Integrated Impact Assessment (IIA)

Informing our approach to fairness

Name of proposal	Health Improvement for Ethnic Minorities and Migrant Communities
Date of original assessment	September 2016
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Assessment team	Craig Blundred
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Version control

Version	1
Date	4 October 2016
Replaces version	0

This is our assessment of the potential equality and other impacts of this 2016-17 Budget proposal, based on the available evidence. It is a 'living document' and we will review it throughout the consultation period. A formal review will take place on all proposals when consultation closes to consider comments and information from all stakeholders, research or new and emerging policy.

Section A: Current service

1. What does the service do?

We currently fund 2 services which provide health improvement advice and education to Black and Minority Ethnic (BME) and migrant communities.

Both services are delivered by third party providers as follows:

- Newcastle upon Tyne Hospitals NHS Foundation Trust deliver a Health Improvement Service for Ethnic Minorities (HISEM); and
- Riverside Community Health Project provide a Migrant Health Worker for Eastern European Migrants

These aims of the services are to:

- Reduce health inequalities through collaborative working and taking a 'proportionate universalism' approach
- Identify, assess and promote health and wellbeing
- Promote equity in accessing services and challenge discrimination
- Provide expert advice and support to partners and agencies

A significant proportion of the work is one to one support for recently arrived migrants, asylum seekers, and refugees to access and utilise health services. The Migrant Health Worker for Eastern European Migrants project estimate that approximately 50% of their migrant health work is focused on supporting people to access health services, and the Health Improvement Service for Ethnic Minorities (HISEM) have estimated that 47% of their contacts as similar.

2. Who do you deliver this service for?

The services deliver to the following groups:

- Migrants
- Refugees
- Asylum Seekers
- Black and Ethnic Minorities

The tables below show the number of individuals supported by these services in 2015-16:

Health Improvement Service for Ethnic Minorities (HISEM)	
Asylum Seekers	551
Refugees	26
Migrants	170
Residents	49
Students	7
Migrant Health Worker for Eastern European Migrants	
Numbers of individuals assisted	798

3. Do you have any statutory requirements?

There are no statutory requirements to provide these services.

4. How much do you spend on this service?			
Gross expenditure	**Gross income**	**Net budget**	**Capital projects**
£247,100	£247,100	£0	£0

5. What workforce delivers this service?		
Posts	**FTEs**	**Comments**
These services are delivered by third party providers. Information from the current providers indicate that the 2 services are delivered by the following workforce:		
Health Improvement Worker for Eastern European Migrants	1	Employed by a third party provider
Health Improvement Worker for Ethic Minorities	7 posts (not all FTE)	Employed by a third party provider. It is not possible to state how many FTE posts deliver the Health Improvement Service for Ethnic Minorities as the information has not been released by the current provider.

Section B: Change proposal

1. What is the proposal to change the service?

In Newcastle, we believe that our public health function should become more clearly orientated towards ***macro*** effects on population health, rather than ***micro*** interventions.

In practice, this means we want to move away from using our public health funding for activity that is aimed at specifically-targeted, small volume, high-risk groups, towards activity that is more aimed at broader approaches with the intention of both improving health and narrowing inequalities for these communities at a population level.

We are therefore proposing that a new model of delivery be implemented in order to improve the population health needs of Black and Minority Ethnic (BME) and migrant communities**. This will involve working with NHS and other community groups to build their capacity for understanding and responding to the needs of specific groups.**

Our proposed model is based on a collaborative approach and seeks to align public health improvement activity for these communities with wider health improvement work that is being delivered across the city. The new delivery model will focus on developing training programmes for professionals, developing collaborative working practices and working alongside other council and health service bodies to develop an asset based approach to health improvement.

Asset based approaches are ones which recognise, unlock and build on communities and individuals (often untapped) skills, strengths, aspirations and networks, and enables them be active in improving their own, and others wellbeing and health, rather than passive recipients of others' actions.

The delivery model will include:

- Delivering training and support to enable organisations that work with these communities to provide equitable and fair access to services.

- Training and supporting agencies to develop whole of society approaches to improving the health of asylum seekers, refugees, migrants and members of the BME community.
- Collaborating with agencies and organisations to coordinate approaches to improving the health of these communities.
- Providing expert support and advice to organisations on the health needs of migrants, refugees, asylum seekers and the BME community.

By utilising an approach that seeks to build the capacity of existing services to respond to improving the health needs of BME and migrant communities, we believe that we can increase the reach of our support and therefore the numbers of people that are subsequently engaged. This is a standard model of health improvement team working.

This proposed public health model will no longer fund direct one to one support to recently arrived migrants, asylum seekers, and refugees to help them access and utilise health services. Although we recognise this activity is important, we do not believe it should be funded as a public health activity and instead, we will work with Newcastle Gateshead Clinical Commissioning Group and our NHS partners to explore opportunities for this element to be funded as part of mainstream NHS provision.

The proposal will mean that funding for the 2 existing services will end on 31 March 2017. Instead, we will invest in the new proposed model from 1 April 2017. The level of investment will be less than our current expenditure in order to achieve savings of £136,446.

It would be our intention for delivery of the new model to be a mixture of Council delivery **and** third party external delivery. We believe this 'mixed economy' model of service delivery provides:

- increased opportunities for service delivery to be based on the needs of local communities and delivered in local settings by a locally / community based provider;
- increased opportunities to align the work with wider health improvement work that is being delivered across the city; and
- a broader skills and experience base to inform service design and delivery.

2. What evidence has informed this proposal?

Information source	What has this told you?
Anderson, L. et al., 2015. COCHRANE Community coalition-driven interventions to reduce health disparities among racial and ethnic minority populations. *Cochrane Database of Systematic Reviews*,	Developing programmes of work to support health and care staff, improve accessibility of services and address policies have been demonstrated to make small gains in improving health. A collaborative approach to engaging with BME communities may improve the health of those communities
Jayaweera, H., 2011. *Health of Migrants in the UK : What Do We Know ?*	There are a number of health challenges that face member of ethnic minority groups, migrants, asylum seekers and refugees. Many migrants arrive relatively healthy however there are a number of potential health issues that affect different categories of migrant. Asylum seekers and refugees may be fleeing war and be affected by post-traumatic stress disorders

	and other mental health problems. Women may have experienced physical and sexual abuse during trafficking
Public Health England & NHS England, 2014. *A guide to community-centred approaches for health and wellbeing*	Participatory approaches to health improvement in communities of interest are effective in addressing marginalisation and powerlessness caused by health inequalities
World Health Organization, 2016. *Strategy and action plan for refugee and migrant health in the WHO European Region*	Highlights the need for a broader approach to refugee and migrant health beyond the health sector, outline that the health system should ensure there is support to refugees and migrants within the system and that it should foster effective community participation to empower refugees and migrants. Communication about health and health services should be appropriate to the group and assist them to access services
Newcastle upon Tyne Local Migration Profile 2015	This highlighted that between 3300 and 7000 new long term immigrants (people who are expected to stay longer than a year) arrived in Newcastle in 2013. Net migration (the difference between immigration and emigration) was just under 3400 in 2013. The number of new migrant workers arriving in Newcastle was approximately 3750 in 2014. There has been a large increase in the number of workers from EU accession countries with around 1200 arrivals in 2014. These are predominantly Romanian with a smaller number of Polish and Slovak arrivals. However the largest number of workers arriving are from non-accession countries with just under 2600 arriving in 2014.
Regional Refugee Forum Health Focus Group	Requirement for a more cultural aware approach to health and wellbeing. Don't want additional services but want existing services to be more aware and provide equity across the system.
Health Improvement Service For Ethnic Minorities	Annual report shows that a high proportion of their work is assisting asylum seekers / refugees/ migrants to access services.

3. How much will you spend on this service?

	Gross expenditure	Gross income	Net budget	Capital projects
Year 2017-18	£110,654	£110,654	£0	£0

4. What will the net savings be of this proposal?

	Gross Saving	Implementation Cost	Net Saving
Year 2017-18	£136,446	£0	£136,446

5. What impact will this have on the workforce?			
	No. FTEs	**% workforce**	
Year 2017-18	Services are delivered by Third Party providers		

6. Who have you engaged with about this proposal?			
CONSULTATION			
Date	**Who**	**No. of people**	**Main issues raised**
September 17	Ophelia Project	2	- Support for a dedicated language clinic - Issues regarding urgent GP appointments - Development of a health hub
PLANNED CONSULTATION			
Date	**Who**	**No. of people**	**Main issues raised**
October 17	Current service providers (2)	Future consultation	
Date TBC	Regional Refugee Forum	Future consultation	
Date TBC	Voluntary and community organisations working with migrants / asylum seekers / refugees	Future consultation	
Date TBC	Newcastle Gateshead Clinical Commissioning Group	Future consultation	
Date TBC	Strategic Migration Group	Future consultation	
Date TBC	NCVS / On the Hoof (monthly publication)	Future consultation	
Date TBC	Health services, including General Practice	Future consultation	

7. What are the potential impacts of the proposal?				
Staff / service users	**Specific group / subject**	**Impact** (actual / potential disadvantage, beneficial outcome or none)	**Detail of impact**	**How will you address or mitigate disadvantage?**
People with protected characteristics				
Service users	Younger people and / or older people (age)	None	There is no evidence to suggest the proposal will have a disproportionately negative impact on people because of their age.	Not applicable
Service users	Disabled people	None	There is no evidence to suggest the proposal will have a disproportionately negative impact on people because of their disability.	Not applicable
Service users	Carers	None	There is no evidence to suggest the proposal will have a disproportionately negative impact on people because of their caring role.	Not applicable
Service users	People who are married or in civil partnerships	None	There is no evidence to suggest the proposal will have a disproportionately negative impact on people because of their marriage or partnership status.	Not applicable
Service users	Sex or gender (including transgender, pregnancy and maternity)	None	There is no evidence to suggest the proposal will have a disproportionately negative	Not applicable

			impact on people because of their sex or gender.	
Service users	People's sexual orientation	None	There is no evidence to suggest the proposal will have a disproportionately negative impact on people because of their sexual orientation.	Not applicable
Service users	People of different races	Potential disadvantage due to possibility of a reduction in 1-2-1 support.	People arriving from countries with less developed health care systems may have difficulty accessing the care they need, particularly services such as sexual health or tuberculosis services	By training staff in other organisations we will increase the scope of appropriately qualified staff who will be able to deliver support to the various communities. There is no guarantee that they will engage but we will work with services to ensure that people are supported to access their services.
Service users	People who have different religions or beliefs	None	There is no evidence to suggest the proposal will have a disproportionately negative impact on people because of their religion or belief.	
People vulnerable to socio-economic disadvantage				
Service users	People living in deprived areas	Potential disadvantage due to possibility of a reduction in 1-2-1 support.	Many economic migrants and refugees / asylum seekers live in the more deprived areas of the city	By training staff in other organisations we will increase the scope of appropriately qualified staff who will be able to deliver support to the various communities. There is no guarantee that they will engage but we will work with services to

				ensure that people are supported to access their services.
Service users	People in low paid employment or in households with low incomes	Potential disadvantage due to possibility of a reduction in 1-2-1 support.	Many economic migrants and refugees / asylum seekers have low paid employment and / or live in households with low incomes.	By training staff in other organisations we will increase the scope of appropriately qualified staff who will be able to deliver support to the various communities. There is no guarantee that they will engage but we will work with services to ensure that people are supported to access their services.
Service users	People facing barriers to gaining employment, such as low levels of educational attainment	Potential disadvantage due to possibility of a reduction in 1-2-1 support.	Language skills may hinder gaining employment	By training staff in other organisations we will increase the scope of appropriately qualified staff who will be able to deliver support to the various communities. There is no guarantee that they will engage but we will work with services to ensure that people are supported to access their services.
Service users	Looked after children	None	There is no evidence to suggest the proposal will have a disproportionately negative impact on looked after children.	
Service users	People facing multiple deprivation, through a combination of factors such	Potential disadvantage due to possibility of a reduction in 1-2-1 support.	Many economic migrants and refugees / asylum seekers may face multiple deprivation.	By training staff in other organisations we will increase the scope of appropriately qualified staff who will be able to deliver support to the various

	as poor health or poor housing / homelessness			communities. There is no guarantee that they will engage but we will work with services to ensure that people are supported to access their services.
Businesses				
Staff	Businesses providing current or future jobs in the city	Potential disadvantage	The current services that are funded are delivered by third party providers and the proposal may result in staff reductions within these organisations.	We will continue to work with current providers to understand the impact of this proposal on their organisation. The proposed model will continue to include some third party delivery.
Geography				
Service users	Area, wards, neighbourhoods	None	There is no evidence to suggest the proposal will have a disproportionately negative impact on Newcastle wards or neighbourhoods.	Not applicable
Community cohesion				
Service users	Community cohesion	Possible impact on relationship with local authority	Community relationships have been built through the existing services and there may be a possibility that ceasing to fund or changing the focus of these projects may have an impact on these relations.	Clear consultation processes and explaining the benefits of moving to a new model.
Community safety				

Service users	Community safety	None	There is no evidence to suggest the proposal will have a disproportionately negative impact on community safety.	Not applicable
Environment				
Service users	Environment	None	There is no evidence to suggest the proposal will have a disproportionately negative impact on the environment.	Not applicable