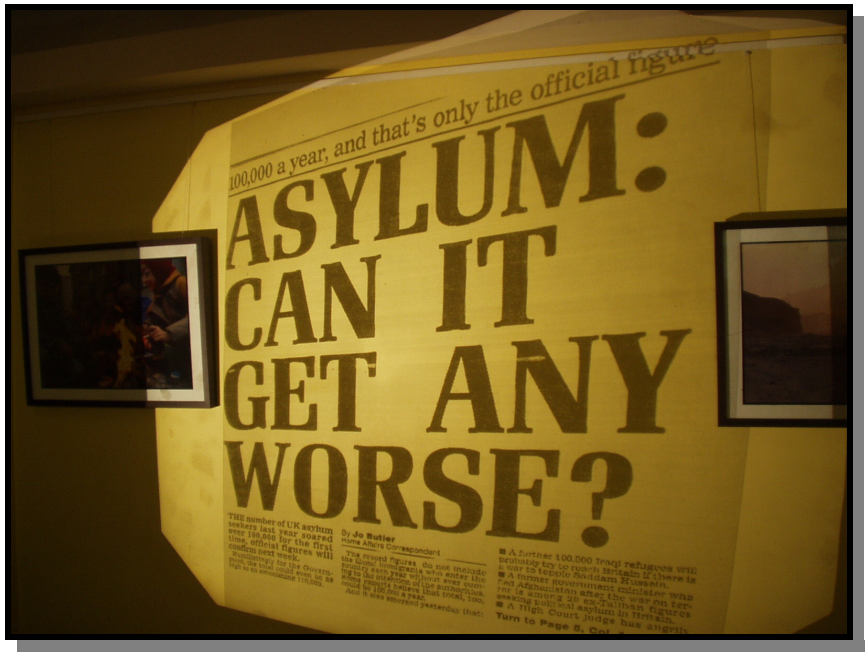

Asylum Pulse: Are we feeling it right?

Health Needs of Refugees & Asylum Seekers in the boroughs of Kensington & Chelsea and Westminster

A Report by the BME Health Forum &
The Migrant & Refugee Communities Forum

December 2003

"Asylum Pulse: Are we feeling it right?"

The BME Health Forum &
The Migrant and Refugee Communities Forum

Final Report from the Task Group:

Health Needs of Asylum Seekers & Refugees in Kensington & Chelsea and Westminster

December 2003

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December 2003

Table of Contents

ACKNOWLEDGEMENTS **5**
EXECUTIVE SUMMARY **6**
INTRODUCTION **7**
The Task Group Context 7
Policy and Legislative Context 8

METHODOLOGY **9**
The selection of groups 9
Community consultation training 9
Developing the pro forma 9
The overall process 10
Comments on the methodology adopted 10

THE TASK GROUP COMPONENTS **11**
List of completed consultations 11
Fact -finding visits 12

FINDINGS **14**
1. Awareness of Current Mainstream Health Services 14

1.1. Primary Care Services 14
1.1.1 Registering with a GP 14
1.1.2 Awareness of services provided 15
1.1.3 Visits to the GP 16
1.1.4 Referrals to specialists 17
1.1.5 Changing GPs 18
1.1.6 Awareness of complaint procedures 18

1.2. Hospital Services 19
1.2.1. Awareness of hospital facilities 20
1.2.2. Specialists 20
1.2.3. Accidents and Emergencies 20
1.2.4. Maternity Services 21
1.2.5. Operations/ post-operations 21
1.2.6. Follow -ups from operations 22
1.2.7. Medical errors 22
1.2.8. Awareness of complaints procedures 23

1.3. Health and Social Care Professionals 24
1.3.1. GPs 24
1.3.2. Hospital consultants 25
1.3.3. Frontline staff 25
1.3.4. Nurses and health visitors 26

1.4. Co-ordination between GP services and hospitals 26

2. Provision of interpreting services 26

3. Other Health Services 28
3.1. Women's Services and Sexual Health Services 28
3.2. Dentists 29

3.3. Mental Health services 30
3.4. Opticians 30
3.5. Pharmacists 31
3.6. Paediatrician and other children's services 31
3.7. Support for the elderly 31
3.8. NHS Direct 32

4. Provision of adequate/ culturally sensitive Health Services 32

5. Issues Mainly Relevant to Asylum Seekers 33
5.1. Immigration status 33
5.2. Housing and dietary requirements 33
5.3. Dispersal and the continuity of care 34
5.4. Access to schooling 34
5.5. Unemployment 34

6. Accessing information 35

7. Good practice in the process of running community consultations 36

MAIN RECOMMENDATIONS 37

8.1. Service-Providers and Commissioners 37
8.2. Primary Care Services 37
8.3. Hospital Services 38
8.4. Other Health Services 39
8.5. Provision of Interpreting and Independent Advocacy Services 40
8.6. Provision of Adequate / Culturally Sensitive Health Services 40
8.7. Issues Mainly Relevant to Asylum Seekers 41
8.8. Preventative Work, Including Health Promotion 41
8.9. Partnership projects between community and statutory sectors 42
8.10. Other recommendations 42

THE WAY FORWARD 43

Appendices

Appendix A: List of the steering group members 44
Appendix B: Pro forma questionnaire 45
Appendix C: Assessment table 48
Appendix D: The seven days induction process at Ashford's Induction Centre 49

Acronyms

A&E: Accident and Emergency
BME: Black and Minority Ethnic
DOH: Department of Health
FGM: Female Genital Mutilation
HIMPIC: Health Improvement Information and Resource Centre
KCW: Kensington and Chelsea and Westminster
MRCF: The Migrant and Refugee Communities Forum
NHS: National Health Services
PALS: Patient Advice Liaison Service
PCT: Primary Care Trust
KCW: Kensington & Chelsea and Westminster

***"The health system in the UK is a maze and we do not know to whom to go for help."* An Iraqi asylum seeker said.**

Acknowledgements

The BME Health Forum and the Migrant and Refugee Communities Forum would like to thank all those who participated in the Task Group, and especially representatives from community groups who held consultation events. The BME Health Forum and MRCF would also like to thank Bridget Davies for taking the minutes of the consultations.

This report has been written by Myriam Cherti, Community Development Worker at the Migrant and Refugee Communities Forum, with the help of Aisling Byrne, the former BME Health Forum Manager.

We also would like to thank Judith Blakeman from the KCW Community Health Council; Zrinka Bralo, Executive Director of MRCF and Amjad Taha, BME Health Forum Manager, for their support.

Executive Summary

This Report gives the findings and recommendations from a community-based Task Group looking at the health needs of Refugees and Asylum Seekers in Kensington & Chelsea and Westminster. The aim of the project was to undertake a series of consultations, co-ordinated by community groups themselves, to hear from their members' and users' experiences in using NHS services in KCW. The objective was to look at unmet needs, as well as at ways of working towards service improvements that better reflect the needs of Refugees and Asylum Seekers.

The project was undertaken from January - October 2003, and was co-ordinated by the *Migrant and Refugee Communities Forum* and the *BME Health Forum*. A total of 20 community consultations were undertaken, involving over 300 people. Of these: approximately 80% of those who participated in the consultations were refugees, 15% were asylum seekers, and 5% were settled migrants. The findings do not claim to provide quantitative data, nor to represent the views of all BME communities - what they do is share in detail the experiences of more than 300 refugees and asylum seekers using health services in KCW.

It is hoped that the findings and recommendations will be taken up by NHS Trusts providing and commissioning health services in KCW – most of whom were involved during the duration of the project. Given recent policy and legislative developments which put patients' experiences, involvement and engagement at the centre of the NHS, the MRCF and the BME Health Forum hope to work with Trusts in taking forward some of this work.

While most of the findings are not new and are issues and concerns that arise again and again, the fact that they continue to arise indicates that sufficient action has not yet been taken. And many of the recommendations do not have cost implications, but relate to issues of attitude and culture change. The issue of interpreting, for example, arises over and over again, despite there being a free interpreting service available which NHS staff need to book. The role of GPs was recognised as key to the NHS:

> GP surgeries were described by many participants as "*the nerve centre of the health system*"
>
> One woman with children found it so difficult to see her GP when needed that she started booking appointments every two weeks, then cancelling them if not needed.
>
> One elderly Eritrean man explained that *"People needing health treatment are not aware of the system – they cry at home, and then give up".*
>
> An Iraqi man explained: "*The health system in the UK is a maze and we don't know to whom to go for help."*
>
> And a Refugee Doctor put it: "*Here you have to know your rights and do everything for yourself; otherwise you are marginalized*."
>
> People felt it was at the level of GP and primary care services that action was most needed to improve access and respond to the needs of refugees and asylum seekers.

We hope that the information, recommendations and findings contained in this report will assist with the continued development and improvement of health services, and access to these services, by refugees and asylum seekers and their families.

Introduction

This Task Group was a 9-month project that started in January 2003. The aim of the project was to look at the health needs of Refugees and Asylum Seekers in Kensington & Chelsea and Westminster, including their access to services. It looked at unmet needs, as well as at ways of working towards service improvements that better reflect the needs of Refugees and Asylum Seekers.

The aims and objectives of the Task Group were:

- Reviewing health needs of Refugees and Asylum Seekers in KCW, including access to services
- Identifying the gaps, if any, in use of health and social care services for the client groups
- Providing base-line information that could be used in planning and commissioning of service in both voluntary and statutory sectors
- Providing community groups with capacity-support, to enable them to engage effectively, in an on-going manner and on an equal basis with statutory sector providers and commissioners.
- Making recommendations to influence voluntary/statutory bodies in looking at the health needs of refugees and asylum seekers, given the obligations on statutory bodies under the Race Relations Amendment Act and Section 11 of the Health and Social Care Act to consult and engage local communities, including this target community of Refugees and Asylum Seekers.
- Collating qualitative information that could be used as base-line data when considering the needs of refugees and asylum seekers in the KCW area.

This Task Group included the following:

- Undertaking 20 consultation events in partnership with community groups, to obtain feedback from Refugees & Asylum Seekers living in KCW, based on their experiences of using the health services.
- Undertaking three fact-finding visits to local and regional service providers: The Refugee Council's One-Stop-Shop in London, the Dover Induction Centre (run by the charity, Migrant Helpline), and the Medical Foundation for the Care of Victims of Torture.
- Holding a Public Meeting, with speakers on particular areas of interest related to health issues for Refugees & Asylum Seekers, including the local MP, Karen Buck.

This final report from the Task Group includes findings from the consultations and recommendations for future service- provision. Although this is the end of the Task Group, the BME Health Forum and the Migrant and Refugee Communities Forum (MRCF), with the members of the Task Group, will continue to monitor how the recommendations and findings from the report are taken forward. They will continue to be involved in this group, and in lobbying for the recommendations from the community consultations to be taken up by service- providers – both voluntary and statutory – and commissioners.

Policy and Legislative Context

This Task Group, along with previous task groups co-ordinated by the BME Health Forum, came about in the light of recent legislative changes that require PCTs and NHS Trusts to consult and work in partnership with their local communities. The following section of the report gives details of these different legal requirements.

Section 11, Health & Social Care Act 2001[1]:

Requires every public body, as of 1 January 2003, to which this section applies (PCTs, NHS Trusts, Health Authorities) to make arrangements to ensure that people for whom services are being, or may be, provided, either directly or through representatives, are involved in, and consulted on, the planning and provision of services; and on the development and consideration of proposals for changes in the way these services are provided and decisions are made affecting the operation of these services.

Patients' Forums will monitor the performance of this duty. This is a new statutory duty, which means consulting and involving: not just when a major change is proposed, but in ongoing service- planning; not just in the consideration of a proposal, but in the development of that proposal; and in decisions about general service delivery, not just major changes.

Race Relations Amendment Act[2]:

This Act, resulting from the Stephen Lawrence Enquiry, adds to the general duty to eliminate racial discrimination and promote equal opportunities, by specifying the creation of a Race Equality Scheme aimed at preventing 'institutional racism', and ensuring that the UK's racial diversity is properly represented at all levels. **The aim is to help public authorities to provide fair and accessible services, and to improve equal opportunities in employment.** The Act intends that race equality shall be 'mainstreamed' within the organisation; in other words, that attention to equality is built in to all its policies, at all levels and at all stages.

All Public Bodies are required, from 2002, to produce an annual *Race Equality Scheme* outlining their process to improve delivery and equality in their services, and how they are involving local communities in this process. The challenge is to mainstream this process to ensure that race equality is a central part of mainstreamed service -provision, commissioning and management.

COMPACT with the Voluntary & Community Sector:

The Compact[3] provides a framework that sets out the principles and undertakings that should underpin the relationship between the voluntary and community sector and government. The Compact is integral to increasing the involvement of the public and patients in health. It is aimed at creating a new approach to partnership, and a relationship of mutual advantage. It has undertakings on both sides, compliance mechanisms and codes of good practice to make the agreement work. Local Compacts aim to do this locally, between the voluntary and community sectors, local authorities and other local public bodies.

[1] For more information please refer to the following website (http://www.doh.gov.uk/involvingpatients/positionstatement.htm)
[2] For more information please refer to the following website (http://www.cre.gov.uk/duty/index.html)
[3] For more information please refer to the following website (http://www.doh.gov.uk/compact/index.htm)

The Department of Health is determined to see all NHS organisations in England signed up to a geographically relevant Local Compact by 31 March 2004. The new duty on NHS organisations to make arrangements to consult and involve patients and the public, Section 11 of the Health and Social Care Act 2001, provides a useful opportunity for NHS organisations, not already signed up to a Local Compact, to do so. The Local Compact will be one mechanism that NHS organisations will be able to use to demonstrate their compliance with the new duty. NHS organisations signed up to a Local Strategic Partnership (LSP) will already be working within, or towards establishing, a Local Compact.

Department of Health: "Experience shows that the process of producing a Local Compact is as important and influential as the final document itself. A Local Compact, as a dynamic mechanism for an evolving relationship, should be a valuable tool for both the voluntary and community sectors and NHS bodies in the context of new policies and improving NHS local delivery. A Local Compact should be an integral part of the on-going consultation and involvement process of monitoring, reviewing and implementing service changes.

Methodology

This Task Group was made up of representatives from community and voluntary groups, as well as statutory agencies (**See Appendix A**). The BME Health Forum funded community organisations to run consultation sessions with their own communities. These were done with at least 6 participants in each, and each group provided a written account whose findings are included in this report. As in the previous Task Groups co-ordinated by the BME Health Forum, a similar approach was adopted, where community groups have been actively involved since the start of the project. One of the aims of the BME Health Forum is to lobby for greater involvement of BME communities in policy- making and service-planning and commissioning.

The selection of groups

More than 30 different BME community groups in Kensington and Chelsea and Westminster were contacted, briefed about the Task Group and invited to join the steering group and participate in the consultations. These groups were also encouraged to attend a two-day training on 'How to Run Community Consultations'. Attending the training was made a requirement to run the consultations. Only those who expressed real commitment to participate in the whole process and run the consultations were selected.

Community Consultation Training

Community representatives, who facilitated the consultations, attended a two-day training organised by the BME Health Forum with an experienced trainer, on 'How to Run Community Consultations'. A feedback session was then held after all the consultations were completed, to obtain the facilitator's opinions on the process adopted for this Task Group. This session was integrated into the training that was offered to them.

Developing the Pro Forma

Five volunteers from the steering group met before the start of the training on How to Run Community Consultations, in order to develop a pro forma to be used as a guide to assist the groups in running the consultations (**See Appendix B**). The pro forma was not a questionnaire, but rather a tool to be used by the facilitator to prompt questions related

to specific health issues. The groups had the choice of using it or adopting their own methodology, if they thought that it was more appropriate for their community group. Some groups, like the Refugee Doctors Scheme, even went beyond the suggested pro forma and developed an extra assessment tool in a table format, where they asked the participants to rate the different health services, etc. (**See Appendix C**).

The overall process

Regular meetings were held throughout the process of this Task Group; and the BME Health Forum and MRCF provided community groups with extra capacity support, including the provision of a note-taker. This latter, along with the project co-ordinator, also attended most of the consultations.

The process adopted for this Task Group proved to be a successful mechanism for providing a co-ordinated approach to getting feedback from various communities and community organisations. The Task Group was a successful structure in which community organisations, statutory agencies, local and national voluntary organisations as well as academic institutions were engaged on an equal basis from the outset. This process involved carrying out the aims and objectives of the Task Group in developing the questionnaires and undertaking the community consultations. Findings and recommendations from other relevant reports have also been included in this report.

Comments on the methodology adopted

Strengths of the methodology

- An empowering process for the BME communities, as they were involved in the project from stage one and were funded to run the consultations themselves.
- The training that was provided helped community facilitators enormously in running the consultations and developing their skills.
- Developing the pro forma helped facilitators raise the major issues and facilitate the consultations themselves.
- Funding community groups to run the consultations gave them the opportunity to create the right environment for the running of the sessions.

Limitations of the methodology

- The consulted groups are not representative of all the different BME communities in KCW.
- Only the views of individuals who have access to local community-based organisations have been voiced.
- A time frame should have been set for the experiences that people have had. This would ensure that complaints from years ago were not repeated over and over again.

Task Group Components

List of Completed Consultations:

20 consultations took place over a period of 3 months, with the participation of over **300** individuals from different BME communities (see the list below).

- About 80% of those who participated in the consultations were refugees
- About 15% were asylum seekers
- About 5% were settled migrants

Name of organisation/group	Number of participants
1. 50+ Eritrean Welfare Association	40
2. Al Muntada, Iraqi Community Association	15
3. Arab Women's Voice	12
4. DADIHYE Somali Development Association	9
5. Earl's Court Refugee Advice Centre	13
6. Egyptian Community	20
7. Health Support Team at Bayswater Families Centre	7
8. LATCA, Latin American Community Association	20
9. Refugee Dentists Scheme	8
10. Refugee Doctors Scheme	13
11. Persian Day Centre	10
12. Somali Mothers and Children Association	12
13. Somali Welfare Association	14
14. St Antonio Eritrean Refugee Women's Group	34
15. Sudanese Community Information Centre	11
16. UMARU, Angolan Women's Association	13
17. Refugee women at the Muslim Cultural Heritage Centre	24
18. Single mothers asylum -seekers at Earl's Court Refugee Advice Centre	6
19. Male asylum -seekers at Earl's Court Refugee Advice Centre	8
20. Westminster Algerian Welfare Society	12

Fact Finding Visits:

Three fact-finding visits were organised as part of this Task Group, to local and regional service-providers:

- The Refugee Council's One-Stop-Shop in London
- Ashford Induction Centre (run by the charity, Migrant Helpline)
- The Medical Foundation for the Care of Victims of Torture

These fact-finding visits were organised in order to complement the information that has already been gathered from the consultations, in order to give a more comprehensive picture of the experiences of refugees and asylum seekers using different health services.

1. Refugee Council's One-Stop Shop, Brixton, London (www.refugeecouncil.org.uk - see services and activities section)

The service offers help and advice in various areas, including:

- Lack of financial support and/or accommodation;
- Problems with legal representation;
- Claiming asylum;
- Issues with the Home Office, NASS and those receiving support from Local Authorities;
- Housing, education and health, and help with accommodation problems;
- A children's advice and support service at the drop-in advice centre.

The drop-in service also provides hot lunches, showers, second- hand clothes and tracing services for missing relatives. The One-Stop Shop receives over 200 people each day, most of whom are new arrivals to the UK.

A group of 12 people who were members of the Task Group visited the Centre for 3 hours. We were given a tour of the building, observing the process at each stage of support and assistance provided by the One-Stop Shop.

2. Ashford Induction Centre – run by the charity Migrant Helpline, Kent Committee for the Welfare of Migrants (www.migranthelpline.org.uk)

Migrant Helpline is one of six agencies funded by NASS, to provide assistance and support for asylum seekers and refugees entering and living in the UK. The head office is in Dover, dealing with those clients claiming asylum in Kent. They oversee and administer the three induction centres in the Kent region, the only such centres in the UK at the present time.

Migrant Helpline established the first induction centre in the UK in January 2002. Its functions include delivering a set of comprehensive briefings to asylum seekers on the end-to-end asylum process, their rights and responsibilities and detailed information on their dispersal to other regions of the UK.

During our visit, staff members gave several presentations on the different services they provide. Their target is a seven-day induction process (**See Appendix D),** during which the asylum seekers are health-screened, briefed on the asylum process and dispersal,

and on their rights and responsibilities. In fact, we had the chance to attend one of their briefings with a number of Iraqi asylum seekers. We also had the opportunity to talk on an individual basis with a few asylum seekers and get their own opinions on the centre.

Briefing with a group of Iraqi asylum seekers at Ashford Induction Centre

3. The Medical Foundation for the Care of Victims of Torture (http://www.torturecare.org.uk/)

The Medical Foundation is a human rights organisation that exists to enable survivors of torture and organised violence to engage in a healing process to assert their own human dignity and worth. Their concern for the health and well-being of torture survivors and their families is directed towards providing medical and social care, practical assistance, and psychological and physical therapy. It is also their mission to raise public awareness about torture and its consequences.

The Medical Foundation has a programme of 12 sessions over 6 months, followed by a hand-over meeting. The referred cases that come either from GP practices, voluntary organisations or sometimes self-referrals are assessed within 10 days. Once they decide to take a case, they agree with NASS not to have the patient dispersed until the sessions end. Most of their clients are from Ethiopia, Eritrea, the Congo and Francophone Africa.

The challenges that they face are: interpreting; capacity of the organisation, as they get 10 to 15 new cases every week; clients with HIV/Mental Ill-Health do not access the services properly; follow- up of cases after the clients are dispersed. There were cases where the patient had to leave London and his/her condition became worse after dispersal; yet he/she couldn't get treatment, sometimes for up to 6 months after being dispersed. Sometimes these patients end up coming back to London, hence taking the risks of losing their entitlements.

FINDINGS

Although this Task Group focused specifically on needs and access to health services by refugees and asylum seekers in KCW, the findings and the recommendations have implications for both health and social care service -providers and commissioners, from both the voluntary and statutory sectors.

The findings in this report do not claim to provide quantitative data, nor to represent the views of all BME communities - what they do is share in detail the experiences of more than 300 refugees and asylum seekers with the health services in KCW. This following section draws out the comments, concerns and issues most commonly raised.

It should be noted that a number of the issues raised are common concerns of all health services users, no matter what their background; however, there are specific issues relevant to refugees and asylum seekers that need to be addressed.

A thematic analysis was adopted here, to analyse the set of data collected through the consultations and the fact- finding visits, as we believe it is the best methodology and allows us to highlight clearly all the major concerns raised.

1. Awareness of Current Mainstream Health Services

The majority of participants were registered with a GP practice and had used hospital services. There was a general **misconception, however, about the role of health service professionals** and a lack of awareness of the services provided in Primary Care settings - this includes the roles of GPs, nurses, counsellors, health visitors, etc.

The **GP's surgery** was described by many participants as "***the nerve centre of the health system***," and they felt it was at that level that action was most needed to improve access and respond to the needs of refugees and asylum seekers.

Recommendations for Action: PALS, Community Health Development Teams and HIMPIC should include in their health promotion, information and resource production initiatives, information on the role of different health service professionals – i.e. services provided by Health Visitors, District Nurses, GP practice staff, including counsellors, etc – all who can be accessed through GPs. In addition, teams working with newly arrived asylum seekers need to include in their registration process general information on the role of GPs and services offered by their practices in the registration process.

1.1 Primary Care Services

1.1.1 Registering with a GP

There were some instances where participants, especially newly arrived asylum seekers, said that they found it very difficult to register with a local practice and that practice staff **always gave the excuse that they were either living beyond the practice boundary, or that their lists were full**. One example was given where a woman said that *"I tried to*

join the same practice as my neighbour and was told that I fell outside the boundaries of the practice".

Some participants mentioned that it took them a **few months to be able to register with a GP**. Sometimes, **they were asked to produce their passports** in order to do so, while in other cases **the GP surgeries said that if a patient could not provide an interpreter, then he/she would not be registered**. For the above-mentioned reasons, there was a general feeling amongst the participants that they were discriminated against as refugees or asylum seekers; while British people were regularly taken on by a GP.

Sometimes registering with a female GP proved to be difficult, and even if women disliked being examined by a male doctor, it was agreed that they often had no choice.

Recommendations for Action: Information on accessing and registering with GPs produced in different community languages, as well as other PALS outreach work, should include information for patients, explaining the process of registering with GPs and what to do if there is a problem: what to do if a GP's list is full, and their rights – e.g. entitlements to interpreters. Additionally, resources produced in different community languages should include information on registering with a GP, what to do if a patient is refused registration, and where to go for help and advice on finding a GP. These resource should also include information on the new GRIP interpreting on-line booking service.

Long waiting times for GP appointments

Some GP practices are over-subscribed, and as a result have an average waiting time for appointments of about 2 – 3 weeks.

In one instance, a woman with children found it so difficult to see her GP when needed that she started booking appointments every two weeks, then cancelling them if not needed.

Recommendations for Action: One way of reducing the problem of long waiting times for GP appointments is giving **more support to refugee doctors** as this remains a major untapped resource. In fact, they can contribute greatly to redressing this imbalance. Information on patient choice needs to be provided to community groups through leaflets and outreach work. Information on the Patients' Choice initiative needs to be provided to community groups through leaflets and outreach work.

1.1.2 Awareness of services provided

The level of awareness of the services provided varied according to two categories: refugees who are already established in this country, all of whom are registered with a doctor, and asylum seekers placed in temporary accommodation or those who had returned to London following dispersal. **Newly arrived asylum seekers seemed less informed about their entitlements** to free health care and other benefits.

In terms of awareness of primary, secondary and specialist health services the issues highlighted were the following:

- Although refugees and asylum seekers were registered with a GP surgery, they very rarely visited their doctor. Many said that this was because there was a **long waiting list for appointments** - usually 2–3 weeks.

- Many participants **did not know about other services they could approach, besides their GPs.** One elderly Egyptian woman preferred to stay at home if she was ill, rather than go to the surgery, because her own GP was absent so often and she didn't want to see another GP. While an elderly Eritrean man explained that, *"People needing health treatment are not aware of the system – they cry at home, and then give up".*

Most refugees and asylum seekers were **not aware of other services provided by GP practices** such as counselling, access to a nurse for general health advice, and health visitors. The majority of the participants with children stated that they had never been explained the role of health visitors, and thought that they only visit for vaccination purposes. The participants were also **not aware of Minor Injuries Units, and Walk-In-Clinics.**

Recommendations for Action: Resources, outreach work and community-based services produced in different community languages targeted at asylum- seekers should include information on their rights and entitlements; and contact links for further regularly updated information, i.e. the Refugee Council, etc. need to be provided to front-line staff and GP receptionists

NHS Trusts – hospitals and the PCT – should work with community organisations to raise awareness of particular services including Breast -Screening, Cervical Smear Tests, Access and Entitlements to Dentists, Opticians etc; and providing formal structures for on-going user feedback, to ensure that concerns are taken into account when developing or restructuring these services.

1.1.3 Visits to the GP

- Several men and women asserted that the first thing a GP says is "*There's nothing wrong with you*." As one Somali refugee mother explained, her GP announced, "you look fine", without even actually looking at her. This woman took her baby to the GP four times, but even when he was sick and had a fever she said he was all right. So she decided not to visit the surgery any more, but to rely on the pharmacist/chemist.

- Most participants then complained about the **short time allotted per consultation**, as it did not go beyond 10 minutes. Moreover, it was explained that if a patient comes with more than one health problem, only one is dealt with and the patient has to book another appointment to discuss additional problems.

- **Completing the practice registration form proved to be a problem** for a lot of participants. They said that they had no help, except from their relatives or friends.

- It was felt that GPs do not give enough information about medical problems and procedures; but **practice nurses were commended as good sources of information and support.**

- Participants also complained about **GPs not taking the trouble to follow up tests, or even obtain test results.** There were complaints that test results were not received by the GP in time for discussion. Sometimes this creates a lot of stress for the patient, as was the case for an Egyptian woman who waited three months for a diagnosis, fearing she had cancer, then had an operation. During the waiting time her life was put on hold and she was very depressed.

Recommendations for Action: Resources, outreach and community-based services produced in different community languages targeted at asylum seekers should include information on their rights and entitlements, and contact links for further regularly-updated information, i.e. the Refugee Council, etc. Clear information should be provided on what to do if a GP surgery's list is full and where people can go for further advice and information.

The PCT should review provision of interpreting services for patients, to ensure interpreters are provided when patients are completing the practice registration forms. Patients should not be required to bring friends or relatives, and especially not children, for this purpose.

1.1.4 Referrals to specialists

According to some participants, they were **not used to the concept of GPs.** As one Sudanese refugee woman said, *"at home they would go to a hospital if ill."* While other participants stated that primarily **the role of their GP was to refer them to a specialist rather than provide diagnosis**. This often leads to tensions between the GP and the patient.

Many related the fact that **GPs delay referrals to specialists** by giving painkillers, to the fact that specialist treatment is very expensive. And because of their status as refugees or asylum seekers, people felt that such referrals were less likely to happen. A number of people thought that this had been the case with them.

- One woman said she was treated for kidney stones for 10 years, before it was discovered she actually had gallstones.

- Another Somali woman suffered for 8 years without referral to a specialist. When she finally saw one, he said that she waited for too long and that she needed a spinal injection, which might or might not help – and had a risk of paralysing her.

Recommendations for Action: Information packs provided to newly arrived asylum seekers should include information on the role of GPs, explaining that referrals to hospital and specialised services are made through the GP. Patients from other countries might be used to a system where the patient goes directly to hospital and not first to a GP.

1.1.5 Changing GPs

Issues related to changing GPs were also raised during discussions with the participants. The following are some of concerns:

- *"If one wants to move to another GP one needs to lie (for example, you should present as being new to the area), otherwise the doctor will say he is too busy,"* mentioned a refugee doctor.

- "*When changing to a new GP on moving to a different area, the transfer of notes took a long time*", stated another refugee doctor.

- There were also issues related to **the fear of changing GPs and being unable to register with a new one.** This fear was mainly experienced by asylum seekers, who feel very vulnerable in the health care system. This was the case for a Somali man: he has been in the UK for 4 years, and has been badly depressed, with no official status. He recounted how he had been evicted from his lodgings. Seeking help from his GP, he was given continued anti-depressants but no support in terms of a letter for his housing situation. He was now homeless, with no benefits, but was scared to change his GP.

- Others do not see any point in changing GPs, even if they are not satisfied: as one Sudanese woman said, "*They all have the same attitudes. The NHS should do something about them".*

Recommendation for Action: Community Health workers employed by the PCT and Hospitals should provide awareness sessions on new public and user involvement initiatives, particularly in relation to PALS and Patient Forums. It was suggested that joint projects should be developed whereby PALS officers are placed within statutory as well as community sectors on an on-going basis, to ensure community-based service- provision and on-going user feedback and engagement.

1.1.6 Awareness of complaints procedures

Although a large number of refugees and asylum seekers were dissatisfied with their GP, none of them knew that there was a complaints procedure in place. They also stated that **they would not complain, as they had found it extremely difficult to find a GP** who was willing to take them on in the first instance, and they did not want to go through the same process again. Asylum seekers were the most reluctant to complain, as they felt vulnerable and at the mercy of the system.

Recommendations for Action: As mentioned above, information packs and resources should include information on what people can do if they want to change their GP, or if they want to make a complaint. Contact details should also be provided in publications in various languages for the Patients' Forum, PALS and other advocacy services where people can get help and advice.

1.2 Hospital Services:

The discussion with participants on hospital services raised a number of issues including:

- **The lack of transport to and from hospital was criticised**. People had been told not to dial 999 again as no ambulance would come, and they should take a taxi. But people felt this was not an option that would be easy for refugees and asylum seekers. However, it was mentioned that when **ambulances were called, they came quickly**.

- A number of participants said that they **could not understand hospital forms**, **questionnaires,** etc, and could not properly express their need for interpreters. Participants felt that hospital staff do not readily offer interpreters to assist them with paperwork. But even when they were there, **interpreters sometimes failed to know the technical medical words**, so they sometimes explained things incorrectly to doctors and patients.

- Interpreters are not always supplied for an appointment because of the uncertainty of waiting times.

- Several women spoke of problems with child-care. There was no one to look after children if the mother was ill in hospital and the father was working – a situation which added to the stress the family was under at that time.

- There were no complaints about hygiene in hospital, except that one person found a dog in the asthma clinic he attended.

- **Awareness of Hospitalisation and Discharge procedures:** Participants had a mixed reaction in terms of the information given to them by the hospital staff. However, **overall the feedback was very positive**. Some participants said that they were given information in their mother tongue about the procedures and support services once they were discharged, which they appreciated.

Recommendations for Action:

- Local hospitals should review their policies and practices with regard to provision of interpreting services, including access to telephone interpreting to facilitate completion of forms, questionnaires, etc. This information should be included in information provided to patients in different community languages, as well as to receptionists and other front-line staff.

- Provision of translated appointment letters / cards: Many participants said that they missed their hospital appointments because they couldn't read letters sent to them. They suggested that it would be better if the letters were sent in mother-tongues; or if the patient was illiterate in their native language it would help if they were contacted by telephone by the interpreter nearer to the appointment date. Free on-line service on www.harpweb.org (Department Of Health - supported site). Front-line staff need to be made aware of this free facility.

- If patients are not fluent in English, consent forms before operations should only be signed in the presence of an interpreter, or after making sure that the patient understands fully what the operation involves.

- Good practice examples of provision of information on hospitalisation and discharge procedures should be extended to other services, including primary care services.

1.2.1 Awareness of hospital facilities

- A large number of participants were not aware of the facilities available within St. Mary's, including access to prayer facilities: many ended up praying in their own cubicles. Although all the participants had stated that they were provided with halal vegetarian meals, they were not informed about the availability of this beforehand, and many ended up asking their families to bring them food from home.

- An issue that was of a major concern to a lot of women was that of **mixed wards**. All women felt that mixed wards were **not appropriate, as they did not provide privacy;** and the majority of women remained in their cubicles for the whole period of hospitalisation. Although some women asked for a single sex ward, the majority were not aware who they should ask.

Recommendations for Action:

- Local hospitals should review their publicity and information materials on the different facilities they offer.
- Women suggested that the prayer facilities at St Mary's Hospital be divided into two - a section for women and a section for men

1.2.2 Specialists

As was mentioned in the above section, getting a referral from a GP to a specialist is very difficult; however, when it does happen there are additional problems that arise:

- An Iraqi asylum seeker had a kidney operation in France. In London he was sent for an X-ray as he was still in pain; but was told he was all right. A few days later he developed a severe kidney infection. Also, shot in both legs and with bullets still lodged, he was referred to a specialist, but so far, and after three appointments, the hospital was still **unable to match a specialist to an interpreter**.

- A female Somali refugee commented on a past experience she had while attending a hospital appointment for an eye examination: the doctor didn't look into her eyes but told her that nothing was wrong with them. The woman felt that she didn't get proper attention from the doctor because she was a refugee.

- Most refugees who attended that same consultation explained that they had had at least one experience like the participant mentioned above. They felt that they don't receive the correct treatment and they do not get the same degree of service as British people, because they are refugees.

- However, the refugee doctors found that when they wanted to change a booked appointment and revealed they were themselves doctors, compliance was the rule; i.e. doctors give doctors the best treatment, in general. They then said that "*All patients should be treated the same; but the sickest should have the most attention*."

1.2.3 Accidents and Emergencies (A&E)

The discussion usually gets heated when participants are asked about their experiences with A&E. The most recurrent issue that was raised was the **extremely long waiting**

time, which led many to think about the definition of "Emergency" as very vague and unsatisfactory. As one elderly Persian lady said:

> "*When we go to the hospital for an emergency we see other people take flasks and food because they know that they are going to wait to see a doctor for hours and hours.*"

The refugee doctors tried to explain that the long waiting hours at the A&E are due to the fact that patients are prioritised in terms of the urgency of their needs. Patients are often seen by junior doctors, who can then refer them to a registrar; and sometimes senior registrars need a consultant's opinion, and this means a long waiting time.

Chelsea and Westminster Hospital, compared to other hospitals, **was felt by many to be the best for A&E services.**

However, a number of examples were given condemning A&E services at Chelsea and Westminster Hospital. For instance, an Egyptian woman who had a miscarriage was taken by ambulance to A&E and waited, bleeding and on a drip, from 3 am to 9 am to be seen by a doctor.

Recommendations for Action: To ensure that patients do not have the wrong impression or expectation of A&E services, information produced for patients by PCTs as well as hospitals should highlight the realities of using A&E services in various community languages – i.e. on notice boards, leaflets for patients, etc.

1.2.4 Maternity Services

A number of issues were raised in relation to local maternity services:

- Some participants mentioned that at some local hospitals more babies were delivered annually than had been planned for, so the service was inadequate and the large number of emergency cases relegated the normal ones to second place.
- St. Mary's was said by more than one woman to be unsatisfactory for maternity services and "*bad with Arabic patients*". One Iraqi woman was told, "*If you don't like it, go private*".
- In one instance, a Sudanese woman related how she had been pregnant, started to bleed, went to St. Mary's by ambulance but felt that her treatment there was so callous she discharged herself and went to Chelsea and Westminster, where the treatment was good.
- There was also a general feeling amongst women that they were discharged too soon after childbirth, and they then developed problems, e.g. high blood pressure and related stress.

1.2.5 Operations/post-operations

Participants expressed a few concerns in relation to operations, such as **the absence of translated consent forms and patients being discharged too soon** after their opera-

tions, etc. The following are a few cases mentioned during the consultations:

- A mother was asked to sign a form for her child's operation, but it was not explained what the operation was for.

- An elderly lady was given an appointment for an operation in the hospital. Every three months the date was changed - the appointment has been changed 3 times so far. She said *"It is Chelsea and Westminster Hospital that keeps changing the appointment. In the meantime I've changed my mind about the operation."*

- One child had a tonsillitis operation and was asked to leave very soon afterwards in order to liberate a bed for another patient. His mother took him home, but he was so ill that she had to use emergency services.

- Two cases were cited where women went to hospital for operations, but came out with infections unrelated to the original problems.

- Another two cases were cited of operations cancelled because of non-availability of machines at the last moment – one of these operations was a major one where the woman was already anaesthetised. She needed counselling afterwards.

1.2.6 Follow-ups after operations

Although most participants were, generally speaking, satisfied with the follow-up they received after operations, a number expressed concerns saying that they were being discharged too quickly and were not asked to come back for a follow-up. As was the case of an Iraqi man who had a heart operation but had no follow-up for a whole year afterwards.

Another case: a Sudanese woman had recurring problems during pregnancies, either premature births or deaths in the womb, but there were no follow-up investigations. The most recent birth was premature and the child died, after which the hospital admitted they had not given good care and would do better in future. Because of her experience, this mother has developed stress-related high blood pressure. There was a similar case of another woman who had 4 miscarriages, which were not followed up.

These stresses, and inadequate care during pregnancy, can lead to mental health problems, as part of the strains of living in a different culture.

Recommendations for Action: It is suggested that Hospitals provide discharge information and letters in patients' native language, or by using an interpreter, to ensure that patients are fully aware of follow-up services they will receive, and if they have questions about this, how they should make inquiries.

1.2.7 Medical errors

Several participants mentioned cases where a medical errors had occurred. Some of these could be seen as minor, while other had detrimental consequences on the patient. The following are a few examples:

- At one hospital a woman was given date-expired medicine.

- A woman prevented her relative from receiving the same medication twice in a short period of time (minutes). While another saw a nurse canalise the vessel for intravenous infusion and the nurse assistant take it out because she thought the infusion was finished.

- One pregnant woman's child was found to be dead when scanned. She was sent home with tablets to abort, but they didn't work. She went to hospital on a Friday, was told to return on Monday but was in severe pain on the Sunday and called an ambulance. The hospital told her to go home, but she refused and was finally given a bed when it was clear she had an infection. The stress from this led to high blood pressure.

- One pregnant Iraqi woman had problems with her placenta, but was sent home because the hospital was too busy. Before reaching home she began to bleed, so she returned to the hospital and was finally there for 7 months. She believes that because of this experience, she developed over-active glands and suffers from depression.

- A Somali refugee woman was paralysed by an injection while giving birth. While another Somali woman had a hysterectomy without giving her consent.

Recommendations for Action: Information and publicity on the complaints procedure and using PALS services should be made available in various community languages. Community-based health advocates and Patients' Forum's staff should also include in their outreach work information to raise patients' awareness on making informal and formal complaints and expressing their concerns.

1.2.8 Awareness of complaints procedures

Although a number of refugees and asylum seekers were dissatisfied with the services at the hospital or suffered from medical errors, they did not complain. The main reasons for this were language barriers; lack of awareness of any complaints procedures, and a belief that their complaint would not be taken into consideration.

They felt that the health service had deteriorated over the past 11 years, and that they themselves were discriminated against because they didn't know their rights. As one refugee doctor put it "*Here you have to know your rights and do everything for yourself; otherwise you are marginalized*."

Recommendations for Action: PALS and Complaints Services in Hospitals should provide information in the main community languages on patients' rights to make a complaint, and how and where they can receive advice and assistance with this. People suggested hospitals put signs up in various languages to inform patients that they can contact PALS for advice, information and support. Health advocates also can play a key role in assisting patients in making a complaint.

1.3. Health and Social Care Professionals

1.3.1 GPs

Many participants perceived GPs as being difficult, and complained about a number of issues. Some of these were: GPs did not spend enough time trying to understand the patients' problems nor examine them properly; they expected the patients to come with a diagnosis when visiting them; they were not sensitive to their culture or religion; and/or did not take the patients' concerns seriously. Numerous examples were given:

- One woman stated that she *"Had an appointment with my GP about [her] back problem and he didn't bother to examine [her]. Instead he only wrote a repeat prescription and handed it to [her] at reception, whereas the next patient was ushered into his consulting room"*.

- *Similarly, another woman* explained that *"The problem with the GPs is that they only look at you and prescribe painkillers, they do not proceed with further examinations or request further tests..."*

- Another woman said, *"When I go to see my GP he doesn't give me time to talk about my health problems, he quickly ends the appointment without even making eye contact, and looking most of the time at his computer…"*

- Another participant mentioned that when he went to see the GP because of recurrent backaches, the GP told him to be careful because it was just in his mind, implying "*you are mentally ill*". When the patient insisted on being referred to a specialist he gave him three choices, asking him where would he like to go; physiotherapy, the back pain clinic or the orthopaedic surgeon? The patient replied: "*How would I know which one is the right option, I am not a doctor, and you know better in this field*?" Finally he referred him to the orthopaedic surgeon.

- An elderly Persian lady mentioned "When *I have a continuous problem, doctors just give me a repeat prescription. I want the doctor to measure the difference since taking the prescription; I want the doctor to give me advice about the diet I should be on for this problem; I want to use his expertise for this problem, not find out by trial and error.*" Another lady explained that her doctor had not checked the effectiveness of the prescription he had given her, and she believes that because it was repeated so many times she developed an allergic reaction to the medication.

- *Another elderly lady added, "In my own country they do a full assessment and examine me thoroughly. The doctors there respect us more, and explain to us things etc. Here, the doctor writes the prescriptions with no explanations… We have to beg our doctor to take our blood pressure. We think this should be made more easily available to us because of our age."*

Some GPs were described as rude, and sometimes making inappropriate or insensitive comments, as this woman explained, "*When seeing my GP, she asked me if I was working, then she told me that all my pains and aches are as the result of not working."*

One particular GP, in the area of Earls Court, was widely condemned by a group of asylum seekers for rudeness and shouting at patients. The general feeling in the group was that asylum seekers were discriminated against.

However, the majority of participants, especially those registered with Arabic-speaking GPs, expressed their satisfaction. They said these GPs were able to speak their language and, most importantly, they understood their culture and needs.

Several participants explained that **Paracetamol was prescribed for all ills** and often given with no proper examination. Some related this to their status, as this man said:

> "*Perhaps the government pressurises GPs to do the minimum amount of prescribing for asylum seekers: people in work receive better treatment*. "

Some even tried to persuade their doctors to prescribe them the right treatment, as this Somali woman did, but her GP told her *"you are low on the scale."* All the participants agreed that if they wanted the right treatment they needed to push for it.

Recommendations for Action: Information packs on accessing health services – including GPs - should include information on the role of GPs and other staff based in GP practices. This information should also explain that referrals to hospital and specialised services are made through the GP. Patients from some countries might be used to a system where the patient goes directly to hospital and not first to a GP.

1.3.2 Hospital consultants

Similar concerns to those about GP treatment were raised by participants regarding hospital consultants. Participants were also concerned about the fact that very often during their hospital visits, or as in-patients, **consultants brought in trainees without the prior consent of the patient**; as was the case of a woman who had an operation on her glands; but her symptoms persisted, so she went back to see the consultant who was then engaged with some trainees. Without any proper tests, he told her that she had high acidity. She felt the explanation was for the benefit of the watching trainees.

Recommendation for Action: Hospitals should ensure that information is provided to all patients in their mother tongue, so they are aware that they can choose whether to agree to having trainees present during their appointment.

1.3.3 Front-line staff

Users had the perception that **front-line staff** – both in primary care settings and in hospitals – **are less sympathetic and often prejudiced** and *"favour other patients over Muslim ones"*. Some of the participants felt that it has become more apparent following the events of September 11, and those wearing *hijab* felt intimidated by staff. Some said that they even stopped visiting their GPs altogether, to avoid all the problems.

Recommendation for Action: It is suggested that improved cultural awareness training should be provided for all staff– including front-line staff such as receptionists. This should include visits to local community groups – which could also be included in induction programmes for new staff.

1.3.4 Nurses and health visitors

Patients' overall perceptions of **nurses and health visitors** were that they are more *"gentle and caring and easier to talk to than doctors."*

However, in some consultations there were **queries about the roles of health visitors**. Others, who have had some experience with them, did not find them particularly helpful. In one instance of a young child with wheezy breathing, the health visitor gave no good advice.

Although the experience of most participants with nurses was described as positive, there were a few cases where some participants suffered from poor treatment from nurses.

- In one case, a woman at St Mary's Hospital, after giving birth to her babies by caesarean section, the nurses then put a lot of pressure on her to look after her babies. She was told having babies is very normal, and to stop complaining about it. She stated that she was in a lot of pain and it was more painful when she was asked to do everything for her baby herself. She was left traumatized by her treatment and dreads becoming pregnant again.

- In another case, it was recounted that a woman had a baby in hospital and the bed broke. The nurse then said, "*That's because you're fat*".

Some participants described **school nurses** as inefficient. For example, because of staff shortages they could not take a child to hospital if there was an accident. They felt that they should know more about what to do, and have solutions to problems in case of accidents.

1.4 Co-ordination between GP services and hospitals

From the numerous consultations, it was felt that there was a **lack of co-ordination between GP and hospital services (A&E)**. Better co-ordination and liaison were described as highly desirable for more effective services.

A number of cases were mentioned where the patient was trapped between the A&E services and their GPs:

- When fire broke out, a woman fell from a window and hurt her head. She was taken to hospital, bleeding, was seen and sent to her GP, who sent her back to the hospital who refused to treat her. An Arab doctor finally treated her.

- A man had an operation; but now when he attends hospital they refer him to his GP who then sends him back to the hospital. There seems to be no adequate liaison.

2. Provision of Interpreting Services

Most participants, especially refugees, were aware of interpreting services that are available, although some said that they still used their relatives, including their young children, to interpret for them. The underlying reason for this is the issue of **confidentiality**: they felt that their community is very close-knit and that they did not want other people to find out about their health or family problems.

Participants stated that **health professionals** – including front-line staff – were **not pro-active in providing interpreting** services and sometimes even refused to book interpreters for patients. When a client asked for an interpreter, they felt health professionals were very reluctant to provide one. In one case, when an elderly client requested an interpreter from the receptionist at her GP practice, she was told that they did not provide interpreting services and that she should register with an Arabic-speaking GP.

Some participants highlighted that their appointments were usually for 20 minutes, instead of the allocated 10 minutes, when they were provided with an interpreter. All participants felt that **this was good practice,** as it allowed them to discuss their health problems with their GPs properly.

It was felt that there is a lack of provision of **interpreters who speak the same dialect**, are of the same gender and are familiar with the cultural and religious background of the patient.

Most interpreters – both family relatives and even sometimes trained interpreters - are often inadequate in medical terminology, so GPs tend to merely prescribe tablets.

There is **a chronic lack of interpreters** – patients are told to bring their own, and even if one is booked, he/she does not always turn up. Very often, when the interpreter does not turn up the patient is obliged to book another appointment, sometimes waiting weeks to see the GP again, and months for a hospital appointment. This obviously has serious repercussions for the patients, hence contributing to a deterioration in their health.

As for those who prefer to attend their appointments without an interpreter, they are often misunderstood, thus taking the risk of getting a wrong diagnosis or contributing a medical error. This risk is especially high when it comes to cases that have to be dealt with by A&E services.

Locally, health advocates provided help and assistance to patients informally through many community organisations, and often on a voluntary basis. However, various local independent advocacy providers are struggling with their workload and lack of resources.

Recommendations for Action:

- More and better-trained interpreters are highly desirable.
- Recruiting more heath advocates to work both at the level of community organisations and health service providers
- Interpreting medication: Currently no one has the task of interpreting when patients receive medication from pharmacists. Extending the use of access to Language Line by pharmacists or other interpreting services should be implemented.
- Diversity and cultural awareness training should be provided for all staff – including receptionists – so they are aware of patients' different needs.
- GP practices and hospitals should develop a pro-active interpreting/translation policy and ensure that all staff are aware of the process for booking interpreters for all appointments, and that this is a free service provided by the NHS.
- Patients also emphasised that GPs should put up notices in different languages, particularly in relation to the provision of interpreting services, so that patients would know that they could ask for an interpreter should they require one.

3. Other Health Services

3.1 Women's Services and Sexual Health Services

Participants were also asked about their awareness of ante/post-natal services, family planning, cervical screening, breast-screening and sexual health services.

In **Ante/post-natal services:** most women were informed of these services by their GP/ nurse once they became pregnant; although a large number of **women felt that they did not understand why they needed to visit an ante-natal clinics,** and some did not attend at all. In terms of **ante-natal exercises**, the majority were not informed of any activities and stated that even if they were, they would not attend as these classes were not exclusively for women and they felt were therefore **not culturally appropriate for them**.

In general, post-natal treatment was not complained about. However, one woman who gave birth in East London four days after arriving in the UK said she was well looked after there; but at her second childbirth at Chelsea & Westminster Hospital, she was provided with much less attention and support from all staff.

Female genital mutilation was described as often not understood by medical staff. It often results in caesarean births; hence much wider knowledge of its implications and training for staff are needed. It was also said to be difficult, in childbirth, to be guaranteed delivery by a woman doctor, although this was much desired.

Participants had **mixed opinions about family planning.** Some found it useful and the advice they received answered a lot of their questions, while others found it not culturally/ religiously appropriate. One woman was much affronted when she went to her (female) GP about her new pregnancy and the doctor immediately suggested an abortion, although she had only two other children and abortion is not acceptable to Muslims**.**

Cervical and Breast Screening services: Participants were more aware of Cervical than Breast Screening services. When asked how often they had had Cervical Smears done, women above 50 years of age said that once in your lifetime should be enough. Those with more awareness about Smear Tests were overwhelmingly mothers with young children born in the UK. Virgins and young girls do not want to be treated by male doctors for smear tests, for example, especially if they have had FGM.

Most older women didn't know about breast screening services, or said they weren't relevant to them. Furthermore, some of those who had attended an appointment for breast screening said that the clinic was very far away and they had a very stressful experience and found it difficult to communicate with staff, as the service did not provide interpreters. They also felt very exposed and humiliated as the changing area was far from the consultation room. Most of those who attended the clinic said that they would not go back. When asked whether they would attend a session if it was in a mobile clinic held within a community setting, they said this would be better.

Sexual Health Services: Most of those consulted **had no knowledge of any sexual health services** available and thought that that they were not relevant to them. They did, however, express concerns about thrush and urine infections, and stated that they only consulted their GPs once the problem became acute.

Recommendations for Action:

- In order to improve access to antenatal clinics, classes could be held in the mother tongue of the participants, and should also be made more culturally appropriate by having sessions for women only.
- It was suggested that there should be more Mobile Clinics for breast-screening with a community worker and/or interpreter, which should improve access to these services.
- There should also be better provision of information on sexual health services in different languages, readily available to local communities.

3.2 Dentists

A number of participants were not very informed about their entitlements with regard to dental treatment, especially what the NHS covers and what it doesn't. For example, there was a woman who said that she had not been told of free dental treatment during pregnancy, as there was no information except in English. Information regarding this and other entitlements should be available in other languages. Those who are more familiar with the service had a number of concerns, namely:

- The **long wait for dentists' appointments** was deplored. One case was cited of a child aged three and a half who couldn't sleep because of painful teeth. At the clinic, a letter was sent to the hospital, which said there would be a wait of 8 or 9 months. The mother took him to Guy's, where he was offered an "emergency" appointment in 4 months. But when she protested vigorously and refused to leave the hospital until her son was seen by a dentist, they were given one the next week. Other mothers agreed that forceful requests needed to be made.

- It was said to be hard to find a good dentist; and for refugees and asylum seekers only the basic forms of treatment were allowed without payment. Participants said that when they go to NHS dentists they are told that if they want a good material to deal with cavities they can provide alternatives, but at an additional cost. Many regretted the fact that they were not eligible for the whole NHS service (crowns, etc).

- In **the absence of interpreters**, participants often do not communicate properly with their dentists, nor understand the contents of the consent forms they are asked to sign. This can lead to incorrect treatment, or wrong extractions. Such was the case of a **Somali woman who had a fractured tooth, was anaesthetised for the extraction, and when she came round all her upper teeth were gone…** Another dentist then wanted £800 for remedial work. She was advised not to complain, as it *would "make things worse*".

- Another man complained that he received dental treatment during which a metal part of an instrument was left in his mouth and infected all his teeth. The dentist said nothing about it, and the metal is still there. He feels dentists don't care about asylum seekers, regarding them as transients.

Recommendations for Action

- Resources and information leaflets aimed at asylum seekers and refugees should be provided in different community languages, so that people are aware of their entitlements to dental treatment and any costs involved.
- More support should be given to refugee dentists, who remain an untapped resource in many refugee communities.

3.3 Mental Health services

Mental health related problems are very common amongst refugees and asylum seekers in different degrees. Many of them have experienced torture and are still suffering from psychological trauma. Others show signs of anxiety and depression, partly because of their uncertain future. Dealing with mental health issues can be quite challenging, as mental health professionals have to be very sensitive about which approach they adopt in assessing and dealing with these problems. It is important for these professionals to make sure that the chosen treatment is culturally appropriate, since different people have different coping mechanisms and may not necessarily be familiar with a 'western' concept such as counselling.

A number of participants who were, however, aware of the availability of some mental health services found that getting referrals to these services can be difficult. As this Algerian woman explained

> "GPs *should be more aware that physical pains could be caused by psychological problems…why do they not refer patients for counselling or mental health treatment?"*

However, those who managed to be referred for counselling deplored the long waiting list; some have to wait for three to six months.

Recommendations for Action:

- The mental health of all asylum seekers should be assessed, and appropriate treatment and/or support should be given as required
- Every culture has its own framework for mental health and mechanisms for seeking help in a crisis, therefore treatment requires specialist diagnostic and counselling skills
- More research needs to be done to determine how best to provide culturally competent mental health care, and the recommendations and findings for improved service provision should be considered by local service commissioners.
- Mental health advocates need to be given additional support to be able to assist refugees and asylum seekers.

3.4 Opticians

Optical treatment was described as good on the whole, with complaints about the need to pay for frames after the first one. Many were unable to afford new frames. There were also complaints about the poor quality of prescribed lenses, which scratch easily and cannot be replaced without charge.

An eye check-up every two years was also considered too long an interval. One woman had diabetes (which can affect eyes), but was told that more frequent check-ups must be paid for.

3.5 Pharmacists

Interpreting medication: currently **no one has the task of interpreting medication**. Participants felt that this should be part of the interpreting service. As this elderly Persian

woman, living on her own, stated,

> *" We don't speak the language and because there is no interpreter in the chemist they don't explain about the medication. Pharmacists put medicines in small bottles, with no instructions, not even what part of you it's for. We expect the pharmacist to explain when to take the medication, what to eat what not to eat etc."*

Recommendations for Action: *Currently no one has the task of interpreting the provision of medication by pharmacists. Extending the use of Language Line or other interpreting services to enable pharmacists to access these services is one way of solving this problem.*

3.6 Paediatrician and other children's services

Some participants praised hospital paediatricians. However, a number of other participants had **very little knowledge of the services that were available for children**; they did not know about school nurses or health visitors. There was a general feeling that children's needs were far from being covered. Some participants even mentioned that their children grow up without being seen by a paediatrician.
A number of parents were also concerned about the fact that reminders were no longer sent out for children's inoculations and vaccinations.

Specific services for children with special needs were also described to be hard to access. An example of an Albanian woman was given, who has a 9-year-old daughter needing speech therapy because of hearing problems; but it was only after 3 years that she was able to access such a service.

3.7 Support for the elderly

It seemed that the majority of participants were **not aware of the services or facilities available for the elderly.** An example was given of an 80-year-old woman, whose daughter said she needed support at home, but who did not know how she could ask for support from Social Services or about any other services offering help in this regard.

Some elderly participants also described **accessing primary care health services as difficult**. For example, one Somali man described how his elderly mother, living in a hostel with him, wanted to register with his GP, but was refused. She was ill for 3 months, during which time she was without a doctor. Another old woman who wanted to register with a GP opposite her home was told to stay with her present one, who was further away.

Another issue, which was of great concern to many elderly people was the lack of regular health checks for people over 50: for blood pressure, cholesterol, etc. One Algerian lady felt there was something wrong, so asked for tests and was then found to have a high cholesterol level. "*Thorough check-ups were only available abroad*" they said.

Many elderly participants complained about the long waiting time they were faced with

when they need to see their GPs. One elderly Persian lady said: ***"****my complaint is when I am sick the doctor gives me an appointment for 2-3 weeks time. In the meantime I get well, and then when I see the doctor I don't need him*." She then added, " *I can wait one day, two days but not more than that. When it's an emergency I need to see my doctor straight away… They suggest you go to the hospital for an emergency matter, but I have to wait 6 or 7 hours to see a doctor, so there is no way I can do this. They don't see me properly and then say I have to see my own doctor*.**"**

Similar complaints were mentioned with regards to referrals to hospitals. An elderly Eritrean woman said, *" I changed my doctor. The new doctor referred me to the hospital for an x-ray and the specialist. It took two years on medication, then I had an injection into the joints and all the pain disappeared. Now I have an appointment for the other hand and expect I shall have to wait another two years. It's a long process, and meanwhile I have to suffer."*

Recommendations for Action: District nurses and other outreach-based health workers should review publicity about their services and access issues to ensure that elderly people in the community who are marginalized are aware of their rights and existing services.

3.8 NHS Direct

Very few of the participants knew about NHS Direct and that they provided language facilities.

Some of those who were familiar with the service expressed their satisfaction with the facilities it provides. However, others mentioned a few issues of concern, including the long wait for an interpreter. As one elderly Persian man explained " *The idea is good, but it involves a long wait which results in having to spend a long time on the telephone at the expense of the caller…when you are waiting on the line they put music on- as if we want to hear music - we want information not music."*

4. Provision of adequate/ culturally sensitive Health Services

- **Signage in mother-tongue languages:** All those consulted felt that finding their way through hospitals was very difficult, and some patients had lost their appointments because they couldn't find their way. They also stated that it would help greatly if the signs were in different languages. Furthermore, they emphasised that GPs should put up notices in different languages, particularly in relation to the provision of interpreting services, so that patients would know that they could ask for an interpreter should they require one.

- **Provision of translated appointment letters / cards:** Many participants said that they missed their hospital appointments because they couldn't read the letter. They suggested that it would be better if the letters were sent in mother tongues; or if the patient was illiterate, in their native language. It would help a lot if patients were contacted by telephone by the interpreter near the appointment date.

- Patients felt that more and improved **cultural awareness training should be pro-**

vided for all staff– including front-line staff like receptionists.

- **Provision of *Halal* Food**: Most participants said that they were given the option of having either *Halal* or vegetarian food, and they felt this made a big difference as before family members would have had to bring in food for them.

- Participants gave good feedback on **hospitalisation and discharge procedures**. Many said that these were provided in different languages and using different methods such as videos, etc.

5. Issues mainly relevant to asylum seekers

Although some asylum seekers were registered with a GP there is still a **misconception about their entitlements to free health care**. Many have stated that practices have turned them down on the basis that they have said that they were asylum seekers. Those registered with a G.P have said that very often doctors became very impatient when they were asked to prescribe medicine either for themselves or for their children. Also, in terms of awareness of primary, secondary and specialist health services there was a feeling that they were lost in the system. As one Iraqi man puts it, "*The health system in the UK is a maze and we don't know to whom to go for help."*

Participants also cited a number of other factors that are not taken into account and that affect their health in many different ways.

5.1 Immigration Status

Participants highlighted the fact that their status very much adds to their stress and anxieties, resulting in health factors including stress-related illnesses such as depression, and other physical illnesses.

There was a case of major confusion on immigration status and health entitlements amongst Iraqi asylum seekers who came to the country in February, before the war in Iraq began, and whose immigration cases remained pending. An example was given by an Iraqi man who arrived in February, was staying with his brother and has been refused benefits or even an ID card. He applied for asylum when he entered the country, but otherwise seems to be outside the system. When he was sick he went to a GP, but was told he must pay for prescribed medicines. He said he knew many other Iraqis who are in the same situation.

There is also evidence that suggests that the health status of new entrants may worsen in the two to three years after entry to the UK. According to a report published by the King's Fund (2000), dispersal has left asylum seekers marginalised and impoverished; and insufficient resources have been allocated to the NHS in dispersal areas to meet the special health needs of the group.

5.2 Housing and dietary requirements

The majority of participants raised their concerns about the very poor quality of accommodation that they were placed in, including overcrowded housing, shared toilets and bathrooms, lack of cooking facilities, presence of cockroaches and mice; poor furnishings, small living spaces, cramped bedrooms and the effects this has on their health and well-being.

Living in a hostel or B and B especially affects their mental health, sometimes even leading to suicidal impulses. It was impossible to invite friends in because of the squalid conditions, and rats in the building. This increases asylum seekers' sense of isolation.

Refugees who came to the UK following the closure of the Sangatte Refugee Camp in France especially felt that they were being treated as "commodities" and without respect. The poor quality food in their "hotel" (with no provision for diets), the lack of hygiene, the dilapidated furniture, the unisex baths and toilets, the lack of cooking facilities, laundry which returned garments dirty, rats in passages and even in bedrooms, all led to psychological tensions and poor health. Even support in learning English that they had been promised, had arrived at the very end of the 3-month period.

There are strong links between damp, mouldy housing and respiratory conditions, asthma and skin problems. Evidence of damaging health effects is strongest amongst children, with estimates that children living in damp mouldy homes are one and a half to three times more likely to suffer coughs than children in dry homes.

5.3 Dispersal and the continuity of care

Dispersal policies have serious repercussions on the health of people seeking asylum, in different ways. Many of the consulted asylum seekers were asking whether their medical files would be transferred if they moved or were dispersed. As this is often not the case, these people are usually compelled to interrupt their medical treatment and start again with fresh tests and medical assessments once they are placed in the dispersal areas. This often leads to a deterioration of their health condition. A wider use of **hand-held medical records** is advisable, in order to avoid these problems.

During our visit to the *Medical Foundation for Care of Victims of Torture*, they pointed to the fact that follow-ups of cases after their clients have been dispersed often take a long time. There were cases where the patient had to leave London and his/her condition got worse, yet he/she could not get treatment sometimes for up to 6 months after being dispersed. These cases encourage patients to come back to London, hence taking the risks of losing their entitlements.

5.4 Access to Schooling

There are also health implications for children who are deprived of going to school, as they cannot be registered if they are not permanent residents; and they spend months at home.

Research has indicated that the most beneficial event for a refugee child can be their becoming part of the local school community, with its attendant benefits of learning and making new friends. Although bullying remains a potential hazard that must be guarded against, it should not be used as an argument against integration.

5.5 Unemployment

Asylum seekers are not entitled to work: this often impacts on the health not only of the individual, but also of the whole family. This is an extremely painful experience, especially for professionals e.g. doctors or dentists working in sandwich shops or similar employment.

Recommendations for Action:

- A consultation exercise with key players in the field (including policy-makers, service-providers, local communities and asylum seekers and refugees) should be held to strengthen research on the impact of UK immigration controls on the health of asylum seekers.
- Comprehensive physical and mental health assessments of all asylum seekers should be done on arrival, with appropriate follow-up treatment and/or support
- Adequate accommodation is a fundamental aspect of a person's health, as stable accommodation promotes good mental health and reduces the demand upon other health and social services.
- Health-care professionals need to develop a greater understanding of cultural, social and other issues relating to asylum seekers.
- In order to benefit from free health-care e.g. medical prescriptions, dental treatment and checks etc., asylum seekers need to obtain an HC2 certificate by completing a lengthy form that is only available in English and Welsh. These forms should be widely publicised so that asylum seekers are aware of them at the time of application.
- Barriers to health-care are not just experienced by asylum seekers but by other UK residents too. It is important that all people have the same provision. It can cause tension where asylum seekers appear to have more provision than other members of the community.
- To facilitate continuity of care, asylum seekers should be given a hand-held copy/ duplicate medical record, including test results, to take to their next doctor.
- While it is beneficial for asylum seekers to access the services of GP practices, it cannot be assumed that GP practices can absorb this extra workload without additional funds and resources. It is imperative that the health-care professionals in GP surgeries have sufficient time and resources to meet the complex needs and language requirements of asylum seekers.

6. Accessing information

For refugees and asylum seekers to have access to information on health services and facilities is vital. Lack of awareness of health entitlements can sometimes lead to fatal results, as was the case of an Iraqi woman who had breast cancer, which spread before she could be attended to, and she died. As one elderly Eritrean man said,

> "*The problem for this community is that information is not provided in a way they can understand. Mistakes are sometimes made – wrong diagnosis, even wrong operations; and if someone dies it is described as negligence."*

There was said to be **good information in the community about health promotion**, HRT, smoking, breast and cervical screening. Problems were aired among themselves, but they needed directions where to ask, and felt they should have leaflets in different languages setting out their rights in the context of health- provision. More information was wished for at community centres: information from medical professionals, and explanations of diagnoses and treatments. **Face to face information awareness sessions were described as the most effective.**

Recommendations for Action:

- Provide an overview to refugees and asylum seekers of how the health system works in various community languages.
- Information needs to be provided on where to get support and information, such as the availability of health advocates and community groups.

7. Good Practice in the process of running community consultation events

An important outcome from this Task Group has been the **process** adopted for the community consultations.

A **capacity development** process was adopted; this involved organising a **training session** on how to run community consultations, with resources and materials provided; **support** on preparation and planning for running them; development of a ***pro forma* questionnaire**; and involvement of the groups and organisations engaged in the **process and policy-development aspect** of the Task Group.

It is also important to mention that members of the Task Group felt that the support, training and resources that were provided helped them to run **well-planned and more strategic consultation events**, and enabled them to see how their feedback would contribute to the policy-making and commissioning process for services.

Given this, it was suggested that as good practice, **NHS Trusts should offer capacity development and resource support to community groups** when they are involved in consultation events. This should include payment to the group (for venue, refreshments, child care, etc.), training on running sessions, production of a pro forma on the aims and objectives of the session, involvement in the process of how feedback will be taken up by commissioners and service-providers, and involvement in meetings related to the project throughout its duration.

Given the **requirements of the Race Relations Amendment Act** and the obligation to involve BME communities in consultation and all aspects of the organisations' policies and procedures relating to race equality, together with developments around the new public and user-involvement structures (PALS, Patient Forums, local Commissions, etc.), these good practice recommendations will assist NHS bodies with these requirements.

It was suggested that the requirement to involve communities in consultation initiatives – as per the Race Relations Amendment Act – should be **built in to service level agreements and contracts** with service-providers (statutory and voluntary), to ensure that this process is mainstreamed and that consultation and feedback are received in a sustainable and effective manner.

MAIN RECOMMENDATIONS

Most of the recommendations set out below have been suggested during the consultation meetings by members of the community, or were provided by members of the steering group.

PLEASE NOTE – they are the same recommendations listed in the text of this report.

8.1 Service-Providers and Commissioners

The consultations have identified the need to develop a **multi-agency, genuine partnership approach to service-planning, development and delivery**. This should include Health and Social Care service-providers and commissioners – PCTs, Hospital Trusts, Mental Health Trusts, and Social Services – grassroots community organisations as well as umbrella organisations, academic institutions and local training providers. The process adopted for these types of consultations is crucial in **establishing a sustained multi-way dialogue between different partners and, most importantly, building up a mutual and multi-way participatory communication.**

Grassroots community and voluntary sector organisations need to be provided with **capacity support** – including funding for core costs, organisational development support, etc. – in order to engage effectively, in an on-going manner and on an equal basis, with statutory sector providers and commissioners.

A formal, **effective and co-ordinated structure for taking forward grassroots community issues at a strategic level** needs to be developed. The previous KCW *Facing Up to Difference Strategy Group* (co-ordinated by the KCW Health Authority) where community, voluntary and statutory sector representatives met to address the health and social care strategic policy issues affecting the local BME communities provided a format for this, and it is recommended that a similar co-ordinated structure be developed.

It is equally important to approach the whole concept of 'consultation' with caution, in order to avoid falling into the trap of 'consultation fatigue,' where numerous consultations by different service-providers take place within communities, with no proper follow-ups. This can lead to a duplication of work and scepticism and an increasing lack of trust within communities. **Consultations should be viewed under the lenses of active and continuous participation of BME groups in the whole process of service-planning, development and delivery**, thus **changing the negative approach of communities being passively consulted to communities actively participating as equal and essential partners.** In order to ensure that this will happen, more resources need to be mobilised to enable and ensure the participation of the powerless and the so called 'hard to reach' communities.

8.2 Primary Care Services:

- **Long waiting times for GP appointments.** One way of addressing this problem is by giving **more support to refugee doctors,** as they remain a major untapped resource and can contribute greatly to redress this imbalance. It is also imperative that the health care professionals in GP surgeries have sufficient time and resources to meet the complex needs and language requirements of asylum seekers.

- PALS, Community Health Development teams and HIMPIC should include in their health promotion, information and resource production initiatives, information on the

role of different health service professionals – i.e. services provided by Health Visitors, District Nurses, GP practice staff, including counsellors, NHS Direct, Minor Injuries and Walk-in-clinics etc.

- Information on accessing and registering with GPs – produced in different community languages. Other PALS outreach work, should include information for patients, explaining the problems and issues in registering with GPs – what to do if a GP's list is full, and where to go for help and advice on finding a GP, and their rights (entitlements to interpreters etc).

- Information packs in different community languages, targeted at asylum seekers should include information on their rights and entitlements, and contact links for further regularly-updated information, i.e. the Refugee Council, etc. These information packs should also include information on the role of GPs, explaining that referrals to hospital and specialised services are done through the GP.

8.3 Hospital Services:

- **Local hospitals should review their policies and practices with regard to provision of interpreting services**, including access to telephone interpreting, to facilitate completion of forms, questionnaires, etc. This should be included in information provided to patients in different community languages, as well as to receptionists and other front-line staff.

- **Provision of translated appointment letters / cards**: Many participants said that they missed their hospital appointments because they couldn't read the letter. They suggested that it would be better if the letters were sent in mother-tongues; or if the patient was illiterate in their native language it would help if they were contacted by telephone by the interpreter nearer to the appointment date.

- Consent forms before operations should only be signed in the presence of an interpreter, or after making sure that the patient understands fully what the operation involves.

- Good practice examples of provision of information on hospitalisation and discharge procedures should be extend to other services, including primary care services.

- Local hospitals should review their publicity and information materials on the different facilities they offer, since many services do exist and are made culturally sensitive, yet the patients are not aware of their existence. Therefore, hospitals should ensure that information is provided to all patients in their mother tongue so they are aware that they can choose whether to agree to have trainees present during their appointment.

- PALS and complaints services in Hospitals should provide information in the main community languages on a patient's rights to make a complaint, and how and where they can receive advice and assistance with this. People suggested hospitals having signs up in various languages to tell people that they can contact PALS for advice, information and support. Health advocates can also play a key role in assisting patients in making a complaint.

- **Provision of single sex wards,** as most women felt that mixed wards were not appropriate because they do not provide privacy; and the majority of women remained

enclosed in their cubicles for the whole period of their hospitalisation.

- **Lack of co-ordination between GP and hospital services (A&E)**. Better co-ordination and liaison were described as highly desirable in the provision of more effective services.

8.4 Other Health Services

Women's Services and Sexual Health Services

- In order to improve access to antenatal clinics, classes could be held in the mother tongue of the participants, and should also be made more culturally appropriate by having sessions for women only.

- It was suggested that there should be more Mobile Clinics for breast-screening, with a community worker and/or interpreter, to improve access to breast-screening services.

- There should also be better provision of information on sexual health services in different languages, readily available to local communities.

Dentists, Opticians and Pharmacists

- Resources and information leaflets aimed at asylum seekers and refugees should be provided in different community languages, so that people are aware of their entitlements.

- Give more support to refugee dentists, who remain an untapped resource.

- Currently, no one has the task of interpreting medication. Using Language Line or other interpreting services through which pharmacists can access these services could be one way of facing this problem.

Mental Health services

- Training or awareness-raising on issues in relation to post traumatic stress syndrome as well as other health issues should be provided to relevant frontline staff in the NHS to enable them to diagnose and deal with it.

- Every culture has its own framework for mental health, and mechanisms for seeking help in a crisis; therefore treatment requires specialist diagnostic and counselling skills.

- More research needs to be done to determine how best to provide culturally competent mental health care.

- Mental health advocates need to be given more support to be able to assist refugees and asylum seekers

8.5 Provision of Interpreting and Independent Advocacy Services

- More and better-trained interpreters /health advocates are highly desirable.

- **Issue of Confidentiality:** using the same interpreter for all the patient's consultations can help develop trust. Sensitivity should be exercised in selecting an interpreter, with regard to factors such as gender and political or cultural background. The same interpreter should not be used for members of the same family, as this may result in some members of that family not trusting that confidentiality will be respected.

- Recruiting more heath advocates to work both at the level of community organisations and health service providers

- Interpreting medication, since currently no one has this task. Using Language Line or other interpreting services could be one way of facing this problem.

- GP practices and hospitals should develop a pro-active interpreting/translation policy ,and ensure that all staff are aware of the process for booking interpreters for all appointments.

- Patients also emphasised that GPs should put up notices in different languages, particularly in relation to the provision of interpreting services, so that patients would know that they could ask for an interpreter should they require one.

- **Double appointments for patients requiring interpreters and advocates:** Some participants have highlighted that their appointments were usually for 20 minutes, instead of the allocated 10 minutes, when they were provided with an interpreter. All participants felt that this was a very good practice as it would allow them to discuss their health problems properly with their GPs

- **Provision of interpreters who speak the same dialect:** Lack of provision of interpreters who speak the same dialect, are of the same gender and are familiar with the cultural and religious background of the patient.

8.6 Provision of Adequate / Culturally Sensitive Health Services

- It is suggested that improved **cultural awareness training should be provided for all staff–** including front-line staff such as receptionists. This should include visits to local community groups – which could also be included in induction programmes for new staff.

- There should be UK guidelines and a regularly updated list of resources that will inform health-care professionals on how best to deal with asylum seekers and meet their needs.

- In relation to St Mary's Hospital, many women stated that **prayer facilities** are available. However, they emphasized that the area was too small and not segregated. Prayer facilities **should be divided into two sections**, one for men and another for women.

- **Good Practice on Hospitalisation and Discharge Procedures:** Participants gave good feedback on hospitalisation and discharge procedures. Many said that these

were provided in different languages and using different methods such as videos etc.

8.7 Issues mainly relevant to people seeking asylum

- A consultation exercise with key players in the field (including policy-makers, service providers, local communities and asylum seekers and refugees) should be held to strengthen research **on the impact of UK immigration controls on the health of asylum seekers**.

- An efficient immigration process so that claims are decided fairly and quickly.

- Information and access to health care should be provided to all people seeking asylum immediately on their arrival.

- Adequate accommodation, as stable accommodation promotes good mental health and reduces the demand upon other health and social services.

- Health-care professionals need to develop a greater understanding of cultural, social and other issues relating to asylum seekers.

- In order to benefit from free health-care e.g. medical prescriptions, dental treatment and checks etc, asylum seekers need to obtain an HC2 certificate by completing a lengthy form that is only available in English and Welsh. These forms should be widely publicised so that asylum seekers are aware of them at the time of application.

- Barriers to health-care are not just experienced by asylum seekers but by other UK residents too. It is important that all people have the same provision. It can cause tension where asylum seekers appear to have more provision than other members of the community.

- To facilitate continuity of care, asylum seekers should be given a hand-held copy/ duplicate medical record, including test results, to take to their next doctor.

- While it is beneficial for people seeking asylum to access the services of GP practices, it cannot be assumed that GP practices can absorb this extra workload without additional funds and resources. It is imperative that the health care professionals in GP surgeries have sufficient time and resources to meet the complex needs and language requirements of asylum seekers.

8.8 Preventative Work, including Health Promotion

- To develop **information and awareness, consultation sessions should be held jointly with grassroots community organisations** and within community settings. NHS Trusts – hospitals and the PCT – should work with community organisations to raise awareness on particular services including Breast-Screening, Cervical Smear Tests, Access and Entitlements to Dentists, Opticians etc, and developing formal structures for on-going user feedback to ensure that concerns are taken into account when developing or restructuring these services.

- Awareness sessions on new public and user involvement initiatives, particularly in re-

lation to PALS and Patient Forums, should be provided. Develop joint projects whereby **PALS officers are placed** within statutory as well as **community sectors,** to ensure community-based service-provision and on-going user feedback.

- Look at current **good practice examples** of provision of information on hospitalisation and discharge procedures and **extend them to other services, including primary care services.**

- **Awareness and information** sessions on **specialist services should be helpful,** including Dentists, Opticians, Community Dieticians, Walk-In Clinics, and **NHS Direct.**

8.9 Partnership projects between community and statutory sectors

From this consultation, it is clear that there is a need to develop a **multi-agency, genuine partnership approach to service -planning, development and delivery**. These should include Health and Social Care service- providers and commissioners – PCTs, Hospital Trusts, Mental Health Trusts, and Social Services and academic institutions – grassroots community organisations as well as umbrella organisations and local training providers. There is also a need for an ongoing process approach, and not just a one-off event.

Given the above, and the outcome of the consultations in terms of the need to recruit **health advocates and bilingual health and social care professionals** as well as frontline staff, short-term as well as long-term measures need to be developed to address difficulties in accessing current mainstream services and the gap in service-provision.

8.10 Other recommendations

- **Link** in current local initiatives on **training for health advocates** (e.g. MRCF Training on Health Advocacy) to current recruitment drives within the PCTs and other Trusts, to employ PALS Officers

- **Extend and build on** the current joint **Refugee Doctors and Dentists Scheme**

- **Provide long-term** training and **employment opportunities** for members of the **local community**

- **Undertake a Skills Audit** locally and **match it** with current **local health and social care vacancies**.

- **Recruit bi-lingual community link-workers** based part-time in a community setting and part-time in a statutory setting.

- **Resource/Fund community -based bilingual health advocates**

- **Develop "satellite" nurse-led clinics within community settings,** providing basic health checks, information and advice and **link it to the PALS service.**

- **Develop a Training/Capacity Support** Programme for the Task Group members, in consultation with them.

- Reduce the amount of paper work required of doctors, and give more time for individual consultations
- GPs should be able to dispense medicines at the surgeries in emergency cases.
- Follow up incidences of discriminatory practices, with the help of health advocates

THE WAY FORWARD

The success of this Task Group will be measured by better access of refugees and asylum seekers in KCW to the different existing health services, as well as by an increase in the awareness of refugees and asylum seekers' needs by service- providers and commissioners. For a positive change to occur, a mutual commitment to some of the most important recommendations by both the statutory and voluntary sectors will need to take place.

Community organisations can play, and in fact are already playing, an important role in health promotion and dissemination of information about the different health services. However, they need to be empowered through structured working relationships with statutory service providers in order to build an active partnership, rather than a passive provider-user relationship. The nature of the needs of the newly arrived asylum seekers and refugees are often complex and overwhelming and they do not always fit within the existing statutory framework. The statutory service -providers are often pressured by national and local priorities and targets, restrictions and reductions of funding, lack of awareness of other cultures' needs and an institutional working culture that does not provide space for complex needs. Second-tier community voluntary organisations such as the *Migrant and Refugee Communities Forum* (MRCF) and the *BME Health Forum* can help facilitate the process of change by building the capacity of the community organisations, while acting as an advocate for the needs of various communities.

One year after the launch of this report there will be a meeting to ascertain the extent to which recommendations have been taken up. But in the meantime, the BME Health Forum and MRCF will continue to disseminate the findings and recommendations of this report through presentations at different meetings, including the two PCTs, the Trusts and other service providers and commissioners. Presentations at Equality and Diversity and Race Equality meetings are very important, so that some of the recommendations would be included into the action plans that are in course of development. Feedback to communities also needs to take place in order to help them meet the needs of their members more strategically.

For further information:

If you would like any further information on this report or on how the findings and recommendations form this Task Group will be taken forward, please contact:

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or

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Appendix A - List of steering group members

Abdi Ibrahim	Somali Welfare Association
Aisling Byrne	BME Health Forum
Aliya Elagib	Sudanese Community Centre
Amira Gorani	Westminster PCT
Anne O'Neil	Community Health Development Team
Annie-Mae Shaw	New Roots
Aranos Teclehaimanot	Eritrean Elders 50 Plus Group
Asma Miah	Carers Network Westminster
Bilal El-Harras	Westminster Mental Health Advocacy Project
Carola Addington	Kensington & Chelsea Social Council
Carole Sturdy	Voluntary Action Westminster
Cllr. Pat Mason	Royal Borough of Kensington and Chelsea
Colleen Williams	Westminster City Council
Coreen Allen	Voluntary Action Westminster
Denise Forde	Grove House Hostel
Eamon O'Toole	Health Support Team Westminster PCT
F. Kunva	AKHB
Faith Ndrangu	Ugandan Support Group
Fidaa Mahmoud	MRCF the Migrant and Refugee Communities Forum
Fidelma Carter	Westminster PCT
Frederick Marais	Imperial College
Gareth Jones	CNWL Mental Health NHS Trust
Glynnis Joffe	Westminster City Council
Gosaye Fida	Westminister PCT, Refugee Health Advocate
Gosia Brykczyinska	RCN Refugee Project
Straughair, Graham	Chelsea and Westminster Healthcare NHS Trust
Hammam Barbary	Egyptian Community Centre
Idina Dunmore	Westminister PCT Health Support Team
Iman Acharya	Genuine Empowerment of Mothers in Society
Jennie Mussard	Westminster, Public Health
Joan Gould	K&C Advocacy Alliance
John Hoffman	St. Mary's Hospital
Joy Stanton	Lemas WCC Education
Judith Blakeman	KCW Community Health Council
Katja Huijbers	MRCF the Migrant and Refugee Communities Forum
Kitty Fitzherbert	Voluntary Action Westminster
Kois Miah	CEMVO Health Network
Lisa Todd	Job Centre Plus
Loula Oraby	Arab Women's Voice & Resource Centre
Louise Maile	Westminster PCT
M. Mavangilu	North West Angola Assoc.
Marilyn Offord	Job Centre Plus
Maryana Obeid	Sure Start, N-W Kensington
Melanie Ridge	Macmillan Cancer Relief
Miriam Colque	Latin American Community Association
Mostafa Ragab	Egyptian Association
Myriam Cherti	MRCF the Migrant and Refugee Communities Forum
Naume Ocaya	RBK&C Asylum Team
Nick Tittle	Community Safety, K&C Police
Olatoun Bankole	Westminster PCT
Olga Garzon	Family Support Group
Patrizia Lorefice	African People's Link
Priscilla Cunnan	Imperial College
Rachel Phillips	Health Support Team
Shelleyna Rahman	Church St. Neighbourhood Forum
Shivam Kundapur	Sure Start, NW Kensington
Simon Barber	NHS Direct, St. Charles Hospital
Sue Arnold	NW London NHS Workforce Confederation
Tecle Gebremichael	Eritrean Elders 50 Plus Group
Umbreen Daechsel	Westminster City Council
Yemi Oloyede	Refugee Support Service
Yildiz Biray	Kensington &Chelsea PCT
Yohannes Fassil	Westminister PCT, Head of Diversity
Zrinka Bralo	MRCF Migrant and Refugee Communities Forum

Appendix B

Pro Forma Questionnaire

Issues to raise during Community Consultation as part of BME Health Forum & the Migrant and Refugee Health Forum's Task Group:

Health needs of Refugees and Asylum Seekers in Kensington & Chelsea and Westminster

The following are issues that have been suggested by the Steering Group for this Task Group to be used during the community consultations run by community groups. They have been grouped together under headings to help give a structure to the discussion.

Note to facilitators:
Please make sure that all comments made during the consultation session are recorded by a note taker or noted on flip chart paper during the session.

We are aware that not all issues will be relevant to some groups and settings- so please feel free to focus on those subjects that are relevant to the people in your group.

1- Who/what do people access for?
- General healthcare information/advice
- Health care (e.g. physical or emotional care and support)

2- Are people registered with a local GP (doctor)?
If not, what are the main reason/s for not registering?

Do people use GP/doctors services?
If not, what are the main reason/s?

1- What are people's experiences in accessing GP/doctor services?
- What are the main problems that people encounter when using these services?
- How can these services be improved?
- GPs/doctors
- Appointments
- Interpreting services
- Religion/culture
- Nurses and other health professionals in GP surgeries
- Continuity of care
- Referrals
- Completing of forms
- Gender sensitivity/compatibility – i.e. treatment by women doctors and nurses

2- What are people's experiences of using hospital services?
- What problems do the participants encounter when using these services?
- How can these services be improved?
- Interpreting services
- Hospital community outreach services- links with community groups
- Issues regarding re-access to and registration with GPs
- A&E refer back to GP
- Out-patients
- Minor injuries
- Completing of forms
- Hospital Pharmacies
- Follow-up appointments
- Gender sensitivity/compatibility – women doctors and nurses

Appendix B - Pro Forma Questionnaire

3- What are people's experiences of using other services?
What are the main problems that people encounter when using these services?
How can these services be improved?

- Opticians
- Dentists
- Counselling Services
- Pharmacists
- Physiotherapy
- Occupational Therapists
- Osteopathy
- Dieticians
- District and Specialist nurses
- NHS direct
- Admiral and McMillan nurses
- School nurses

4- What barriers are there likely to be for users in accessing health services?
How can mainstream service providers help to overcome these barriers?

- Culture/language
- Confidentiality
- Transportation
- Hours of operation
- Gender sensitivity/compatibility
- Family and children needs

5- What are women's experiences in accessing services specific for them?
What are the main problems? In what areas are improvements or additional cover age necessary?

- Access to female GPs and other health staff
- Women's services in clinics
- Maternity services & ante-natal services
- Sexual health services
- Family planning
- Midwives

6- What are young people/children's experiences in accessing services specific for them? What are the main problems? In what areas are improvements or additional coverage necessary?

- Paediatricians
- School nurses
- Health visitors

7- What are the elderly's experiences in accessing services specific for them? What are the main problems? In what areas are improvements or additional coverage necessary?

- General health care
- Transport
- Home visits
- Carers

8- What are disabled people experiences in accessing services specific for them?
What are the main problems? In what areas are improvements or additional cover age necessary?

- General health care
- Transport
- Home visits
- Carers

Appendix B - Pro Forma Questionnaire

9- What are the main difficulties of carers in responding to their needs?
- Support
- Flexibility
- Information about services and entitlements for carers

10- How does the current legislation related to Asylum Seekers and people newly-arrived to the country affect people's health status?
- Entitlements including benefits, money, etc.
- Housing
- Food and basic living requirements
- Dispersal to the North of Britain or to another borough
- Access to health services/providers
- Continuation and co-ordination of medical/health care

11- What health information and services are currently available?
What health information and services do you think could be provided?
Where do you think access arrangements and additional services need to be loc ated?
- Waiting rooms
- Community centres, long-term care facilities
- Religious establishments
- Chemists
- GP surgeries

12- How do we ensure that users understand/know about sufficient health information and services?
- Advertising - Training
- Health advocates
- Educate health providers
- Social services

13- How do people get involved in improving health services or give their feedback to health services?
- Complaint procedure
- Feedback on services - user involvement, consultation meetings, PALS
- Partnership work - community and statutory services
- Health promotion
- Advocacy

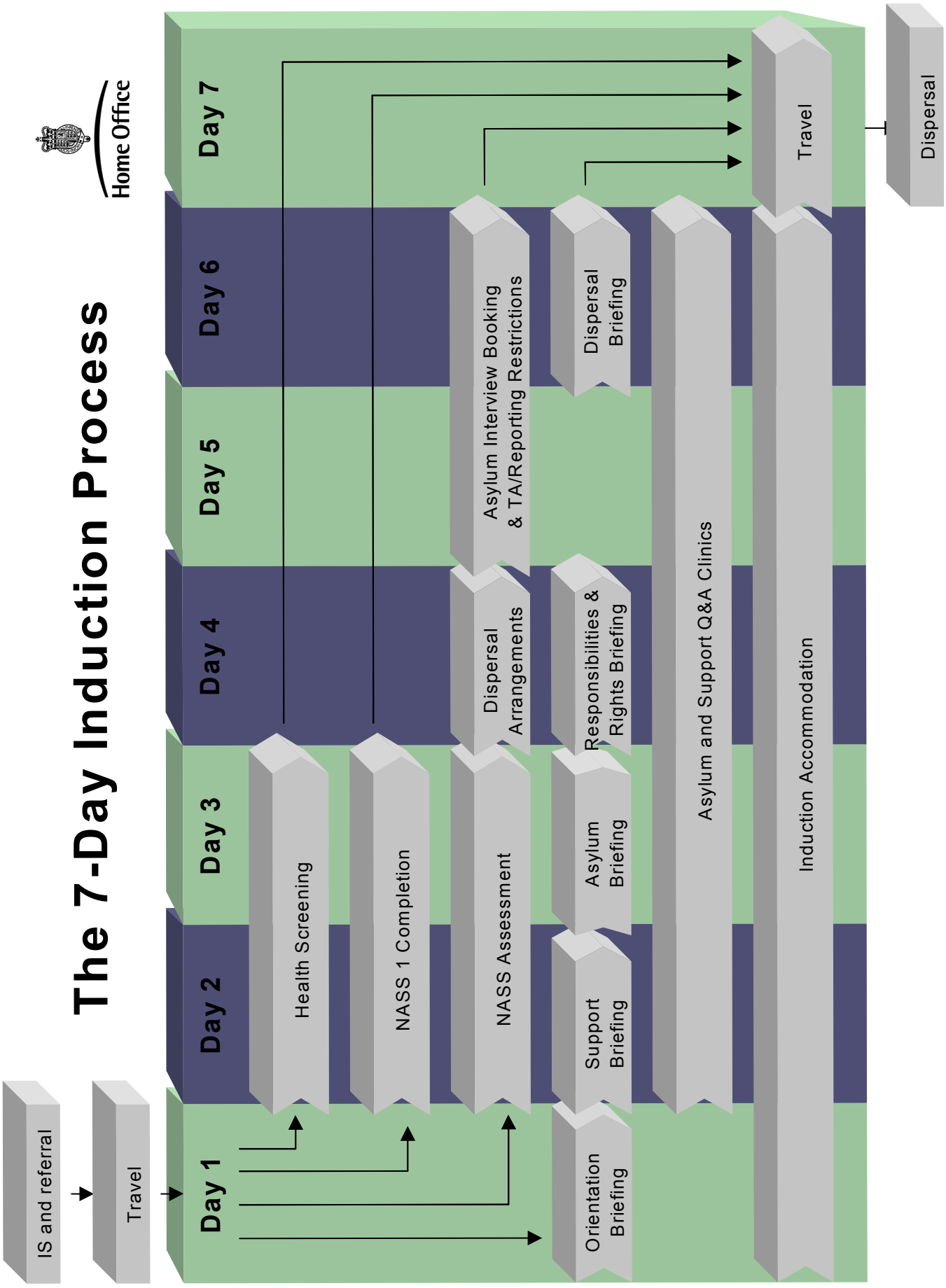
14- Relevant case studies
What are the main health issues/concerns for people?

Appendix C - Assessment Table

Issues	GP	Hospital	Referrals	Nurses & other health professionals	Dentists	Other (Opticians Physiotherapists, Chemists, Dieticians, Carers)
Availability of Information						
Registration Facilities						
Appointments						
Consultation Time						
Standard of Care						
Transportation						

5= Excellent
4= Very Good
3= Good
2= Poor
1= Very Poor

Appendix D


The 7-Day Induction Process
Home Office
IS and referral
Travel
Day 1
Day 2
Day 3
Day 4
Day 5
Day 6
Day 7
Health Screening
NASS 1 Completion
NASS Assessment
Dispersal Arrangements
Asylum Interview Booking & TA/Reporting Restrictions
Orientation Briefing
Support Briefing
Asylum Briefing
Responsibilities & Rights Briefing
Dispersal Briefing
Asylum and Support Q&A Clinics
Induction Accommodation
Travel
Dispersal