Wakefield Health Needs Assessment for Residents born outside the UK

Organisational Stakeholder Engagement

People and organisations who work with and provide services for migrant communities, living within Wakefield District

Health Needs Assessment Report: Number 1.

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1. Introduction

This organisational stakeholder engagement summary report is the first of a series of reports which will be published in the coming 12 months, as part of the Wakefield Health Needs Assessment for residents born outside the UK. Other reports in the series will include:

- the voices of those with lived experiences of being a non-UK born national,
- findings of a health and wellbeing services survey,
- and a report describing the demographic and health profile of non-UK born communities residing in Wakefield.

Each of the reports will be collated together to lead to the development of an overarching document with the aim of shaping future services for non-UK born communities. Our vision is that all partners will use the information in the collection of reports, to drive improvements in access, experience and high quality outcomes, and also to future proof their service offer so it meets the needs of our current and future Wakefield residents. In the interim, each report will enable continual service improvements and provide greater knowledge and understanding for all partners supporting residents born outside the UK.

This work is being completed alongside the evolution of the newly Core20Plus5 funded 'health inclusion' evidence-based healthcare model, being delivered by Bevan Healthcare, for vulnerable migrant communities living within the Wakefield District.

This report summarises the qualitative findings following a series of focus groups and in-depth interviews. 57 organisational stakeholders were represented from a wide range of sectors and organisations, including those who work at local government level, those who work in migrant services, NHS and healthcare professionals and those who work in the third sector. Wakefield Public Health Team at Wakefield Council commissioned an independent research agency, Enventure Research, to undertake and document the engagement with all organisational stakeholders.

1.1 Participant profile

Figure 1 below shows the split between individual or paired interviews and focus groups, and Figure 2 shows the breakdown of stakeholder type.

Figure 1: Breakdown of interviews and focus groups

Type of engagement	Interviews / focus groups	Number of stakeholders
In-depth interviews (individual stakeholder)	11	11
Paired interviews (two stakeholders)	5	10
Focus groups (three or more stakeholders)	8	36
Totals	**24**	**57**

Figure 2: Stakeholder type

Stakeholder type	Number of stakeholders
NHS professionals / healthcare professionals	18
Third sector	6
Local government / government	22
Migrant services	8
Other stakeholders	3
Total	**57**

It is important to note that qualitative findings are not meant to be statistically accurate, but instead are collected to provide insight and greater understanding based on in-depth discussion. Furthermore, qualitative research is based on participants' perceptions of what they believe to be true so may not be factually correct in some instances.

2. Overall Background

Meeting the health and wellbeing needs of residents born outside the UK is becoming increasingly important due to the multifaceted factors influencing the delivery of services e.g. UK migrant health policy, UK migration policy, conflict and human rights violations amongst others.

Over the last 10 years, the number of people coming from other countries for reasons including; to work, to study, to be with their family and because they are refugees to Wakefield district, has grown. Because of this, and national policy decisions, the need for services to support non-UK born communities has also grown. However, over time, these services may be offering different types of health and wellbeing support and care, and may not always meet the needs of our non-UK born residents. To make sure health and wellbeing services are the best they can be, the Health Needs Assessment Working Group are working with non-UK born communities, those who work with them and service providers, to carry out a Wakefield Health Needs Assessment for residents born outside the UK.

This is an opportunity as a system to influence change and help us achieve our aim of ongoing improvement to health and wellbeing services. Our vision is that the services people can access meet their needs and help them have the best health and wellbeing possible, especially the most vulnerable.

Together, with people who plan and deliver services and non-UK born communities, we can make sure everyone is included in decisions that affect their lives right from the start. This means we can understand what services look like now, what is needed, where there may be gaps, what works well now and what we could do more of. Working together, we can decide what the most important areas are to work on and the best way to get to where we want to be. We can also find out what has worked well in other places and use this learning to help us. To do this work the Public Health Team at Wakefield Council and Wakefield Integrated Care Board (ICB) have formed a Migrant Health Needs Assessment Working Group who will oversee the project.

The term 'migrants' describes people with a wide range of circumstances. There are many different reasons why a non-UK born national decides to move to the UK. There are also various categories of migrant based on the persons' reason why they moved to the UK including:

- Refugee
- Asylum Seeker
- Refused Asylum Seeker
- Trafficked person
- Undocumented Migrant
- Working/Economic Migrant
- Family Migrant
- International Student

Currently, there are several models of health care provision being delivered to similar migrant groups within the Wakefield District. Health care provision consists of bespoke commissioned health services provided by South West Yorkshire Partnership NHS Foundation Trust, Bevan Healthcare and routine General Practices services. These models vary in the level of provision and the associated wraparound support.

Each of the models are aligned to asylum accommodation (hotels, hostels, community housing) procured by the Home Office; which local partners have little or no influence or control over. Aligning healthcare services to individual settings has been the only pragmatic way to try and ensure accessible health care provision, however, this could lead to potential inequities. For some healthcare provision this has been hugely challenging due to the speed at which large accommodation sites (hotels) have established within the district, at short notice. Access to health care for working migrants, family migrants and international students is identical to the local resident population and is provided by General Practices. Victims of modern slavery and undocumented migrants are less likely to be known to health care services.

3. Key Findings Summary

This section of the report provides a condensed summary of the key findings. To read about these in more detail, please see the main findings section of this report.

- Participants provided mixed feedback regarding the management and delivery of health and wellbeing services aimed at supporting non-UK born residents. Some thinking the current provision is working well and others feeling there is opportunity for improvement, particularly around growth in suitably skilled workforce capacity to support the programme.

- Collaborative and inter-agency working has worked well for service provision and should continue, alongside improved communication and information sharing between services. A key suggestion was identifying an organisation to act as an overarching coordinator of Wakefield partners working within the health and wellbeing sector. A dedicated multi-agency forum to ensure an organised approach to local service delivery would be important, as participants felt this was currently lacking.

- Some Third Sector organisations were praised for their positive work for and with non-UK born communities. However, participants largely felt that partners should do more to strengthen and diversify the Third Sector offer for residents born overseas in the Wakefield District to bring it in line with other localities. Key aspects included Third Sector sustainability for example paid employed workforce, furthering the development of robust procedural practices, increased funding opportunities, increasing volunteering opportunities and protecting the welfare of individuals delivering Third Sector services.

- Outreach and engagement work with communities has worked well, particularly with community and faith leaders, and should be continued with a particular focus on those who are disengaged with services or may be falling through gaps.

- Whilst it is positive that there is a health team on-site at the Initial Accommodation, there is some opportunity for improvement at this facility. Examples included

extending the hours of healthcare provision, improving the condition and facilities of the building, and providing devices and internet access.

- The key barriers to non-UK born communities accessing health and wellbeing services are language and communication which could lead to several poor outcomes. This included children and family members being expected to act as interpreters, a lack of understanding what services are available to them, how to access them, and a fear of misunderstanding what is being said which could deter some individuals from accessing services altogether. As such, these need greater consideration in relation to translation of resources and interpreter services.

- Not having an NHS number or having duplicate health records can cause difficulty accessing services safely. It can potentially delay patient care, result in incomplete health records, and prevent healthcare information following a person when they are dispersed to another area/GP. There are inconsistent or informal routes for signposting and referral to other services which can lead to inconsistencies between populations/settings.

- Some non-UK born nationals may need access to specialised health and wellbeing services based on certain characteristics such as gender, country of origin, culture, journey to the UK and any specific mental health needs caused by experiences of trauma.

- Increasing awareness of the health and wellbeing services available in the Wakefield District would be beneficial to both non-UK born communities and those working within the services. Organisations are seen as disjointed and non-UK born communities may not understand what is available to support them.

- Overcoming boredom and isolation for adults and families residing in Initial and Contingency Accommodation should be a key priority for partners to improve their health and wellbeing as those seeking asylum are unable to work. Suggestions included facilitating more sports and activities on-site, providing appropriate resources and equipment for sports, offering opportunities around training, volunteering and employment skills and providing support around access to transport.

- Although they were asked to consider all non-UK born communities, most of the stakeholder feedback centred on adults and families residing in Initial and Contingency Accommodation, with very limited feedback on adults and families residing in dispersed accommodation and other non-UK born communities e.g. family joiners. This reflects the population groups for which participants were most involved with in terms of service delivery.

- Social cohesion between non-UK born communities and the local general population is needed for adults and families to feel welcomed, so that they can integrate into wider society, and to break down negative misconceptions of non-UK born communities.

- Due to the significant changes and increases to the non-UK born population as shown in the Wakefield Joint Strategic Needs Assessment (JSNA)[1], all partners should ensure that future services are flexible and proactive to meet the needs of this population.

- Improved representation of non-UK born communities within the health and wellbeing services provided in the Wakefield District could build trust between those born outside the UK and the services and encourage increased use to improve their health and wellbeing. Suggestions of how to improve representation included co-designing and co-producing services with communities, employing those with lived experience to work within the services, and developing a peer mentor programme.

- External factors such as poor communication from the Home Office and Mears, adults and families residing in Initial Accommodation and Contingency Accommodation not being provided with an NHS number upon entry to the UK, the dispersal process, and the restrictions placed on asylum seekers and refugees can have a negative impact on their health and wellbeing. Partners should use its voice to advocate for improvements.

- There should be more consideration for children's needs in the health and wellbeing services available, particularly around provision of education. Resources to support personal, social, emotional, and physical development were considered to be lacking within the Initial Accommodation setting.

- Staff working with non-UK born communities and within the health and wellbeing services would benefit from training on issues such as understanding and engaging with those born outside the UK, understanding different cultures and how to make appropriate referrals within the services. Partners should devise and coordinate a local training programme.

- Examples of good practice in local areas mostly focused on Leeds and Sheffield, particularly around the idea of facilitating a hub or drop-in centre for social activities and service provision, as well as the Doctors of the World Safe Surgeries approach which has been adopted nationwide.

4. Main Findings

Management and delivery of health and wellbeing services for non-UK born residents.

When asked to identify what has been working well for health and wellbeing services in the Wakefield District, participants provided mixed feedback, with some thinking the current provision is working well and others feeling there is opportunity for improvement. It was acknowledged that certain individuals within organisations are key to encouraging and facilitating discussions, resulting in change.

Some participants perceived the Council to have responsibility for the management and delivery of health and wellbeing services. They were concerned that it can sometimes be unclear who the most appropriate person to speak to is or who is responsible for what within the Council, which can lead to contacting multiple people who may not be able to help.

[1] www.wakefieldjsna.co.uk

Therefore, understanding organisational roles and responsibilities of all partners and services involved or who become involved in supporting non-UK born communities will be instrumental in progressing forward.

> *“There’s a lot more partnership working and engagement…But because there are so many people involved, there can sometimes be inaction. It can take longer to get some things sorted.”*

> *“From an ownership point of view…you don’t know who is responsible for what. We need a clearer understanding of who does what…otherwise I end up going to everybody.”*

Positive working practices were largely associated with the learning during and following the Covid-19 pandemic and the benefits of forging new relationships and networks at that time. The Roving Vaccination Programme was highlighted as a model of exemplar practice on numerous occasions, in particular its outreach and engagement activities. Also highlighted was the creation of ad hoc multidisciplinary meetings to manage live situations, through open dialogue, making sure all areas are covered, not only around health concerns but wider influencing factors.

When discussing the future of health and wellbeing services for non-UK born communities in the Wakefield District and what ‘good’ services look like, participants provided a series of improvements that they felt needed to be made. These mostly related to personnel such as staffing turnover and corporate memory gaps, and a perceived lack of ownership and responsibility of some services or the support needs of adults and families residing in Initial and Contingency Accommodation.

Importance of suitably skilled workforce capacity and training.

The loss of corporate memory through staff turnover amongst organisations, particularly within the Council and the limited capability to resolve the Council’s staffing capacity has been challenging, both for the Council and their partners. This was perceived to have affected working relationships between the Council, services and other organisations in recent years, however this was not exclusive to the Council.

> “There’s also been a lot of turnover in terms of personnel within Mears, so you build a relationship up with one person and then they move on. So it can be quite a challenge to maintain a relationship with them and a trusted partnership.”

Having a workforce who are culturally competent is extremely important to help alleviate healthcare disparities and improve health and wellbeing outcomes. This relies on personalised approaches through the understanding of different cultures, cultural practices and migration routes.

Participants felt that staff working within health and wellbeing services would benefit from training around certain issues such as understanding and engaging with non-UK born community groups, understanding different cultures and how to make appropriate referrals within the services.

It was acknowledged that some groups can sometimes appear difficult or demanding, or that they have arrived to the UK without relevant documentation which can be a frustration. However, it was explained that these issues tend to be beyond the control of the person for reasons such as being unable to gather documents when fleeing their country of origin, or that the individual may be experiencing mental health issues which are presenting in a way that makes them appear to be awkward to cooperate with

“More investment needs to be put into staff training about engaging with migrant communities. Especially for those working in universal services where you will naturally come across a community and not particularly understand how to engage with them appropriately…We have EDI training through the Council, but I think it needs to be a little more comprehensive at times. Just how to engage with communities in an effective way.”

Participants suggested partners devise and coordinate a local training programme so individuals' knowledge and understanding of working with non-UK born communities is updated to better serve those accessing services. Frontline staff would also benefit in having a functioning partnership to sustain working relationships between individuals and organisations.

Collaborative working between services and organisations has worked well and should continue alongside improved communication and information sharing.

One of the key improvements that participants thought worked well in health and wellbeing services, was the collaborative working between organisations. Participants thought it was good to build on any existing links they had made, particularly during and since Covid-19, and had also found it beneficial to forge new links to better support the non-UK born communities. Participants explained that collaborative working has been useful for them as it allows expertise to be drawn from other areas and the multi-agency meetings provide a broader understanding of the services as a whole.

“*There’s a definite progression in how cultural organisations are speaking to each other about this type of work. Sharing practice, sharing resources, sharing insights and data. There’s a real appetite and enthusiasm to do even more of that and … that feels really important.”*

Whilst collaborative working was seen to be working well by some participants, others felt that this could be improved upon, as well as improving communication and information sharing between services. Participants thought that making improvements in this area would ensure that non-UK born communities including those adults and families residing in Initial and Contingency Accommodation are provided with a continuity of care, providing that there are no issues around anonymity, confidentiality, or data sharing.

Collaborative working between services and organisations should, therefore, be encouraged and facilitated by system partners wherever possible to enable resources and knowledge to be shared between services. This could be through hosting permanent multi-agency meetings with an individual organisation acting as an overarching coordinator of Wakefield partners working within the health and wellbeing sector.

The Council and wider partners should further develop and strengthen the Third Sector offer in the Wakefield District.

Participants talked favourably about local Third Sector organisations, for the positive work for and with non-UK born communities, for example, helping to welcome them to the district, making them feel settled as much as possible, and arranging different activities and events to support social inclusion.

While the Third Sector was praised for the active contribution, it was acknowledged that more was needing to be done to get more Third Sector organisations involved in supporting migrants within Wakefield District. Inhibiting factors for existing organisations shared by

participants included inconsistent funding and/or lack of funding, increased operational costs, loss of volunteer capacity, and volunteer exhaustion and burnout.

Discussions around the Third Sector offer in the district centred around the perception that it is limited and not as strong or diverse as other areas. Participants aspired to improving the local Third Sector offer so it was comparable with other areas such as Leeds.

> *"I must say, the third sector is quite limited in Wakefield. I think that's one thing we need to stimulate and encourage…"*

> *"We've got one or two voluntary sector organisations with incredibly small remits…Everybody's doing pockets of good, but it's not cohesive."*

Leeds was described as better developed in terms of high level operational and strategic development. Having a greater number of organisations available to support and deliver commissioned and non-commissioned services, paid professional employed staff, greater capacity for volunteering opportunities, stronger developed safe working practices e.g. risk assessments, safeguarding etc.

Outreach and engagement with non-UK born communities should continue, with a particular focus on those who may be disengaged from services.

Another practice identified as having worked well was outreach and engagement with non-UK born communities, particularly with faith leaders and those in trusted positions within communities. It was believed that this worked well around Covid-19 vaccinations. Participants felt the uptake of vaccinations would have been lower without engaging with trusted leaders in communities before wider engagement took place.

> *"One of the things is buddying up. We'd really like to be funded to have some outreach and do some more community work with people living in our area. But we would need some expertise for that...With a view to helping them feel welcome and part of something…and doesn't separate them."*

It was suggested that outreach and engagement should continue, and participants were keen for this to focus on non-UK born community groups who may be disengaged or otherwise fall through the gaps of the health and wellbeing services. Whilst participants thought this may be difficult to do, it was suggested that services could establish where non-UK born communities tend to socialise so that engagement can be focused in these areas.

> *"We need to try and work out who we're missing and reach out to them. If you set something up, the people who are willing to engage will do so. It's how we find the people who aren't willing to engage. How do we reach them? It's a hard one, and there will be pockets in each community who we're not reaching."*

> *"Finding those people who haven't got that confidence, the money, the language, or their mental health is very poor and they're staying in their room all day. Getting those people to access services and activities is much more difficult."*

There are opportunities for improvement at the Initial Accommodation in the Wakefield District.

Participants praised service provision within the district's Initial Accommodation to support adults and families residing in Wakefield, including the provision of on-site health services and the positive relationships it has with other services, a few suggestions were made to improve this facility.

"The health team within [Initial Accommodation] deliver really amazing work for the population who live in there. Things have radically changed for that setting in the last three years with length of stay becoming so much longer, and also the medical need and complexity of residents becoming so much more intense. Particularly with it going from a setting which mainly housed fit, young, single men, to one that houses vulnerable women who have experienced trauma and their kids. And with that, they experience service pressures and need to develop new pathways and ways of working, but what I'm really impressed by is the level of care that people are receiving in there and the shift that's had to happen…I just wanted to register how proud I am of them as a service."

Participants' main concern was that the hours of on-site healthcare provision was limited to 9:00am until 5:00pm Monday to Friday, which can sometimes lead to misuse of healthcare services such as requesting an ambulance or visiting A&E when not appropriate. It was, therefore, felt that these hours should be re-evaluated so that adults and families have access to healthcare at all hours in some form, even if this were to be someone being on call in case of emergencies rather than being on-site. The health team have a specific, specialist remit, which does not cover everything that a GP practice would provide, with mixed feedback provided.

Other suggestions included improving the condition of the building, which is old and in poor or unsuitable physical condition in some parts and is not conducive to normal family life, or on a par with perceived modern UK living standards. It is challenging for residents to follow NHS advice about feeding and weaning their children, sleep training and toilet training, when living long-term in a fully catered setting, in a single family room with a shared bathroom along a corridor, and rotated laundry. Provision of devices and free internet was suggested to prevent digital health exclusion.

Language and communication are one of the main barriers to non-UK born communities successfully accessing services and this needs to be routinely incorporated into service delivery.

Translation and interpreter services are vital to be able to communicate efficiently with people who may not have a good understanding of the English language. Several participants felt that these services had been working well in the Wakefield District as they had not experienced any issues around telephone interpreter availability and felt that resources were translated into a variety of languages. Something that was working particularly well was the presence of a face-to-face interpreter, as participants felt they could sometimes pick up on non-verbal cues and body language that would otherwise be missed over a telephone call.

"We managed to get face-to-face interpreters and they can pick up on some of the softer signals that over-the-phone interpreters can't. They could turn round and say 'Well they've said this, but they didn't sound very convincing in the way that they said it' or they're able to have a bit of back and forth with them before translating into English for us."

"I know at the local school there's 600 children, and the last time I spoke to the headteacher, he said there were 46 different languages in the school."

"Even within languages, there's different dialects."

Despite some feeling that the translation and interpreter services are adequate, participants still identified language and communication as the main barrier to accessing health and

wellbeing services. Participants were concerned that not all communication needs were being catered for, whether this is due to their literacy level, resources not being translated into correct languages or dialects, or cultural nuances not being considered. Due to this language and communication barrier, participants were worried that some migrants may not understand what services are available to them or how to access them, or may be nervous of accessing services out of a fear of misunderstanding what is being said.

> *"My experience in working with the Eastern European communities in Wakefield District…We find out that usually people say that the main problem is the language, even people who can communicate in English – maybe it's not a very high standard of communication…but they're worried. They're worried if they will not understand the question, they're worried they will give the wrong answer, or they're worried if they will not understand how much they have to pay for something. And usually that's the reason why they are refusing just to attend some services or some groups."*

> *"Some women I've spoken to…want much more in the way of informal ESOL teaching. They don't necessarily want to be able to read and write, but they want to function. It's about communication – talking to your doctor, getting on the bus, talking to your child's teacher, talking to your neighbour…We don't do enough. There isn't enough of an offer."*

There was also some concern around the current interpreter services, with the main issue being a lack of available interpreters at short notice or outside regular working hours. As a result, participants found that children and family members were expected to act as interpreters which is not always appropriate. Some were also having to use Google Translate in lieu of interpreters which does not always provide like-for-like translations. Another concern related to privacy and confidentiality, as some migrants may not wish to disclose private information in front of an interpreter, although this is a difficult barrier to overcome.

> *"I'm not sure that navigating across services into secondary care is as easy. When we flag up that a patient needs a translator on a referral, not all languages that are present in our local area are listed. One that I often come across is Pashto"*

> *"In mental health services, there are no translatable words for things like stress, talking therapies. And those are the words used to promote the services. IAPT is now NHS Talking Therapies, so if you're not familiar with the concept of counselling and therapy, it doesn't mean anything. There's no translation for depression and anxiety which are the two key aspects, so it's very confusing if you don't know what they are and you don't know who it is you're going to."*

Some non-UK born communities may have different health and wellbeing needs to the local general population based on various characteristics and are, therefore, likely to need specialised health and wellbeing services, including mental health.

Many participants recognised that some non-UK born communities have different health and wellbeing needs compared with the local general population based on several characteristics such as gender, country of origin, culture, and their journey to the UK and their reason for leaving their country of origin.

> *"It's understanding the folklore they bring with them. Like we say if you go out when it's cold and wet, you'll catch a cold. Sometimes you've got to decipher that, but that requires an understanding of the cultural nuance."*

“Some people have a journey that involves getting on a plane and coming to the UK, or they might have touched down in a different country and then travelled onward to get here. But then some may have experienced trauma, they could have arrived on a small boat or been trafficked. Understanding their differences and cultural diversity is vast.”

“There can be a fear or an anxiety about accessing health services…Around cancer screening, culturally cancer can be very stigmatised…In some cultures, cancer’s just so taboo. It’s not mentioned and therefore the screening uptake isn’t very high.”

“There’s generally a lack of cultural understanding on both sides. I think what we’ve alluded to is about helping migrants coming to understand some of what we consider to be social norms and practices in the UK, but then also understanding from their perspective. Because some of the messages that we’re trying to get across…might be at odds, for example, with some of the cultural practices that happen in other countries. And so it’s trying to reach that mutual understanding.”

Due to the different health and wellbeing needs they may have, participants felt that some non-UK born communities need specialised health and wellbeing services. Examples included psychosexual services, gender-specific services such as same-sex clinicians and female-only physical activity provision, more in-depth health assessments and culturally appropriate food and health provision.

In addition to specific physical health needs, participants also discussed the complexity of mental health needs. It was generally understood that vulnerable non-UK born communities including those seeking asylum can experience a wide range of mental health issues that stem from a range of causes, from low level mood and anxiety to complex post-traumatic stress disorder (PTSD) and suicidal ideation. As such, participants thought it was important to offer tailored mental health support for these groups, as the services available to the local general population may not always be appropriate, particularly for those who have experienced significant trauma.

“There’s not enough attention paid to the trauma that people come with…and it’s not even just the trauma that people come with. When the Rwanda thing came, there was a huge hubbub that people stopped coming to things because they were terrified that if they came, they would be picked up. There was a lot of fear as a result that happened.”

Some participants also highlighted that those born outside the UK may find it difficult to access mental health support in the first instance for several reasons. The main barrier was that mental health is often stigmatised in their country of origin.

“There’s a stigma or lack of understanding of what the mental health services are. It’s a real barrier…That concept of talking to resolve issues can be quite alien to many people. They can come expecting their problems to be sorted out, like their house and the things that are impacting them. Those are the things they come expecting to talk about, so they’re quite disengaged when they realise this is just talking, and what help is that?”

Other barriers included a lack of referral pathways for complex mental health needs, inadequate services for migrant communities, long waiting lists for support, knowledge and expertise of the referrer and the level of experience the provider has in Human Rights based trauma informed practice.

“There is a need for trauma counselling. It’s really inaccessible for people. They will often go through IAPT and then be told it’s not for them because they’ve potentially got PTSD or something more severe than the things that Improving Access to Psychological Therapies (IAPT) can deal with like low mood, anxiety. Then they don’t go anywhere because there isn’t anything for them.”

Suggestions for changes included more involvement from Occupational Therapists, more group sessions and specialist trauma training for counsellors. It may also be beneficial to focus some work on de-stigmatising mental health support for those who may have negative perceptions of these services.

Both non-UK born communities and professionals working within the services would benefit from increased awareness about the services available in the Wakefield District.

Throughout the research, it was apparent that there may be a lack of awareness of the health and wellbeing services available that needs to be addressed, which applies to both non-UK born communities and those who work within the services themselves. Participants believed that those born outside the UK were often confused about how to access services in the UK as they can be vastly different to what they are used to in their country of origin. Participants also found that non-UK born communities tend to have different expectations of UK healthcare services compared to the reality, such as expecting to be given an appointment immediately or expecting different medication than what is available, which can lead to misunderstanding or misusing services, or avoiding using services altogether.

“Their expectations of care are different. If I offer them tablets, they don’t like it because they want an injection because that’s what they would get locally…So trying to align their expectations of care with what we can offer is often quite difficult.”

To improve understanding and awareness of the health and wellbeing services available to non-UK born communities in the Wakefield District, it was suggested that partners should provide an information pack upon arrival about how to access and navigate these services if this was not already the case. Participants also believed that this information could be communicated through different channels such as online via existing websites, face-to-face information sessions and working with community and faith leaders to disseminate valuable information.

“There’s a lot of support and services out there but finding it and connecting it a bit better would be helpful…When we have enquiries from mental health services wanting to refer people who don’t meet our criteria, it’s really hard to find other services to support them. I think that’s a real gap.”

“There are lots of people in need who are looking for services and looking for support and there are lots of organisations who are out there who are able to provide that help, but it’s not quite joined up at the moment. I think a lot of the services don’t know what other services exist that they could link up with and help with. Much of the feedback we get is that people have problems getting access to the services they need for whatever reason.”

Whilst it was agreed that services within the Wakefield District are offering valuable support and operating well on an individual basis, they were widely considered as being disjointed or working in silos due to a lack of awareness of what other services are available. Participants felt it would therefore be beneficial partners to have a collective understanding of all services supporting migrants in the district so that they are able to contact the most appropriate person or service if necessary, or better signpost migrants to other services they may need.

Overcoming boredom and isolation for adults and families residing in Initial and Contingency Accommodation.

According to participants, one of the main concerns about adults and families residing in Initial and Contingency Accommodation was their sense of boredom and isolation. Participants felt there were several contributing factors such as a lack of activities, being unable to work and their physical location. Participants were also concerned that boredom and isolation could lead to wider issues such as mental health issues and possible substance abuse.

> *"There's things that don't really come under health provision but can really have a significant impact on people's health. The main one probably being boredom… The last thing you need is someone being stuck in a hotel room for 20 hours a day staring at a blank wall and reliving through some of the trauma they've been through."*

Overcoming boredom and isolation for adults and families residing in Initial and Contingency Accommodation was identified as a priority to focus on through a few preventative measures. Suggestions included facilitating more sports and activities on-site, providing appropriate resources and equipment for sports, offering opportunities around training, volunteering and future employment skills (as those seeking asylum are unable to work until they are granted refugee status), and providing support around access to transport. Participants identified a number of barriers relating to boredom and isolation, financial struggles, transport, immigration status, geographical restrictions and limited volunteering opportunities.

> *"The barriers to accessing physical sport and activities need to be removed. It's all very well saying they'll organise a weekly football session. Do the lads have kit to play in? Have they got football boots? How are they going to get there? Where's the investment and the infrastructure to allow people to do this?"*

> *"How creative can we be about volunteering and training?...Some people at [Initial Accommodation] are really committed to being here and making a life, so if you offer them volunteering, they will take it. They understand that if they keep doing things, it's good for them, but if they stay in [Initial Accommodation], it's not good for them. They'll get depressed and unmotivated and life will be much worse…Maybe if there was more integration and stuff with local communities, and not just education."*

It is also positive to note that several participants from a range of services said they would be willing to support with activities to try and overcome the sense of boredom and isolation, felt by adults and families residing in Initial and Contingency Accommodation.

Social integration and cohesion are needed between non-UK born communities and the local general population.

Participants suggested that they were becoming increasingly concerned about the narrative surrounding individuals seeking asylum which they felt was being fuelled by national government policies and certain media outlets. As a result, participants believed that community tensions were worsening in some areas between the local general population and asylum seeking communities and were concerned about non-UK born communities suffering from abuse and anxiety around their safety.

As participants were concerned that non-UK born communities may not feel welcomed in the Wakefield District, they thought that more could be done to facilitate community integration to remove social barriers between non-UK born communities and the local general population.

"I think integration within the community is really important. Education, healthcare, schooling. Being part of a community and having a sense of somewhere to be."

It would, therefore, be beneficial for all partners to explore ways to facilitate social integration between non-UK born communities and the local general population, as participants felt this would be mutually beneficial. The most common suggestion was to host more free community events, where those born outside the UK can learn about the local culture and the local general population can learn about our non-UK born communities and their backgrounds.

"Have community events to bring communities together and they can mix. A lot of it is just ignorance, so bring them together face-to-face…It's important for their mental wellbeing that there is cohesion within our communities. They need to feel welcome and it's important that they have that cohesion, and that people can live there happy."

Significant changes and increases to the non-UK born population in the Wakefield District mean that future services should be proactive and flexible.

Participants highlighted that there have been significant changes to the non-UK born population arriving in the Wakefield District, compared with in the past.[1] One of the key changes was the increase in non-UK born population groups residing in the district, particularly refugees and asylum seekers, and their increased length of stay in Initial and Contingency Accommodation, due to delays in decisions and dispersal challenges centred around national policy. At the time of writing this report participants said that the average length of stay has risen significantly from several weeks to several months, and in extreme cases, over a year. Another change highlighted by participants was the shift in the demographics of adults and families residing in Initial Accommodation, from fewer young single men to more families with young children, requiring input from schools and children's services.

"[Initial accommodation] has changed massively over the last couple of years in terms of its occupants. We used to have pregnant ladies who would come and were very swiftly moved on, and now we're seeing full pregnancies and full families so we're trying to cater to that a little bit more and looking at how we can ensure a smoother process through our system."

"You'll get a new hotel pop up which means you need a practice to be able to spring into action to be able to deliver services. Because the health inclusion service will do initial health assessments and screening, but anything that's core general practice still has to be done by the GP."

Participants were concerned that the services were not adapting to the evolving needs of the adults and families residing in Initial and Contingency Accommodation and were being reactive rather than proactive. The main concern was that adults and families require access to a wider range of services such as optometry, dentistry and secondary care referrals as they are staying in Initial and Contingency Accommodation for longer.

"It's across the board and not exclusive to migrant groups, but trying to get a dentist on the NHS is impossible. It's really difficult for any of our clients who have got severe dental issues to get any treatment."

[1] www.wakefieldjsna.co.uk

Taking this into consideration, it was suggested that all partners should ensure that future health and wellbeing services are flexible and can be adapted at short notice to increased levels of need.

Improved representation of the needs of non- UK born communities within all services including health and wellbeing could build trust and encourage more non-UK born residents to use services.

Several participants suggested that the representation of the needs of non-UK born communities within all services including health and wellbeing needed to improve in the future in order to build trust. Suggested ways in doing so for the partners to consider included partnership working with those born outside the UK to co-design and co-produce the services with a robust quality assurance system, employing those with lived experience to work within the services and developing a peer mentoring programme.

> *"A lot of the time, it's us who thinks we're providing a good service. We want to ask the people who are using the services what they think a good service is, what they need. What we think is good could be absolutely fantastic, but it could also be rubbish. We need to ask the people what they think, and I don't think we're very good at that."*

External factors can have a negative impact on health and wellbeing services for non-UK born communities and system partners should use its voice to challenge these.

Whilst participants understood that some things were beyond the control or responsibility of the Council and local NHS partners, they felt it was important to discuss their impact on delivering health and wellbeing services. Examples included not being provided with an NHS number, poor communication from the Home Office and Mears about those seeking asylum who are due to be arriving in the district, issues with funding, the dispersal process and the policies and restrictions placed on those seeking asylum that negatively affect them.

It was, therefore, suggested that all parts of the Council, the NHS, other system partners including Third Sector partners should use their voice and position to challenge these external factors, by using existing escalation routes or finding new ways to lobby government to make changes.

Future services should be more considerate of the needs of children living in Initial Accommodation, particularly around education.

Several concerns were raised about service provision for children living in Initial Accommodation, particularly around education. Education was seen as been important to integrate within the wider community. Pressure on school places and concerns about children being dispersed after becoming settled within a school led participants to explore the possibility of providing alternative learning opportunities for children and adults.

One participant also voiced their concern about whether it would be appropriate for some children to attend school if they have experienced trauma in their country of origin and the impact this has on their ability to learn.

Resources for children in Initial Accommodation were also a concern. It was felt that the current resources and play equipment were inadequate and that families could be supported with more practical resources such as help with school applications, bus fares and school uniform.

“The local authority has the duty to deliver education and they’re still not delivering it. They do some things really well, but if I just speak about education, which is a huge thing, we need someone [at Initial Accommodation] every single week helping the families to fill out application forms to get them into school. That was promised by the local authority over a year ago, and it’s still not happening every week. It’s really difficult…They need the routine that somebody is going to be here to deliver sessions and get them into school.”

A couple of participants also raised the issue of supporting children in special circumstances, with a specific example being when a mother is admitted to hospital to give birth but has older children that need to be looked after. Those who discussed this scenario said that when this has happened in the past, migrant children have been placed into temporary foster care accommodation which can be emotionally distressing to both parties.

Based on these points, it would be beneficial for partners to explore additional ways to support children in Initial Accommodation and any future family Contingency Accommodation.

Out of area examples of good practice.

When asked to provide examples of health and wellbeing services working well in other areas, the most common suggestions were Sheffield and Leeds. One thing that both areas had in common was a drop-in centre or hub where asylum seekers and refugees can socialise with others and engage with relevant services. Participants felt that this could be replicated within the Wakefield District, although one participant highlighted that something similar used to be available but has since ceased to operate due to a lack of partner involvement. Nevertheless, participants listed a range of services that would be suited to a hub such as health workers, teachers, housing officers and representatives from the Council to discuss how different services operate.

“One thing that’s really great in Sheffield is a weekly multi-agency drop-in. I think that’s a really good way of facilitating joined-up working between key agencies, and it’s also a focus for all asylum seekers and refugees to come and interact with each other. It’s kind of like an informal conversation club alongside lots of different tables of agencies where people can go and get practical support.”

Other examples of good practice in Sheffield and Leeds included multi-disciplinary meetings, a refugee forum, a strong Third Sector network, better integration between non-UK born communities and the local general population, better mental health support and providing better access to a wider range of services.

Something that was discussed by several participants but is not specific to any area was the Safe Surgeries approach, whereby GP surgeries adopt several changes to the way they operate to demonstrate that they are a safe space for migrants to access healthcare. Participants felt that this was something that could be implemented in the Wakefield District as it could remove potential barriers to migrants accessing healthcare and improve their overall experience.

“I find it quite astounding that Wakefield doesn't adopt the Safe Surgeries approach that other areas have got…Basically, it's a safe surgeries toolkit, seven steps to make your general practice environment safe for everyone. So this is looking at migrants and at tackling more vulnerable cohorts. Don't insist on proof of identification or address, never ask to see a visa or proof of immigration status, do what you can to protect, use an interpreter, display posters and reassure clients that

your surgery is a safe space. And empower frontline staff with training and inclusive registration policy. So is it not that we start with the GPs in Wakefield?"

5. Key Conclusions

This section of the report provides a condensed summary of the key conclusions based on the information provided within the report.

- Ensure suitably skilled workforce capacity.
- Devise and coordinate a local training programme.
- Identify an organisation to act as an overarching coordinator of Wakefield partners working within the health and wellbeing sector.
- Collectively understanding organisational roles and responsibilities.
- Have a dedicated multi-agency health and wellbeing forum.
- Develop and ensure culturally competent services which are flexible and proactive.
- Increase awareness of the health and wellbeing services available.
- Formalise informal referral pathways with clear eligibility criteria.
- Have consistent NHS registration procedures.
- Build migrant-centred and trauma-informed mental health services.
- Great consideration in relation to translation of resources and use of interpreter services for building trust, avoidance of misinformation and protecting children.
- Continue outreach and engagement, including opportunities to learn English.
- Strengthen and diversify the Third Sector offer for non-UK born communities;
    - Building sustainability
    - Increased funding opportunities
    - Increased volunteering
    - Protecting the welfare of individuals delivering Third Sector services

- Improvements to be made within Initial Accommodation;

    Enhancing healthcare provision
    Lifestyle improvement factors (nutrition and physical activity)
    Environmental improvement factors (conditions and facilities of the building, green space, digital access)
    Strengthen support to children and their families

- Build upon strategies to overcome boredom and isolation within Initial and Contingency Accommodation and build social cohesion.

- Improve representation of non-UK born communities in designing and improving services.

- Advocate for improvements in services supporting the welfare of non-UK born communities.

6. Next Steps

To share the findings with those partners who participated in the interviews and focus groups through the delivery of virtual and face-to-face feedback sessions. This will offer participants, the opportunity to validate the key findings and document subsequent learning and key actions which can be undertaken to improve health and wellbeing services for non-UK born communities.

For those participants to cascade the findings further within their organisations and networks to maximise the benefits of the findings to influence future working practices.

To publish the report and attend local interest forums and governance meeting as and when appropriate, to disseminate the findings and provide an update on the Health Needs Assessment to date.

From January 2024, work will begin to capture the voice of those with lived experience of being a non-UK born national. Wakefield Public Health Team at Wakefield Council is commissioning an independent agency to undertake this piece of work and report the key findings. This will be under the direction of the Health Needs Assessment working group.

As this is the first in a series of reports to be published in the coming 12 months. Each of the reports will be collated together to lead to the development of an overarching document with the aim of shaping future services for non-UK born communities.

To support this work, we are already developing strategic partnerships and linking with existing workstreams, to progress the emerging findings and deliver improvements in health and social care.

Acknowledgements

We would like to acknowledge the input of Enventure Research who through a commissioning process were responsible for conducting interviews and focus groups. They captured the lived experience of organisational stakeholders delivering services and care to migrant communities residing within the Wakefield district, which informed the content of this report. We would like to thank the members of the Migrant Health Needs Assessment Working Group for the guidance and support in overseeing the management and deliver of the organisational engagement.

Edited by: Emma Smith, Head of Health Protection, Public Health Wakefield Council.
Supported by: Kerry Murphy, Jenny Waddington, Pat McCusker, Amanda Stocks, Peter Shepherd, Laila Charlesworth, Pam Taylor and Natalie Knowles.

Any enquiries regarding this document should be sent to healthprotection@wakefield.gov.uk.

Published January 2024.

Appendix 1: Discussion Guide

Wakefield Council

Migrant Health Needs Assessment
Stakeholder Engagement

Focus Group / Interview Discussion Guide

Please note this discussion guide is intended as a guide to the moderator only. Sections may be subject to change during the course of the focus groups/interviews if, for example, certain questions do not elicit useful responses. Wording and explanations may change to suit the audience.

BEFORE FOCUS GROUP/INTERVIEW START TIME (for online meetings)

- Participant(s) asked to join/arrive five/ten minutes early and wait in waiting room to allow the group/interview to start on time
- Participant(s) asked to review the joining instructions and participant information sheet
- Participant(s) will have completed the online form (proving consent to record the discussion)

Introduction (10 mins)

Welcome everyone. Provide a brief overview of the session:

- Information about confidentiality
- Background to the research
- Introductions
- Discussion around current health and wellbeing services for migrants and what good services and activities / health and wellbeing opportunities looks like
- End of discussion – 75-90 minutes in total for a focus group or approximately 30 minutes for a depth/paired interview

Confidentiality:

- Everything said during this discussion is confidential. There are no right or wrong answers.

- Enventure Research is an independent research agency, not part of Wakefield Council or any government / public agency.

- We may use quotes from this discussion within the report, but these will remain anonymous and any identifying information will be removed.
- We work to the Market Research Society Code of Conduct and GDPR.
- All views and opinions of all present are important and valid.
- The group/interview will be recorded – thank you for completing the online consent form. The recording will only be used to listen back to and write up notes. It is not passed to anyone else, including Wakefield Council, and will be securely deleted once the research project has finished. Please don't talk over each other.

Background to the research:

I hope you have got an idea of what we will be discussing in this session. I will just recap and summarise the background of the research.

Non-UK born communities living within the Wakefield District have substantially increased in the past ten years. Contributing factors include economic/workforce migration, family migration, the delivery of resettlement schemes and people seeking asylum.

The Public Health Team at Wakefield Council and local NHS organisations are embarking on a piece of work looking at the needs of our non-UK born communities.

This work will help us to better understand the needs of our non-UK born communities, so that these can be reflected in decisions that affect their lives. Supporting future service improvement, ensuring local services are shaped to support the health and wellbeing needs of local non-UK born communities.

We have been commissioned by Wakefield Council to talk to a wide range of stakeholders to explore:

- *what 'good' looks like for health and wellbeing outcomes and services delivering health and wellbeing support for non-UK born communities living within the district*
- *local examples of good practice in addressing health needs, and understand how they can be replicated, and where there is there room for further improvement*
- *where there are gaps and challenges, including interdependencies, to achieving improved outcomes and scope out potential solutions to address them*

We will then take all this information and feedback from stakeholders, and provide Wakefield Council with a full report with recommendations that identifies areas that it can work on for short, medium and long term ambitions.

On publishing the report Wakefield Council and NHS partners will host a feedback forum to share the report findings.

Definition of what a migrant is

I also want to clarify who we mean when we say migrants. Migrants can be:

- Working/economic migrants
- Migrants to study
- Family migrants
- Asylum seekers, refugees and resettled migrants
- Trafficked migrants / victims of modern slavery
- Undocumented migrants

Non-UK born residents may have lived in the UK for many years or only a few weeks/months.

What we mean when we say services

I also want to clarify what I mean when I ask you think about services and activities. It's an umbrella term and not just about health services, but it also includes the wider things such as planning and support, social connections, peer mentoring, activities, holistic approaches and much more.

Recording the session

As I said previously, I'm going to record the session. Just to reiterate, this is for me only, so I can take notes later rather than having to write lots of things down now. I will delete the recording as soon as I've taken the notes and will not be sharing the recording with anyone else, including Wakefield Council.

START RECORDING

Getting to know each other (fg 5-10 mins / depth or paired 5 mins)

It would be good if you could introduce yourself and briefly tell me/us what your role is within your organisation and what work you do or have done with non-UK born communities.

For focus groups/interviews - Please can we go around the screen/room and introduce yourself and provide some background on what you do.

Discussion (fg 60-70 mins / depth or paired 30-40 mins)

Current services

- In your own experience, what do you think has been working well in terms of health and wellbeing services for non-UK born communities?
- Which services are these?
- Why do you think it has been working well?

Explore……dentists, GP services, screening, immunisations, politics

Issues…….language, translator availability, cost to travel for services, childcare, employment (inability to work – boredom/de-skilling), skills, school, housing, culture, trust, food, ability to understand the systems, one size does not fit all, emotional experience / what people have experienced in own country,

What is needed to be healthy?

- What do you think non-UK born residents in Wakefield need in order to be healthy?
- What do you think works best – activities / pathways / services / interventions?
- Are there enough activities / pathways / services / interventions to suit the current non-UK born population? What about the future non-UK born population?
- Are there any differences in needs when considering different cultures, traditions or values?
  Moderator note: Explore different groups of non-UK born communities if relevant

How services have developed over last few years

- How have services and activities developed over the last couple of years?
  Moderator note: Explore if systems have changed or been introduced, new delivery mechanisms, network structure, funding streams, organisation restructuring
- What has been the impact of these services and activities? Have these been positive or negative? In what way have they made the impact?
- Is there anything that could be done differently to improve the services and activities and make them even better?
  Moderator note: If participant(s) suggests something outside of council responsibility, ask participant(s) who they think is responsible for delivering this

Good services

- What do you think good services and activities / health and wellbeing opportunities for non-UK born residents look like?
- What are the key aspects/key drivers of these?
- Would good services and activities look different for those in different migrant groups? What are the differences?

Examples of good services in **<u>other</u>** areas

- Do you have any examples of health and wellbeing services working well outside of Wakefield?
- What is done differently?
- Do you think this could be rolled out / replicated in Wakefield?
- Is it only applicable to / does it only work with specific migrant groups? If so, who? Why is that?

Note to moderator: *If participant(s) highlight services that have not been successful, explore what could be done to improve them? What solutions are needed? Has there been*

an impact of Home Office practice and/or policy? What are the realistic and achievable solutions available to participants?

- What outcomes are needed to work towards for good services and activities?
- How should changes in services be prioritised? What is the most important thing(s) to change first of all? Why? What impact would this have? What timeframe would you expect these changes to be implemented in?

Summary and close (5 mins)

Based on everything we have discussed today:

- What are the most important points we have discussed today?
- What is the ONE change you would make? Suggested changes need to be realistic and achievable and done at a local level (not done by a change in national policy). What timeframe would you put on this?

Moderator to:

- ***Thank everyone for their time and input***
- ***Any other questions/points to raise? If you think of any other things, these can be emailed – please simply respond to the email with the details of this interview/focus group***
- ***Thank & close***

Appendix 2: Terms of Reference for Wakefield Migrant Health Needs Assessment Working Group

WAKEFIELD MIGRANT HEALTH NEEDS ASSESSMENT WORKING GROUP

TERMS OF REFERENCE

2 FEBRUARY 2023

PURPOSE

To collectively plan and develop the operational approach and mechanisms to undertaking the Wakefield Migrant Health Needs Assessment, ensuing we are successful in achieving our agreed aims, objectives, and outcomes.

FUNCTIONS

- Maximise the participation of people with Lived Experience and organisational stakeholders, capturing their knowledge, reflections, and specialist opinions to provide richer locally focused intelligence.
- For members to provide expert advice and guidance in their specialist areas, identifying gaps in specialist knowledge, which may need to be acquired externally to the existing group membership.
- Support collaboration and shared intelligence between members to maximise the operational deliver of the health needs assessment plan
- For members to participate in dedicated Task and Finish Groups, to complete defined pieces of work which contributes to the delivery of the health needs assessment plan
- Review and monitor the delivery of the health needs assessment plan, generating a meaningful and co-produced final report.
- Work together to raise awareness of the health and wellbeing needs of migrant communities living within the Wakefield District, amongst all organisational stakeholders.

ACCOUNTABILITY

The working group will be accountable to the Wakefield Public Health Management Team via Emma Smith, Head of Health Protection and the Primary Care Performance and Operational Group via Natalie Knowles, Primary Care Development Manager, and the Head of Health Protection.

Each member will be accountable to their own organisation for their contribution.

MEETINGS

Will take place virtually for 1 hour every month.
Task and Finish groups will be scheduled as required.

SECRETARIAT

Organising the meetings, taking notes, and sharing papers will be managed by the Public Health, Health Protection Team

CHAIR & VICE CHAIR

Chair: Head of Health Protection, Wakefield Council

Vice Chair: Public Health Manager, (Health Inequalities & Poverty), Wakefield Council

MEMBERS

Emma Smith, Health of Health Protection, Wakefield Council (Lead)
Natalie Knowles, Primary Care Development Manager, Wakefield District Health & Care Partnership
Dasa Farmer, Senior Engagement Manager Wakefield District Health & Care Partnership
Cathie Railton, Programme Manager (Yorkshire & Humber), OHID
Adam Atack, Refugee Integration Service Manager, Migration Yorkshire
Katie Comer, Consultant in Health Protection, UKHSA
Pam Taylor, Service Manager, Customers, Area Development & Cohesion, Wakefield Council
Kerry Murphy, Public Health Manager, (Health Inequalities & Poverty), Wakefield Council
Pat McCusker, Covid Response Manager (Vulnerability & Health Inequality), Wakefield Council
Georgina Swift, Health Improvement Team Leader, Wakefield Council
Anna Carson, Senior Environmental Health Officer, Wakefield Council
Peter Shepherd, Senior Public Health Intelligence Analyst, Wakefield Council
Jenny Waddington, Health Protection Manager, Wakefield Council
Amanda Stocks, Insight-led Behaviour Change Specialist, Wakefield Council
Jo Fitzpatrick, Associate Director Population Health: Personalisation & Engagement, Wakefield Council
Paul Jaques, Public Health Intelligence Manager, Wakefield Council
Chris Dugher, Specialist Health Improvement Officer, Wakefield Council
Linda Fielding, Studio of Sanctuary Programme Coordinator, The Art House