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
Lead officer	Eugene Milne
Assessment team	Craig Blundred
Review date	September 2017

Version control

Version	2
Date	3 February 2017
Replaces version	1

This is our assessment of the potential equality and other impacts of this 2017-18 budget proposal, based on the available evidence. It is a 'living document'. We have reviewed this assessment following a period of consultation and will continue to review it as we implement the proposal.

Newcastle City Council

Section A: Current service

1. What does the service do?

We currently fund two 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

From 1st April 2015 – 31st March 2016

- The total no. of client who received initial home visit = 803
- The total no. of follow-up home visit = 719
- The total no. of clients who received information and health check at drop-in centres, community venues and events = 1334
- The total no. of university student supported to register with a GP during university Refresher Week = 95
- The total no. of clients who attended health talks = 251

- The total no. of professionals /workers received cultural awareness training = 86
- The total no. of telephone contacts = 1720

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.

We are currently reviewing the impact these changes would have on immunisation rates as existing services may already be picking up immunisation advice and support.

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**
2017-18	£110,654	£110,654	£0	£0

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

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

5. What impact will this have on the workforce?

	No. FTEs	**% workforce**
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**
September / October 17	Current service providers (2)	Trust response: On a much more specific level, we note that with regard to the detailed Integrated Impact Assessments (IIA's) there is concern that there are inaccuracies in the report for Health Improvement Service for Ethnic Minorities (HISEM) and Migrant Communities, not least the data they have included relating to HISEM. The report only includes the number of home visits undertaken by the team, not the level of activity carried out. We believe this is misleading to the reader and should be corrected Once again there appears to be a shift in Public Health (PH) responsibility from the Council to Health providers with an expectation that partners, including the Trust, will take on more PH duties despite being under pressure themselves. These changes do not appear to be reflected within the current budget proposal consultation. Riverside Health Project Broadly supportive. Highlighted that the voluntary sector has much to offer in this field. Suggested that if there were two posts proposed, that one could be a joint appointment in the third sector with one post being based in the local authority. Identified the need for a possible transition post to support signposting.	
Date TBC	Regional Refugee Forum	The group had seen the IIA and proposal and wished to feed back on the proposed changes. Overall they felt that they didn't want specialist services to deliver support to refugees and	

		asylum seekers. Rather they felt that mainstream services should deal more effectively with refugees and asylum seekers. They felt that they hadn't received very much support from HISEM to date – they had carried out a small survey in Newcastle and no one was aware of the service. Felt that the RASC community face very different issues to the rest of the BME community. Felt that cultural awareness is vital and that there is a need to move to a "more competent approach which captures the unique circumstances of the community". The issues their members face are not simply related to cultural issues but also the immediate individual circumstances since seeking asylum status. Early intervention is key – including linking with those organisations providing the Compass Contract. Communities are not getting health information on time and it was felt that this should be part of the Compass project linked to their contract. Agreed that the proposed changes to the HISEM work are the best approach and should be delivered through the Compass contract. Would like us to ensure that the Regional Refugee Forum are seen as a partner in the process.
Date TBC	Voluntary and community organisations working with migrants / asylum seekers / refugees	See NCVS response
Date TBC	Newcastle Gateshead Clinical Commissioning Group	No mention in CCG response

Date TBC	Strategic Migration Group	Future consultation
Date TBC	NCVS / On the Hoof (monthly publication)	NCVS response This approach seems sensible as long there is support from the NHS. Thought needs to be given as to the short/ medium term impact on individuals and families. We would welcome the new services being delivered by community-based, local voluntary sector providers. We note NCVS is mentioned as a possible consultee, but no approach has been made to us.
Date TBC	Health services, including General Practice	Trust response
	Public Responses	To leave a lot of new migrants and refugees without support and make them vulnerable. People will not be able to access the health services they need. People will get ill or more ill. People may die. If at risk people cannot access vaccinations they pose a health risk to the wider community. There will be a gap when the existing service stops. If the service is replaced by staff training, there would potentially be no help for these people until the new staff and organisations have been trained.
	Advice and support team Your Homes Newcastle	I am concerned that the above statement assumes existing services have spare capacity or that those services will even exist going forward. Has any assessment of the capacity of the existing services been made to know or what their future funding, indeed their existence is likely to be. Explore opportunities pretty much makes the statement that you have not secured agreement from CCGs to fund this. The CCG's are not in a position to pick up the tab for this and I am sure you are aware of this. We have worked with the Syrian families as part of the Home Office contract and they would not have been able to access primary health services at all without access to one on one support. They would not have been able to get registered with GP's, issues around lack of immunisations would not have been adequately picked up without our

		intervention. The dentists are currently actively resistant to providing interpreting facilities at all for any treatments and without our constant intervention and escalating the issue to a director level, our Syrian families would not have received dental treatment at all. Whilst we have funding to provide this to a select group of Syrian families, we do not have capacity to deliver this to other refugee families (who are the majority). I am especially concerned that in deciding to take a macro rather than micro approach, you may in the long term threaten public health at a macro level, in part through the lack of immunisation of this group and the lack of any identification of risk of TB. Through not accessing primary health care service properly (ie not been registered with a GP) MMR immunisations will be routinely missed and could affect long term herd immunity. Our experience of dealing with a severely disabled person with a heart condition and who was a refugee with no English language skills was that without one on one support he would have been severely and disproportionately affected (and in fact he was regardless). In that particular case, he was due to have an operation and was given a 20 page doc (in English) outlining potential risks and explaining the procedure. NHS refused to translate and instead asked the support worker to read it to the customer (which incidentally we refused to do because there were numerous complicated health terms which only a medical professional could explain). Refusal by NHS staff to organise interpreters has meant appointments have had to be cancelled and then rearranged. In this particular case it may be that these delays ultimately may have contributed to this man's death as he did not then receive an (overdue) operation required to save his life. So I have to disagree with this assumption. People with mental health issues who did not speak English are also going to be disproportionately affected by this change. We worked with a lady who did not speak English and who needed to access CMHT services. Even with our intervention they delayed arranging interpreters in a timely fashion, which may have contributed towards a deterioration in her mental health and ultimately she attempted suicide attempt. This person was then not assessed under the mental health act over the whole weekend until we found out on the Monday that she was in hospital (on a general ward) and arranged for an interpreter to meet us there (at which point NHS staff arranged a mental health assessment and the ward sister came to talk to her). This meant for 3 days, when we were not involved (we don't work over the weekend) they used her 15 year old daughter to interpret but they did not directly use interpreters or have a direct

		conversation with this lady for 3 days. I use this an example to demonstrate that the NHS are in no way in a position to currently be trusted to provide adequate services with people who do not speak English without 3rd party intervention.

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 impact on people because of their sex or gender.	Not applicable
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 as poor health or poor housing / homelessness	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 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	Clear consultation processes and explaining the benefits of moving to a new model.

			projects may have an impact on these relations.	
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