ethnic
FGM – Female Genital Mutilation
HCP – Health Care Professional
OCCG – NHS Oxfordshire Clinical Commissioning Group
PCTs – Primary Care Trusts
PHC – Primary Health Care

The terms 'patients' and 'clients' are used fairly interchangeably and according to the context to refer to refugees, asylum-seekers and vulnerable migrants. 'Patient' is generally used in the context of their attendance at health care services, while 'client' is generally used in the context of their accessing the services of voluntary sector organisations and responding to this study.

Executive summary

This study was carried out on behalf of the Oxford-based charity Refugee Resource from January to June 2016. It was funded and supported by Healthwatch Oxfordshire.

It explores the primary health care needs of asylum-seekers, refugees and vulnerable migrants in Oxford city. These groups are among the most marginalised and disadvantaged in British society, tending to live in the most deprived areas. There is ample anecdotal evidence that they are amongst those facing the greatest barriers in accessing local services including primary health care.

The aim of the project was to help address health inequalities in Oxford city by investigating the experiences of this population group in accessing and using primary health care services, identifying the issues faced by primary health care providers in delivering services to this patient group, and making recommendations to improve access and ensure services are as appropriate as possible for these patients.

In terms of significance, this was a relatively small and primarily qualitative study. However, the consistency of responses across the range of service users, primary health care professionals and voluntary sector organisations who responded supports the validity of the findings. In addition, the findings are supported by considerable research that is already in the public domain.

In terms of bias, we acknowledge that the sample of health care professionals interviewed was likely to have been biased toward those with greatest concerns about the issues in question and were from medical practices seeing relatively high numbers of refugees, asylum-seekers and migrants. Regarding the service users who responded, it is important to note that most were already being supported by at least one voluntary sector organisation. The study did not reach those living 'beyond the system' with no support structures, those living in destitution, and only a few recent arrivals to Oxford. The latter would face much greater barriers to accessing services than those we interviewed.

The study found that, with a few exceptions, most of the refugees, asylum-seekers and vulnerable migrants interviewed have had positive experiences of accessing primary health care in the UK. Most were very appreciative of the treatment received and the compassion and sensitivity shown by health care professionals toward them. Nevertheless, they face a range of linguistic, cultural and administrative barriers to accessing appropriate care.

The health care professionals involved in the study were all committed to delivering an equitable service for this patient group, and were clearly doing all they could to provide an exemplary service. Nevertheless, they also faced many challenges in meeting the needs of this group who can present with complex health issues related to their experiences of war,

torture, exile and loss, as well as the challenges of adjusting to a new life in the UK, often with little or no English.

The findings led us to propose the following five recommended areas of actions for those commissioning Oxford's primary health care services - the Oxfordshire Clinical Commissioning Group (OCCG).

1. **Recognition of the health needs of refugees, asylum-seekers and vulnerable migrants as a key inequality issue that requires specific support and resources**

   Although this patient group is relatively small in numbers, their health care needs are often very high. Most of them do not wish to be seen to be demanding, and are extremely appreciative of the health care they have received in this country. Similarly, the number of GP practices with significant numbers of patients from these groups is small, but the challenges for them are huge. "*This is a small population with very high needs. The number of practices (treating them) is small and so they go under the radar.*"
   Action by: OCCG and all providers

2. **Funding GP surgeries to run a Locally Enhanced Service**

   Because refugees, asylum seekers and vulnerable migrants tend to present with complex issues – medical, psychological and social – as a result of experiences in their home country, and the process of adapting to life in the UK, GPs and patients alike expressed the need for longer appointment times. GPs felt this would enable them to make better assessments and provide more appropriate medical attention and care. We therefore recommend a Locally Enhanced Service, modelled on the lines of that set up for Kosovan refugees in the late 1990s, where GPs, and possibly Practice Nurses, can see patients for extended appointment times. This would mean funding more GP hours.

   We propose that funding is made available so that all GP practices are able to offer this enhanced service, with the expectation that this would primarily be drawn on by practices seeing large numbers of refugees, asylum seekers and migrants.

   Consideration could be given to a proposal of initial consultations with GPs of 20-40 minutes, and on-going extended appointments if needed in complex cases and where interpretation is required. Efforts should be made where possible to provide continuity of GP so that these patients, for whom trust may be a major issue, do not have to re-tell distressing life histories repeatedly to new health care staff.

   We propose that efforts are made to offer appointments to asylum seeking children and young people at the end of their school/college day, so as to least disrupt their education.

Action by: OCCG

3. Interpreters

Face to face interpreting is rarely used in GP practices for good reason, but we found some demand from both providers and patients for greater availability of this service given the complexities and sensitivities often involved. It is recommended that greater provision is made for this where there is clear need e.g. for longer initial assessment appointments and for some on-going treatment where there are complex cases or mental health issues. Interpreters need to be carefully selected and fully trained.

Patients should be made more aware of their right to request a phone interpreter for appointments with HCPs (healthcare professionals): this should always be offered at the time of making an appointment when it is clearly needed, including offering a choice of gender of the interpreter. Consideration should also be given to how interpretation at the Reception Desk can be supported, possibly via phone interpreting, to facilitate registration and the making of appointments for those with little or no English.

The NHS cards produced by the OCCG for patients requiring Language Line interpreting support need to be widely publicised in both the community and GP surgeries.

Action by: OCCG, GP surgeries and voluntary sector organisations

4. Awareness-raising/training for health care professionals

Many health care professionals (HCPs) showed great understanding, sensitivity and compassion towards this patient group. To support their work, we recommend that training be made available for them on:

i. the experiences of refugees, asylum-seekers and vulnerable migrants. Refugee Resource and/or Asylum Welcome may be able to offer this training if funded to do so.

ii. HCPs also need to be clear about the entitlements of this group to primary health care services. In particular, receptionists may find this helpful as the reception desk can be the site of friction around registration, entitlements to health care and language support needs. Those medical practices that have accrued considerable experience in supporting refugees, asylum-seekers and migrants could also be invited to provide orientation to others on good practice or simple 'what works', if funded to do so.

iii. It would also be useful for HCPs to be aware of what other support services are available from organisations such as Refugee Resource and Asylum Welcome to which they can signpost refugees, asylum seekers and vulnerable migrants.

iv. A useful awareness-raising tool would be a short (5-10 minute) video of service users talking about their experiences of accessing and using primary health care services, the challenges they encountered and how these were overcome. The development and production of this would require funding.

Action by: OCCG could fund voluntary sector organisations like Refugee Resource, Asylum Welcome and other voluntary sector organisations to run such training sessions for GP surgeries, including developing an educational video.

5. Outreach work in communities with high numbers of refugees, asylum-seekers and migrants to orient them to primary health care service

There is not always a clear understanding amongst these communities, particularly amongst new arrivals, of how the NHS primary care system works. This is exacerbated by language barriers and unrealistic expectations. Outreach work is needed to help orient them on what to expect from and how to access services: GP services, how to register, pharmacies, prescriptions, health promotion issues, preventative health care messages, availability of interpreters, role of nurses, health visitors and midwives etc. This might be done through group awareness-raising sessions, with follow up to solve individual problems once they have started using the health system. Such sessions could be supported by the distribution of printed information in different languages about how health services run. These could also be distributed in the community eg. to GP surgeries, children's centres, schools, community centres, nurseries etc.

Voluntary sector organisations such as Refugee Resource or Asylum Welcome could potentially organise such awareness-raising sessions if funded to do so. In the spirit of the 'shared care' model, HCPs and administrative staff could also attend and provide orientation if funded to do so. The various statutory teams tasked with outreach work into disadvantaged communities in Oxford could support such initiatives, including the OCCG Equality and Access Team, Social Prescribers, Care Navigators, potential Health Champions, and Oxford Migrant Health Initiative with its medical students. Voluntary organisations, their Support Workers and community groups such as the Asian Women's Group, could also be requested and resourced to support such initiatives.

The vital role played by voluntary sector support workers in liaising between HCPs and patients needs to be financially supported whenever possible, eg on a sessional basis according to need.

Action by: OCCG funding to voluntary sector organisation to facilitate this outreach work.

We acknowledge the great deal of positive work being done by primary health care professionals in Oxford to provide good and appropriate services to refugees, asylum-seekers and vulnerable migrants, despite the enormous pressures they are under.

We believe that with sufficient funding and working together as 'shared care' partners on the recommendations outlined above, the primary health care services, local communities and voluntary sector organisations could achieve much greater impact in providing an equitable service and reducing the health inequalities faced by refugees, asylum seekers and vulnerable migrants in Oxford.

1. Introduction

This study was carried out on behalf of the Oxford-based charity Refugee Resource from January to June 2016. It was funded and supported by Healthwatch Oxfordshire.

The work was carried out by Refugee Resource associates, Jane Shackman and Fiona Gell, with overall management from Maxine Myatt (formerly Interim Director of Refugee Resource).

A Project Reference Group oversaw the strategic direction of the project and supported its practical implementation. This comprised representatives of Refugee Resource, Asylum Welcome, Healthwatch Oxfordshire, a member of the refugee community, and the Equality and Access Manager of the Oxfordshire Clinical Commissioning Group (OCCG).

2. Background and context

2.i Refugees, asylum seekers and vulnerable migrants: multiple layers of disadvantage

Asylum-seekers, refugees and vulnerable migrants are among the most marginalised groups in British society and among those facing the greatest barriers to accessing quality primary health care (PHC) services. Many of them may have fled from human rights abuses during violent political, ethnic or religious conflict, or suffered imprisonment, torture, persecution or rape used as a weapon of war. Many, including unaccompanied children and young people, will have made difficult and dangerous journeys to reach the UK to seek sanctuary and safety. On the journey they may have experienced abuse, exploitation, hunger, illness, and debt, separation from family members, robbery, threats or assaults.

In the UK, they typically face multiple layers of disadvantage, negative impact from the current high political profile of migration and refugee issues, and often confusion over entitlements to health care. They are likely to experience destitution, poor and limited accommodation, vilification by the media, and isolation. As a result they are among the least advantaged groups within society, tend to live in the most deprived areas, and are among the groups facing the greatest barriers in accessing local services. In addition, asylum seekers face a complex asylum claims process.

Some people, mainly women, within this client group may also have suffered harmful cultural practices such as forced marriages, so-called 'honour-based' violence, and female genital mutilation/cutting.

The recent Red Cross report *'Poor health, no wealth, no home: a case study of destitution'* (2015) examined the impact of destitution on asylum seekers in South Yorkshire and found that refused asylum seekers in particular are a group characterised by vulnerability, poor health and wellbeing and an inability to satisfy their essential needs such as food and shelter. There was a pattern of deteriorating health in those destitute for the longest.

Other studies suggest that *"in almost all indices of physical, mental and social well-being, asylum-seekers and refugees suffer a disproportionate burden of morbidity. This population is … disempowered and is restricted in access to services"* (Taylor, 2009).

2.ii Refugees, asylum seekers and vulnerable migrants: experiences of accessing healthcare

"*Primary Care is healthcare provided in the community to diagnose and treat health needs and send people on to specialist services. Primary care services include GP practices [GPs, practice*

nurses, health visitors, midwives], dental surgeries, opticians and pharmacies. These services are most people's first point of contact with the NHS and where 90 per cent of interaction with the NHS takes place." (Healthwatch England, March 2015 p8).

There is ample anecdotal evidence from Refugee Resource, Asylum Welcome and organisations working nationally to support refugees, asylum-seekers and vulnerable migrants, to suggest that these groups face many barriers to accessing appropriate quality primary health care.

We reviewed studies which reiterated many of the same barriers that these patients face when accessing and using health care services, including confusion over entitlements to health care. They often also have complex and untreated medical conditions and have suffered particularly traumatic experiences affecting their mental and physical health. Although some of these studies and reports are not recent, they serve as a baseline of the kinds of issues facing refugees, asylum seekers and health care professionals. They also serve to illustrate the many positive aspects of health care services in the UK, whilst indicating areas of continuing concern.

The complex health needs of many patients from excluded groups such as asylum-seekers and refugees, homeless people, Romany travellers, those with learning difficulties or mental illness etc, can pose a huge challenge to over-burdened GP surgeries who can struggle to cope: "*Providing they have access to friendly care, more of these patients are high users with complex needs. So, as self-employed contractors, many GPs do their best to avoid them. Less business-like GPs, who believe that these people need and benefit from care more than any other social group, end up with a disproportionate number of such patients, in many cases enough to make ordinary practice impossible"* (Hart, 2010 p250).

Healthwatch England has commissioned and produced a number of relevant reports in relation to access to and use of health care services; many of these look at issues from the perspective of BME groups and although not specific to refugees and asylum seekers, the issues are very similar. For example, findings include difficulties in relation to interpreting services, the report quoted above stating: *"Patients who require translation services are not receiving an equitable level of care to those who don't."* (Healthwatch England, March 2015 p9). Other issues of concern include too short appointment times, the need to be aware of particular barriers facing BME patients, and the importance of providing relevant information to them.

Healthwatch England and Healthwatch Islington have provided an excellent resource in these studies, which give clear findings and recommendations for further action. Their publications and other reports we drew on during this study are listed in Appendix A. However, despite all the knowledge that has been generated across the country by these studies, this specific project was motivated by needing to know more about the situation for

refugees and asylum seekers local to Oxford in accessing and using primary health care (PHC) services.

Two local studies gave us some background: in 2014 Healthwatch Oxfordshire commissioned and funded the Asian Women's Group in Oxford to study the access of Asian women, in Oxford and Banbury, to GP services, mental health services and domiciliary services (Shafique, 2014). The barriers to access that they found included cultural barriers (feeling embarrassed talking to someone they don't know; their husband not liking them seeing a male doctor), having to rely on family as interpreters, unfriendly receptionists, language difficulties, not knowing how to complain or lacking the confidence to do so, lack of transport, lack of information about services, and practices failing to recognise the need for Halal medication.

Research carried out by Refugee Resource on access to counselling services for refugees, asylum seekers and vulnerable migrants in the Thames Valley found a wide range of barriers to accessing local services, including health services (Gell and Shackman, 2015). These included language barriers (lack of translated material or consistent quality interpreters); a concern that services may be culturally inappropriate; lack of understanding about how to access services and what to expect from them; lack of awareness about their rights to services; issues of trust and fear of lack of confidentiality; lack of certainty about immigration or legal status in the UK and fear of possible consequences of being deported, sent home or losing children; social acceptance of domestic violence in some cultures with women not feeling they have the right to seek support; restrictions on freedom of movement for some women resulting in isolation at home; and chaotic and unstable lifestyles making it hard to keep appointments.

2.iii Entitlements to primary health care

Primary health care (PHC) in England can be accessed free, by all, regardless of immigration status. Some services (prescriptions, dental treatment, sight tests, glasses and contact lenses) are chargeable, although people on a low income can apply for financial assistance using an HC2 form.

Entitlement to primary health care services in the UK is set out in the NHS guidance document '*Patient registration standard operating principles for primary medical care (General Practice), 27 November 2015*. In particular, this clarifies the position of migrants and asylum-seekers who do not have access to documents. Relevant aspects of this guidance are detailed in Appendix B. Other guidance on entitlements for asylum-seekers and patients with no recourse to public funds is also given in Appendix B[1].

[1] This guidance is from NHS England, the Refugee Council, and the NRPF Network

The key points in the NHS guidance are:

- "*A patient does not need to be 'ordinarily resident' in the country to be eligible for NHS primary care – this only applies to secondary (hospital) care. In effect, therefore, anybody in England may register and consult with a GP without charge…Therefore all asylum-seekers and refugees, overseas visitors, whether lawfully in the UK or not, are eligible to register with a GP practice." (section 3).*
- There is no regulatory requirement to prove identity, address or immigration status in order to register as a patient with a medical practice. "*Inability by a patient to provide identification or proof of address would not be considered reasonable grounds to refuse to register a patient."*(section 2.1.). Establishing an individual's identity is not the role of the GP. However, it is legitimate, within the guidelines provided, for a practice to ask for patient ID as this helps to ensure correct matching of a patient to the NHS central patient registry.

Registration can only be refused if: the patient lives outside the practice's catchment area; the practice has closed its list in agreement with the NHS commissioner; the practice has other reasonable grounds providing these do not relate to race, gender, social class, age, religion, sexual orientation, appearance, disability or a medical condition (NRPF Network, 2015).

In order to access *chargeable PHC services* (prescriptions, dental treatment, sight tests, glasses and contact lenses) free of charge, asylum seekers need an NHS charges HC2 certificate. This is part of the NHS *Low Income Scheme* which offers full help with health costs. Migrants with no recourse to public funds may also be entitled to full or partial help through this scheme. People in receipt of JSA or ESA[2] can access these services free of charge: one medical practice said that most refugees attending their clinic received these benefits if not in work.

Maternity care (care for pregnant women, childbirth at hospital and postnatal care) can be accessed by asylum-seeking women. Failed asylum seekers may be charged for these services but NHS guidance states that "*maternity care is 'immediately necessary' and must not be withheld because the woman is unable to pay"* (Refugee Council, 2013).

2.iv. Number of refugees and asylum-seekers in Oxfordshire

In 2012 Refugee Resource attempted to estimate the number of refugees and asylum-seekers living in Oxfordshire. In the absence of census and administrative data, a community

[2] Jobseeker's Allowance (JSA); Employment and Support Allowance (ESA)

survey found that interviewees knew of 3,000, comprising 33 nationalities. Actual figures were expected to be much higher. Most lived in the areas of greatest deprivation including Barton, Rose Hill and Cowley.

Regarding unaccompanied asylum-seeking children (under 18 years old), the Children's Society Orientation Programme, which caters for all new arrivals in Oxfordshire aged 13-17 years, worked with 43 new unaccompanied arrivals from April 2015-March 2016. The previous year they worked with 32[3]. In June 2015, the total number of being supported by Social Services in Oxford was 95[4].

2.v Refugee Resource

Refugee Resource has provided therapeutic support to refugees and asylum-seekers in Oxfordshire since 1999, initially through counselling, and later through the phased additions of a women's social and educational group, mentoring, advice and advocacy, and finally a men's group. It extended its services to vulnerable migrants in 2015. It is well placed to support refugees, asylum-seekers and vulnerable migrants in accessing primary health care services (PHC) and this project enabled it to deepen its understanding of the experience of its client group in accessing primary health care, the challenges faced by PHC providers in meeting their needs appropriately, and what more can be done to improve clients' access to and experience of quality health care.

[3] These figures are assumed to represent the totality, or majority, of new arrivals in Oxford.
[4] Personal communication, Children's Society

2.vi OCCG equalities strategy

The OCCG Strategy for 2014/15-2018/19 makes a clear commitment to improving health and reducing health inequalities as part of its agenda for transformational change, and it sets out a plan for closing the gap for population groups who experience worse health outcomes (OCCG strategy for 2014/15-2018/19. p24-25).

The strategy aims to do this by supporting the delivery of targets set out in the Oxfordshire Joint Health and Wellbeing Strategy 2015-2019 (Oxfordshire Health and Well-being Board[5], June 2015). This makes clear the concern for targeting disadvantaged and vulnerable groups, and identifies ethnicity as a key factor in health inequality. Tackling social disadvantage is identified as one of three fundamental cross-cutting issues across their whole service: '*The aim here is to level up health and wellbeing across the county by targeting disadvantaged and vulnerable groups. This will vary from topic to topic but will include rural and urban disadvantaged communities, black and ethnic minority groups, and people with mental health problems…..*" One of the specific challenges identified is "*the persistence of small geographical areas of social disadvantage containing high levels of children's poverty, especially in Banbury and Oxford ….These are also the more culturally diverse in the country containing ethnic minority groups who have specific needs."*

The OCCG's equality objectives for 2016-2020 include *"Improve access, quality of experience and outcomes for our population by involving and listening to patients from all protected characteristic groups and other vulnerable groups whose voices may be 'seldom heard"* (OCCG, Jan 2016).

This study aims to support the work of the OCCG in listening to those voices and proposing ways of closing the gap for those experiencing worse health outcomes.

[5] The Board is made up of the OCCG, NHS England and OCC

3. Project aim and objectives

3.i Project aim

The over all aim of the project was to help address health inequalities in Oxford city by investigating the experiences of service users (refugees, asylum-seekers and vulnerable migrants) in accessing and using primary health care services, the experiences of primary health care providers in delivering services to this patient group, and making recommendations to improve access and ensure services are as appropriate as possible for patients from these groups.

3.ii Project objectives

- To support the joined up approach of Oxfordshire Clinical Commissioning Group, Oxfordshire County Council and NHS England to improve health and tackle health inequalities by identifying measures to improve access to appropriate PHC services for this client group
- To strengthen the work of Refugee Resource and other voluntary sector organisations, including Asylum Welcome, in sign-posting and supporting these clients to access appropriate PHC services
- To strengthen the voices of refugees, asylum-seekers and vulnerable migrants on policy-making platforms responsible for providing equitable PHC services

3.iii. Key questions guiding the study

i. How accessible are primary health care services – GPs, practice nurses, midwives, health visitors, dentists, pharmacists and opticians – to refugees, asylum-seekers and vulnerable migrants, and what are the barriers to access?

ii. How appropriate is the service provision for these service users, i.e. what is their experience of using these services, with particular reference to language, culture, religion, expectations, and their lived experience as migrants or refugees?

iii. What are the challenges faced by primary health care providers in delivering services to this patient group, what is currently being done to improve accessibility and appropriateness of PHC services, and what more could be done?

4. Methodology

The primary means of gathering information was through interviews, focus groups and the administration of questionnaires with the following three groups of respondents.

(i) **Service users**, i.e. asylum-seekers, refugees and vulnerable migrants. Through formal interviews, informal interviews over lunch or in office receptions, questionnaires and a focus group with the Refugee Resource Women's Group, we elicited the views of 41 service users. One recently arrived refugee family kept a diary of their experiences with health care services for one month. These service users were all clients of Refugee Resource, Asylum Welcome or Connections Floating Support. They were contacted as follows:

- *Refugee Resource clients (26):* 10 formal interviews - many of these people had also filled in questionnaires and/or attended the women's focus group session. An additional 7 women filled in questionnaires at the office reception. An additional 9 women joined the women's focus group.
- *Asylum Welcome clients* - 12 brief informal interviews over lunch or in the office reception
- *Connections Floating Support clients* – 3 formal interviews

The profile of these clients was:

- *Gender:* 27 women and 14 men
- *Age*: 34 were up to 50 years and 7 were over 50 years.
- *Country of origin:* Afghanistan, Syria, Iraq, Iran, DRC, Brazil, Algeria, Turkey, Sri Lanka, Albania, Egypt, Indonesia, Pakistan, Zimbabwe, Myanmar, Morocco, Sudan, Somalia and one unknown.

(ii) **Service providers** i.e. primary health care practitioners. We elicited the views, either by interview and/or questionnaire, of 12 individual HCPs (GPs, practice managers, practice nurse, midwife, dentist, social prescriber). We also received a questionnaire from a team of health visitors and had a roundtable discussion with GPs in one surgery. We did not interview pharmacists or opticians. Staff from the following 5 local health centres responded to our request for engagement with this study: Bury Knowle, Barton & Wood Farm; The Leys; Cowley Road; St Bartholomews; and Luther Street. Contact with health care practitioners was facilitated by the OCCG Equality and Access Manager who sent a short questionnaire to all 25 GP practices in Oxford city via their Locality Co-ordinators, and to Community Dental Services, Local Pharmacy Committee, City Practice Nurses, Head of Midwifery and a number of Health Visitors. The questionnaire asked two key questions and included an invitation to contact us if willing to contribute further via interview. We also directly approached GP surgery Practice Managers.

(iii) **Voluntary sector organisation staff and volunteers** who support refugees, asylum-seekers and migrants. This comprised the staff team, 4 mentors and 1 interpreter from Refugee Resource. Also staff and volunteers from Asylum Welcome, Connections Floating Support, Elmore, Emmaus, The Children's Society staff team and the Homeless Service Manager, Urban Village Medical Practice (NHS North Manchester CCG. We elicited their views either by interview or questionnaire.

Questionnaires were developed, piloted and sent out by email. A sample of the questionnaires used can be found in Appendix C. Face-to-face and phone interviews were semi-structured, primarily qualitative and guided by a schedule of questions. A consent form was signed by face-to-face client interviewees.

Significance and bias

This was a relatively small and primarily qualitative study. However, the consistency of responses across the range of service users, primary health care professionals and voluntary sector organisations who responded supports the validity of the findings. In addition, the findings are supported by considerable research that is already in the public domain.

It was difficult to locate HCP interviewees, partly because of their heavy workloads and time pressures. Those who did manage to respond appeared to be those with a particular concern about these issues, and were probably those with the highest numbers of refugees, asylum-seekers and migrant accessing their practices. We acknowledge that this self-selection means that the sample is likely to be biased in favour of those who are more concerned about and sympathetic to the plight of these patients, and who more proactively seek solutions to the challenges they face in accessing health care.

We also experienced some difficulty locating asylum seeker and refugee clients, some of whom may have been hesitant or distrustful of speaking to interviewers they did not know. Those that we did interview were all in contact with a voluntary sector organisation – Refugee Resource, Asylum Welcome or Connections Floating Support – and so were all 'linked into the system' in some way. It is important to note that we therefore did not reach refugees, asylum-seekers and migrants living 'beyond the system' with no support structures, those living destitute, and only a few recent arrivals to Oxford. The latter would face considerably greater barriers to accessing services than those we interviewed.

Confidentiality

In order to protect the confidentiality of respondents, the report does not identify the country of origin of service users where individual views or quotes are given, nor the practice to which health care professionals are attached.

5. Findings

This section presents our findings on the barriers to accessing quality and appropriate primary health care, the ways in which health care professionals are trying to overcome these barriers, and the suggestions of respondents for improving services. Each section draws on the responses of service users, service providers and voluntary sector organisations.

5.1. Access to services

5.1.i Awareness of entitlements to primary health care services

Despite the availability of information on entitlement to primary health care services for refugees, asylum-seekers and migrants, and information available on various websites, there remains considerable lack of clarity amongst providers regarding entitlements, and the documentation required to register with GP practices. HCPs found that changes in legislation mean that it takes considerable dedication to locate the information and keep up-to-date with the latest regulations on entitlements:

"It is difficult to find out what they are entitled to, as there is confusion for professionals and clients. What they are entitled to changes often and is different dependent on which country they are from."

Sometimes staff in GP surgeries thought patients were not eligible for *primary* health care services, when in fact the guidelines are clear that they can be accessed freely by all regardless of immigration status[6].

"*This group is often not eligible to public funds and in theory is only able to access emergency care. Therefore mothers have to pay for Midwifery care."*

"Every year we have some example of someone being denied registration despite the practice being under contract to provide universal ante-natal care through to delivery"….. "A patient was de-registered from our surgery because her visa had expired. This was half way through her pregnancy. I had to insist that she stay on the system as a temporary patient so she could continue to access antenatal care." Another example given by this HCP was a woman who had been trafficked being de-registered. She believed these decisions were mainly financially driven.

One HCP thought some practices avoided registering refugees and asylum-seekers with no papers because of the time, workload and bureaucracy involved in supporting these patients given their already over-stretched services.

Other practices do their best to facilitate care for patients whatever their circumstances:

"We take a lenient approach, we realise people may have difficulties providing documents so we take a humanitarian approach to this."

"We are GPs, not immigration officers"

Most clients we spoke to were relatively clear about their entitlements to primary health care, though most had been in the UK for long enough that they would have worked through the process by the time we spoke to them. For some this took a long time eg one man who said *"I paid for my dental treatment for years until my wife was pregnant and I found out about these benefits."* Asylum Welcome provide good guidance on entitlements to health care. Clients also appear to have found out how to register with a GP with relative ease. They mentioned being supported by Asylum Welcome (helped with HC2 forms), a midwife (helped with child vaccinations), a women's refuge support worker, and a nursery/school.

Health visitors also pointed out the importance of mothers understanding their entitlements to child development support, which can be particularly important for these children who may come from countries where play is not prioritised.

5.1.ii Access to GPs

Registering with a GP surgery

[6] This is not true of *secondary* health care.

Many of the clients had managed to register with a GP without much trouble. However, this was not always true. Some encountered problems when they were asked for documentation they could not provide, usually identification, proof of address and sometimes immigration status. One was also asked for proof of income as well as identity, found that a letter from the Home Office did not suffice, but a document showing his benefits finally enabled him to register.

The NHS England guidance is clear that inability to prove identity, address or immigration status does not constitute reasonable ground for refusal. Several surgeries clearly stated that they do not demand proof of ID in order to register patients. However, some mentioned it was more difficult when patients were unable to provide an address. Surgeries find ways around this problem: a dentist mentioned the Department of Health has a 'false postcode' for the homeless; other clients give the address of a voluntary sector organisation. If the patient has no ID, one practice said it registered them as temporary patients.

Support workers told us that vulnerably housed and homeless refugees and asylum-seekers often face difficulties accessing GPs because of lack of a stable address. This can be a particular problem for this group who may need them as the gateway to mental health support. Some find their way to Luther Street Medical Practice, but others need alternatives to this as *"many clients are scared to go because of the rough sleepers that frequent it."*

Some clients had decided to register only when they had an urgent health problem, sometimes because they did not know which practice to register with. One said "*I'm not sick. I'll go to the GP when I'm sick.*" Another said the same about registering with a dentist.

Language was clearly a barrier to registration for some. For example, a patient being told *"you cannot register if you don't speak English as you won't be able to fill out the form,"* as opposed to being offered support to do so via Language Line or other means. Phone interpretation (used during GP consultations) is not available at the reception desk. Several HCPs and patients mentioned how helpful it was for them to be accompanied by a Support Worker, at least for the first few sessions, particularly if language was a barrier. Examples of this were workers (some voluntary) from Asylum Welcome, Connections Floating Support, the women's refuge, and social workers who accompanied young people. Help from these support workers is needed particularly during registration, especially with form-filling if they speak little English, and first appointments, but some need that continued accompaniment for much longer.

The OCCG has a produced a card which, we understand, patients with no English can bring with them to the surgery requesting Language Line phone interpreting support, although we could not find evidence of its use (see section 5.2.ii).

Another barrier is that some refugees and asylum-seekers are suspicious of authority figures (which GPs may be perceived as), because of experiences they may have undergone, find it difficult to trust others, and may therefore be anxious about filling in questionnaires and registration forms.

When a patient moves out of the area where they are registered with a GP, they are generally advised to re-register with a GP in the area they move to. This is so that GPs don't have to travel far to do home visits, and to facilitate liaison with health visitor teams. Some surgery staff and patients reported patients being very unhappy about this, as they have built up a trusting relationship with a GP which is very important to them. Practices acknowledged this patient discomfort and made decisions on a case by case basis as a result. This can be a particular issue for refugees and asylum-seekers who tend to move house often.

A voluntary sector organisation told us they felt that very few refugees and asylum-seekers are not registered with any GP. Those that are not registered – perhaps because of problems related to mental illness, bad experiences with GPs, or feeling that 10 minutes consultations are too short - were reported to access care at A&E.

Making appointments with the GP

Most clients said they managed to make appointments without much difficulty. But difficulties can occur where there is a language barrier.

"*The main challenge for the client is…..in making a booking because of the language barrier. The access to the service is very good and simple. But not speaking English makes it very difficult to book an appointment." (*Interpreter).

A few clients had had bad experiences with receptionists who they perceived as being 'rude' or 'aggressive'. Sometimes they were embarrassed when receptionists asked about their health issues in the public area of the reception.

Patients were not always aware they have the right to choose their GP, and the gender of their GP.

If the service user is able to bring their own support worker or interpreter with them, this can facilitate the process greatly: "*Sometimes I do help the clients book appointments and give them information on different subjects but still they have to learn the language if they want to adapt to the society.*" (Interpreter)

Unaccompanied asylum-seeking children face specific challenges. They may lead rather chaotic lives making it hard to remember to keep appointments. Those in further education can miss significant college time due to the many appointments they have to attend (Home

Office, legal, health etc). Offering them appointments at the end of the college day would benefit their continuity of their studies.

Waiting times

A few clients complained about having to wait 2-3 weeks to see the GP they wanted. But this is common across the NHS for any patient. On the whole though, many clients were very impressed with GPs who called them back at home quickly. Women also say children are seen quickly.

5.1.iii Access to dentists

Most clients said they were able to register with a dental surgery with little problem. Two people said they did not know where to find a dentist and would wait until a dental problem occurred to register. Some sought help from Asylum Welcome with this. Those who are homeless can access the dental surgery at Luther Street Medical Centre.

A support worker noted how asylum-seekers have to 'prove their right' to free dentistry (and free prescriptions). Dental treatment is a chargeable service on the NHS, although those on low incomes can apply for financial assistance. The HC2 form entitles asylum-seekers to dental care. However, in practice, this can take up to 8 weeks to arrive. There therefore appears to be a potential 'problem period' between arrival in the UK and receipt of HC2 form when some asylum-seekers cannot access dental treatment. For example, one asylum-seeker felt he had to pull his own infected tooth out as he could not afford a private extraction at £200 and had not yet received his HC2 form.

The dentist we spoke to noted that if there is doubt about a patient's entitlements to dental care they may have to charge them and have the patient reclaim the cost later with an exemption certificate, but *"we would not refuse treatment to someone who was in acute pain"*.

5.2. Quality of service

The following sections relate to *all* primary health care services (not just those of GPs).

5.2.i. Quality of care overall

Most refugees, asylum-seekers and vulnerable migrants we interviewed reported positive experiences with primary health care professionals. Many were full of praise for them, both in terms of treatment received, and the understanding, compassion and sensitivity with

which they were treated. HCPs were described as *'kind', 'they really listened', 'caring', 'tried to find creative solutions if I couldn't understand'*.

"Many asylum-seekers have incredibly supportive and understanding GPs." (support worker)

"Where clients have been in crisis, it has never been a problem to get an emergency appointment with a GP if they are registered." (voluntary sector organisation).

One GP practice has recently been collecting feedback from voluntary sector organisations on its impact on their refugee and asylum-seeker clients so as to improve its service to this patient group.

However, a few patients had not always felt well treated and had been quite distressed by their experiences. Incidents were mentioned where the patient felt they had not been listened to, had not been treated with respect, courtesy and patience, where their concerns had been dismissed uncaringly with lack of interest from the GP, or that their health issue had not been adequately addressed. In one case the patient felt that the GP concerned was not interested in his welfare, due to the very delayed diagnoses and referrals on to specialist services, which resulted in a deteriorating health condition. Several clients mentioned stressful and upsetting encounters with reception staff who were sometimes described as 'aggressive' and 'rude', and sometimes felt to 'block' their registration. It appeared that these incidences were often triggered by difficulties in communication (language), or lack of understanding on the part of both HCPs and patients about entitlements to care.

Interpreters, mentors and staff from voluntary sector organisations involved in supporting patients with health appointments concurred with the above analysis of primarily excellent care with a few exceptions. These support workers do a great deal of invaluable work themselves to sign post clients to appropriate services and/or accompany them to surgeries to register or attend appointments. They emphasised the need for HCPs to show understanding, patience, and respect because of the diversity of countries of origins and experiences of these patients. They also noted that the language used by HCPs is sometimes too technical for patients to understand and urged the use of more 'lay' language – one interpreter said she also struggled to find the right technical words sometimes.

There were several suggestions for offering HCPs training on working with refugees and asylum-seekers so that they could better understand the needs and circumstances of this group. Refugee Resource offers occasional such one day courses eg. the *Working with refugees and asylum-seekers'* course run as part of the Oxford Cooperative Training Scheme. This addresses the experience of asylum seekers and refugees before and after coming to the UK, including working with people from other cultures who have been traumatised by war and other major catastrophes; the mental health of refugees and asylum seekers and responding appropriately to their distress; and local services available to support them. Refugee Resource also gives training in working with interpreters, working cross-culturally, and communicating when the patient hardly speaks any English and there is no interpreter.

One interpreter noted the need to help HCPs understand about cultural constraints on women, eg not being able to talk openly with male GPs about any health issue. She also noted that psychosomatic symptoms can arise from the experience of being separated from family, community and home, and perhaps fearing for the safety of children and family left behind in conflict zones, which can lead to emotional distress and which can be particularly difficult to bear during periods of religious observance such as Ramadan.

A number of publications to support HCPS on working with migrants exist. See Appendix D.

The HCPs who were interviewed or responded to the questionnaires were, without exception, absolutely committed to delivering an equitable service for this patient group, and doing all they could to provide an exemplary service. It was evident that there was an enormous willingness and energy to engage with refugee and asylum seeker patients and the particular issues and challenges they can present with, and that many HCPs work hard to find effective ways to communicate with them and provide the most effective treatment. They provided many examples of initiatives they are taking to do so. Nevertheless, they mentioned gaps and issues that need to be addressed as outlined in the following sections.

5.2.ii Language barriers and means of communication

Some practices receive patients from an increasingly high number of different language groups eg St Bartholomews have registered patients from 160 countries; the Cowley Road Medical Practice registered new patients from 33 countries in the month of February 2016. From the patient point of view, there was a mixed picture with regards to the barrier that language presents for those with little or no English: some felt they managed sufficiently well,

others found it more challenging. Support workers, interpreters and mentors all said that the language barrier is a significant issue in accessing good health care.

For health care professionals, communication problems and lack of appropriate interpretation can mean that health problems do not get quickly diagnosed. This can lead to frustration for patients and extra time for GPs because of repeated visits by anxious patients. One GP noted that "*language barriers lead to longer consultations, and increased risk of misunderstanding the system, prescriptions and health promotion advice.*" However, a significant challenge for GPs in using interpreters is their lack of time with each patient.

A variety of creative ways round communication barriers are found, but overall it is a significant issue for the refugee, asylum-seeker and migrant community. The following are the means of communication used by those who speak little or no English.

Informal mechanisms tend to be used in the first instance, for example, relying on family or friends to interpret. This can work well for registration but compromises communication with HCPs, particularly if children are involved in interpreting, and particularly for discussing very personal, or sensitive, issues such as mental health. Some women used their husbands to interpret for them, which can often result in the husband's opinion being expressed rather than the translated opinions of his wife. One HCP gave the example of a young woman who was brought to see the GP by her uncle who interpreted for her. His niece had no English and he answered all the GP's questions without asking her. The GP did subsequently arrange for an interpreter.

Support workers from voluntary sector organisations (often volunteers, and often not speaking the language of their client) said there is an over-reliance on them to help with communication by GP surgeries. Some described language as a '*major problem'* for their clients and called for professional interpreters to be offered more readily. For example, a mentor who spoke one of the same languages as her client (not the client's first or second language) was used repeatedly to interpret *'as best I could'* in both primary and secondary care settings, including being asked to attend with the woman when she went for scans. This was because phone interpreting was either not available or of poor quality. At a sexual health clinic appointment the mentor was initially, and appropriately, asked to leave the room but did become involved assisting with subsequent discussions. One GP echoed the difficult position these support workers often find themselves in by saying that while appreciating their support enormously it would be even better if they spoke the patient's language. Some voluntary sector organisations felt there was an over-reliance on their support workers by HCPs instead of bringing in professional interpreting support: "*Support workers are there to support our clients, not as an 'add-on' to PHC services."*

Bi-lingual/multi-lingual HCPs. A few GPs in the surgeries we spoke to were able to work in other languages: Arabic, Urdu, Punjabi, Hindi and French. This is a valuable resource, but it needs to be managed carefully so that these staff do not become heavily

over-booked by patients from their language group. Better provision of interpreters (phone and/or face-to-face) would help to reduce the pressure on GPs who can work in other languages.

Professional interpreting can be really critical in some instances eg one voluntary sector organisation notes that refugees and asylum-seekers tend to take medication eg anti-depressants and anti-biotics, randomly because they have not understood the correct regime.

Telephone interpreting (Language Line): Many patients accept the offer of this for communicating with an HCP. However, some patients had not been offered this service, and were not aware of it, when it could have helped them. On the whole patients seemed fairly satisfied with this service. However, there were exceptions: one patient who reported poor and inaccurate interpreting; another said the interpreter did not give enough time for the patient to respond; a GP reported that the service is '*not always satisfactory*'; and a young Muslim woman patient who, when finding herself connected by phone to a male interpreter, and feeling unable to talk to a man about her health issues and unable to explain her discomfort to the GP, simply left the surgery with her health problems unresolved. This highlights the need for HCPs to be aware of the cultural sensitivities around the gender of interpreters, particularly for female patients, to offer choice wherever possible, and always to book a female interpreter for antenatal care. Others described it as an impersonal system for discussing sensitive medical issues with the GP – this was less of an issue with dentists and opticians.

The NHS Oxfordshire has produced cards for patients requiring Language Line interpreting support, on which they can indicate their language needs, and then present these to reception at GP surgeries[7] (see below for an approximation of the card). Although they have been disseminated to local medical practices, within communities and voluntary sector organisations, no-one we asked – neither service user, service provider nor voluntary organisation – knew of these. GP practices and voluntary organisations may need reminding of their existence and of their potential usefulness.

[7] The official card can be found in the NHS OCCG leaflet 'Your Health' http://www.oxfordshireccg.nhs.uk/wp-content/uploads/2013/03/English-migrant-leafletfinal-2.pdf

NHS	***Language Line Solutions***
My preferred language is ……..	
But I also speak .....…and need an interpreter to help me communicate with you.	
Please call Language Line on:	
0845 603 7915	

From the HCP point of view, while phone interpreting is often helpful, it can be too cumbersome and slow to be feasible in the time allowed. The process of calling into the interpreting service, being connected to an appropriate interpreter, and then having the three-way conversation whilst examining the patient, is said to be extremely difficult to achieve in a 10 minute appointment: *"a huge disincentive for booking an interpreter*" (GP). See below for the need for longer appointment times for these patients.

Face-to-face interpreting is very rarely used in primary health care. The reason is that it needs to be booked in advance, interpreters may need to travel to Oxford from London, depending on language and dialect, and since patients do not always attend appointments there is a high risk of wasted funds, and is not always realistic for a 10 minute appointment. Although one GP said "*face-to-face interpreting is better but it puts the cost up so we rarely book it"*, the interpreting budget is held by the OCCG rather than GP surgeries, so cost to the surgery should not be a factor blocking use of this service. Several GPs said that the presence of a face-to-face interpreter for an initial longer appointment with refugees or asylum-seekers, who often arrive with complicated and distressing emotional and physical health problems, would be extremely helpful.

Only one client reported using a face-to-face interpreter in a primary care setting. This was during a home visit from a Health Visitor and the experience was poor. The interpreter *"said something different from what I said; the interpreter talked to the Health Visitor about me rudely and was laughing. I could understand, but I couldn't explain."* Others mentioned that lack of trust in interpreters was an issue for some clients.

The Children's Society[8] funded face-to-face interpreters for PHC sessions for clients supported through the therapeutic service on occasion, when really needed, because although clients whose first language is not English try very hard to present well in English,

[8] The Children's Society closed their office and services in Oxford in August 2016

they often don't understand the complex medical vocabulary. They were able to build on existing interpreting relationships developed through family therapeutic work and this made discussing sensitive issues easier for the client.

An additional issue raised by two interpreters who have worked in PHC settings is the challenge for interpreters that what is needed to achieve good communication between patient and HCP is often not just interpretation but also a facilitation to help each understand the perspective of the other. While this role is beyond the official remit of the interpreter, these two interpreters clearly felt that, particularly for this client group, an over-stepping of their official 'interpreting' boundary was warranted and necessary:

"*My job as an interpreter is to ensure the client understands everything that she is told. My job is not only translating [the words] but interpreting [what they mean] as well. So if the client leaves happy and satisfied then I think that it was a good session."*

"*I have to tell the doctor about other things too - the preventive medicines she takes and the treatment she has had - because she doesn't know what the doctor needs to know."*

Other creative solutions: If none of the above forms of communication are available, patients reported working with HCPs to come up with creative solutions such as using Google translate (eg. dentists, a nurse, a hospital receptionist); women phoning their husbands during the appointment to interpret for them; using hand signals; or GPs writing down notes for women to take home with them. One interpreter uses Whatsapp to translate messages for her client who then takes the translation to her optician. One midwife brings translated pages from the NHS Choices website up on her screen for patients to read (detailed pregnancy and labour information) and then writes the weblink on a note for the woman to take home. Appreciation was expressed about many HCPs being willing to come up with these creative solutions.

The longer-term issue of the need to increase support to non-English speakers to learn English was also highlighted.

5.2.iii. GP services

Patients' choice of GP

The fact that patients can request the gender of their GP does not always appear to be clear to patients. One Muslim woman was to be seen by a male doctor for an internal examination which was not culturally appropriate for her. She was subsequently seen by a woman, but ideally this issue would have been anticipated.

Length of GP appointments

One of the most significant issues that this study found, and that needs to be addressed, is the difficulty posed for GPs and this patient group of the 10-minute appointment slot.

Many service users felt that 10 minutes was too short to be able to discuss what they needed to with GPs, to understand the diagnosis properly, or for the GPs to fully understand their health issues. In addition, there was frustration that they were often told they could only raise one health issue per appointment. Some women said this was so even if they booked a double appointment. This is likely to be a particular problem for new arrivals who may present with multiple health concerns.

GPs echoed the concerns about not having enough time with these patients who frequently present with multiple complex problems:

"*They often present with a life-time of problems and it is very difficult for this to be unpicked in a normal consultation lasting 10 minutes."*

"I always go over-time with them, usually appointments run to 20-30 minutes. They have multiple problems, of all sorts, not just medical. They never come in with one problem."

GPs spoke about the high level of physical and psychological needs of this group related to both their experience of having had to flee their home country, and the process of adjusting to a new culture and environment in the UK. They often come from countries embroiled in conflict and present with horrific experiences and trauma as a result of war, exile, separation from families and bereavement. Because of the poor state of health services and levels of poverty in many countries of origin, they can also present with long term physical and mental health conditions which have been poorly managed or gone untreated.

If unused to a culture of preventive health care, they may not be used to accessing healthcare when they feel well and may present late when very unwell. Mistrust in authorities and fear of information being passed on to the government may mean they are reluctant to share relevant information. If the patient has little or no English, all of these factors will need to be communicated, at best, through a phone interpreter.

This means that one of the major challenges for GPs in caring for these patients is time; and their primary need is longer appointment times to enable them to understand the complexity of the patient's situation and to be able to make a full assessment. Already some GPs spend a lot more time in initial and follow up consultations with these patients, offering double appointments for complex cases. Some GPs proposed the return of the **Locally Enhanced Service** (LES) model whereby GP surgeries would be funded to provide extended appointments for those patients who are particularly vulnerable. Other GPs endorsed this suggestion. The LES model came into existence during the Kosovo war (1998-9) when a few practices in Oxford received very high numbers of new registrations from

Kosovans who had fled the war. When then crisis was over the LES ceased to exist but the numbers of refugees and asylum-seekers have remained high[9].

GPs said that what would enable them to give the care and attention needed to properly support this patient group is to be able to offer extended appointments for initial consultations (20-40 minutes was suggested) and on-going extended appointments in complex cases and where interpreters were used.
"Such a service would enable us to spend more time being proactive in their health management (review, assess, examine patient) and would provide opportunity for longer appointments."

In addition, LES would facilitate more comprehensive new patient health checks including checks for infectious diseases, mental health, nutrition, cervical screening and immunisations (children). Nurses could do much of this assessment with GPs doing the mental health checks. PRAXIS (London) and The Haven (Bristol – see section 5.3.) provide a good model for this full initial health consultation. Those who have been through FGM are referred to the Rose Clinic in the John Radcliffe Hospital – the Somali community in Oxford are a particular cause for concern in this regard.

An additional issue mentioned by some GPs is a concern about the lack of an appropriate, specialised service to refer patients on to for support with managing the psychological impact of trauma resulting from war, torture and displacement. In the light of this, more awareness-raising about the therapeutic counselling service offered by Refugee Resource could be done amongst health professionals.

5.2.iv Dentists, midwives, nurses, health visitors, opticians and pharmacists

The information we collected about service users' experiences of visits to health visitors, nurses, midwives, dentists, opticians and pharmacists was rather anecdotal, as our focus was on GPs. However, the few responses we received were from people who indicated they had received good care.

Midwives and Health Visitors:

"The midwife was very helpful and the health visitor came to my house. It was very useful as she gave me training about breastfeeding. I didn't have experience, the advice and information was useful."

Nurses: *"The nurse who tried to do the blood test was very good, she was very understanding. She tried to understand me, she spoke slowly and used google translate, she really tried to help me."*

[9] Source: OCCG

Opticians: One optician was praised by a migrant who referred him to a GP where a serious eye problem requiring medical attention was identified. Another identified initial concerns in relation to a refugee child who was subsequently admitted to hospital with a serious illness.

Dentists: The issue of lack of understanding about preventive dental care has already been mentioned. The prohibitive cost of dental care, for those unable to claim for chargeable NHS services, was also mentioned eg. one woman finding a treatment at £50 was more than she could afford. In addition, as previously mentioned, there seems to be an issue of asylum-seekers not having access to dental treatment in the period between arrival and receiving their HC2 form.

5.2.v Patient expectations about primary health care services

The views of refugees, asylum-seekers and vulnerable migrants

This group inevitably tend to judge the quality of primary health care they receive in the UK according to their experiences of health care in their home country. For those who come from countries where access to good health care has been very restricted, clients expressed enormous relief and gratitude for the medical attention they have received in this country. For others, the NHS sometimes falls short of their expectations in the following areas:

- **Less medication, particularly antibiotics**, being prescribed than expected
  "I was just sent home with painkillers".
  "Why could they not at least have prescribed me antibiotics?"
  Some had come to understand and appreciate the NHS protocol on limiting the use of antibiotics. Some acknowledged the over-prescription of antibiotics in their home countries, particularly in fee paying systems. Others were not so clear about the rationale for limiting the use of antibiotics which indicates the need for targeting awareness-raising to this patient group.

- **Slower referrals to specialists** than expected: *"I was just sent home with painkillers and told to come back in 2 weeks. Why didn't they refer me straight away?"*
  Several people echoed this feeling. Others were frustrated they had to go through the GP to access specialists as they did not understand or accept the role of GPs as gate-keeper to these services. However, one woman who said the GP did not refer quickly enough, followed on by saying she recognised she would have to learn the new system "*and you have to change your ideas and imagination."*

- **Preventive health care** being promoted by GPs, dentists and other HCPs. This was clearly not the practice in all home countries. One common example mentioned

was Syrians being advised by HCPs to cut down on sugar intake. Another example was a Syrian man who was very upset with his dentist telling him to brush his teeth and cut down on sugar: he did not see such advice as the role of a dentist, and he left the practice as a result. GPs echoed the difficulties for patients who lacked a culture of preventive healthcare and an understanding of the risks of not looking after their own health eg. diet, risk of diabetes, misuse of alcohol. This indicates a need to target preventive health care messaging toward this client group.

In addition, sexual health and contraception was mentioned as an area where there was a lack of preventive healthcare understanding in this patient group. "*There is a lack of understanding and knowledge of women's health, sexual health and contraception. This leads to the use of termination as contraception, and not accessing the midwife until late in pregnancy. They do not use the GP appropriately and will go straight to the Emergency Department" (comment from an HCP).* One respondent became pregnant by accident as she did not know about sexual health and contraception having never been exposed to such discussions in her home country and having felt ashamed to discuss it with anyone. She did not know why her periods had stopped until a nurse suggested a pregnancy test. A GP commented that many newly arrived women don't understand the need for contraception and get pregnant quickly on arrival, and that awareness-raising about contraception was needed with this group.

- **Longer appointment times with GPs.** Many clients mentioned that 10 minutes felt too short an appointment to explain their medical problems, even more so when there were language difficulties or other misunderstandings.

Other less commonly mentioned expectations:

- Weekend treatment from GPs. One person expected this, but subsequently found the emergency out-of-hours service at Manzil Way.
- Quicker appointments with GPs: one man felt 3 days was a long wait.
- Having the same GP or dentist at each appointment. Several female patients mentioned this in relation to their GP, and one man in relation to his dentist, although they subsequently learnt that they could see their own GP/dentist if they were prepared to wait. For patients who present with complex issues, distressing life histories and issues of trust, continuity of health care staff (and interpreters) is particularly important so that they do not have to continually repeat their stories.

The views of health care professionals

GPs noted that this client group can have unrealistically high expectations of what the NHS can offer, e.g. the speed of referrals. One said:

"I have had situations where our health and social care system has not been rapid enough or generous enough in its response to a situation, in the view of the service user."

These expectations are often fed by patients not understanding how the primary health care system works, nor the role of GP as 'gatekeeper' to specialist services.

There are additional expectations and pressures on GPs, and presumably other HCPs, who speak the same language/s as patients, and/or are seen by patients to share the same cultural background. This can lead to higher expectations of them from patients and an increase in patients from those same groups wanting to register with them. Even if the HCP is not fluent in the patient's language and does not share the same cultural or country background, patients nevertheless often assume a special affinity exists and that the HCP will give them extra help: *"Patients expect me to fully understand them and to assist them with all sorts of things (as well as medical). They assume I will definitely go the extra mile for them."*

In addition, patients may have different health belief systems and no culture of preventive medicine (see above).

Case study of a refugee family's experience of primary health care in Oxford

The following is extracted from a diary kept by the mother of a newly-arrived asylum-seeking family during the month of April 2016. The family arrived in the UK in November. The mother was asked to record the family's interactions with primary health care services for the whole month. The issues that arose illustrate many of those raised in interviews and questionnaires in this study: language barriers as they relate to entitlements, registration, consultations and expectations. The following are translated extracts from the diary.

Entitlements and language: *"The first week my son went to book an appointment to see the GP. Unfortunately with his poor English, he could not get appointment with the GP. The receptionist told him that he could not see the doctor unless it was an emergency. A few days later he went to the optician. They asked him for £20 to get checked. That time he was with a friend from school who speaks English. His friend advised him that he could ask the Job Centre to provide a letter to the optician so he could get a free check and glasses. So he asked and they gave him a form to fill. He went to Asylum Welcome to fill the form as he couldn't because of his poor English."*

Consultations, expectations and language*: *"In the first week of April I received a letter to go to the JR hospital for a test . I had to be there by 8.15am and I knew I had to be there by the time, so I went out early with my son, about 7am. We made it early to the hospital. However when we arrived we couldn't get the correct department, we didn't know the direction inside that big hospital and we didn't know who to ask, and how to ask in English. We walked a lot in the hospital halls and lobbies before we found the department. We arrived there at 8.20am and I was afraid that I miss the test, but fortunately it was fine. I entered the room and the female doctor who carried out the test was talking a lot. I was saying "No English, no English". No interpreter was provided and I went out the room with no understanding of what she talking about. We, myself and my son, didn't know what to do next, so we waited in the waiting area expecting someone would show up with interpreter explaining to us anything. After half an hour waiting someone from the reception approached us, using google translation, he told us that we could leave and the hospital would contact us about the result."*

(* Despite this example being about secondary care, it still illustrates the confusion that some patients can feel in primary care when language barriers prevent them from understanding what is happening).

Registration and language: *"Recently my husband went to the same GP surgery where we have been registered since we arrived UK in November 2015. The same female receptionist who used to give us a hard time accessing the GP to get appointments was arguing with my husband that he had to register in different GP surgery, saying that the family had moved and need to register with the closest GP etc. My husband, who knows few English, insisted that he didn't want to change the GP surgery and want medical care to treat the infection. Finally she accepted to register him and book an appointment for him in a week. He went to the first appointment and they asked him to go for a second appointment when he underwent a small procedure I consider two appointments in two weeks is an improvement, as usually it takes really long time to get a follow up appointment."*

(NB. The family had recently moved out of the catchment where they were originally registered with a GP. By early May they were still looking for a new GP surgery in their area with whom to register and planned to ask Asylum Welcome for help with this).

The mother's conclusion: *"I wish if the medical staff, including the receptionist of the GP surgery, treated us better than this. They note that we are strangers and have no English but they don't really bother to do more efforts to understand us, while we do a lot of efforts to communicate with them. Also here were need to go through lot of procedures and have also to wait to have access to medical tests and then the results of this tests. Between these waiting periods we really don't know what our medical condition is, or what we need to do to take care of our health, or get rid of the pain."*

Lessons from the case-study

This case-study of only one month's contact with the health service illustrates many of the challenges patients may face when they are newly arrived in the UK with little or no English: problems accessing a GP (despite the patient being in pain); not understanding the need to register with a GP practice in your new catchment area when you move house; not understanding entitlements to opticians; difficulty filling in the form to register with the optician; not understanding the doctor's diagnosis or what is going to happen next; having different expectations of the NHS than what is actually offered ie going through more procedures and testing than they are used to, and then having to wait longer for results; and no interpretation being offered at any stage. It illustrates the efforts that are made by the patients to work within the system but, despite their best efforts, ending up bewildered by the system, not knowing how to keep themselves well, and feeling badly treated.

The importance of the support Asylum Welcome was able to provide with filling in registration forms and advising on where to register with a GP was clear.

It also illustrates the challenges for GP surgery reception staff when working with patients with little or no English: what to do when the patient wants to book an appointment but speaks no English and there are registration issues; how to handle patients who want to stay with the practice but have moved to a new address outside the catchment area. It highlights the reception desk as a site of friction around registration and entitlements for both staff and patients, since NHS-funded interpretation is not available at that point. But it should also be noted that some staff had clearly made special efforts and compromises to try to support these patients, eg. the GP receptionist relenting on registration despite the patient having moved house; and hospital staff trying their best to communicate through google translate.

5.2.vi Orientation and support for patients to access PHC services

As we have seen in previous sections, newly arrived refugees, asylum-seekers and migrants often do not know how the PHC system functions, what to expect of it, or what kind of services they are entitled to.

- They may be fearful of what will happen to information they provide, and what medical treatments they will be given.
- Misunderstandings easily occur as the following examples illustrate:
  - One GP told a patient that her children under 5 years old would need to see the health visitor. The patient had no knowledge of the role of a health visitor and become worried that her children might be taken away. Fortunately the GP realised this and was able to explain the HV role.
  - One patient needed to have blood taken for a test, but was reluctant, not understanding why he needed the test. A support worker ascertained that he feared contamination, which was a risk in his home country, and was then able to explain the precautions taken in the UK to ensure this did not happen.
- They may simply not know that they can ask for a female GP, an interpreter, a double appointment, or a chaperone to accompany them.

Targeted efforts to orient and support these patients are therefore important. Several initiatives were mentioned: some GPs talked about particular efforts they make to explain to this patient group how services function and to take into account their specific needs and concerns. One noted that these patients are "*often very suspicious of authority figures like doctors, and nervous about having to fill in questionnaires and registration forms".* Because of this, and the fear sometimes of institutions and that information given in health consultations might be '*passed on to the State',* this GP said: *"We are very overt in explaining our systems and that we are separate from the state and do not share information.*"

Some local surgery websites indicate the different languages spoken by GPs. There is also a considerable amount of translated information about the NHS on various websites (see *Appendix E*). However, despite the availability of relevant translated information, there seems to be little awareness amongst service providers or service users about their existence. It seems that a strategy to promote awareness of them is needed.

Several HCPs suggested that an orientation course on how to use the primary health system works could be set up specifically for this patient group, including follow up support to solve any problems once patients have started using the health system. Such sessions could be organised by a voluntary sector organisation such as Refugee Resource or Asylum Welcome if funded to do so (the Refugee Resource women's group already has a good model of educational sessions which sometimes address health issues). But in the spirit of the 'shared care' model, HCPs and administrative staff could also attend and provide orientation if funded to do so.

There are various statutory teams and voluntary organisations with a remit for outreach work into disadvantaged communities in Oxford that could possibly support such initiatives, including the OCCG Equality and Access team, social prescribers, care navigators, the Oxford Migrant Health Initiative and volunteer community Health Champions. *Appendix F* contains further information on these.

Support workers

In addition, there are support workers in voluntary sector organisations who provide assistance to individual vulnerable clients. These people, whether paid or voluntary, play an

incredibly helpful role in helping patients to access services, including health services, and assisting with mutual understanding and communication.

"Having a support worker makes the whole thing much easier." (GP)

"I have had a consult with a refugee recently and he was accompanied to the surgery by a support worker. This was very helpful to both myself and the patient." (GP)

Clients talked about the orientation and help in accessing PHC services that they had received from support workers in Asylum Welcome, Connection Floating Support, the Women's Refuge and Refugee Resource mentors. Asylum Welcome offers assistance with registering with a doctor, liaising with hospitals and clinics, and completing forms for free medical care. Together with Connection Floating Support they deliver the Syrian Resettlement contract.

Unaccompanied minors may be accompanied by social workers (occasionally), key workers for those in semi-independent accommodation or children's homes, or foster carers. Post 18, when leaving care, can be a time of vulnerability when social workers are not always available for support – the Children's Society will sometimes to step in to accompany them in this case. It was noted that support workers can play a more useful role still if the HCP asks the minor to give permission for them to share medical information with the support worker.

The value of these support worker posts in helping to reduce health inequalities needs to be recognised and funding granted or continued wherever possible, eg on a sessional basis according to need.

There are also many small community groups in Oxford that are formed around ethnic identity, which have in-depth knowledge, experience and social networks that could be an invaluable resource in developing strategies to improve access to primary health care for their respective ethnic or language group. Examples were given where individuals in a community provided valuable help to community members. The Asian Women's Group have been engaged in valuable research to study the access to GPs, mental health services and domiciliary care of Asian women in Oxford with the support of Healthwatch Oxfordshire (Shafique, 2014).

The above examples of statutory and voluntary sector teams, roles and initiatives demonstrate that there are many resources that exist in the statutory, voluntary and community sectors that could be drawn on to reach out to refugees, asylum-seekers and vulnerable migrants and improve their access to and experience of primary health care services. These need to be promoted more widely to HCPs and patients alike and also need to be used more effectively.

5.2.vii Information sharing and cross referrals with other services

When Support Workers from voluntary sector organisations are able to accompany refugees and asylum-seekers to appointments, particularly the initial visit to a GP, it makes a great difference to both patients and providers. It greatly assists GPs in communicating with, assessing and treating the patient (medications, scheduling further appointments, support plans etc). Syrians who have arrived in Oxford recently via the '*Vulnerable Persons Relocation Scheme'* (2015) which resettles vulnerable Syrians living in refugee camps, have access to this support.

In addition, the information provided to GPs when these Syrian refugees are referred to them has been extremely helpful. One GP commented: "*Because Syrians came from refugee camps in Turkey, International Red Cross/Crescent had done medical checks and provided background, there were some complex health issues. This information was very useful."* GPs call for more such information from other support agencies wherever possible. The Children's Society regularly sent background information on clients supported by the therapeutic service to GPs, with the permission of the client concerned.

Outside these organised systems of immigration, it is harder to plan for such information flow. Refugee Resource could potentially provide such information to a GP if a client requested this, or if they knew the client was going to a new GP whom they intended to continue seeing. However, the main constraint here would be the issue of trust as many refugees and asylum-seekers have lost trust due to their experiences and are wary of who knows what about them. In addition, Refugee Resource is not necessarily aware of when their clients are going to register with, or visit, a GP so the practicalities may be a challenge.

Several health care professionals talked about the need for specific support services for refugees and asylum-seekers beyond provision of health care, recognising that social conditions are known to contribute to poor health, both physical and psychological. One HCP talked of the many non-medical problems patients can have (social and housing problems, debt, parenting issues), *"which impact on their health and prevent their health from improving."* This was also recognised by support organisations:

"So his medical condition/treatment has been affected by other issues of homelessness and destitution, so actually there are more basic needs than health care that are not being met, for example housing, destitution and homelessness seriously affect health, it's an appalling bad situation for all, this has a huge impact on health."

"We are seeing many vulnerable EU migrants with limited or no recourse to public funds which makes a holistic approach difficult."

For many asylum-seekers housing is the key issue – some sofa surf, sleep in cars or on the streets in a 'state of limbo' while their applications are being processed. Poverty is a key issue.

A health visitor team painted a bleak picture of the many social issues impacting negatively on many of these clients: families living in unsafe, over-crowded, infested, multiple occupation houses; others living in isolation without extended family; women isolated and disempowered, often with their children left back in the home country, often harassed and vulnerable to rape in houses of multiple occupation, unable to report domestic abuse for lack of knowledge of how to do this and language; debt; slavery; others vulnerable to alcohol, drugs and gambling.

HCPs work closely with other services to try to provide holistic support for these patients. Examples mentioned were: practising a multi-disciplinary team approach utilising safeguarding framework and case conference management; regular meetings with others parts of the community team such as 'Families in Needs'; or working with the Oxford Street Population Outreach team (OXSPOT).

Opportunities for liaising with support services for this client group in the voluntary sector eg. Refugee Resource and Asylum Welcome, are not always used as HCPs are not always aware of them. One HCP suggested that Refugee Resource should remind GP practices of its existence and the scope of its work.

With a wider perspective, the importance of greater integration of this client group into society as a whole, so as to make use of their skills, and to provide them with training and employment opportunities, was noted.

5.2.viii Making complaints

The question of service user knowledge about the NHS complaints system was not asked systematically, but anecdotal evidence suggests that immigration status and cultural factors are likely to be factors in whether patients choose to make a complaint.

Two respondents from voluntary sector organisations said that refugees and asylum-seekers would be unlikely to make complaints about the health care they receive as they would not want to be seen to cause trouble.

"*They have no cultural understanding that it is their right to get (medical) help; they are anxious to please, meek, self-effacing, they don't assert their rights. They don't want to do anything that might cause trouble.*"

One family had been reluctant to use the complaints system as to have complained would have conflicted with their cultural norms and religious beliefs as Buddhists. Despite having been through a tortuous process of delayed referrals and diagnosis "*it would have been like revenge and would have left a bad feeling while we feel lucky my husband can still walk.*"

5.3 Innovative concepts and models from elsewhere

The following are three initiatives which support refugees and asylum-seekers to get equal access to health care, and may provide useful lessons for such work in Oxford.

(i) City of Sanctuary/Surgeries of Sanctuary.
City of Sanctuary is a movement committed to building a culture of hospitality and welcome, especially for refugees seeking sanctuary from war and persecution. The network of local groups includes boroughs, towns and cities across the UK and Ireland, all committed to building this culture of welcome across every sphere of society. The City of Sanctuary Health Stream provides a forum for asylum seekers and refugees to have a voice and share their experiences and for these to be used to influence health research, policy and practice, so as to ensure that the Department of Health's slogan '*No decision about me, without me*' includes sanctuary seekers. Specialised services have developed to meet their needs for example, Primary Care Practices specifically set up for asylum seekers. In addition, health care practitioners have tried to understand and meet the needs of this vulnerable group. This stream aims to support City of Sanctuary Groups and health practitioners to develop and share good practice in health care for sanctuary seekers. In recognition of good practice it offers a Sanctuary Award which can be applied for by those who can show written evidence that they have learnt about asylum issues, have embedded a culture of welcome and inclusion, and are sharing this learning with others.
https://cityofsanctuary.org/
https://health.cityofsanctuary.org/2016/05/05/city-of-sanctuary-health-stream-is-taking-off

(ii) Urban Village Medical Practice, Manchester. This is a one year pilot project that aims to improve access, inclusion and health outcomes for asylum seekers. Its three strands are (i) Strategic work to influence/offer evidence for extended, specialist service for refugees and asylum seekers (ii) Pilot a model of services that would be more readily accessible for refugees and asylum seekers. In essence this will be a Care Navigator who is shared by 5-6 GP practices, who has 'lived experience of refugee and asylum seekers' and has a second language, whose main task will be to train GPs around issues such as registration of refugees and asylum seekers and their entitlements to health care. GPs will be able to refer refugees and asylum seekers to the Care Navigator for help accessing other support services. The Care Navigator will also help patients navigate their way around health care services. (iii) Work with Home Office and SERCO (who operate 2 immigration removal centres) to explore issues such as: what information are they giving refugees and asylum seekers; how can they get a better information flow; and how they can work closer together with the pilot project to create better pathways.

(iii) The Haven, Bristol. This is a specialist primary healthcare service for asylum seekers and refugees who are new to Bristol. It is a 'first stop' clinic run on behalf of all three previous PCTs in Bristol. It provides a comprehensive health assessment for those who have

not yet registered with a GP. This includes access to the Haven GP, public screening and immunisations. They also facilitate registration to primary care practices. They regularly work with people who have experienced traumatic events and can sign post to other helpful services such as counselling and refugee support organisations. Their appointments are long enough to give them time to respond to complex needs. They are able to work with people over several appointments according to their individual need before discharging them to the care of a GP practice. https://www.montpelierhealthcentre.co.uk/services/haven/

(iv) Praxis, London. This voluntary sector organisation offers many services to support refugees, asylum seekers and vulnerable migrants, including information about accessing health services and workshops providing health information.
http://www.praxis.org.uk/about-us-page-2.html

6. Recommended actions: 5 key areas

This study has found that, with a few exceptions, most refugees, asylum-seekers and vulnerable migrants who were interviewed have had positive experiences of accessing primary health care in the UK. They are extremely appreciative of the treatment received and the compassion and sensitivity shown by health care professionals toward them. Nevertheless, they face a range of linguistic, cultural and administrative barriers to accessing appropriate care.

The health care professionals involved in the study were all committed to delivering an equitable service for this patient group, and were clearly doing all they could to provide an exemplary service. Nevertheless, they faced many challenges in meeting the needs of this group who can present with complex health issues related to their experiences of war, torture, exile and loss, as well as the challenges of adjusting to a new life in the UK, often with little or no English.

The findings lead us to propose the following five recommended actions. If sufficiently resourced, we believe these could make a significant impact on reducing the health inequalities faced by refugees, asylum-seekers and vulnerable migrants in Oxford.

1. **Recognition of the health needs of refugees, asylum-seekers and vulnerable migrants as a key inequality issue that requires specific support and resources**

Although this patient group is relatively small in numbers, their health care needs are often very high. Most of them do not wish to be seen to be demanding, and are extremely appreciative of the health care they have received in this country. Similarly, the number of GP practices with significant numbers of patients from these groups is small, but the challenges for them are huge. "*This is a small population with very high needs. The number of practices (treating them) is small and so they go under the radar.*"

Action by: OCCG and all providers

2. **Funding GP surgeries to run a Locally Enhanced Service**

Because refugees, asylum seekers and vulnerable migrants tend to present with complex issues – medical, psychological and social – as a result of experiences in their home country, and the process of accommodating to life in the UK, GPs and patients alike expressed the need for longer appointment times. GPs felt this would enable them to make better assessments and provide more appropriate medical attention and care. We therefore recommend a Locally Enhanced Service, modelled on the lines of that set up

for Kosovan refugees in the late 1990s, where GPs, and possibly Practice Nurses, can see patients for extended appointment times. This would mean funding more GP hours.

We propose that funding is made available so that all GP practices are able to offer this enhanced service, with the expectation that this would primarily be drawn on by practices seeing large numbers of refugees, asylum seekers and migrants.

Consideration could be given to a proposal of initial consultations with GPs of 20-40 minutes, and on-going extended appointments if needed in complex cases and where interpretation is required. Efforts should be made where possible to provide continuity of GP so that these patients, for whom trust may be a major issue, do not have to re-tell distressing life histories repeatedly to new health care staff.

We propose that efforts are made to offer appointments to asylum seeking children and young people at the end of their school/college day, so as to least disrupt their education.

Action by: OCCG

3. Interpreters

Face to face interpreting is rarely used in GP practices for good reason, but we found some demand from both providers and patients for greater availability of this service given the complexities and sensitivities often involved. It is recommended that greater provision is made for this where there is clear need e.g. for longer initial assessment appointments and for some on-going treatment where there are complex cases or mental health issues. Interpreters need to be carefully selected and fully trained.

Patients should be made more aware of their right to request a phone interpreter for appointments with HCPs: this should always be offered at the time of making an appointment when it is clearly needed, including offering a choice of gender of the interpreter. Consideration should also be given to how interpretation at the Reception Desk can be supported, possibly via phone interpreting, to facilitate registration and the making of appointments for those with little or no English.

The NHS cards produced by the OCCG for patients requiring Language Line interpreting support need to be widely publicised in both the community and GP surgeries.

Action by: OCCG, GP surgeries and voluntary sector organisations

4. Awareness-raising/training for health care professionals

Many HCPs showed great understanding, sensitivity and compassion towards this patient group. To support their work, we recommend that training be made available for them on:

i. the experiences of refugees, asylum-seekers and vulnerable migrants. Refugee Resource and/or Asylum Welcome may be able to offer this training if funded to do so.

ii. HCPs also need to be clear about the entitlements of this group to primary health care services. In particular, receptionists may find this helpful as the reception desk can be the site of friction around registration, entitlements to health care and language support needs. Those medical practices that have accrued considerable experience in supporting refugees, asylum-seekers and migrants could also be invited to provide orientation to others on good practice or simple 'what works', if funded to do so.

iii. It would also be useful for HCPs to be aware of what other support services are available from organisations such as Refuge Resource and Asylum Welcome to which they can signpost refugees, asylum seekers and vulnerable migrants.

iv. A useful awareness-raising tool would be a short (5-10 minute) video of service users talking about their experiences of accessing and using primary health care services, the challenges they encountered and how these were overcome. The development and production of this would require funding.

Action by: OCCG could fund voluntary sector organisations like Refugee Resource, Asylum Welcome and other voluntary sector organisations to run such training sessions for GP surgeries, including developing an educational video.

5. Outreach work in communities with high numbers of refugees, asylum-seekers and migrants to orient them to primary health care service

There is not always a clear understanding amongst these communities, particularly amongst new arrivals, of how the NHS primary care system works. This is exacerbated by language barriers and unrealistic expectations. Outreach work is needed to help orient them on what to expect from and how to access services: GP services, how to register, pharmacies, prescriptions, health promotion issues, preventative health care messages, availability of interpreters, role of nurses, health visitors and midwives etc. This might be done through group awareness-raising sessions, with follow up to solve individual problems once they have started using the health system. Such sessions could be supported by the distribution of printed information in different languages about how health services run. These could also be distributed in the community eg. to GP surgeries, children's centres, schools, community centres, nurseries etc.

Voluntary sector organisations such as Refugee Resource or Asylum Welcome could potentially organise such awareness-raising sessions if funded to do so. In the spirit of the 'shared care' model, HCPs and administrative staff could also attend and provide orientation if funded to do so. The various statutory teams tasked with outreach work into disadvantaged communities in Oxford could support such initiatives, including the OCCG Equality and Access Team, Social Prescribers, Care Navigators, potential Health Champions, and Oxford Migrant Health Initiative with its medical students. Voluntary organisations, their Support Workers and community groups such as the Asian Women's Group, could also be requested and resourced to support such initiatives.

The vital role played by voluntary sector support workers in liaising between HCPs and patients needs to be financially supported whenever possible, e.g. on a sessional basis according to need.

Action by: OCCG funding to voluntary sector organisation to facilitate this outreach work.

End note

We would like to acknowledge the great deal of positive work being done by primary health care professionals in Oxford to provide good and appropriate services to refugees, asylum-seekers and vulnerable migrants, despite the enormous pressures they are under.

We believe that with sufficient funding and working together as 'shared care' partners on the recommendations outlined above, the primary health care services, local communities and voluntary sector organisations could achieve much greater impact in providing an equitable service and thereby reducing the health inequalities faced by refugees, asylum seekers and vulnerable migrants in Oxford.

Appendix A – Bibliography

Annotated references

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Highlights the difficulties for vulnerable people, including asylum seekers and undocumented migrants in registering with GPs with concrete recommendations for action which appear to have applicability to the Refugee Resource study in Oxford, for example:

- *GP practice administrative and clinical staff are trained on entitlement to NHS care.* Everyone is entitled to free primary care regardless of immigration status.
- *Partners and Practice Managers ensure registration policies are in line with Standard Operating Principles from NHS England.*
  This includes accommodating for individuals who do not have proof of address or ID.
- *Frontline administrative staff receives training in the practice's registration policy* including handling situations where an individual does not have paperwork and knowing when a temporary registration is appropriate.
- *Practice Managers and administrative staff receive training working with vulnerable patients.*
- *GP practices ensure their services are accessible for vulnerable individuals and sensitive to their needs:* appointment booking options for those without access to a phone or the internet; interpreters are used when needed.

Gell, F and Shackman, J. '*Developing capacity across the Thames Valley for specialist counselling for victims of crime who are refugees, asylum-seekers, vulnerable migrants, or from BME groups with little or no English*', Refugee Resource (2015).
This project investigated the barriers to counselling and made recommendations to overcome them. Many of the findings and recommendations closely align with this project; the recommendations to improve access and equality of provision included:

- Improved access to trained interpreters
- Translated material on services
- Outreach work with BME communities (to raise awareness, find pathways into isolated communities, identify client needs, and adapt services accordingly)
- Learning from good practice

Healthwatch England, *'Primary Care: a review of local Healthwatch reports'* (March 2015)
http://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/primary_care_a_review_of_local_healthwatch_reports.pdf
Findings include difficulties in relation to interpreting services: '*Patients who require translation services are not receiving an equitable level of care to those who don't.'* Also raises issues of concern in relation to all patients, e.g. too short appointment times, unhelpful receptionists.

Healthwatch England, *'People's experiences of primary care'* (Dec 2015)
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This research study with seldom heard patient group, including women from Pakistan, the Roma community and people who are deaf, found many positive aspects of health care but with two key areas that needed improvement: (1) Access (eg. limited interpreting services, trouble registering with GP, difficulty making appointments, limited choice of GP seen), and (2) Being listened to (e.g. 'one-issue rule' per appointment, attitude of some staff, particularly GP receptionists).

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'http://www.healthwatchislington.co.uk/sites/default/files/short_report_-_gp_reception_customer_service_2015_0.pdf
Examines improvements following training for reception staff – all patients, including BME, are affected by receptionist behaviour.

Healthwatch Islington, *'Interpreting Services: mystery shopping GP practices'* (2015)
http://www.healthwatchislington.co.uk/sites/default/files/mystery_shopping_interpreting_services_2015.pdf. Looks at interpreting services in Islington, with specific recommendations for action by CCG Commissioner, Practice Managers, GPs, Patient Experience Manager (CCG) and Communications Manager (CCG).

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Considers how all players in three-way interactions could be more empowered to enhance communication: health practitioners, interpreters and patients. Evidence is growing that using trained interpreters improves quality of care, while poor interpreting results in adverse outcomes, failure to 'bottom out' patient agendas, repeated consultations, unnecessary investigations or patient safety. Concludes that the health and economic costs of not working with trained interpreters may appear obvious but deserve greater emphasis in research to help push development and implementation of interventions to enhance the quality of interpreted consultations in the required direction.

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Appendix B: Entitlements to Primary Health Care for refugees, asylum-seekers and migrants

1. NHS guidance for GP registration

Primary healthcare is delivered through GP practices, NHS walk-in centres, dentists, pharmacist and optometrists. **These can be accessed free by all regardless of immigration status.** Some of these services (prescriptions, dental treatment, sight tests, glasses and contact lenses) are chargeable, although people on a low income can apply for financial assistance.

Evidence that an increasing number of people were having difficulty registering with a GP because they were unable to provide documentation to the practice in support of who they are or where they live let the NHS to publish the following guidance: **' *Patient Registration Standard Operating Principles for Primary Medical Care (General Practice) ,27 November 2015.*** This clarifies the position of all patients and, in particular, addresses the needs of migrants and asylum seekers who do not have ready access to documents. The emphasis is on the NHS legal duty to reduce inequalities and how the impact of requiring documentation could be potentially discriminatory. The key points are given below.

- A patient does not need to be 'ordinarily resident' in the country to be eligible for NHS primary medical care – this only applies to secondary (hospital) care. In effect, therefore, anybody in England may register and consult with a GP without charge. There is no set length of time that a patient must reside in the country in order to become eligible to receive primary care. Therefore all asylum-seekers and refugees, overseas visitors, whether lawfully in the UK or not, are eligible to register with a GP practice.

- Registration by a GP can only be refused if their lists are officially full, patient lives outside GP catchment area, other reasonable grounds not related to race, religion etc.

- GP practices are able to register new patients who live outside the practice area without any obligation to provide home visits or services out of hours when the patient is unable to attend their registered practice. It is for the practice to decide, at the point of registration, whether it is clinically appropriate and practical to register the individual patient in that way.

- There is no regulatory requirement to prove identity, address, immigration status or NHS number in order to register. And there is no contractual requirement for practices to request this. Nor is establishing an individual's identity the role of the GP. However, there are practical reasons why seeing some form of ID will help

ensure the correct matching of a patient to the NHS central patient registry, to ensure previous medical notes are passed on to the new practice. It is legitimate therefore for the practice to apply a policy to ask for patient ID as part of their registration process. The guidance outlines how this should be done.

- Any practice requesting identity documents or immigration status must apply the same process to everybody. Otherwise they are potentially discriminating.

- If a patient cannot produce any supportive documentation but states that they reside within the practice boundary, they must be registered unless there are reasonable grounds to decline.

- Some patients will legitimately be unable to produce appropriate documentation. Examples include:
    - people fleeing domestic violence staying with friends or family
    - people in unstable accommodation or street homeless
    - people staying long-term with friends but who aren't receiving bills
    - people working in exploitative situations whose employer has taken their documents
    - people who have submitted their documents to the Home Office as part of their application
    - people trafficked into the country who have had their documents taken on arrival
    - children born in the UK to parents without documentation.

  Reasonable exceptions therefore need to be considered and the individual registered With sensitivity to their situation.

- Where necessary (eg. homeless patients) the practice may use the practice address to register them if they wish[10]. If possible, practices should try to ensure they have a way of contacting the patient if they need to (eg. with test results).

- While everyone is entitled to register with a GP, some are not eligible for secondary care. GPs should refer patients to secondary care on clinical grounds and it is up to the receiving organisation to assess eligibility for free care

- If a patient cannot find a GP that will accept them (eg. practices full), they should contact the NHS England Thames Valley Team who can intervene on their behalf.

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[10] *NHS Choices* also says that homeless people can use a temporary address eg a friend's or a day centre. Patients can be registered as temporary patients for up to 3 months.

2. Guidance on patients with No Recourse to Public Funds (NRPF)

The NRFP provides the following guidance (NRFP Network Factsheet, 2015). Those with NRPF are those who have:

- Leave to remain in the UK with the condition of NRPF eg. spouse visa, student visa, limited leave granted under family or private life rules
- Leave to remain subject to a maintenance undertaking eg. as the adult dependent relative of a person with settled status (5 year prohibition on claiming public funds)
- No leave to remain eg. visa overstayers, illegal entrants

The NRPF condition is specified on their residence permit, entry clearance vignette or biometric residence permit and will say 'no public funds'.

All people with NRPF are entitled to access primary medical care as detailed in the NHS guidance above.

For chargeable PHC services (prescriptions, dental treatment, sight tests, glasses and contact lenses), migrants with NRPF who receive local authority support are not automatically entitled to these. They may have access if they fall into one of the exempt group eg. age, pregnant, specific medical condition. They may also be entitled to full or partial help through the *NHS Low Income Scheme* with an HC2 certificate - see below.

Other services which must be provided free of charge to migrants with NRPF include: A&E; family planning, diagnosis and treatment of contagious diseases; diagnosis and treatment of sexually transmitted infections; treatment of a physical or mental condition caused by torture, female genital mutilation, domestic violence or sexual violence when the patient has not travelled to the UK for the purpose of seeking such treatment.

3. Guidance for Asylum Seekers

Asylum-seekers are entitled to access NHS primary care services, free of charge, whilst their asylum applications are under consideration. People cannot be refused registration because they are an asylum seeker.

NHS Guidance: The NHS booklet HC11 (2015) '*Help with health costs'* (p16) sets out entitlements for those seeking asylum. The Home Office will send people seeking asylum who they support financially, including those on subsistence support only, an NHS charges certificate (HC2) for full help with health costs. The asylum seekers will get this with their first support payments. People *seeking asylum who are not supported by the Home Office,* and *failed asylum seekers*, may be entitled to help with health costs because of their age. Otherwise, they may apply for the appropriate exemption certificate or may claim under the NHS Low Income Scheme.

The *Host Oxford Guidebook, Oxford City of Sanctuary* notes that if someone's asylum application has been refused but they are unable to return home, they can still receive the following without charge: GP and emergency hospital treatment, NHS dental treatment, sight tests and prescriptions.

HC2 Certificates: People on low incomes may be eligible to receive financial help through the *NHS Low Income Scheme.* The patient may need to apply for an HC2 certificate by completing an HC1 form (available from Jobcentre Plus offices, most NHS hospitals, NHS Choices, and sometimes doctors, dentists and opticians). The HC2 certificate is a Low Income Scheme certificate for full help. It entitles the patient to free NHS prescriptions, dental treatment, sight tests, optical vouchers (for glasses, contact lenses), travel to receive NHS treatment, treatment for infectious diseases (including tuberculosis) and STIs, HIV/AIDS tests and treatment, some hospital treatment (A&E treatment; non-emergency treatment including maternity services). Without an HC2 form, a patient can receive GP services but none of the above services.

Maternity care for asylum-seekers: Maternity care includes care for pregnant women, childbirth at hospital and postnatal care. The Refugee Council leaflet (2013) '*Do you need help to access healthcare?*' states that "*asylum seeking women who are waiting for the outcome of their asylum applications, including appeals, should not be asked to pay for the maternity services. Women who have had a final asylum refusal may be charged for these services but NHS guidance says that maternity care is 'immediately necessary' and must not be withheld because the woman is unable to pay. The hospital may need information from you about your intentions to return home to help them establish the urgency of treatment needed. Please note that hospitals have discretion to provide treatment even when there is no prospect of the patient paying for it".*

Appendix C – sample of questionnaires used

1. Questionnaire for GPs and other primary health care professionals

Researching Access to Primary Health Care Services in Oxford city for Refugees, Asylum Seekers and Vulnerable Migrants

We need your help!

Refugee Resource is an Oxford-based charity which is helping to address health inequalities in Oxfordshire by investigating the experience of refugees, asylum-seekers and vulnerable migrants as users of primary health care services, and the issues that arise for health care professionals in supporting them. There is evidence that these patient groups are amongst those facing the greatest barriers to accessing appropriate health care. Refugee Resource is carrying out a short research project on these issues until May 2016. It is funded by Healthwatch Oxfordshire and supported by the Oxfordshire Clinical Commissioning Group (OCCG) Equality and Access Manager. The research will identify challenges and ways to overcome them for service providers, identify unmet need and barriers to access for patients, and recommend how services could better meet the needs of this group.

Your help in responding to the following questions would be much appreciated:

i. Please outline below, what, in your experience, the challenges are of providing primary health care to refugees, asylum-seekers and vulnerable migrants.

ii. Please outline below what ways you have found to overcome these challenges, and what might help you to do so in the future.

We would greatly appreciate being able to follow up some respondents with a brief telephone call. Would you be willing to speak by phone to one of the project researchers for 10-15 minutes during April/May? If so, please indicate this below. We will not identify you in any way unless you explicitly give your consent for us to do so.

It would help our research to know the spread of health professionals responding, so we would appreciate your details below. However, if in the report you would prefer your comments to be anonymous, please indicate this below.

Name: Role:

GP Practice (if applicable):

Willing to be followed up: Yes No

Phone: Email:

Do you wish to remain anonymous: Yes ☐ No ☐

Can we name your Practice/Service (not you as an individual) Yes ☐ No ☐

Please return your answers to: Maggie Dent (OCCG) or Jane Shackman (Researcher):
Maggie.dent@oxfordshireccg.nhs.uk janeshackman@waitrose.com

Thank you

2. Questionnaire for refugees, asylum seekers and vulnerable migrants

What has been your experience of visiting your G.P. (family doctor)?

Refugee Resource is researching the experiences of refugees, asylum seekers, and migrants in using GP and other Primary Health Care Services (x7) in Oxford.
We want to highlight difficulties and barriers, as well what has helped.
We will make recommendations to those who provide deliver health care services, so that refugees, asylum seekers and migrants can more easily access and use the primary health care services they need.

Your answers will be anonymous.

Gender M ☐ F ☐ Country of origin ☐

Under 20 yrs ☐
20 - 50 yrs ☐
Over 50yrs ☐

1. When did you arrive in Oxford?

Less than 6 months ago ☐
6 months – 3 years ago ☐
Over 3 years ago ☐

2. Are you registered with a GP? Yes ☐ No ☐

3. How many times have you visited a GP in the last year? ☐

4. What was good about the service?

……

……

What made it difficult?

……

……

What would have made it easier?

……

……

5. How would you rate the service you received from 1–10? (1= worst & 10= best)

6. Would you be willing to talk to one of our project workers in more depth about your experience of visiting the GP, dentist, nurse, health visitor, midwife, pharmacist or optician? We offer a £10 voucher for this in recognition of your time. If so,

Name ……

Contact details……

Interpreter needed/language……

3. Questionnaire for Voluntary Sector Organisations

Research on access to Primary Health Care Services

Questions for intermediary organisations who may signpost refugees, asylum seekers and vulnerable migrants to Primary Health Care services

Please return this form to: janeshackman@waitrose.com or phone Jane on 01249 446889 if you would prefer to talk through your answers rather than write them.

Name ……..

Organisation……..…… **Job/role in organisation……**

1. Signposting to PHC services

1.1 Do you sign-post refugees, asylum-seekers and migrants to primary health care services? Yes ☐ No ☐

1.2 If so, to which ones (please tick): GPs, dentists, nurses, health visitors, midwives, pharmacists, opticians

2. Access to services

2.1 What have been the challenges/barriers for refugees, asylum-seekers and vulnerable migrants in accessing these services?

2.2 What has helped them overcome these barriers?

2.3 What else is needed?

3. Quality of services

3.1 Were there any problems in the quality of services they received?

3.2 How sensitive do you feel PHC providers are to the specific circumstances/needs of refugee and asylum seeker clients?

3.3 Can you give specific examples of good practice you know about?

3.4 What could be done to improve the quality of services?

4. Further contacts

4.1 Do you have contacts in Primary Health Care who might be interested in talking to us about these issues? Please provide name/contact details:

4.2 Do you know any refugee, asylum seeker or vulnerable migrant clients we could speak to about their experiences? Please provide name/contact details:

Thank you for your help

Appendix D - Resources for HCPs working with migrants

Public Health England Migrant Health Guide (2)
This is an updated version of the former HPA Migrant Health Guide. Information is more up to date. The guide covers a range of topics from assessing health of new patients from overseas, country specific information, health topics for communicable disease, and non-communicable disease, NHS entitlements for migrants.
https://www.gov.uk/topic/health-protection/migrant-health-guide

HPA Migrant Health Guide Please note this Guide was produced by the former Health Protection Agency (HPA) and is now archived so it is no longer kept up to date. However there are still some very useful resources in the archived version, which the new Migrant Health Guide by Public Health England may link to.
http://webarchive.nationalarchives.gov.uk/20140714084352/http:/www.hpa.org.uk/MigrantHealthGuide/

TS4SE (Training and Support for Services and Exiles)
A range of useful resources and a free online training toolkit that provides information and practical tips for effective engagement with patients from migrant, refugee and minority communities. Designed for frontline staff, the toolkit can be easily used by individuals on their own or by teams within a group setting.
http://ts4se.org.uk/migrants-healthcare.html
http://ts4se-health-resources.org.uk/

British Refugee Council, Policy and Research
http://www.refugeecouncil.org.uk/policy_research
http://www.refugeecouncil.org.uk/search?q=Access+to+health+services
Includes briefing papers and leaflets on Access to Health Services, such as '*Do you need help to access healthcare*' (April 2013)
https://www.refugeecouncil.org.uk/assets/0002/8061/Do_you_need_help_to_access_healthcare_English.pdf

Appendix E – Translated resources on primary health care for service-users

Multi-lingual information available on NHS Primary Health Care and other services

'The National Health Service' fact sheet
Local health centre websites post this fact sheet which explains the role of the NHS to non-English speakers. It is available in 20 languages. It is generally found on the webpage for new patients/non-English speakers. It covers issues such as the role of GPs, their function as gatekeepers to the health services, how to register and how to access emergency services. It advises how to book an interpreter at the GP surgery, and on the phone with NHS Direct.

NHS Choices website http://www.nhs.uk/pages/home.aspx
This gives comprehensive information about NHS health services and health conditions and has a translation facility. Most pages of the website can be translated into more than 90 languages using Google Translate.

COACH (County of Oxfordshire Advice on Care and Health) - http://www.my-coach.org.uk/
Developed by the Oxfordshire GP Federations with NHS funding, COACH is a one-stop 24/7 health and care resource, with easy access to information needed to understand and manage health conditions and find local health and care support services. It also encourages patient self-care. The website can be viewed in a number of different languages.

OCCG's website is being updated and will have different languages available. This is part of the NHS Accessible Information Standard and Wed Accessibility Initiative (WAI).

OCCG leaflet for migrants '*Your Health*' http://www.oxfordshireccg.nhs.uk/your-health
This is available in the following languages: Bengali, Cantonese, Farsi, Kurdish, Polish, Portuguese, Punjabi, Arabic, Mandarin and Urdu. It is an informative and accessible guide to health services, how to register with a GP, how to book an appointment, entitlement to request a female practitioner, and what to do if you do not speak English.

The Maternity Action website
http://www.maternityaction.org.uk/advice-2/mums-dads-scenarios/3-women-from-abroad/
Maternity Action is a charity committed to ending inequality and improving the health and well-being of pregnant women, partners and young children. This site contains information leaflets about entitlements to health care for refugees, asylum seekers, failed asylum seekers, trafficked women, unregulated migrants and other marginalised groups. 'Know your rights!' materials are available in Polish, Spanish & Portuguese.

Talking from the Heart – multi-lingual videos on counselling

Short films commissioned by At Medics, a group of NHS GP practices in London, and produced by Maslaha, on mental health (depression and anxiety) and counselling. http://www.talkingfromtheheart.org . Maslaha has worked in partnership with doctors from AT Medics, specialist counsellors, therapists, Islamic scholars and imams to develop these short films. The films offer help with what happens in a talking therapy session; what the Qur'an has to say about keeping healthy; what is meant by 'depression,' 'anxiety' and what support is available, including therapy; dealing with some of the common concerns many people have about seeking support *('I don't need help, and can deal with everything myself,' or 'I will bring shame to my family and community'*). GPs and mental health practitioners can use these films as a resource with their clients during appointments, or to understand some of the issues and links between health, mental and emotional health, and faith.

NHS smartphone App on how to navigate the NHS

In March 2016 an NHS Navigation Hackathon was held to design an innovative free-to-download app to help migrants navigate the NHS. It covers GPs, hospital visits, midwifery, pharmacies, mental health, health visiting and A&E. This website describes the rationale for developing the app and how it works http://nhsnavigationhack.co.uk.

Appendix F – Statutory teams and voluntary organisations with an outreach function

Statutory teams

OCCG Equality and Access Team: There are three part-time Equality and Access Commissioners, managed by an Equality and Access Manager, in this team. They replaced the Health Advocacy Service that existed until the cessation of the Oxfordshire PCT in 2013[11]. Although they no longer support individual patients, they still do outreach to '*seldom heard groups*' and part of their role is to ensure that patients can access health services. This includes dissemination of information including leaflets and Language Line cards. (The unique offer of the old Health Advocate model was the cultural and linguistic diversity of the team which enabled them to act as a bridge into local communities especially with Asian women).

Social Prescribers: There is one Social Prescriber in Oxford employed by a GP Practice and funded by Personal Medical Services. Her key role is to help patients access support for their *non-medical* needs by signposting them to a broad range of statutory, voluntary and community resources to help address their emotional and social needs.

Care Navigators: They perform a similar role to the Social Prescriber Coordinator and also do home visits and work with vulnerable and more complex patients, often elderly people with long-term conditions. They are part of a pilot project based in some city Practices and funded by the Prime Minister's Challenge Fund.

Oxford Migrant Health Initiative[12]: medical students and doctors are volunteering to offer help, support and advocacy for refugees and asylum-seekers at the Cowley Road Health Centre. The pilot scheme will start during summer 2016 and will be open for 1 or 2 sessions per month. The aim is to better support this patient group.

Volunteer Community Health Champions: The OCCG is currently scoping a role for these Health Champions in the regeneration areas of Oxford and Banbury. One model being explored is for well-connected community workers to be trained as Health Champions as part of their existing jobs, with support from the Health & Wellbeing

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[11] The NHS Health Advocacy Service aimed to promote appropriate access to primary care services and preventive health initiatives to BME communities and new migrants in Oxfordshire. A group of specialists from different cultures who could speak several languages between them, they acted as a link between health professionals and the public, promoting understanding of cultural issues. They accompanied individuals to GP or hospital appointments; worked with community groups on health improvement initiatives; and visited clients in their homes. They advised health professionals on cultural issues, supported training events, and worked on public health initiatives with ethnic minority communities.

[12] Contact: anna.carlqvist@hotmail.com

Partnership groups. Their main function would be to sign-post people to the right services. They would link to Oxford's GP Practice Social Prescriber.

Voluntary organisations

Voluntary sector organisations that support this client group in Oxford include Connections Floating Support, Open Door, British Red Cross, Emmaus, Elmore Community Services City of Sanctuary, Oxford Homeless Pathways and OXSPOT (Oxford Street Population Outreach Team) [13]. One medical practice told us "*We liaise with other voluntary agencies such as Refugee Resource and Asylum Welcome making sure that newly registered patients are connected with city centre outreach support (OXSPOT).*" Turpin and Miller (legal advisors) also provide important support for this client group.

Circles of Support is a service provided by Age UK Oxfordshire. It was funded originally by the Cabinet Office and extended by the OCCG. It has Community Networkers based in community health teams, who work with adults who have significant health needs and are lonely or socially isolated, to explore options for practical help and social contact, and to signpost or introduce them to activities and relationships in their local communities.

Oxfordshire Community and Voluntary Action (OCVA) acts as an information source about services that can support refugees and asylum-seekers including on health issues[14].

[13] Until August 2016 this list included The Children Society.
[14] www.ocva.org.uk/refugee-advice.