



**Including
migrant
populations in
Joint
Strategic
Needs
Assessment
A GUIDE**

Acknowledgements

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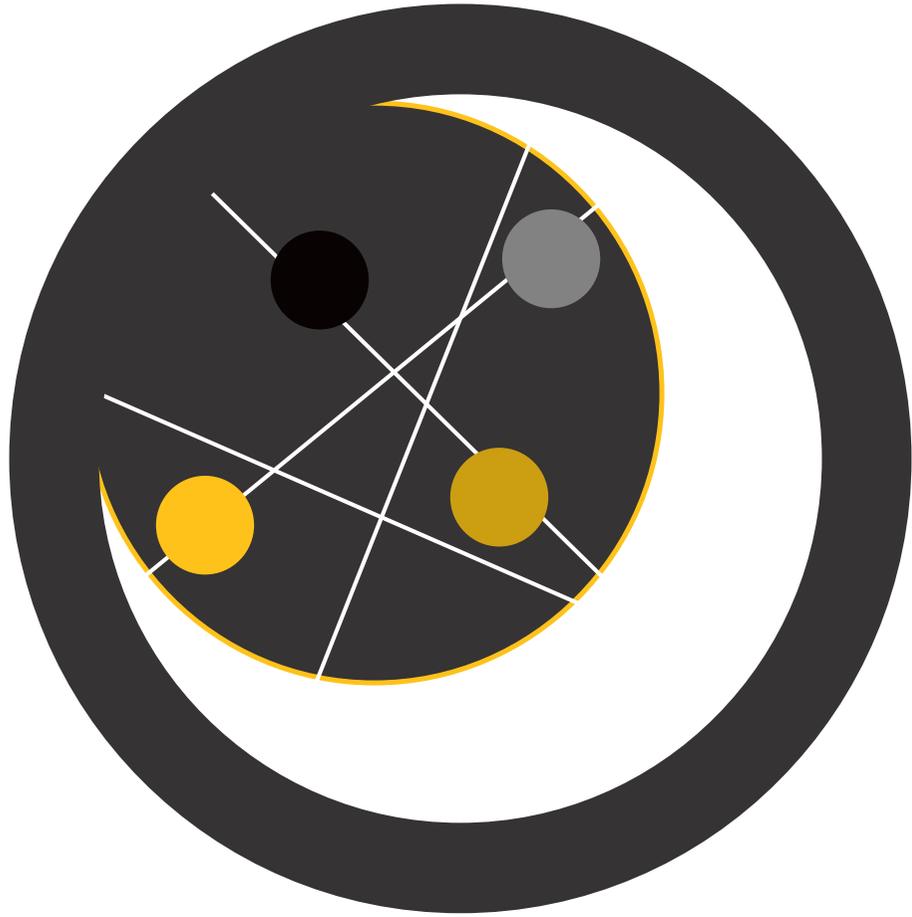
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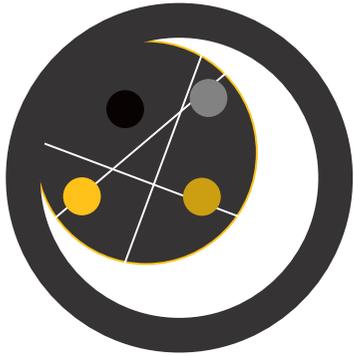
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Foreword

This Guide is written to assist those writing a Joint Strategic Needs Assessment (JSNA) as part of the process of commissioning.

A JSNA is not detailed academic research, and it is not an end in itself. Rather, it is a critical part of the process of commissioning: it identifies areas of concern that warrant changes to provision, to longer term strategy or to areas needing further focused assessment.

A first step to understanding local need must be a basic understanding of the demography of the local population. As such, some understanding of migration and how it might be changing the local population is essential. Knowledge of local migration and needs is also important in assessing equity of provision as migrants are in all areas, even when not visible or seldom heard.

A variety of situations can trigger the assessment process, including local perceptions. For example, a service may consider that it is unable to fully meet the needs of a new migrant group, or there may be wider population concerns about competition for resources. This Guide will help

planners and commissioners to build an objective analysis of population needs, taking into account issues of perception and prioritisation.

The Guide is arranged in three parts:

- a 'How To' section
- a set of notable examples
- a series of appendices with more detailed information

The examples include one of migrant inclusion in a JSNA, and others illustrating a range of existing service models providing innovative solutions to health and social care needs. We hope these examples will provide inspiration when commissioning services for migrant populations in your area.

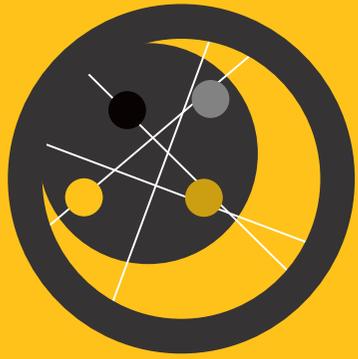
We welcome feedback on any aspect of the guide for future development.

Contact: [David Chappel](#)

Including migrant populations in Joint Strategic Needs Assessment

Contents

Including migrants	4
Who are migrants?	4
Why include migrants?	8
Determinants of health and wellbeing for migrants	10
How to include migrants	11
Key principles	11
Key components	12
1. Focusing	12
2. Information collection	14
3. Mapping	15
4. Interviewing and case studies	15
5. Storing and disseminating information	16
6. Creating conclusions and momentum for change	17
Notable examples	18
Appendices	28
Appendix 1 Who are migrants?	28
Appendix 2 Key features of co-producing JSNA	32
Appendix 3 Using routine data on migrants	34
Appendix 4 Starting contacts	38
Appendix 5 Resource list	39
Appendix 6 References	44



Including migrants

Who are migrants?

Migration is not new. For hundreds of years, people have left their place of origin to live in other countries and cultures, and in the last 100 years this trend has increased. Today, according to the International Office for Migration, 3.1% of the world's population are migrants¹. The IOM also reports that the percentage of migrants has remained relatively stable as a share of the total population, increasing by only 0.2 per cent over the last decade.

Migrants are now part of communities throughout the UK and, though government immigration policy and legislation may set limits and conditions, migration will continue to be an important factor in UK demographics.

Migrants arriving in the UK

In 2009, an estimated 567,000 people arrived to live in the UK for a period of a year or more. Of these, 17% were British citizens.

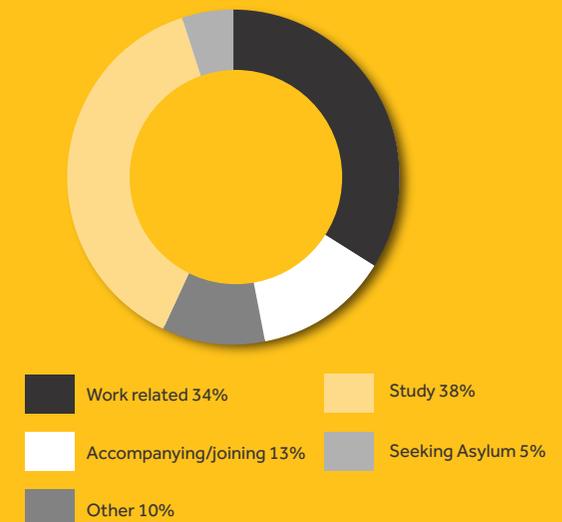
Of the total 567,000, it is estimated that:

- 34% came for work related reasons
- 13% were accompanying or joining others
- 38% came for formal study
- 15% came for other reasons

Those who came for other reasons included 24,485 people making an application for asylum (totalling 30,675 people including dependants)².

In the same year, 368,000 people left the UK (for similar reasons, although more for work than study). Of these, 38% were British citizens³.

Reasons for people coming to the UK in 2008
estimated proportions

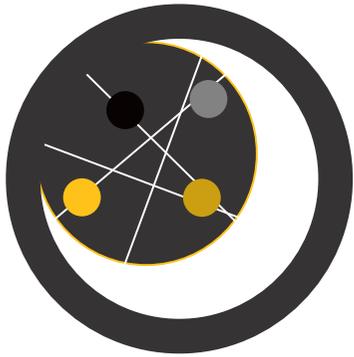


How to
include
migrants

MIGRANTS ARE PEOPLE WHO HAVE MOVED FROM THEIR USUAL PLACE OF RESIDENCE TO LIVE IN ANOTHER COUNTRY FOR REASON OF WORK, EDUCATION, FAMILY, SOCIO-POLITICAL PERSECUTION OR WAR.



Who are migrants?



JSNA HAS TO BE FOCUSED ON "IDENTIFYING GROUPS WHERE NEEDS ARE NOT BEING MET AND THAT ARE EXPERIENCING POOR OUTCOMES"⁴.

Including migrants

Dynamism and diversity

Migration is dynamic. Within the space of four years, for example, the position of Polish nationals rose from thirteenth to first in the list of foreign national groups coming to live in the UK.

Perhaps the only shared characteristic of migrants is that they come from another country. Migrant populations are diverse and like any other group have social, cultural and material assets. In addition, local areas across the UK face distinctive issues according to the particular composition of the population, the rate of change, and other social, economic and political factors.

Demographic variation of this magnitude and speed has a significant impact on local needs, and services must be able to respond promptly and appropriately. The JSNA is an important tool in bringing this about.

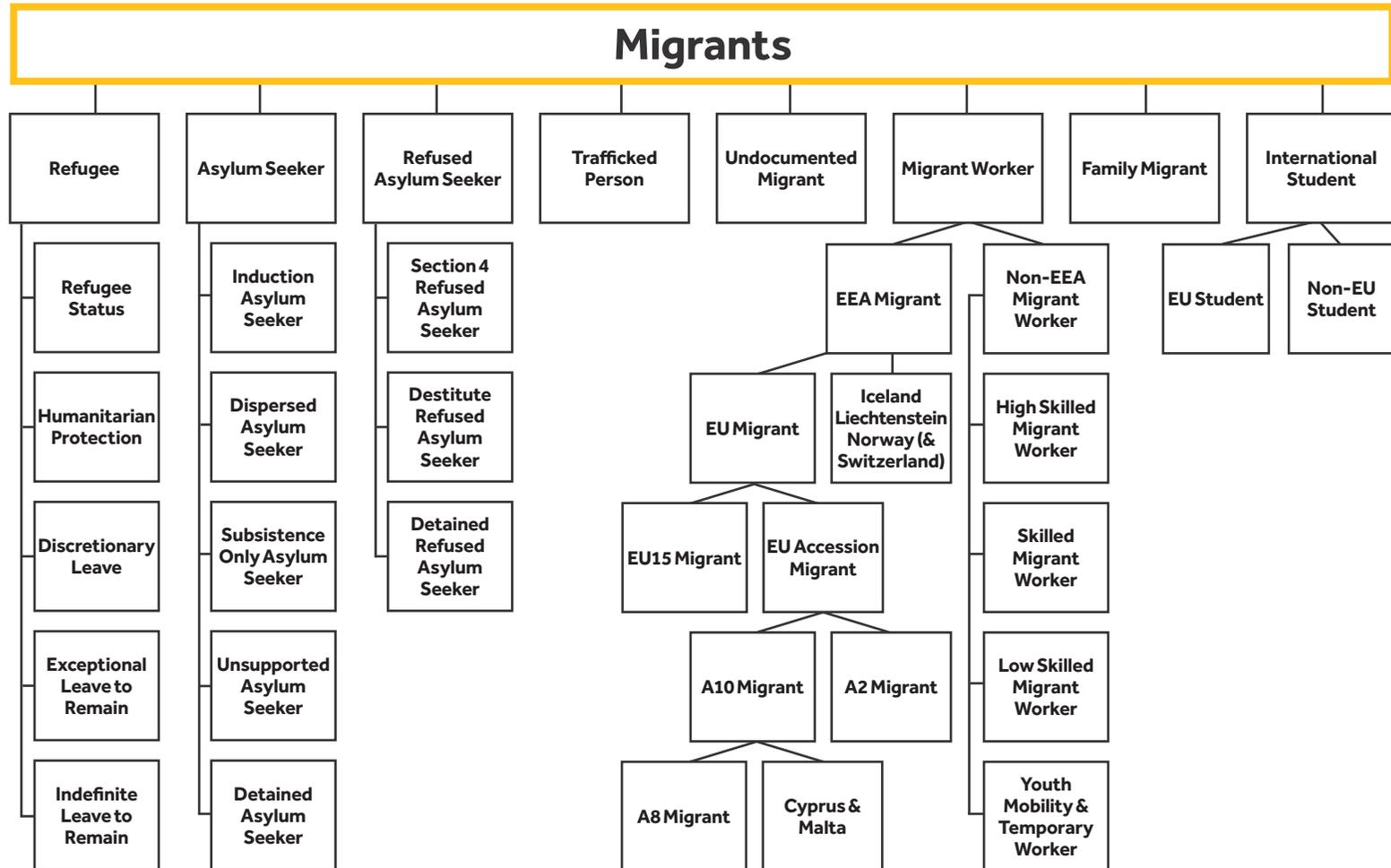
The process of JSNA described here is one of general scoping to gain an overview of local populations and their needs. This can serve as a basis for more meaningful detailed work about specific populations such as:

- Polish workers and families.
- People from Central or sub-Saharan Africa with high rates of HIV.
- Undocumented Chinese men or women working in restaurants.
- Refused asylum-seekers living in Section 4 accommodation.
- Students from Asian countries studying at the local university.
- Slovakian Roma.
- Torture survivors.
- Young separated refugees without recourse to public funds.
- People coming to join family already resident in the UK.

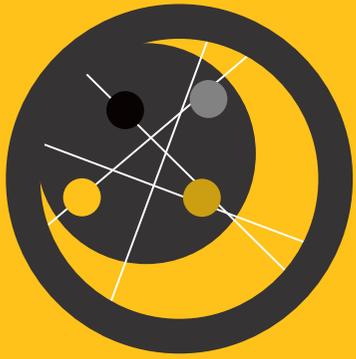
Including migrant populations in Joint Strategic Needs Assessment

Who are migrants?

This diagram shows different 'types' of migrants in the UK (as developed by the Yorkshire and Humber Migration Partnership). See Appendix 1 for definitions.



Who are migrants?



Including migrants

Why include migrants?

"EQUALITY ISN'T A
MINORITY INTEREST.
A FAIRER SOCIETY
BENEFITS EVERYONE IN
TERMS OF ECONOMIC
PROSPERITY, QUALITY
OF LIFE AND GOOD
RELATIONS WITHIN AND
AMONG COMMUNITIES.
THE RESPONSIBILITY
FOR BUILDING A
SUCCESSFUL
SOCIETY RESTS WITH
ALL OF US."⁵

Migrant populations are usually locality-specific and change over time, sometimes rapidly. A proactive approach – one of understanding and inclusion – will pay dividends in the long term (as opposed to waiting until problems are acute).

Despite being small in number, migrant populations are heterogeneous with diverse assets and sometimes complex needs. Some will experience a disproportionate level of need which may be challenging to articulate and to be heard. These factors are more fully explored in the Health and Wellbeing Determinants Mind Map and table in this guide (see pages 9 and 10).

Understanding the needs and assets of migrants within our communities yields a number of benefits, and can be justified in a number of ways:

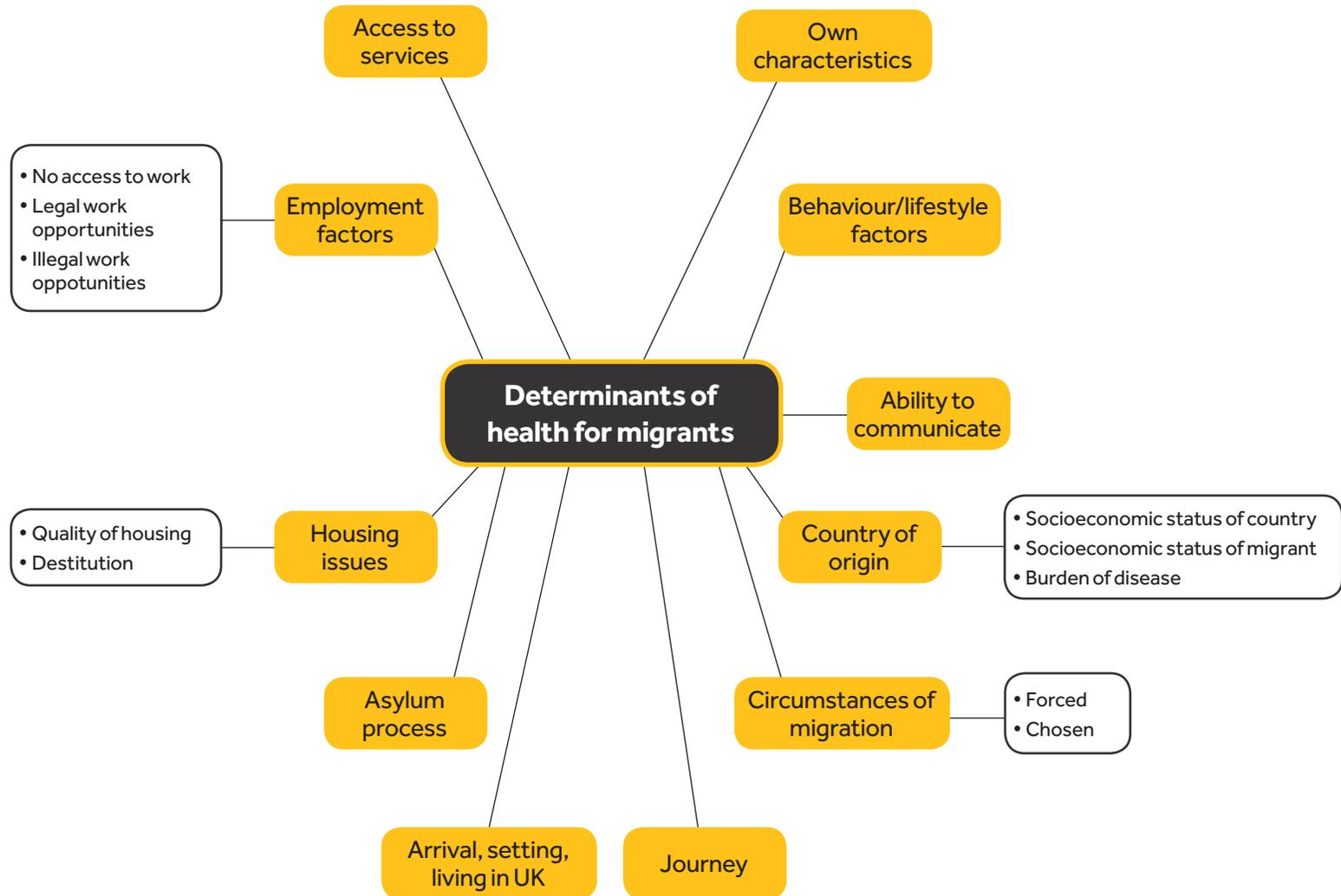
- It is about social justice and is an essential part of addressing health inequalities.
- It is a key component in generating community cohesion.
- It is integral to the economic wellbeing of our society.
- It is about continuing to address the needs of the most vulnerable members of our society and enabling their full participation.

A key output from JSNA is engagement of the migrant community through their involvement in the process. Therefore a likely positive outcome of JSNA is increased understanding of health service provision among migrant populations, and more timely and appropriate uptake.

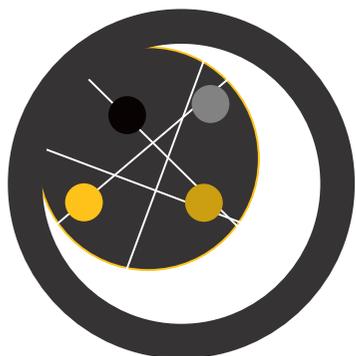
Anticipated benefits of addressing the needs of vulnerable migrants include:

- Early diagnosis of blood borne viruses (HIV, Hep A,B,C), prevention of onward transmission and better outcomes.
- Identification of sexually transmitted disease and prevention of onward transmission.
- Screening for TB, support at diagnosis and improved compliance with treatment, thereby reducing risks for multi-drug resistant TB and extreme-drug resistant TB.
- Early identification of mental health problems and provision of appropriate support, thus reducing risk of crises and suicide.
- Screening for chronic medical conditions allows early identification and support enabling appropriate management, thus avoiding preventable complications, Accident and Emergency attendances, and hospital admission.

Including migrant populations in Joint Strategic Needs Assessment



Why include migrants?



Including migrants

Determinants of health and wellbeing for migrants

Own characteristics	Age, gender, ethnic group, past and current medical history.
Behaviour/lifestyle factors	Smoking, drug and alcohol use, diet, exercise.
Ability to communicate	Language(s) spoken, access to appropriate interpretation, cultural differences such as gender.
Country of origin	Burden of disease and prevalence of infectious diseases. Socioeconomic status (macro – country's position in global economy, micro – personal circumstances in own country prior to migration).
Circumstances resulting in migration (such as war, conflict, persecution, exploitation, imprisonment, torture)	Physical trauma: sequelae of torture (shrapnel, un- or under-treated war wounds or fractures, infection, malnutrition, epilepsy, hearing loss, amputation). Spiritual, ideological, emotional trauma and complex bereavement.
Nature of journey	Prolonged journey, uncertain outcome, physically dangerous, poor hygiene and sanitation, inadequate water and/or nutrition, trauma, extremes of temperature, separation from family and friends.
Arrival and 'settling' process, living in the UK	Poverty, grief, isolation, home sickness, racial harassment, anxiety about family members (present and absent). Denial of right to work, loss of identity, status and means to provide for self and family, loss of hope, despair at own story not believed, limited access to healthy food choices, different expectations of health services, entitlement confusion.
Asylum process	Uncertainty of outcome of process and associated despair, stress.
Housing issues	The quality of accommodation and landlord practice. Poorly maintained or inappropriate housing (including problems such as damp and mould, leaks, draughts, vermin, fuel poverty, inadequate food storage and hygiene facilities, increase risk of ill-health). Overcrowding and houses of multiple occupation. Sharing space with strangers (can have a negative impact on mental health as well as increasing risk of physical ill-health such as food-borne and other communicable diseases). Destitution – has significant negative physical and mental health effects.
Employment factors: no access to legal employment (asylum seekers)	Worklessness impacts on mental wellbeing. Poverty impacts on physical and mental wellbeing.
Employment factors: illegal/unregulated employment	Exploitation, long hours, less than minimum wage, surrendered documents (if have any), little or no job security. Accommodation may be linked to employment: poor quality, houses of multiple occupation. Risk to physical and mental wellbeing: mental distress from circumstances of employment such as trafficking (intimidation threats to family members at home). Direct physical hazards such as sexually transmitted infections (in sex workers). Musculoskeletal injuries such as via exposure to heavy machinery, manual labour in agriculture.
Employment factors: legal employment	Low skill, low paid: poverty impacts on physical and mental wellbeing. Potentially unaware of rights and open to exploitation.
Access to services	Lack of understanding or awareness of service options, unfamiliar systems and language, different previous experiences, for instance of health care and different expectations.

Including migrant populations in Joint Strategic Needs Assessment

How to include migrants

"EFFECTIVE LOCAL DELIVERY REQUIRES EFFECTIVE PARTICIPATORY DECISION MAKING AT LOCAL LEVEL. THIS CAN ONLY HAPPEN BY EMPOWERING INDIVIDUALS AND LOCAL COMMUNITIES."⁹

The needs of socially excluded people are poorly reported in current national data sets and often are not picked up in traditional data sources and surveys⁶.

In order to discover the needs and assets of migrants we therefore have to "go beyond the routinely available local data and work creatively with partners"⁷.

The approach described here incorporates this and other features of 'co-production' (more fully described in Appendix 2). At the same time, it integrates the requirements laid down in the guidance on JSNA for data collection, community engagement, dissemination and consultation⁸.

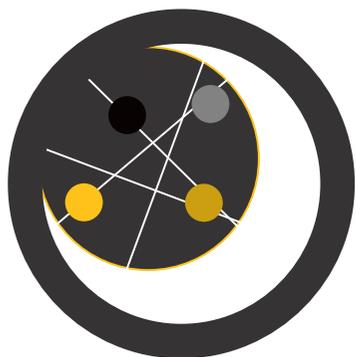
The process can be carried out by an individual or a group. A group may be preferable as it:

- Helps to build in engagement and consultation.
- Increases the data collection and analysis skills of those involved.
- Encourages innovation.
- Builds a momentum for change among the participants.

Key principles

Every JSNA will take a different course, however each will be underpinned by the following key principles:

- All community members are hidden resources and assets.
- A broad range of people (clients, practitioners, voluntary, community and other organisations) are acknowledged as legitimate partners and information sources.
- A network of people are involved in creating, disseminating and using knowledge collaboratively.
- A participative, community development approach is used.
- Qualitative tools such as networking, interviewing, case studies and visits are used.
- The process of generating shared information also creates capacity for service development.
- Long term participation secures sustainability and flexibility in the face of change.
- The process is iterative and non-linear.



Including migrants

Key components of JSNA

1. FOCUSING
2. INFORMATION COLLECTION
3. MAPPING
4. INTERVIEWING AND CASE STUDIES
5. STORING AND DISSEMINATING INFORMATION
6. CREATING CONCLUSIONS AND MOMENTUM FOR CHANGE

1. Focusing

The assessment may be triggered by increased awareness of a new migrant population. It may arise from a service realising that it is unable to fully meet their needs, or concerns about pressure on services, or wider population concerns about competition for resources.

In all cases, the capacity to carry out the assessment will be a consideration. The options are a broader and shallower assessment or a narrower and deeper one. Part of the conclusions of any assessment will be to identify and prioritise more focused work.

In most cases, at this early stage of JSNA, limits are set in terms of selecting a sub-category of migrant (see Appendix 1) to focus on in particular. This may be combined with a health determinant such as ethnicity; status; gender; age; sexual preference; use of a particular service; living or working in a specific geographic area; specific needs, problems or illnesses.

The following are examples of categories that may become the primary focus of a JSNA:

Broader and shallower categories	Narrower and deeper sub-categories
Migrant workers	Migrant workers in a particular industry
Somali women	Somali women living in a neighbourhood using A&E
Polish males	Adult Polish males who smoke
Asylum seekers	Asylum seekers supported under Section 4 living in shared accommodation
Refused asylum-seekers	Access to health and social care services by refused asylum-seekers
Migrant children	Roma children with special needs

Including migrant populations in Joint Strategic Needs Assessment

In order to target the process appropriately it will be useful to ask the following questions:

Change

Why does choosing this subcategory have more likelihood of bringing about change than choosing another?

Impact on wellbeing

How serious is the impact on wellbeing – for instance, the extent of the health and safety risks to migrants working in a particular industry?

Coherence

To what extent does the chosen population all share the same characteristics?

Existing resources

What information sources already exist? (research, grey literature, surveys, consultation report, websites, data)

Numbers

Is the population too small so the information becomes too specific or so big a task that the collection of information is impractical?

Feasibility

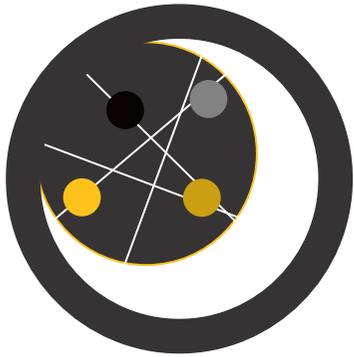
Are there the staff resources and funding to do the work?

Crossover

To what extent does an assessment crossover with other work being done in the area?

Will

Is there sufficient support to implement change?



Including migrants

2. Information collection

Once a decision has been taken about how to focus the assessment, the next stage is one of collecting the relatively easily available information, including:

- Hearing about people's lives. It is important to read and listen to case studies and personal accounts in order to gain insight into the lived experience of different people and communities.
- Written information such as research, grey literature, surveys, consultation reports, websites.
- Statistical information.

With this background – including awareness of subjective experience – you will be more credible to migrants themselves and to local voluntary organisations, enabling you to begin to build the relationships necessary for the work to be effective. This understanding will increase and deepen over the period of JSNA.

The mind map and table on pages 9 and 10, and Appendices 3, 4 and 5 will help you get started.

In finding out about migrants' lives, building networks and identifying case studies, the following are rich sources of information.

- Refugee and migrant community organisations.
- Drop-ins and specialist projects.
- Advice agencies such as Citizens Advice Bureaux.
- Networks such as City of Sanctuary.
- Churches, mosques and other faith-based organisations.
- Employment agencies and employers of migrants
- Staff on the front-line in statutory agencies (GPs, midwives, health visitors, community development workers).
- Tenants' Associations.
- Gangmasters Licensing Authority.

Some of these organisations may be able to arrange meetings between you and migrant groups and individuals.

Including migrant populations in Joint Strategic Needs Assessment

3. Mapping

The second stage is to map out the network of people, partnerships and organisations and any major networking methods (such as newsletter or email lists). This is most easily done through interviewing a couple of 'experts': in every area there are likely to be one or two people with high levels of expertise who can be used as starting points. It is also important to use and add to the sources already identified in earlier stages, such as organisational databases or written guides.

Mapping out organisations and key people can usually be done quickly as, assuming the limits of the assessment have been set carefully, there are often relatively small numbers of people and agencies directly involved. However, don't assume that this initial survey will be comprehensive. There are often sections of migrant communities that have little contact with formal organisations. The overview of the issues affecting the migrant population you are investigating will help you to decide the kinds of organisations that should be included in the survey.

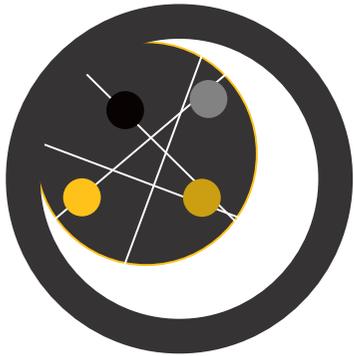
4. Interviewing and case studies

A key component of the assessment process is interviewing. This is likely to require some planning and preparation especially if interpretation or translation is required.

Interviewing may be with individuals or groups. It can be useful to interview multiple participants at the same time, for instance members of a migrant community organisation. The major benefit is that of encouraging discussion between participants and the insights generated by this, and a group approach can enable you to meet more people within a particular time period. The limitations include lack of disclosure if issues are sensitive or if one or two people are dominant voices.

Well organised visits by the JSNA team can be a hugely effective way of building a shared understanding. An additional benefit is that the analytical and information-gathering capacity of partners is increased.

Case studies of organisations and individuals can be a powerful way of communicating the need for change.



Including migrants

5. Storing and disseminating information

The assessment should be recorded in a form that will allow future assessors to understand and build on previous work. This maintains the credibility of the main collecting agency over a period of years, as knowledge is built up about the target group. Partners quickly become disenchanted if repeatedly consulted without any apparent benefit for the groups they work with, and they may experience 'consultation fatigue'. Recording should include: dates, participants, and content of interviews, group meetings, consultations, questionnaires and visits.

Informing people about the assessment

People want to know who you are; why you are doing an assessment; what it is about; how long it will take and how they will be kept informed. Most of all they want to know that it will bring about change.

Active dissemination of the findings should be built into the assessment. The key to doing this successfully is moulding the format and content to suit the audience. Large reports, untargeted leaflets and specialist websites are unlikely to reach many of the individuals and organisations that might benefit from the information generated through JSNA.

Effective means of dissemination include:

- Interviews.
- Email and established communication networks (such as newsletters).
- Structured meetings.
- Workshops.
- Conferences.

Keeping people informed about the assessment

Finding ways of keeping people updated throughout the process is critical to acceptance of the conclusions. People need to be prepared along the way. Going quiet for the period and then presenting people with the answer doesn't work.

Including migrant populations in Joint Strategic Needs Assessment

6. Creating conclusions and building momentum for change

Effective conclusions will be:

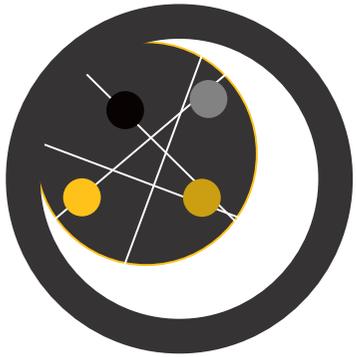
- Specific – only applicable in this particular area to this specific group of people.
- Clearly evidenced by the material you have collected.
- Simply stated.
- Powerful.
- Engaging.

Conversely, poor conclusions almost always take the form of lists of seemingly random and poorly-evidenced recommendations.

Ultimately conclusions are only as useful as the change they bring about: they are an integral part of the commissioning process and subsequent improved service provision.

Bear in mind that circumstances in the world of migration can rapidly change as new policy and/or legislation is introduced or as migrant populations arrive and leave.

JSNA is an iterative process which will require revision. The value of co-producing JSNA is that much of the social capital required to effect change will be generated during the process.



Notable examples

Notable examples

Example of JSNA

Nottingham City JSNA 2010: Asylum Seekers, Refugees and Migrant Workers

[The Nottingham City Joint Strategic Needs Assessment](#) includes a chapter providing an overview of migrant issues in the city, with information on service provision and levels of need. This was introduced in the 2009 JSNA and was written by the Head of Partnerships and Health, who chaired the Refugee and Asylum Seekers Health Forum.

The local authority and health service were successful in securing funding from the Migrant Impacts Fund which enabled them to commission more detailed work for inclusion in the 2010 JSNA. This was carried out by Dr Ruth Bunting, a Health Promotion Specialist with a special interest in Migrant Health at NHS Nottingham City, who had previously conducted a health needs assessment of refugee and asylum seeker health in the area.

In the process of carrying out the health needs assessment, she had interviewed health professionals, asylum seekers, refugees, community representatives and third sector service providers. At the same time, research on EU migrants with a focus on housing included some questions relating to health, and involved several hundred migrants in interviews.

Dr Bunting drew the data together, gathered additional information, and sent the draft JSNA chapter to the health forum for comment. The forum includes representatives of third sector organisations, health providers, and refugee community organizations.

The inclusion of the chapter in JSNA has added weight to work with these communities. It has enabled commissioners and service providers to demonstrate progress, and to show how migrant health impacts on services and on the wider community and health targets. There are, for instance, high rates of smoking among some migrant communities, and also high attendance at Accident and Emergency. Identifying this has enabled service providers to review who they target and how. It has also informed commissioning decisions. The prioritization panel has approved funding for the provision of formula milk to mothers who are HIV positive.

Examples of services commissioned for vulnerable migrant groups

Open Door, Grimsby

[Open Door](#) is a health and social care centre in the East Marsh area of Grimsby, offering a wide range of services to groups that are seldom-heard and hard to reach. This includes migrants, asylum seekers, refugees, trafficked women and Roma as well as British citizens who are vulnerable.

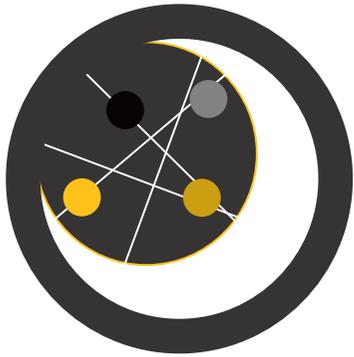
The patient group is unlikely to be seen elsewhere, either because their entitlement to services is limited, or they don't know their entitlement or services, or because they are reluctant or unable for some reason to contact most services. The centre provides a service across a wide range of needs (not just health) because the people it reaches have chaotic lives with multiple needs.

There are a number of benefits to this approach. By building trust and understanding, Open Door is helping vulnerable people to engage more effectively with health services.

Often, someone comes in with one issue, and the staff uncover other problems – or issues affecting other family members – that have gone unreported and untreated. The approach therefore improves individual health, and helps prevent worse things happening. It saves a lot of time: staff help people attend appointments, comply with treatment and avoid multiple encounters with services when one meeting will do.

Mental health is the main issue the project has to deal with.

Open Door is a social enterprise, led by North East Lincolnshire and North Lincolnshire health trusts. The surgery is funded by Care Trust Plus, a joint health and local authority body which manages adult social care.



Notable examples

Migrant Engagement Team, East Riding

East Riding Council has worked with a voluntary sector project, Humber All Nations Alliance (HANA), to develop support services for vulnerable migrants in the area. The East Riding Migrant Engagement Team has a full-time co-ordinator and three part-time East European workers.

The initiative specifically targets migrant men who are homeless in the winter when there is no work. Many live in tents during the summer. During the winter of 2009, breakfast and washing facilities were made available at a local church, and 17 homeless Latvians made regular use of the service. Most of the migrants in the area go to Accident and Emergency rather than register with a doctor, so the project liaised with the Primary Care Trust to gain access to the homeless health service, and ensure an 'MOT' for each man, with interpreters on hand. Most of the men had alcohol or drug problems, so the project links up with the local drug service.

The project reaches out to the wider migrant community, which is predominantly East European. It works closely with other services, including schools, the police, the fire service and the council. They hold open forums in different languages, and these are used to disseminate information about health and other issues. There is a [Polish website](#) and newsletter and a help desk in a local adult education centre where they assist with a range of issues, including understanding letters and getting to appointments.

Including migrant populations in Joint Strategic Needs Assessment

Specialist Midwife for asylum seeking and refugee women, Sheffield

The post in Sheffield arose as a response to the Confidential Enquiry into Maternal and Child Health report of 2003–5, which found that black African women, including asylum seekers and refugees, have a mortality rate nearly six times higher than white women. The report highlighted the poor general health status of refugee and asylum-seeking women accessing maternity care, and the link between vulnerability, social exclusion and adverse pregnancy outcomes.

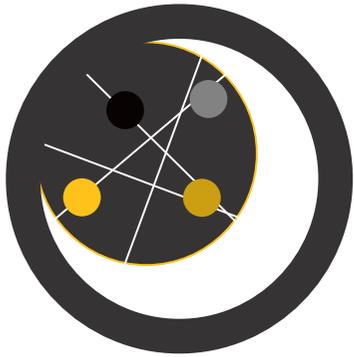
In response a midwife was appointed to provide maternity care to asylum seekers and refugees. She has been highly successful in building trust with this client group so that she can assess their social, psychological and physical needs, and can provide relevant support and signposting. She organises drop-in sessions to allow women of the same language to get together to develop networks of mutual support.

This service avoids costs to the individuals, families and NHS incurred by premature birth, neonatal and maternal complications, and death. This service model is recognised as an excellent way of engaging potentially highly vulnerable women and their babies in health services – as a result of this in 2008 the post-holder received the Addressing Health Inequalities Award from the Royal College of Midwives.

Four example case studies illustrate the complexity of need and the necessity of strong partnership working:

- A 16 year old African girl arrived in Sheffield 32 weeks pregnant, having had no antenatal care. She asked a woman on the street for work and was directed to Social Services. Her own mother died from AIDS; the girl had been trafficked into prostitution. She had been kept in a cellar with other girls until a decision was made to dump them on the streets or kill them – she managed to survive.
- A woman booked late at 24 weeks pregnant after hearing about specialist midwife via word of mouth. The midwife carried out the booking visit at the woman's accommodation – she was living in a cupboard with a blanket on the floor. She had no financial support.
- A woman presented scared that she might be pregnant. She had fled her country two weeks previously. Soldiers had attacked her home in the middle of the night. She had been multiply raped and fled for her life. She doesn't know what happened to her children. Someone she met on the street is letting her sleep on the floor.
- A failed asylum seeker got pregnant after being raped whilst trying to sleep on a bench in the bus station.

Dorothy Smith, Specialist Midwife, Sheffield.



Notable examples

Mulberry Practice, Sheffield

Mulberry Practice works with asylum-seekers and trafficked women in Sheffield. It has been running for seven years, and is funded by the PCT.

The main services are for newly arrived or dispersed asylum seekers. They get a full health screening, including testing for TB and viruses (the TB clinic is funded through Invest to Save). Their urgent health needs are addressed, and their immunisation is updated. They are given information about the health service, and a welcome to Sheffield pack. Interpretation is on offer, in person and by phone, and there is a large range of translated materials.

There is a focus on maintaining mental health and avoiding social isolation. There is access to a counsellor (through Increasing Access to Psychological Therapies), and the practice works with the voluntary sector including Rape Crisis, to ensure support is available. The GPs have expertise in depression, post traumatic stress disorder and understanding the effects of torture. There is physiotherapy, acupuncture and massage. A health visitor, funded by the local authority, helps families rapidly link up with local networks, and there is access to GP's plus the specialist midwife.

The practice also sees refugees coming straight from overseas refugee camps as part of a twice-yearly resettlement programme, and failed asylum seekers who are facing deportation. This latter group is either in receipt of vouchers or destitute. The practice offers them primary care, and works with ASSIST, a Sheffield voluntary project running a night shelter and offering some support. The midwife is a valuable service for destitute asylum seekers.

The same services are on offer to trafficked women. This group has considerable needs and is challenging to work with for various reasons.

The practice delivers a range of benefits. The screening means that undiagnosed TB and blood borne viruses are picked up and treated rapidly, and latent TB is managed, avoiding reactivation. Providing help in navigating the NHS appropriately saves costs of inappropriate hospital appointments and misuse of Accident and Emergency.

The support on offer helps reduce isolation and build community. The practice believes that kind and respectful treatment provides a counterbalance to widespread hostility in the system. The practice deals with some of the distress and anger the asylum experience generates.

Including migrant populations in Joint Strategic Needs Assessment

Slovak Roma Health Visitors, Sheffield

Since May 2004, when the Slovak Republic joined the European Union, South Yorkshire has been a base for migrant Slovak Roma workers from Eastern Slovakia arriving in a classic chain migration. Generations of Roma discrimination, poor living conditions and exclusion from services contribute to highly prevalent communicable and non-communicable disease (including diabetes mellitus, coronary artery disease and obesity), teenage pregnancy and nutritional deficiencies.

Local research has highlighted a number of health and social concerns for Roma including insecure employment, poor working conditions and minimal rights; inadequate access to education and care; long-term health conditions, unhealthy lifestyles and community tensions. Full entitlement to healthcare can be complicated, depending on registration with the Workers Registration Scheme and completion of a stipulated period of employment, as well as 'right to reside'.

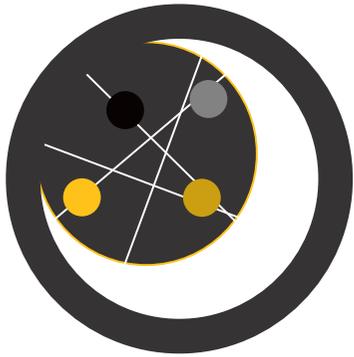
To cater for the expanding Roma community, local health services dedicated some health visitor time to addressing the needs of the Roma community. The health visitors learnt a great deal through a visit to the Slovak Republic. In addition an in-house interpreter is available 1.5 days a week for drop-in services, pre-booked appointments, and is trained to undertake new patient checks in the PCT practices where many Roma are registered. The specific funding for health visitor posts ended in 2010. However health visitor

teams have identified how best to address needs in each of their areas and a significant amount of work continues to be delivered to Roma families. The benefits of the health visitor posts have been significant in improving access to healthcare and appropriate use of services, addressing issues around teenage pregnancy and offering health education on smoking, nutrition, and other key health issues.

A recent health needs assessment of Roma in the Tinsley area of Sheffield estimated the population to be 550-600, and recommended a series of possible solutions to the multiple health issues faced by this population: increasing the availability of healthcare information and advice, using translated materials and a Roma-specific community 'health liaison worker'; improving access to primary healthcare and current public health initiatives through better availability of Slovak interpreters and English language classes; and improving overall relevance and efficiency through better inter-agency collaboration and community involvement in service planning.

Moore, Lizzie, 2010. *A Healthcare Needs Assessment of the Slovak Roma Community in Tinsley, Sheffield.*

NHS Sheffield 2009. *A Report on the Health Needs of New Arrivals and Service Provision.*



"THIS WAS THE BEST DAY
I EXPERIENCED SINCE
COMING TO ENGLAND."

"I FEEL LESS STRESSED
AND WISH I COULD COME
AND DRUM EVERY DAY."

Notable examples

Music Share Project, Wakefield

This project is a partnership between NHS Wakefield District and Wakefield Cathedral aimed at improving the mental health and well-being of asylum seekers through the medium of music.

The project provides a series of music workshops for asylum seekers and refugees, enabling them to share culture through songs, music and stories. It has a manager based at the Cathedral, and involves musical artists and volunteers in each session. Specific sessions are held for women, men and families. In order to reach as many members of the asylum seeking and refugee community as possible some sessions take place at the Initial Accommodation Centre, and some are linked to coincide with Drop-in at the Education Centre.

Teaching each other songs and stories encourages cultural exchange and respect, and builds confidence in a new environment. Participants with more English skills assist those with less, in interpretation, translation and form filling. Sharing food at the end of sessions allows friendship networks to form in a safe and welcoming environment. Additional benefits to clients include improved English language, decreased social isolation and improved well-being through enjoyment of music and integration into the group.

Contact: Ali Bullivent, Education Officer, Wakefield Cathedral, 01924 434484 or Anne Coe, Vulnerable Groups Public Health Senior Commissioning Manager, 01924 317771

Including migrant populations in Joint Strategic Needs Assessment

Patient Profiling, Liverpool

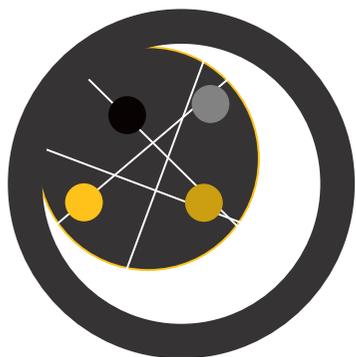
Liverpool Primary Care Trust (PCT) is conducting a patient profiling exercise which will enable commissioners and GP practices to identify vulnerable groups and gaps in service provision. Practices are asked to collect a range of data about their patients, including ethnicity, religion and belief, spoken and read language, and whether interpretation is needed. Immigration status and nationality are not requested, but the data does enable identification of certain trends, such as marked increases of European migrants in areas where employers are contracting in workers.

Existing information on the coronary heart disease, body mass index, diabetes and smoking status of patients is being cross-matched against the new patient profiling data. This means that practices and planners will be able to see where patients and groups of patients are not getting vital healthcare and offer possible explanations and solutions.

The PCT Equality Data Manager provides training to practice staff, so they understand why profiling is important. She also provides a tool kit containing a data collection form, a template to enter the data onto the clinical system, protocols for data entry, information around BME health, a contact sheet for local community groups and health advice leaflets in different languages. At the beginning of the project, there was also training on cultural diversity.

The information is fed back to each practice, and is also shared with commissioners, the Race for Health Programme and the NHS North West's SHA Equality Performance Improvement Toolkit.

For more information, see the [Race for Health](#) website.



"I DID NOT KNOW THERE WAS ANYTHING PRETTY IN THE UK. LAST NIGHT I SLEPT FOR EIGHT HOURS FOR THE FIRST TIME IN MONTHS"

Comment from an asylum seeker after a day outing to the Lake District with the Wellbeing Project.

"WHEN I FIRST CAME TO THIS COUNTRY COUNSELLING WOULD NOT HELP MY SADNESS BUT GETTING OUT AND ABOUT DID."

Client response after a walk in the country with the Wellbeing Project.

Notable examples

Refugee Action Wellbeing Project, Manchester

[Refugee Action's Wellbeing project](#) is part of Target: Wellbeing, a programme funded through BIG Lottery Fund in ten programmes across the North West. It aims to help people achieve healthier and happier lives through projects that increase exercise, encourage healthier eating and promote mental wellbeing. Groundwork Northwest leads the programme and the eight Manchester-based projects are coordinated by Manchester Joint Health Unit.

The Wellbeing project at Refugee Action aims to bring together people living in Manchester from all walks of life to take part in sports, arts and leisure activities in order to improve self esteem and confidence, increase mental wellbeing, reduce social isolation and increase access to mainstream services for refugees and asylum seekers.

The project runs activities in six-weekly cycles supporting people to use mainstream leisure provision such as a women's swimming session, a men's circuit training gym session, and cycling in a park with instructors. The project also offers a variety of one off workshops (laughter, self defence, arts and craft, information sessions) as well as sports days, picnics, museum and gallery trips.

The project takes referrals from a wide range of statutory and voluntary agencies and it works with clients at all stages of the asylum process, including asylum seekers surviving on very low incomes and destitute refused asylum seekers. Many of the clients experience high social isolation and the sessions provide a chance to engage with members of the host communities, to make links, benefit from peer support and find out about other services. The project offers support with bus fares which is critical to ensure clients can access the activities. The project also works in partnership with other agencies to encourage free and accessible leisure provision in areas of refugee settlement in Manchester.

The project believes that physical activity and social interaction can help to combat multiple symptoms relating to stress and isolation, which could reduce pressure on GPs. The project has one part-time dedicated worker and volunteers. The services are heavily subscribed, but the project faces the end of its funding in 2011. It is hoped as the project develops it will give greater voice to asylum seekers and refugees and how they perceive their needs in the difficult situations they survive in.

Including migrant populations in Joint Strategic Needs Assessment

Regional Refugee Forum (RRF) North East

The RRF is an organisation created and managed by the region's refugee led community organisations (RCOs). In 2010 membership stood at 58 RCOs. It unites these organisations in collective action to gather evidence on self-identified issues and produce a collective voice to be heard by the region's policy makers and service providers. It is a registered charity employing seven staff funded through grants for delivery of specific project activities. With restricted funding and outcome targets to meet, it can assist research/consultation projects seeking qualitative data if they match the RRF's self-identified aims, needs and priorities and if direct costs of assistance are met by the external agency.

An example of a research project is one on choice in accessing primary care, exploring the views of asylum seekers and refugees on access and choice issues.

This was conducted by an MSc student of Medical Anthropology from Durham University, who had attended the Regional Migrant Health Group meetings, gaining knowledge of potential issues and meeting the RRF representative.

The researcher completed the Research Request process designed by the RRF to gauge the fit of the request with demand on capacity to assist. The request was considered and approved by the RRF's Executive Committee. Thereafter the RRF gave assistance to the researcher in terms of personal

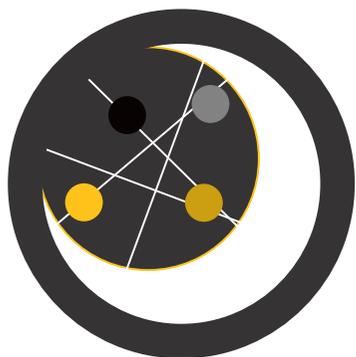
introductions to relevant member organisations, who directly assisted and participated in the research process, while the Committee and staff provided additional consultation as required.

The migrant groups involved were Zimbabwean asylum seekers and refugees living in Tyneside and Teesside from two refugee led community organisations that are members of the RRF: NESAS (North East Southern African Society) and Voices for Change (enabling interviews to be conducted in English).

This research will help a number of authorities to consider options for service in the light of user views. The research project is a sample: RRF could be used to arrange other input to research. The research report has been made widely available and presented to commissioners and others at the annual regional migrant health conference in the North East in June 2010.

Regional Refugee Forum North East: [Georgina Fletcher](#), CEO.

[RRF NE Head office](#): Design Works, William Street, Felling, Gateshead NE10 0JP Tel: 0191 423 6255



Appendix 1: Who are migrants?

The following list is intended to be an easy-to-use guide and is not a detailed representation of immigration law. Immigration is a fast changing policy and legislative environment and information can quickly become out of date.

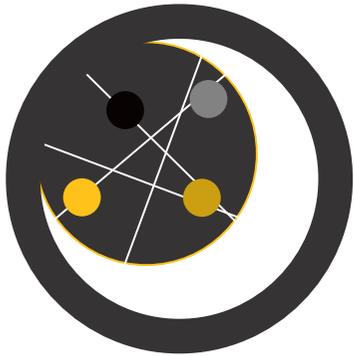
Definitions of 'types' of migrants

Below are definitions of the terms for different types of migrants included in the diagram on page 7.

- **A2 Migrant** – A person from the A2 countries that joined the EU (European Union) in January 2007. The A2 members are Bulgaria and Romania.
- **A8 Migrant** – A migrant from the A8 countries that joined the EU (European Union) in May 2004. These countries are: Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia. The A8 are all members of the A10.
- **A10 Migrant** – A person from the A10 countries that joined the EU (European Union) in May 2004, including the A8 Cyprus and Malta. The A10 includes Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia.
- **Asylum Seeker** – A person who has applied for protection under the UN Convention¹⁰ and is awaiting a decision on this application (including those who are at different appeal stages).
- **Cyprus and Malta** – A person from Cyprus and Malta that joined the EU (European Union) in May 2004. Cyprus and Malta are members of the A10.
- **Destitute Refused Asylum Seeker** – A refused asylum seeker who is destitute, and does not receive Section 4 Support.
- **Detained Asylum Seeker** – A person who is detained during the asylum process. This usually occurs as part of the 'fast-track' process.
- **Detained Refused Asylum Seeker** – A refused asylum seeker who is detained. This is usually prior to deportation.
- **Discretionary Leave** – A person who receives leave to remain in the UK as a refugee, granted if a person does not meet the strict criteria of the UN Convention, but for reasons including family reasons and medical cases.
- **Dispersed Asylum Seeker** – An asylum seeker receiving housing in dispersal accommodation and subsistence (financial) support. This is officially called Section 95 Support.

Including migrant populations in Joint Strategic Needs Assessment

- **EEA Migrant** – A person from countries that are members of the EEA (European Economic Area) which includes the EU plus Iceland, Liechtenstein and Norway. The members of the EEA are Austria, Belgium, Bulgaria, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, United Kingdom. Switzerland, although not actually a member of the EEA, is often also included in policies applying to EEA members.
- **EU 15 Migrant** – A person from the 15 countries that were EU (European Union) members before the EU Accession countries joined in 2004 and 2007. The EU 15 includes Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden, United Kingdom.
- **EU Accession Migrant** – A person from one of the countries that joined the EU (European Union) in 2004 (A10) and 2007 (A2). The accession countries are Bulgaria, Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Romania, Slovakia and Slovenia.
- **EU Migrant** – A person from an EU (European Union) member state, including the EU 15 and the EU Accession countries. The 27 EU states are Austria, Belgium, Bulgaria, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, United Kingdom.
- **EU Student** – A student from the EU (European Union). This often also refers to people from the EEA (and Switzerland) who have similar rights as members of the EU to financial support.
- **Exceptional Leave to Remain** – A person receiving leave to remain as a refugee, granted if the person does not meet the strict criteria of the UN Convention. It was replaced in 2003 by Humanitarian Protection and Discretionary Leave.
- **Family Migrant** – A person who has come to the UK to join a member of their family, and given a right to live in the UK. This term does not normally apply to EU migrants as they are able to enter the UK in their own right, nor does it normally apply to the family of refugees who are given the same status as the person they are joining, and therefore also classed as refugees.
- **Highly Skilled Migrant Worker** – A person who has entered and can work in the UK under 'Tier 1' of the 'points-based system' (introduced earlier in 2008). This applies to a person who is seeking highly skilled employment in the UK or are self-employed or setting up a business.
- **Humanitarian Protection** – A person who receives leave to remain in the UK as a refugee, granted if a person does not meet the strict criteria of the UN Convention but faces a real risk of serious harm.



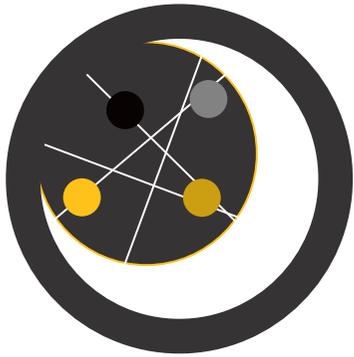
Appendices

- **Iceland, Liechtenstein, Norway (and Switzerland)** – EEA migrants who are from countries that are not members of the EU. This applies to the following EEA members: Iceland, Liechtenstein and Norway. Switzerland is often also included in policies applying to EEA members.
- **Indefinite Leave to Remain** – A person who receives leave to remain in the UK as a refugee, granted for a number of reasons including programmes to clear backlogs in the asylum system (such as 'Family ILR Exercise' and 'Case Resolution').
- **Induction Asylum Seeker** – An asylum seeker receiving who is in Initial Accommodation (Induction Centre), before being dispersed. This is officially called Section 98 Support.
- **International Student** – A person from outside the UK, who is a student in the UK.
- **Low Skilled Migrant** – A person who has entered and can work in the UK under 'Tier 3' of the 'points-based system'. This applies to low skilled workers to fill specific labour shortages. At the time of writing this was 'suspended for the foreseeable future'.
- **Migrant** – A person who leaves one country and resides in another. In the UK this refers to all people who have entered and live in the UK (immigrants). In Yorkshire and Humber, the working definition of 'migrant' includes all groups in the diagram on page 7.
- **Migrant Worker** – A person who has left their country of origin to work in another. In the UK, this includes people entering as EEA migrants and those part of the new points-based system.
- **Migration** – The movement of people between different countries. In the UK this is often used in the context of all migrants coming to live in the UK (immigrants).
- **Non-EEA Migrant Worker** – A migrant worker from outside of the EEA. Non-EEA migrant workers will enter the UK under the points-based system.
- **Non-EU Student** – A student from outside the EU. This may also be used to apply to students from outside of the EEA (and Switzerland). Non-EU students enter and can study in the UK under 'Tier 4' of the 'points-based system' introduced in March 2009.
- **Points-Based System** – New system for migrants from outside of the EEA, to work train or study in the UK. The points-based system contains five tiers which have different conditions, entitlements and entry-clearance checks. There is a points-based assessment to decide if a person qualifies. The five Tiers are: (1) highly skilled migrants, (2) skilled migrants, (3) low skilled migrants, (4) students and youth mobility and (5) temporary workers.

Including migrant populations in Joint Strategic Needs Assessment

- **Refugee** – A person given leave to remain in the UK as a result of a process which began with a claim and/or assessment for protection under the UN Convention. In Yorkshire and Humber this includes people receiving the following statuses: Refugee Status, Humanitarian Protection, Discretionary Leave, Exceptional Leave to Remain and Indefinite Leave to Remain¹¹.
- **Refugee Status** – A person who has been given leave to remain in the UK as a refugee due to meeting the criteria in the UN Convention.
- **Refused Asylum Seeker** – A person who was previously an asylum seeker, whose claim for protection and subsequent claims and appeals have been refused, with all appeal rights exhausted (ARE). They are also sometimes referred to as failed asylum seekers. This includes people who are on Section 4 Support' and people who are 'destitute'.
- **Section 4 Refused Asylum Seeker** – A refused asylum seeker who accesses Section 4 Support. This consists of housing and (subsistence) vouchers.
- **Skilled Migrant Worker** – A person who has entered and can work in the UK under 'Tier 2' of the 'points-based system' (from 27 November 2008). This applies to 'skilled people' with a job offer who are looking for employment in the UK, or are self-employed or setting up a business.
- **Subs Only Asylum Seeker** – An asylum seeker who accesses 'Subsistence Only Support'. This is subsistence (financial) support without housing.
- **Trafficked Person** – A person who is a victim of Human Trafficking, and in this context moved from another country to the UK. The UN defines trafficking in persons as "the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation"¹².
- **Undocumented Migrant** – A person who does not have a valid immigration status either through entering the UK without permission, or because they entered under another status and have stayed beyond the period of time allowed.
- **Unsupported Asylum Seeker** – An asylum seeker who does not access any housing or subsistence (financial) support.
- **Youth Mobility and Temporary Worker** – A person allowed to work in the UK for a limited period of time to satisfy primarily non-economic objectives under 'Tier 5' of the 'points-based system' (from 27 November 2008).

With thanks to Yorkshire and Humber Migration Partnership for sharing this information.



Appendices

Appendix 2: Key features of co-producing JSNA

Co-production

“The central idea in co-production is that people who use services are hidden resources, not drains on the system, and that no service that ignores this resource can be efficient.”¹³

This quote refers to the co-production of services. However, statutory bodies not only produce services, they also produce knowledge and information. Knowledge co-production of this kind can produce similar benefits in innovation and quality. Fundamental to this approach are:

- The recognition that people are assets.
- Valuing the full range of activities that organisations and individuals carry out.
- Trust and reciprocity between statutory bodies and external agencies is promoted.
- Building networks of individuals and agencies involved in knowledge production¹⁴.

Capacity building

The assessor(s) should always be looking for ways of building the capacity of the network to produce knowledge and information that can be used in improving services. This can be done through developing skills, knowledge and confidence both informally and formally. It may involve the strengthening and expansion of networks or encouraging the creation of new organisational structures that network members can be involved in.

Knowledge transfer

The process of knowledge transfer can be seen as one of creation, dissemination, adoption (“the process where old knowledge is revisited or discarded in light of new findings and ideas”¹⁵) and implementation (application of knowledge to services). Classical approaches to knowledge transfer tend to see these stages as linear and separate. The approach suggested here is one where these are interwoven into the assessment from the early stages.

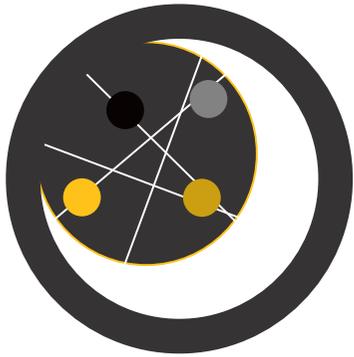
Including migrant populations in Joint Strategic Needs Assessment

Asset approach

Joint Strategic Needs Assessment is often based on a deficit approach which “focuses on the problems, needs and deficiencies in a community”¹⁶. However migrant communities – as with other marginalised communities – “have social, cultural and material assets”¹⁷. For knowledge to bring about change, the JSNA process must focus on assets as well as deficits. It is the assets that are more often the foundation for action.

Long-term

The process of JSNA described in this document has to be long-term for two main reasons. Firstly, in many areas building knowledge about migrants is a large task that can only be approached incrementally if useful information is to be produced. Secondly it is well recognised that “a short-term focus on activities and area-based initiatives can undermine efforts to secure long-term and effective community participation”¹⁸.



Appendices

Appendix 3: Using routine data on migrants

This appendix summarises the main routine sources of data on migrants to the UK, and suggests how to use them. For more detail we recommend the *LGA resource guide*¹⁹ and the Office for National Statistics (ONS) website²⁰.

Introduction

There has been much press comment on the paucity of good data about migrant populations, and considerable work is going on to improve the quality and availability of migration data. However, there are already plenty of data sources that give good enough estimates for most purposes, so it should be reasonably straightforward to give a solid quantitative basis to the JSNA. *The Migration Statistics Quarterly Reports*²¹ (with downloadable local area migration indicators²²) from the ONS contain many of the key data sources avoiding the need to track down each one separately.

Each source has its own purpose and provides one perspective on a very complex and dynamic situation. No one data source gives a complete picture, so a number need to be compared to get an overview. It is rarely necessary to know precise numbers: general patterns and trends are usually sufficient for planning purposes. Taken together, these data can often answer some of the important questions for JSNAs such as:

- How many new people have arrived in the last year (relates to planning primary care provision)?
- What languages do they speak (relates to planning interpreting services)?
- What cultural and religious groups are there (relates to thinking about cultural competence and staff training)?
- Are there groups with particular vulnerabilities? (Helps determine the need for specific service for particular groups such as asylum seekers, international students, workers from the Baltic states.)

Taken with local intelligence on, for example, areas where particular groups have settled, it is not difficult to build a useful picture of the current situation.

Issues to consider in interpreting and comparing sources are:

1. Definitions of 'migrant' vary. For most purposes a long-term international migrant is defined as someone who moves from their country of previous residence for a period of at least a year, but shorter term migration (more than three months) may be important in some areas and many sources do not specify. The point at which a migrant who stays becomes a local resident is also arbitrary – but usually after five years or so, many of the 'new arrival' issues are reduced.

Including migrant populations in Joint Strategic Needs Assessment

2. Second, there are several ways of grouping migrants, including:
 - **Legal status.** The reasons people migrate affect their status and there are different data collection systems for each. The main reasons are: for safety (eg asylum seekers), work (eg Eastern Europeans), education (eg international students), and family (eg marriage).
 - **Country of origin.** This could be country of birth (as in birth and death data) or last country someone was living in before arriving in the UK.
 - **Nationality.** This can change over time.
 - **Ethnicity.** This technically gives no information on migration although occasionally an ethnic group new to an area suggests recent migration. Similarly for specific attributes such as language and religion.
3. Some sources collect data on new arrivals, such as issuing National Insurance Numbers (NINOs) ('flow' akin to 'incidence' in epidemiology) with no mechanism for follow up. Others count how many people are present, such as supported asylum seekers ('stock' akin to 'prevalence' in epidemiology). Very few data are collected on people leaving.
4. Pressure on services often relates to new contacts which are generally more time consuming. Therefore, even if the total population doesn't change, large numbers of arrivals and leavers is an issue – this is known as 'churn'. This can be difficult to measure for the reasons described above, but numbers arriving may be a useful proxy.

The 2011 census (27 March 2011) will include new migration questions, such as month and year of arrival in the UK, intended length of stay in the UK and passports held will give us a much improved baseline in the future.

Key sources of figures

The first three sources cover migrants from all categories who live, work or register with a GP in the UK. The second three sources pick up certain categories of migrant. Note that these are available from the Office of National Statistics as well as the direct links below.

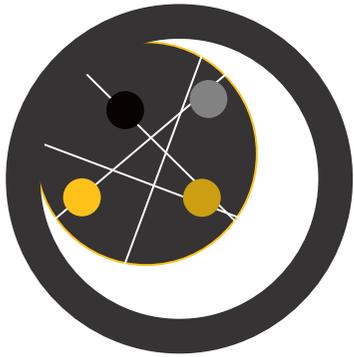
1. Total International Migration (TIM)

[The Office for National Statistics](#) makes estimates of Total International Migration (TIM). This provides the best estimates of long-term immigration and emigration at a national level. The International Passenger Survey (IPS) samples people entering and leaving the UK, and is the key source of information in the ONS estimates of international migration. However, the relatively small sample size means caution should be exercised for local level estimates.

2. Migrant applications to work in the UK (NINOs & WRS)

[National Insurance numbers \(NINOs\)](#) allocated to overseas nationals provide information on all non-UK nationals working legally. Information is recorded on age, gender and nationality on an annual basis at local authority level (usually linked to where the applicant is living).

The number of NINOs allocated to overseas nationals in a local



Appendices

authority area should provide a good indication of the number of overseas persons arriving to work and includes refugees and family joiners. However, it provides no information on out-migration and illegal migrants are not covered.

[The Worker Registration Scheme](#) (WRS) covers citizens of the 'A8' countries which became Member States of the EU in May 2004 who register to work as employees in the UK. It records employees for their first year of employment – access to benefits is only granted if A8 migrants can prove they have been working for 12 months in the UK through registration. Self-employed workers are not required to register and an unknown number of migrant workers do not register. WRS data is usually linked to the workplace address.

3. GP registration ('Flag 4s')

Flag 4s are codes within the NHS Patient Register Data Service (a compilation of the patient lists held by GPs) which indicate that someone who has registered with a GP in England and Wales was previously living overseas. Age and gender are recorded, but other details such as nationality and country of origin are not routinely recorded – although they are in some cases. Flag 4s are particularly useful because they capture most migrants and their dependants. They may be less useful in identifying short-term economic migrants who may choose not to register with a GP, and the flag is lost if people move within the UK.

These data can be accessed through the ONS local area migration indicators. Primary Care Trusts should be able to access the information locally through their Family Health Service functions, and do more detailed analyses. Some areas

have found analysing country of origin, although incomplete, provides valuable detail²³. See [Migration Statistics Quarterly Reports](#).

4. Control of immigration (including asylum seekers)

The Home Office, through the UK Border Agency, is responsible for the control of immigration including applications for asylum, enforcement and grants of settlement and [regularly reports on these figures](#). These figures relate only to those people who are subject to immigration control (those who are not-EEA or Swiss nationals) but can identify different sub-groups of the migrant population such as those applying under work, study, family or asylum routes. Some UKBA Regional Teams and Accommodation providers will make data on supported asylum seekers available to partners such as GP practices in areas where there are concentration of asylum seekers.

5. International students

Around 15% of students in universities are from overseas. There is good data collected by the [Higher Education Statistics Agency](#). It is available online by academic year (so not timely) and records on the basis of university rather than place of residence. It does not cover students in other institutions such as language schools. This is an important group look at for areas with large student populations.

Including migrant populations in Joint Strategic Needs Assessment

6. Other sources

There are many other sources. Two important local authority ones are:

- **Annual School Census or Pupil Census Data.** This covers all pupils in maintained education. It provides information on ethnicity and languages spoken at home, indicating where English is spoken as an additional language (EAL). This is useful where there are many migrant families and is also available nationally from [The Department for Education](#).
- **Electoral register data.** This can be used to identify migrants and monitor movements into and within a local area. However, coverage is partial as not all migrants will register to vote.

Local information

There may be local data sources which are not part of routine national systems. These will only be found through developing local contacts. Possibilities might include:

- Voluntary sector organisations providing services for migrants (such as the Refugee Integration and Employment Service).
- Service data such as use of interpreting services.
- Enhanced surveillance data where status might be recorded such as infectious disease from the Health Protection Agency.

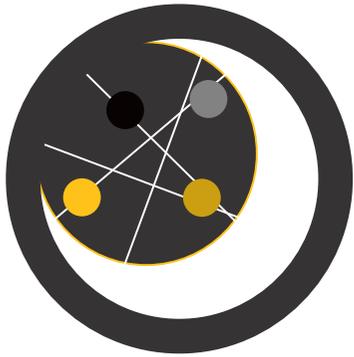
Methodology

There is no fixed way to analyse and present these data. We recommend starting with the three general sources: TIM, NINo and Flag 4 from the ONS quarterly report. These should be broadly comparable and give general numbers and recent trends.

Discrepancies between them might suggest further questions. For example, if GP registrations are much lower than NINos, this suggests a problem getting registered. If they are much higher this might suggest many non-workers – perhaps families or students.

These data sources can be examined in more detail – for example looking at countries of origin. There are good examples of bringing these data together at a national level^{24,25}. Further exploration is probably best driven by local intelligence. For some cities students may be an important group, for others asylum seekers. For some rural areas, migrant workers may be the primary concern.

It is unrealistic to cover all groups in one year so we suggest, year on year choosing different priority groups whilst updating the general numbers each time.



Appendices

Appendix 4: Starting contacts

Using these contacts as starting sources of information you will reasonably quickly be able to map out organisations and individuals working with migrants across your area.

Regional Strategic Migration Partnerships cover the UK and their role is to engage organisations within the region whose work is affected by migration. [Yorkshire and the Humber Regional Migration Partnership's web-site](#) is particularly commended as an information source

There are **refugee and asylum-seekers' forums** in some areas. A North East example is the [Regional Refugee Forum North East](#) (RRF)

The **United Kingdom Border Agency (UKBA)** is the national agency of the Home Office with responsibility for managing migration and some regions will have stakeholder managers. Its [contact page](#) is recommended.

Many health services and local authorities have **specialist workers**.

Private or social **housing providers** work under contract to the UK Border Agency providing housing for asylum seekers and some failed asylum seekers and there may be **specialist housing associations**.

Regional Migration and Health Leads are nominated for each of the English government regions. Details are available from Strategic Migration Partnerships or Regional Directors of Public Health.

Some **local authorities** have leads for new and emerging communities, migrants or refugees and asylum-seekers.

Most regions have one or more **one stop shops** for advice to refugees and asylum-seekers provided by a voluntary sector agency.

Areas with asylum-seekers may have **drop-ins** run by local charities or religious organisations for people who are **destitute**.

Refugee community organisations and other **migrant community organisations** exist in many regions.

Migrant workers may be concentrated within particular **employment sectors**.

Some **religious organisations** act as a focus for migrant support.

Colleges that teach English can be a congregating place for new migrants

Local authorities may provide **specialist support for migrant schoolchildren**.

Appendix 5: Resource list

Key websites

[Department of Health: asylum seekers and refugees](#)

Information on entitlement to NHS treatment and support for NHS healthcare professionals.

[Department of Health: overseas visitors](#)

Information on entitlement to treatment. Includes information regarding trafficked people and failed asylum seekers.

[ICAR \(Information Centre about Asylum and Refugees\)](#)

Information and research on health and other topics, searchable by theme and location.

[The Integration of Refugees: Positive Practice for Health Professionals](#)

Provides information, guidance and examples of positive practice to support the integration of refugees. Developed by the Home Office, Department of Health and NHS.

[Social Care for Refugees and Asylum-Seekers](#)

A guide to support commissioners and providers of social care services to work effectively with refugees and asylum seekers.

[NHS Evidence – Ethnicity and Health](#)

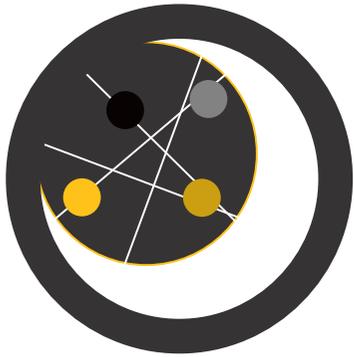
Aims to select the best available evidence about management of a health care service and specific needs in health care for migrant and minority ethnic groups.

[Race for Health](#)

A Department of Health-funded, NHS based programme that works to drive forward improvements in health for people from black, and minority ethnic backgrounds.

[Better Health](#)

Extensive list of evidence-based resources providing information and guidance on issues of health and racial equality. Web resource provided by the Race Equality Foundation. The site also has briefings on health issues and links to useful websites.



Appendices

[Equality and Human Rights Commission](#)

Includes reports, resources and events relating to migration and asylum.

[Health and Safety Executive](#)

Multi lingual guidance for migrant workers, and guidance for employers.

[Researching asylum in London](#)

Has a section on health, which lists research relating to: access to health care; cultural attitudes to health; drugs; HIV and AIDS; mental health; primary care; sexual and reproductive health; TB; torture.

[The Kings Fund](#)

The Information and Library Service has produced a series of reading lists including reports, articles and websites. Topics include refugee health care, mental health and black and minority ethnic communities, ethnic health issues for primary care.

[Yorkshire and Humber Regional Migration Partnership](#)

A database of summaries of research about refugees, asylum seekers and other migrants who have arrived in the Yorkshire and Humber region since 1999.

Including migrant populations in Joint Strategic Needs Assessment

Reports, articles and resources

[The Health Needs of Asylum Seekers](#)

Faculty of Public Health briefing.

[Medact: The Reaching Out Project](#)

Information on maternity rights for women of different immigration status.

[Health and access to health care of migrants in the UK](#)

This briefing (number 19) outlines some important issues for the health of migrants in the UK and suggests ways in which research, policy and practice might address barriers to health, well-being and health care in meeting the needs of migrants.

[Improving the health of asylum seekers: an overview](#)

Provides an overview of asylum seekers in the Northern and Yorkshire region, evaluates information collected about them, describes the current pattern of services provided and highlights examples of good practice.

Occasional Paper 5, North East Public Health Observatory, 2002.

[Migrant Health in North East England](#)

The report describes who the North East's new arrivals are, their numbers and the regional infrastructure there to support them. It considers their health needs, current service provision and commissioning arrangements.

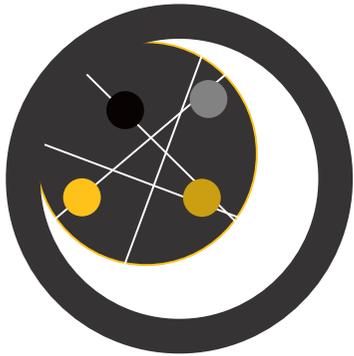
Occasional Paper Number 29, North East Public Health Observatory, 2007.

[Health and Migration in the North West: An Overview November 2008](#)

This overview provides insight into the health of migrants in the NW, including a section on infectious diseases; and health service provision in relation to migration

[Migrant workers from the EU Accession countries](#)

A demographic overview of those living and working in England and Wales and a comparison of infectious disease and immunisation rates in the Accession countries with those in the UK. Health Protection Agency, 2006.



Appendices

Migrant workers in England and Wales

An assessment of migrant worker health and safety risks.
Health and Safety Executive, 2006.

Safety and Migrant Workers: A practical guide for safety representatives

Trade Union Congress, 2007.

Refugees and asylum seekers: A review from an equality and human rights perspective

Equality and Human Rights Commission Research report 52. Aspinall P, Watters C. University of Kent, 2010.

Sexual health, asylum seekers and refugees: A practical handbook

Wilson R, Dumper H, Sanders M. fpa, 2007.

Supporting disabled refugees and asylum seekers: opportunities for new approaches

Examines the nature and extent of disability amongst the refugee population and the support they receive from refugee community and other organisations in London. Refugee Support, 2008.

A manual for advising undocumented migrants

Includes a section on access to health and social care. Sue Lukes, Praxis, 2010.

Including migrant populations in Joint Strategic Needs Assessment

Networks

[Asylum Seeker and Refugee Health Care](#)

An informal network of primary health care professionals, co-ordinated by the Department of Health.

[MEDACT Refugee Health Network](#)

A network of health professionals, academics, students and charities working with refugees and asylum seekers. The network aims to share information and best practice amongst those working to facilitate improving the health of refugees and asylum seekers.

[JISCMail – Minority Ethnic Health](#)

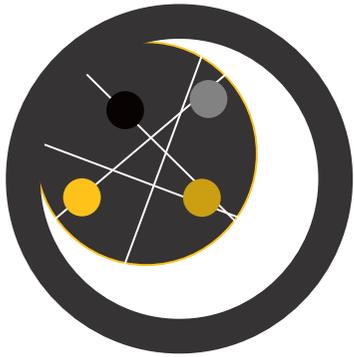
This list is aimed at professionals working in the academic, NHS and local government sectors who continually strive to improve the health of minority ethnic communities in the UK via a multi-disciplinary approach.

[No Recourse to Public Funds Network](#)

A network of local authorities focusing on the statutory response to people with care needs who have no recourse to public funds (NRPF).

[Migrant Rights Network](#)

Supports migrants and migrant community organisations through sharing information, advocacy and campaigning



Appendices

Appendix 6: References

Who are migrants?

- ¹ [International Office of Migration.](#)
- ² [Home Office . Statistical Bulletin 15/10. Control of Immigration Statistics United Kingdom 2009. August 2010.](#)
- ³ [Office for National Statistics \(ONS\). Long-Term International Migration \(MN series\). ONS.](#)
- ⁴ [Department of Health. 2007. Guidance on Joint strategic Needs Assessment. DH. P7.](#)

Why include migrants?

- ⁵ [Equality and Human Rights Commission.](#)

How to include migrants

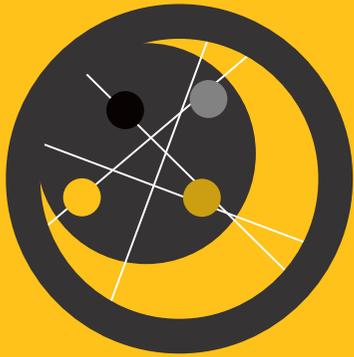
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- ⁷ [Race for Health. \(No date\). Leading Action on Race Equality in Health. NHS. P20.](#)
- ⁸ [Department of Health. 2007. Guidance on Joint Strategic Needs Assessment. DH.](#)
- ⁹ [The Marmot Team. 2010. Strategic Review of Health Inequalities in England post 2010. Fair Society Healthy Lives. P15.](#)

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- ¹⁰ [United Nations. 1951. Convention Relating to the Status of Refugees. UN.](#)
- ¹¹ [Brown. 2008. Status and Category Matter: reufgee types, entitlements and integration support. YHRMP.](#)
- ¹² [United Nations. 2000. Protocol to Prevent, Suppress and Punish Trafficking in Persons. UN General Assembly.](#)
- ¹³ [Boyle and Harris. 2009. The Challenge of Co-production. NEF and NESTA. P11.](#)
- ¹⁴ [Boyle and Harris. 2009. The Challenge of Co-production. NEF and NESTA. P12.](#)
- ¹⁵ [Tranfield, Denyer, Marcos. 2004. Co-producing Management Knowledge. Management Decision: 2004; 42, 3/4.](#)

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- ¹⁶ [Foot and Hopkins. 2010. *A Glass Half-Full: how an asset approach can improve community health and wellbeing*. Improvement and Development Agency \(IDeA\). P7.](#)
- ¹⁷ [Foot and Hopkins. 2010. *A Glass Half-Full: how an asset approach can improve community health and wellbeing*. Improvement and Development Agency \(IDeA\). P6.](#)
- ¹⁸ [NICE. 2008. *Community Engagement to Improve Health*. NICE Public Health Guidance 9. P21.](#)
- ¹⁹ [Prepared for the LGA by Green, Owen, Adam. 2008. *A resource guide on local migration statistics*. LGA.](#)
- ²⁰ [Office for National Statistics. *Improving Migration and Population Statistics \(IMPS\) and the Migration Statistics Improvement Programme*. ONS.](#)
- ²¹ [Office for National Statistics. *Migration Statistics Quarterly Report*.](#)
- ²² [Office for National Statistics. *Local area migration indicators* \(including downloadable zipped spreadsheet\).](#)
- ²³ [Warren, Ramaiah, Teagle. *Compilation of a local profile of immigration using GP registration data*. Ethnicity and Inequalities in Health and Social Care. 2010\(3\):2;6-12. 10.5042/eihsc.2010.0340.](#)
- ²⁴ [Institute for Public Policy Research. May 2010. *Migration Statistics: ippr briefing*. London: IPPR; June 2010.](#)
- ²⁵ [The Institute of Community Cohesion for the Local Government Association. 2007. *Estimating the scale and impacts of migration at the local level*. LGA.](#)



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Further copies are downloadable from:

[Local Government Improvement and Development](#)

[North East Public Health Observatory](#)

[Tandem](#)

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