

ASYLUM SUPPORT POLICY BULLETIN 85

DISPERSING ASYLUM SEEKERS WITH HEALTH CARE NEEDS

1. SCOPE AND PURPOSE

1.1 This document provides guidance for UK Border Agency staff on handling cases of Asylum supported asylum seekers (and their dependants) who have health care needs. It was developed in response to a recommendation from the Review by Hilary Scott, former Deputy Health Service Ombudsman, entitled “Meeting the health care needs of people seeking asylum” which was published on 16 December 2004. The report can be found at:

http://www.ind.homeoffice.gov.uk/ind/en/home/applying/national_asylum_support/nass_news/latest_news.html.

1.2 This bulletin does not cover

- asylum seekers with care needs, for which see PB 82;
- the health care needs of failed asylum seekers who do not have dependent children;
- those in receipt of section 4 support;
- people who have been granted status;
- asylum seekers being moved from Detention Centres; or
- cases considered under the New Asylum Model (see Section 22).

1.3 Annex A is a Department of Health (DH) table which sets out eligibility for free NHS health care for people in selected immigration categories.

1.4 A brief guide to the main structure of the NHS in England is at <http://www.nhs.uk/england/abouttheNHS/default.cmsx>, which has links to information about the NHS in Scotland, Northern Ireland and Wales.

2. APPLICATION OF THIS INSTRUCTION IN RESPECT OF CHILDREN AND THOSE WITH CHILDREN

2.1 Section 55 of the Borders, Citizenship and Immigration Act 2009 requires the UK Border Agency to carry out its existing functions in a way that takes into account the need to safeguard and promote the welfare of children in the UK. It does not impose any new functions, or override existing functions.

Officers must not apply the actions set out in this instruction either to children or to those with children without having due regard to Section 55. The UK Border Agency instruction 'Arrangements to Safeguard and Promote Children's Welfare in the United Kingdom Border Agency' sets out the key principles to take into account in all Agency activities.

Our statutory duty to children includes the need to demonstrate:

- Fair treatment which meets the same standard a British child would receive;
- The child's interests being made a primary, although not the only consideration;
- No discrimination of any kind;
- Asylum applications are dealt with in a timely fashion;
- Identification of those that might be at risk from harm.

3. BACKGROUND

3.1 The UK Border Agency commissioned Hilary Scott in spring 2004 to review how Asylum Support policy and processes impact on the health care of asylum seekers.

3.2 The report concluded that a series of amendments to UK Border Agency processes, clarification of policy, attention to staffing and staff development issues, a focus on good communication with partners and stakeholders and the introduction of a quality assurance programme could all improve confidence in Asylum Support processes, secure more efficient and successful dispersals, reduce risks associated with this high profile area of work and provide welcome support for UK Border Agency staff.

3.3 One recommendation was to produce "a comprehensive policy bulletin dedicated to the way UK Border Agency approaches health care issues that covers the response to applicants' needs for primary, secondary and tertiary care, and specialist services; the care of applicants who have tuberculosis (TB) or who are HIV positive; and the needs of women who are pregnant or have given birth recently. It could also cover the circumstances in which UK Border Agency might request additional clinical information of clinicians caring for applicants, and the most helpful form (for all parties) for that information".

3.4 The report was commissioned against the background of asylum seekers spending long periods in what was known as Emergency Accommodation before being dispersed. The situation has changed considerably since then in terms of dispersal times. Newly arrived asylum seekers no longer spend long periods of time in Emergency Accommodation. Most are moved on in less than four weeks and in many cases in less than two. This is being reduced even further. Initial accommodation (IA), as it is now known, is designed for very short stays; in summary, time for briefings, a health check, an assessment of eligibility for Asylum support, and dispersal.

3.5 Asylum Support policy is to ensure that asylum seekers are dispersed as soon as possible and to suitable long term accommodation. One of the advantages

of this approach is that where necessary they can commence proper health care treatment without interruption.

3.6 However, there are still some cases where asylum seekers have spent considerable periods of time in initial accommodation or have been on subsistence-only support, or who are being moved under the Interim Scheme Project (ISP) and it is to those cases that this Policy Bulletin is primarily directed.

Pre Dispersal Accommodation

3.7 NASS provides accommodation under section 98 of the Immigration and Asylum Act 1999 for eligible asylum seekers:

- who would otherwise be destitute, and
- who are awaiting a decision from the Secretary of State on whether he may provide asylum support under Section 95.

3.8 This accommodation caters for all the essential living needs of asylum applicants while the UK Border Agency sources appropriate longer term dispersal accommodation.

3.9 Formerly referred to as the 'Induction Centre Network' the Initial Accommodation Network consists of twelve sites across the UK which manage the entry and dispersal of applicants.

3.10 Initial Accommodation/Induction Centres comprise two parts - accommodation and processes. Services are delivered in partnership with the relevant local authorities and/or voluntary sector organisations.

These services include:

- meeting the initial accommodation and living needs of asylum applicants
- providing information briefings on applicants' rights and responsibilities while in the United Kingdom
- providing briefings on the UK asylum process and dispersal location
- carrying out (where facilities are available) a health assessment for new applicants
- supporting the applicants' moves to longer term accommodation where they may stay while they remain eligible for Asylum support.

3.11 The Induction Process normally takes between seven and fourteen days to complete but complex cases may take longer. During this time UK Border Agency assessment for financial support is undertaken and longer term accommodation is arranged. A one-day induction process is available for applicants who do not need Asylum Support accommodation.

3.12 Within the Initial Accommodation network are the properties formerly known as Emergency Accommodation. The accommodation used comprises of full-board, former and operating hotels, houses in multiple occupation, hostels, and self-contained/self-catering properties. These properties are acquired, and managed by Voluntary Sector partners, and those that will remain upon completion of the

Emergency Accommodation reduction programme are regarded as suitable for all new admissions.

4. PRINCIPLES

4.1 All asylum seekers who are supported by the UK Border Agency, and their dependants, are entitled to NHS treatment without charge while awaiting a final decision on their applications. Asylum supported asylum seekers also qualify for an HC2 certificate for help with free NHS prescriptions, free NHS dental treatment, free NHS wigs and fabric support, necessary travel costs to and from hospital for NHS treatment, free NHS sight tests and the full value of an NHS optical voucher towards the cost of glasses or contact lenses.

4.2 Where an asylum seeker has been unsuccessful, and rights of appeal are exhausted, the individual is still entitled to continue any course of treatment which began while his or her asylum claim was being considered, without charge for the duration of their stay in the UK.

4.3 The UK Border Agency aims to ensure that all asylum seekers it supports, with health care needs are able to access appropriate medical care and any special facilities they may need and, where appropriate, that continuity of treatment is arranged on dispersal.

4.4 Under Section 97 of the Immigration and Asylum Act 1999, accommodation for asylum seekers supported by the UK Border Agency is provided on a no-choice basis, whilst taking into account an individual's circumstances, in areas where there is a ready supply of accommodation. In general, therefore, accommodation is provided away from London and the South East.

4.5 Except for London and the South East, and subject to operational constraints, asylum seekers are, where possible, allocated dispersal accommodation within the region in which their pre-dispersal initial accommodation is located.

5. APPLICATION FOR NASS SUPPORT

5.1 When applying for Asylum support, the applicant is required to complete a Asylum Support (NASS1) application form. This is an opportunity to provide information about whether the applicant, or any dependants, suffers from a medical condition which needs treatment, medication or counselling. The information supplied by the asylum seeker is treated in confidence. It may be given to other government departments, agencies and local authorities within the confines of the Data Protection Act 1998 for the purposes of enabling support to be provided.

5.2 However, it must be appreciated that many asylum seekers will be fearful of disclosing healthcare needs, probably in the mistaken belief that it will count against them. Asylum seekers should be reassured by those assisting them to complete the Asylum Support application form, that the asylum claim is considered quite separately from their application for Asylum support.

5.3 It is important to include any information which may constitute an exceptional reason to be allocated support in a particular area, or information about ongoing treatment for a medical condition or illness. Initial accommodation, provided prior to dispersal, is only short term and representations about healthcare should be made as soon as possible.

5.4 Most health needs identified in the Asylum Support application will be long-term and treatment should commence on dispersal. However, there may be exceptional circumstances in which an individual is identified as having a short-term immediate health need, which should be treated in the initial accommodation: examples might include a suspected fracture or severe dental pain. The IA health team or similar support can advise if such issues have been resolved, or whether or not a delay to dispersal will be required to ensure resolution (see 7 and 8).

6. INITIAL ACCOMMODATION SITE HEALTH CHECK

6.1 The health screening offered in the induction services includes the following and is in line with recommendations by the British Medical Association (BMA):

- An assessment of current health status and addressing of any immediate concerns.
- Testing for TB. (Tests for other conditions such as Hepatitis A,B C and HIV may be carried out if there is reason for concern.)
- Recording of the patient's history of immunisations and vaccinations. At present TB vaccinations are only offered to 16year olds and under, and MMR vaccinations to 16-25 year olds (as a special risk group).
- Recording of maternity history. Family planning advice is offered to both men and women.
- The identification of special needs and liaison with the UK Border Agency, or whoever is sub-contracted to oversee dispersal, to ensure the provision of appropriate accommodation and support where needed.
- All children under the age of 5 years are seen by a health visitor and nutritional needs assessed and appropriate advice given.
- All those with a history of physical or psychological maltreatment are seen by doctors working within the asylum medical team for appropriate treatment/ counselling. Any concerns regarding children are reported through the correct channels and liaison with Social Services takes place.
- Any sexual health problems are discussed on assessment and appropriate action taken.
- Asylum seekers with mental health problems are seen by doctors working with the asylum medical team and are referred for further assessment to local mental health units as quickly as possible.

6.2 Where induction service health teams believe that dispersal should be delayed on medical grounds (see below for a list of relevant criteria), written notification should be made to the local UK Border Agency initial accommodation team.

7. DELAYED DISPERSAL CRITERIA

7.1 Where the UK Border Agency is notified, and the condition is confirmed in writing, consideration must be given to delaying dispersal in the following circumstances (however, dispersal may still be possible if a dispersal address is available in the same location and the asylum seeker can continue with the same treatment):

- HIV/AIDS (section 10)
- TB (section 11)
- Severe mental health problems (section 12)
- Some pregnancies or certain stages of pregnancy and related obstetric conditions (see Asylum Support Policy Bulletin 61).
- Where treatment is ongoing and only available in the area where the asylum seeker is living.
- Where Asylum Support Policy Bulletin 19 (Medical Foundation for Victims of Torture) applies.
- Where surgery has been booked to take place within a month or a person is recovering from an operation. Dispersal should not take place until the individual has been medically assessed as fit to travel.
- Where it is necessary to arrange continuity of care, for example where a person is undergoing kidney dialysis.
- Infectious and notifiable diseases, including: Acute encephalitis, Acute food poisoning, Acute poliomyelitis, Amoebic dysentery, Anthrax, Bacillary dysentery, Chickenpox, Cholera, Diphtheria, Leprosy, Leptospirosis, Malaria, Measles, Meningitis, Meningococcal septicaemia (without meningitis), Mumps, Ophthalmia neonatorum, Paratyphoid fever, Plague, Rabies, Relapsing fever, Rubella, Salmonella infection, Severe Acute Respiratory Syndrome (SARS), Scarlet fever, Smallpox, Staphylococcal infections, Tetanus, Tuberculosis, Typhoid fever, Typhus, Viral haemorrhagic fevers, Viral hepatitis, Whooping cough, Yellow fever (see section 14).
- Referral or admission to secondary care services due to acute need.

8. CONSIDERATION OF CRITERIA BY UK BORDER AGENCY

8.1 Where issues of delayed dispersal /continuity of care arise in respect of an asylum seeker who is in initial accommodation, the site health team will liaise with the relevant clinician(s) and the local Asylum Support initial accommodation team about dispersal timing. The asylum seeker will take with them to the dispersal area the hand held record providing details of their health assessment received in the initial accommodation. The aim will be to minimise the upheaval of a move to a dispersal area some time after an asylum seeker has settled. In many cases, in-region dispersal will be a possibility.

8.2 In all other non initial accommodation cases, with the exception of pregnant women without any other complication, the liaison with the relevant clinician(s) will

be undertaken by the Complex Casework Team (CCT) with the assistance of the Asylum Support Medical Adviser to ensure continuity of care where necessary. A pro-forma at [Annex B](#) has been devised for that purpose. In many cases, in-region dispersal will be a possibility. [Annex C](#) is a basic flowchart to guide caseworkers through the process.

8.3 In some cases where an asylum seeker has to be relocated urgently or in an emergency (for example in cases of domestic violence, antisocial behaviour or unsafe accommodation) there may be insufficient time to consult the treating clinician and make new treatment arrangements. However any healthcare issues should be taken into account once the relocation has taken place. The treating clinician must be advised of the relocation as soon as possible after the move has taken place, giving the clinician details of the new address of the asylum seeker. This is to enable the clinician to minimise any harm or damage that could arise from the urgent move.

8.4 All letters from NHS clinicians or NHS health professionals who have either written directly on behalf of an asylum seeker or indirectly through the asylum seeker's representative must be acknowledged with the name of the caseworker who will be dealing with the case and be signed, dated and contain a telephone number for the clinician to contact. Letters from private consultants, e.g. medical-legal services should be referred to the CCT to respond.

8.5 Caseworkers should inform the appropriate Asylum Support Regional Health Lead (see [Annex E](#)) by phone and email if there are any health needs that may impact on housing provision and support required once the asylum seeker has arrived in the dispersal area. This is to ensure that the Regional Health Lead is made aware that he or she may need to become involved in supporting the accommodation provider.

9. REFERRAL TO, AND ROLE OF, THE ASYLUM SUPPORT MEDICAL ADVISER

9.1 The Asylum Support medical adviser's role is to advise caseworkers about the general availability of medical treatment throughout the United Kingdom, the asylum seeker's fitness to travel to accommodation and the nature of any accommodation to be provided. However, it is not the medical adviser's role to assess the reasonableness or otherwise of dispersal. That remains a casework decision to be made in the light of his advice and of all other relevant circumstances.

9.2 In addition, when the medical issues are complex the medical adviser liaises between caseworkers and the treating clinicians, to ensure that appropriate support arrangements are established.

9.3 In some cases the induction services health team or CCT may wish to request certain requirements for the accommodation or dispersal area eg. a ground floor room, or an area where particular services are available. Where appropriate, eg in the case of infectious disease, a joint risk assessment should be undertaken by the

induction services health team or the CCT with the local Health Protection Unit and the consulting clinician, to inform the UK Border Agency decision.

10. HIV/AIDS

10.1 Newly arrived asylum seekers with HIV/AIDS who are not currently receiving ongoing treatment in the UK should be dispersed from initial accommodation at the earliest opportunity to enable them to commence treatment on dispersal to a suitable area.

10.2 In other cases dispersal should only take place:

- following expert clinical advice from the treating clinician (including advice about potential dispersal locations). Dispersal should normally only take place if the asylum seeker is medically stable and does not have any other active complication, or
- when asylum seekers and clinicians have had time to adequately prepare for dispersal and have confirmed arrangements with either the UK Border Agency or the Asylum Support Medical Adviser.

The expectation is that these arrangements would be completed within 4 weeks, or 6 weeks in exceptional cases.

10.3 When dispersal is considered possible, caseworkers will not move the asylum seeker until the treating clinician is:

- notified of the asylum seeker's new address;
- satisfied that there are appropriate facilities, (including suitable accommodation facilities) to ensure continuity of care;
- ready to discharge and transfer the asylum seeker's treatment to the receiving Primary Care Trust; and
- able to provide the asylum seeker with sufficient medication to cover them so that the receiving clinician has sufficient time to assess the treatment. This is to ensure that there is no interruption or change of the treatment without sufficient time to properly review the current treatment regime.

10.4 When the asylum seeker is pregnant and HIV positive, additional care is required and the case **must** be transferred to the Complex Casework Team (CCT).

10.5 Extra care should be taken when finding accommodation for families with children infected with HIV. Caseworkers will need to satisfy themselves that any accommodation is located where there are appropriate facilities for treating children with HIV/ AIDS. The Asylum Support Medical Adviser should be asked to provide advice about specific locations.

10.6 Those working with asylum seekers within or on behalf of the UK Border Agency should ensure that asylum seekers understand that disclosure of an HIV diagnosis will not affect their asylum application. This is a major concern for many and leads to late disclosure of significant medical information causing difficulties to the UK Border Agency and to both treating and receiving clinical teams.

10.7 UK Border Agency staff should take account of the information about HIV/AIDS at Annex D when considering dispersing asylum seekers who are HIV positive.

11. TB

11.1 Asylum seekers in induction services are offered TB tests as part of their Health Assessment. A TB protocol has been developed by a sub-group of the National Network of Induction Centre Health Services, in consultation with a number of chest physicians, TB nurses, CCDCs (Consultants in Communicable Disease Control) and similar professionals working in the field of tuberculosis control and treatment. The protocol covers the screening process within the Induction health services. It does not give detailed information about procedures to follow for treatment, management or contact tracing, as these are covered by the guidelines of the British Thoracic Society, (www.brit.thoracic.org.uk).

11.2 Where the results of a chest x-ray have not been read prior to dispersal, it may be necessary for the initial accommodation health team to contact local health teams in the dispersal area and the UK Border Agency should facilitate as necessary making the address available to the health team.

11.3 Where active TB is detected, dispersal should be delayed, and treatment commenced locally under the supervision of a TB specialist. Local accommodation is to be provided until the patient is no longer contagious, and is able to travel. Except for extremely infectious cases, which are highly unusual, the patient will usually be able to be dispersed after two weeks of treatment. The chest physician will advise when dispersal can take place so that treatment can continue in the dispersal area. In some cases, there will need to be direct communication between healthcare providers in initial and dispersal accommodation sites to ensure continuity of care, and the UK Border Agency must facilitate these arrangements.

12. MENTAL HEALTH

12.1 All asylum seekers are eligible to access mental health services in primary care and, following GP referral, in secondary care. Those seeking asylum should have their mental health needs managed in the same way as any other member of the population, and the dispersal process should not adversely affect the mental health of an individual and the care they receive.

12.2 The Department of Health's mental health strategy "*Delivering race equality in mental health*" (2004) highlighted the particular barriers which refugees and asylum seekers face in accessing mental health services. "As well as experiencing the issues associated with the BME (Black and Minority Ethnic) groups to which they belong, refugees have often been exposed to severe physical and psychological trauma as a result of war, imprisonment, torture or oppression. In their new host

country they can then experience social isolation, homelessness, language difficulties, hostility and racism, all of which are strong predictors of poor mental health.” (p. 51).

12.3 Asylum seekers may suffer from the same range of psychiatric and psychological disorders as the general population. However, asylum seekers and refugees are at high risk of developing Post Traumatic Stress Disorder and co-morbid disorders. DH advise that in line with the relevant standards in “A National Service Framework for Mental Health” (Department of Health 1999) <http://www.dh.gov.uk/asset/root/04/07/72/09/04077209.pdf> asylum seekers who contact their primary health care team with a common mental health problem should:

- have their mental health needs identified and assessed;
- be offered effective treatments, including referral to specialist services for further assessment, treatment and care if they require it;
- be able to make contact round the clock with the local services necessary to meet their needs and receive adequate care; and
- be able to use NHS Direct, as it develops, for first-level advice and referral on to specialist help-lines or to local services.

12.4 Abrupt cessation of psychiatric medication can result in a serious deterioration in the mental health of an individual, which goes beyond that which the individual would normally suffer without medication, placing themselves and others at risk. People at risk of suicide are often prescribed medication sufficient for just a few days, to reduce the risk of overdose. Therefore it is imperative that sufficient medication for the dispersal period is obtained and that registration with a new GP is facilitated. Where an individual is receiving ongoing treatment from a psychiatrist or a clinician, or a doctor or nurse states that an individual is at high risk of suicide, serious self-harm or risk to others, the case should be referred to CCT.

12.5 The disruption of therapy with a trusted clinician may be detrimental to an individual’s mental health and compromise their capacity for recovery in the long term. Where an asylum seeker is engaged in physiological and psychiatric services, consideration should be given to deferring dispersal in order to allow treatment to continue and be completed, based on the opinion of the therapist or clinician providing the intervention. This should be a priority where specialist input is only available locally. Where Policy Bulletin 19 applies, dispersal decisions must be in accordance with that policy bulletin.

12.6 The Department of Health is building on existing knowledge in this area by developing a resource pack to help service commissioners and health practitioners to meet the needs of refugees and asylum seekers, to be available in spring 2006. The HARP Mental Health and Well-being Resource provides information of use in assisting asylum seekers and refugees with mental health issues.

<http://www.mentalhealth.harpweb.org>

13. PREGNANCY

Refer to Asylum Support Policy Bulletin 61.

14. INFECTIOUS AND NOTIFIABLE DECISIONS

14.1 If a case of, for example, anthrax, meningococcal septicaemia, rabies or plague actually arose, then the priority would be hospitalisation rather than consideration of dispersal, and it therefore remains improbable that UK Border Agency staff would be presented with such a case for consideration of dispersal. Once the asylum seeker had recovered, then there would normally be no need to delay dispersal.

15. LATE REPRESENTATIONS

15.1 If an asylum seeker reaches the dispersal stage and representations are made for him/her not to travel or for dispersal to a specific location, the case should be referred to the CCT, and dispersal deferred while the case is considered. Representations should only be made based on significant medical issues as described in section 7.1. The dispersal team retains the discretion to re-book or take failure to travel action where illness is trivial, such as failing to travel due to having a heavy cold. In these instances it is anticipated that such minor cases will not be referred to CCT.

16. REGISTERING WITH GPs / NEW CONTRACTS

16.1 Registering with a General Practitioner (GP) is essential to providing access to health services.

16.2 Under existing contracts the arrangements made for assisting asylum seekers to register with GPs vary from provider to provider.

16.3 The UK Border Agency's existing accommodation contracts will soon be replaced with new accommodation contracts. These new contracts are known as Target Contracts. They are currently expected to be signed in January and operational from February 2006. There will be a transition period when Target Contracts and the UK Border Agency's previous contracts will operate at the same time. The transition period will continue until all previous contracts have expired. The Target Contracts will bring a number of changes to the UK Border Agency's dispersal procedures. The differences in terms of dispersing asylum seekers with healthcare needs concern their registration with a GP.

16.4 Under the Target Contracts a provider may be advised in advance of dispersal that an asylum seeker has a pre-existing condition requiring registration with a local GP. However, the provider should not be informed of the nature of the pre-existing condition.

16.5 Caseworkers should advise providers of the impact on dispersal/ accommodation of an asylum seeker's condition/disability rather than specifying the actual illness, e.g. that an asylum seeker needs to be located within easy access of a particular hospital (without saying why), or stating that the asylum seeker must have

self contained accommodation, a personal fridge or downstairs accommodation. If the asylum seeker has an obvious disability/illness that impacts on dispersal/accommodation the impact should be brought to the notice of the provider e.g. that they are not mobile and confined to a wheelchair (it may be necessary to specify the size of the wheelchair) and therefore require ground floor accommodation, low counters and/or special bathroom facilities.

16.6 It may sometimes be necessary to advise providers of asylum seekers who have a history of violence, (possibly as a result of mental illness) where there may be serious and credible concerns that they may harm themselves or others.

16.7 Pre-existing medical conditions and other instances that will require a provider to register a dispersed asylum seeker with a GP include:

- Long term conditions that need regular medication e.g. diabetes, heart problems, asthma, epilepsy, haemophilia, non active TB;
- HIV if already diagnosed and if no continuation of care arrangements have been made before dispersal;
- Acute mental health issues;
- Pregnant women; and
- Children under 9 months.

16.8 If an asylum seeker has a pre-existing condition requiring registration with a local GP and states that he or she is in urgent need of a new supply of prescribed medication, the provider will take the asylum seeker to a GP within 1 working day of his or her arrival at the dispersal address.

16.9 In other cases where the provider is notified by the UK Border Agency of an asylum seeker's pre-existing medical condition, the provider is required to take the asylum seeker to the GP's surgery for registration, within 5 working days of the asylum seeker's arrival at the dispersal address.

16.10 On dispersal, it may become obvious to the provider that an asylum seeker is in urgent and obvious need of medical care. In such a situation the provider is required to take all necessary action to ensure the timely and sufficient care of the asylum seeker. This includes, where appropriate, taking the asylum seeker to the nearest GP, hospital Accident and Emergency Department or calling the emergency services. The provider is required to notify the UK Border Agency of the incident, or its outcome, at the earliest convenient time and not exceeding 4 working hours.

16.11 Accommodation providers are required to ensure that asylum seekers are briefed within 1 day of their arrival at the dispersed accommodation. This service includes assisting dispersed asylum seekers to register with a local GP and a dentist through the provision of verbal and written instructions. The briefing must be delivered in a language that the asylum seeker understands. Target Contract providers must also assist asylum seekers in their accommodation by providing them, where necessary, with information on how to make contact with, and the appointment systems associated with, the local National Health Service.

16.12 If, in any one week period, 10 or more asylum seekers are placed in the same area by the Target Contract provider, the provider shall:

- Notify the relevant PCT asylum health care worker of their arrival;
- Arrange, within 2 working days of the last asylum seeker arriving, for the PCT asylum health care worker to meet all the individuals together so that they can, if they wish, be registered with GPs at the same time.

16.13 If emergency assistance is required (also referred to as an urgent health need) when the asylum seeker arrives at the dispersal address the provider shall take the appropriate action described at 16.10 when, for example, the following type of event is occurring:

- Loss of consciousness, fits or fainting during the journey
- Heavy blood loss
- Suspected broken bones
- Severe chest pain
- Difficulty breathing
- Overdose, ingestion or poisoning
- Pregnancy complications including labour pains or excessive vomiting
- Acute mental health issue
- An inflamed eye or a foreign body in the eye
- Attempted suicide
- Acute toothache and /or facial swelling (the provider should contact NHS Direct (NHSD) for advice on how to get dental treatment)

If in doubt the Provider will call NHSD, describe the symptoms and act on the advice given.

16.14 As a follow up in cases of immediate emergency assistance, the provider shall arrange for the asylum seeker to be registered with a GP as a matter of urgency when he or she subsequently moves into the dispersal accommodation.

16.15 In the event that the UK Border Agency notifies the provider that an asylum seeker is visually impaired to the extent that he or she cannot make the journey alone to receive treatment, the provider will make arrangements for them to be accompanied.

16.16 It is imperative that asylum seekers who have been given hand held records as part of an induction service health assessment take them to each medical appointment.

17. NOTIFYING PCTs

17.1 The UK Border Agency aims to support planning by PCTs. At present, individual notification letters are sent to PCTs (in Scotland Local Health Boards, in Wales, Health Authorities and in Northern Ireland Health Care Trusts) giving them specific name and address information on NASS supported asylum seekers being dispersed to their area. A pilot to improve the timeliness, quality and relevance of this information is currently awaiting the outcome of an IT security review before being implemented.

18. NASS REGIONAL HEALTH CONTACTS

18.1 The regional health contact remit is delivered as part of the stakeholder liaison work done by UK Border Agency regional offices. Within each office there is now a nominated official whose responsibility includes close working with key health partners within the region. Those key health contacts may vary from region to region but always include Primary Care Trusts (PCTs), Social Services, Government Office and the Local Authority Asylum Team (with health representation).

18.2 The remit of the regional health contact is to:

- Facilitate relevant two-way communication between key health stakeholders and the UK Border Agency;
- Act as initial point of contact for regional issues to be resolved by the appropriate owner within the UK Border Agency;
- Contribute a regional perspective to specific cases where there are special health needs; and
- Raise awareness of Asylum Support processes and their impact on health issues.

19. SCOTLAND

19.1 In Scotland, health is a devolved matter and therefore comes under the remit of the Scottish Executive. Asylum health matters are dealt with by the Local Health Boards. All admissions to the Scottish Induction Service are through one location. Urgent health matters are referred to the local GP and asylum seekers are registered with GPs following the induction process. This is undertaken by a dedicated person appointed by the Greater Glasgow Health Board (GGHB). Currently 98% of NASS supported asylum seekers in Scotland fall under the GGHB remit. See www.healthscotland.com.

20. WALES

20.1 In Wales, health matters are devolved to the National Assembly for Wales. All policy development issues concerning asylum seekers, refugees and, of late, migrant workers, are routed through the office of the Minister for Social Justice.

20.2 Wales does not have the benefit of an induction service so all individual asylum seeker health issues are resolved directly between the asylum seeker and the local GP following the initial induction process in their homes. This process is often hastened either by the provider's local contact or by staff of the Welsh Refugee Council. Of the four dispersal points within Wales, two now have dedicated asylum seeker health professionals assigned to them by the local health boards.

21. NORTHERN IRELAND

21.1 In Northern Ireland health is a devolved matter dealt with by the Department of Health, Social Services and Public Safety, which reports directly to the Northern Ireland Office.

21.2 There are 4 Health and Personal Social Services Boards throughout the province, with 18 Health Care Trusts reporting to a Board. However, after the Secretary of State for Northern Ireland's announcement on 22/11/05, this will be reduced to 7 sub-regional health agencies - one for each council area.

21.3 Northern Ireland is not a dispersal area, so an asylum seeker's individual healthcare needs are dealt with by their GP. The Northern Ireland Council for Ethnic Minorities (NICEM) and the Northern Ireland Housing Executive conduct induction for asylum seekers once they are placed in permanent accommodation, and the asylum seeker is assisted by NICEM with any health related issue they may have.

22. NEW ASYLUM MODEL PROCESS

22.1 The Government published a five-year strategy for asylum and immigration - "Controlling our borders - Making migration work for Britain" - in February 2005. It set out plans for new, tightly managed processes for all asylum claimants. Under this New Asylum Model non-detained claimants will be assigned to a case owner in a Complete Case Management Team. The case owner will deal with all the key stages of the claim from the initial asylum decision through to removal or integration. IND envisage rolling out this new approach so that all new asylum claims are dealt with under the New Asylum Model from Autumn 2006.

22.2 The New Asylum Model Team and the Department of Health are identifying and discussing the healthcare implications arising from the new arrangements and further guidance will be issued in due course.

23. REVIEW

This Policy Bulletin will be reviewed in 12 months.

Document Control
Change Record

Version	Authors	Date	Change Reference
2.0	MSM	25/03/09	Update branding only
3.0	SM	18/09/09	Children's Duty paragraph added

ANNEX A		
TABLE OF ENTITLEMENT TO NHS TREATMENT (Correct as of January 2005)		
Status	Primary Care	Secondary Care
Asylum Seeker	A person who has formally applied for asylum is entitled to NHS treatment without charge for as long as their application (including appeals) is under consideration. They will have to pay certain statutory NHS charges (e.g. prescription charges) unless they also qualify for exemption from these (see notes section), and will go on waiting lists. Since asylum seekers are entitled to free NHS treatment, they can apply to a general practitioner to register as a patient. Asylum seekers are exempt from charges for NHS hospital treatment.	A person who has formally applied for asylum is entitled to NHS treatment without charge for as long as their application (including appeals) is under consideration. They will have to pay certain statutory NHS charges (e.g. prescription charges) unless they also qualify for exemption from these (see notes section), and will go on waiting lists. Since asylum seekers are entitled to free NHS treatment, they can apply to a general practitioner to register as a patient. Asylum seekers are exempt from charges for NHS hospital treatment.
Asylum Seeker refused but appealing decision	As for Asylum Seeker	As for Asylum Seeker
Asylum Seeker denied support under Section 55 of the 2002 Act, but still claiming asylum.	As for Asylum Seeker	As for Asylum Seeker
Failed asylum seekers – including those getting Asylum Support Section 4 (formerly “hard case”) support while awaiting departure from the UK	The Department of Health has sought to allay confusion over the entitlements of failed asylum seekers to primary care without charge. Health service Circular 1999/018 states that failed asylum seekers should not be registered, but equally, GP practices have the discretion to accept such people as registered NHS patients. Ministers wish to bring greater clarity and consistency to the rules regarding access to primary medical services and so have recently sought views on this issue as part of a consultation on the entitlement of overseas visitors to NHS primary care services. Ministers are still considering the responses and the outcome of the consultation has not yet been announced. Therefore the current situation remains unchanged - Emergencies or treatment which is immediately necessary should continue to be provided free of charge within primary care to anyone, where in the clinical opinion of a health care professional this is required.	For secondary care, immediately necessary treatment to save life or prevent a condition from becoming life-threatening should always be given to failed asylum seekers without delay, irrespective of their eligibility for free treatment or ability to pay. However if they are found to be chargeable, the charge will still apply, and recovery should be pursued as far as the trust considers reasonable. Any course of hospital treatment already underway at the time when the asylum seeker’s claim, including any appeals, is finally rejected should remain free of charge until completion. It will be a matter for clinical judgement as to when a particular course of treatment has been completed. Any new course of treatment, begun after the asylum claim is finally rejected, will be chargeable (unless the treatment itself is exempt under the provisions of the NHS (Charges to Overseas Visitors) Regulations 1989, as amended, e.g. TB). Trusts should refer to the document “Implementing the Overseas Visitors Hospital Charging Regulations - Guidance for NHS Trust Hospitals in England” for advice on how and when to make the charge in these cases.
Given Refugee Status (a successful asylum seeker or, arriving in the country through a Government initiative, i.e. Refugee Gateway Scheme)	Access to primary care without charge. As for Asylum Seeker.	Access to secondary care without charge As for Asylum Seeker.
Given Discretionary Leave to Remain	Access to primary care without charge As for Asylum Seeker.	Access to secondary care without charge As for Asylum Seeker
Given Humanitarian Protection	Access to primary care without charge As for Asylum Seeker.	Access to secondary care without charge As for Asylum Seeker.

Entitlement to NHS treatment (correct at January 2005 onwards)

Certain services are exempt from charges for everyone. This includes treatment provided solely in an Accident and Emergency Department, treatment of certain specified communicable diseases (although prescription charges may be payable unless exempt) and compulsory mental health treatment. In the case of services which relate to HIV/AIDS only the initial test and counselling is free. People not eligible for free hospital treatment are required to pay the full costs, including drugs, of any HIV treatment beyond the initial test and counselling. Where a person has been identified as chargeable (not an asylum seeker) for HIV/AIDS treatment a HC2 (certificate for full help with health costs) is not applicable and the full cost of the drugs should be recovered from them. Flu immunisations are given to those who are in at risk categories. These categories include anyone over 6 months with respiratory disease (inc. asthma), chronic heart disease, renal disease, diabetes and immunosuppression or staying or living in long stay facilities – or who at the GPs' discretion needs to have a flu jab on a clinical need basis.

Enquiries about this table should be addressed to: Justine Osborne on 0113 2546605, or Justine.Osborne@dh.gsi.gov.uk

Notes

Secondary Care

It is the responsibility of the NHS trust or Primary Care Trust (PCT) providing secondary care to establish if a person is entitled to treatment without charge (although out-patients may have to pay charges for drugs and appliances unless they are exempt). All patients, regardless of their status or nationality are subject to the same basic screening process and should be asked the following question about their residential status as part of the hospital registration procedure:

- Where have you lived for the last 12 months?

A person who has not been living in the UK for the last 12 months is subject to the NHS (Charges to Overseas Visitors) Regulations and can therefore expect to be asked further questions such as,

- On what date did you arrive in the UK?
- What is the basis for your stay in the UK?

Help with Access to Health Services

If asylum seekers and refugees are having difficulties registering with a GP, they should contact their local PCT who will be able to provide a list of practices to which they can apply. Where a person, who is entitled to free NHS treatment, has had their application to join a practice's list of patients refused, they can apply to the PCT, which has the power to allocate them to a GP

PCTs will also be able to provide information on local Community Dental Services and dentists in an area treating patients under the NHS. NHS Direct, provides information on local GPs and NHS dentists. You can also find out about services in your area (including PCT contact details) by going to: <http://www.nhs.uk/localnhsservices/default.asp>

Help with Health Costs

Under the Immigration and Asylum Act 1999 and the Asylum and Immigration Act 1996, most asylum seekers are not entitled to welfare benefits. However they may qualify for:

- Free NHS prescriptions;
- Free NHS dental treatment ;
- Free NHS wigs and fabric support ;
- Necessary travel costs to and from hospital for NHS treatment ;
- Free NHS sight tests ;
- The full value of an NHS optical voucher towards the cost of glasses or contact lenses.

The UK Border Agency will issue HC2 certificates to asylum seekers after they claim asylum and when they are being dispersed.

Asylum seekers not supported by UK Border Agency

Asylum seekers who are not supported by the UK Border Agency or those supported by the Interim Arrangements and who are not otherwise entitled to free prescriptions, will need to complete form HC1 (claim for help with health costs including prescriptions through the NHS Low Income Scheme (LIS)). Health practitioners who come into contact with asylum seekers should encourage them to apply. Failed asylum seekers can also apply.

Since the interim support arrangements were introduced on 6 December 1999, the Patient Services Division (PSD) (previously the Health Benefits Division) of the Prescription Pricing Authority (who run the LIS for the Department of Health) have made arrangements for claims from asylum seekers to be given priority. They have arranged for a separate postcode to be printed on white envelopes, which asylum seekers can use to send off their HC1 claim form.

HC1s are available from the PSD or in bulk from Department of Health, PO Box 777, London, SE1 6XN. Tel: 08701 555 4555 (Department of Health publications order line). Fax: 01623 724 524.

HC1 Completion Guidance Notes

This note contains guidance for case workers and health professionals who help asylum seekers to complete the HC1 form. Asylum seekers who have not received an HC2 certificate from UK Border Agency are eligible to apply for one using an HC1 form under the low-income scheme which is managed by Patient Services at the PPA. Failed asylum seekers are also able to apply for an HC2 certificate using an HC1 form.

Asylum seekers who have received an HC2 certificate should apply directly to UK Border Agency for a new certificate when their old one expires. There is no need to fill in a new HC1 form or to re-apply through Patient Services.

Fast Track System

A system operated by Patient Services is in place that speeds up the process for asylum seeker cases. This fast-track procedure should also be adopted and followed by Social Services:

1. Order bulk supplies of HC1 forms (claim for help with health costs) from Department of Health PO Box 777, London SE1 6XN, Tel: 08701 555 4555, Fax: 01623 724 524.
2. To enable applications from asylum seekers to be fast-tracked, white envelopes (as opposed to the supplied brown ones) need to be used. To obtain these contact Patient Services on their enquiry line, 0845 850 1166.
3. Once the HC1 has been completed and signed by the claimant, post it in the white envelope to Patient Services.

4. Once received, Patient Services give claims in white envelopes priority and aim to issue a reply within 5 days. In order for the appropriate level of support to be given and for the fast-track system to operate as intended, the HC1 form must be completed correctly. However, many assessments are delayed due to forms containing errors or being incomplete.

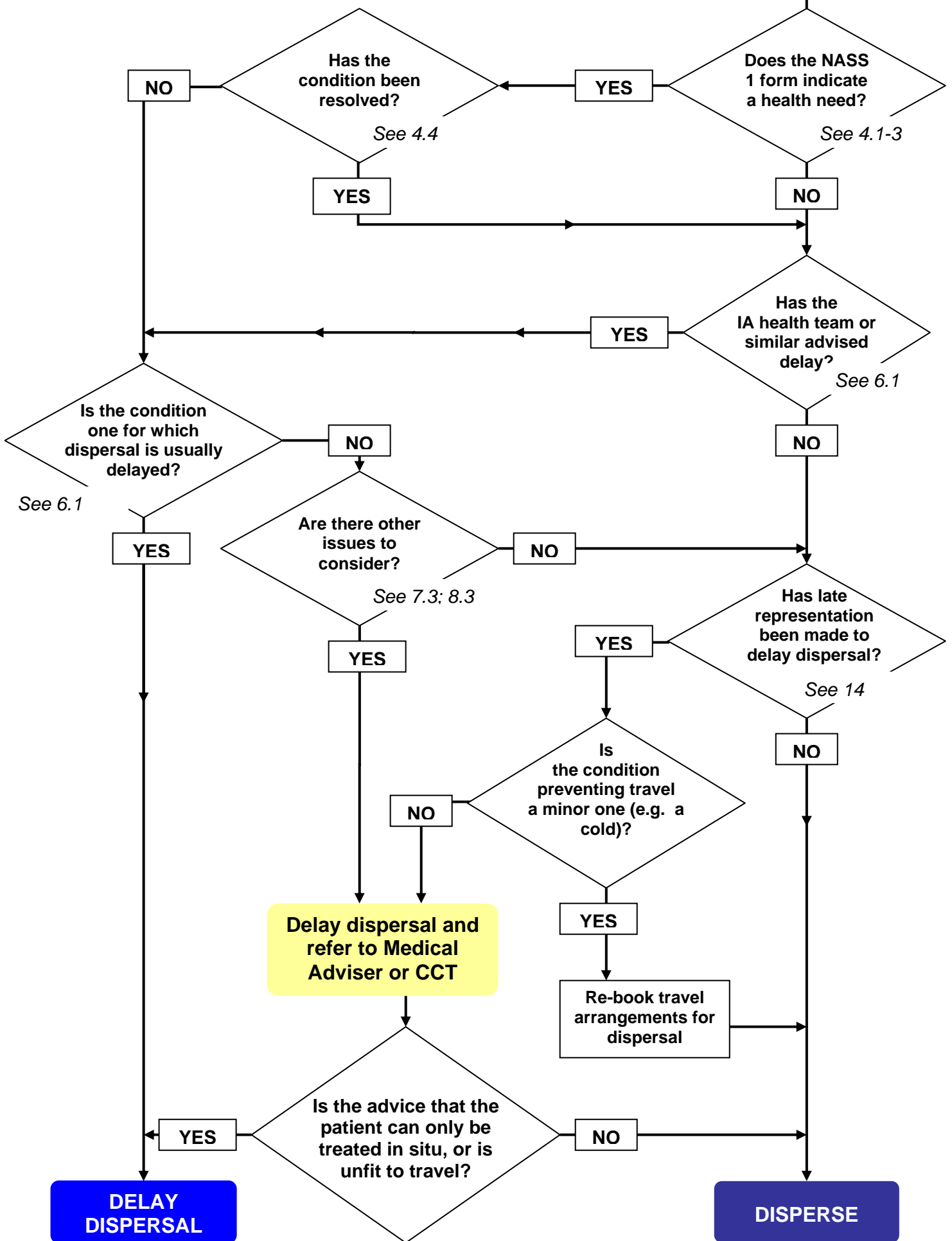
Common errors include:

- **Signatures** – Case workers often sign HC1s on behalf of their clients because the client cannot speak English. Patient Services is unable to accept HC1s signed by a third party, the claimant or partner must sign them or make their mark. The caseworker should ensure that this happens.
- **Income** – Often the amount of income that the applicant / their family receives is not specified on the HC1. Patient Services need to know this information, without it the HC1 will be returned as incomplete. Asylum Support should be recorded in section 5.2 “ Do you or your partner get any other income?”. Throughout the document the ‘no’ boxes should be ticked for which do not apply.

Where income is payable for a child, this is often paid under the Children’s Act. Income paid under sections 17, 23B 23C or 24A is fully disregarded in the assessment therefore if caseworkers could specify the act payments are made under, it will help their clients assessment.

- **Capital** – Although most asylum seekers are unlikely to have any capital or own any capital assets, the ‘no’ boxes must be ticked on the page covering property, savings and other money to indicate this.
- **Extended Families** – Under asylum laws, extended families are assessed and paid as one family unit. Low Income rules are different, assessments are made for traditional family units. Consequently it is not possible to include aunts, cousins or grandparents on a single assessment unless they are a minor for which the claimant and partner have responsibility. It is therefore necessary for separate applications to be submitted and for income details to be broken down accordingly.
- **Asylum seekers living in Hostels/Hotels** – Room numbers need to be added if the applicant lives in a hostel or hotel. In cases where asylum seekers are in temporary accommodation, it may be advisable to use Social Services’, voluntary agency or health centre addresses as large numbers of certificates are returned when asylum seekers move out.
- **Inconsistencies**– There have been cases where the asylum seeker states that they are supported by the UK Border Agency, but no record appears on the database. This may be due to a delay in the data being entered onto the database. However for some cases the spelling of the name on the HC1 is different to the spelling on the Asylum Support supplied database which is used by Patient Services. It is helpful if case workers, where possible, ensure that the spelling of names and order of names are consistent with the info which was given to the UK Border Agency.

START



HIV/AIDS

1. Although HIV remains incurable, treatment advances have now made it a medically manageable condition and life expectancy has dramatically improved in the UK. Rates of HIV transmission from pregnant women to their children have also fallen with appropriate intervention. Key factors underpinning these substantial gains are the long-term engagement by people who are HIV positive with specialist, confidential medical care, very high levels of adherence to drug therapy and an early HIV diagnosis. The long-term relationship that is built up between doctor and patient is important in HIV medicine and a crucial aspect of successful management. There is substantial evidence that clinical outcome is directly related to HIV expertise. Patients cared for in hospitals with substantial HIV knowledge consistently fare better than those cared for in units with less experience. Recommended standards for NHS HIV services (2003) aim to set out consistent standards for all as part of HIV service networks.
2. Interruption of antiretroviral drugs is a key determinant in both treatment failure and the development of long term drug resistant HIV. If doses are missed or supplies of medication run out, not only are the beneficial effects lost but there is a real threat that future treatment options will be jeopardised by the development of drug resistance. For some of the drugs used in HIV, missing as few as one or two doses can be a significant risk. Adherence – the ability of patients to take their medication exactly as prescribed – is highly emphasised in HIV care to maximise treatment benefits and reduce the risks of resistance. Disruption of daily routine has the potential to upset this crucial aspect of care.
3. The drugs have their own limitations – for maximum effectiveness some must be taken with meals, which requires a daily routine. Some require refrigeration if they are not to deteriorate. Side effects are common and may include for example diarrhoea and nausea, which make access to a bathroom particularly important.
4. People with HIV face a range of associated medical problems and co - infections including hepatitis. HIV infection leads to progressive weakening of the individual's ability to counteract an array of complex life threatening infectious and malignant conditions. Although treatment for many of these complications is available, it is often protracted and requires input from a variety of specialists, which may not be widely available.
5. Good HIV care needs to address the medical problems in their full social context. Many newly arrived people in the UK, have particularly complex problems, including a lack of familiarity with western biomedicine. There may be language difficulties and an array of cultural sensitivities that require additional support.
6. Appropriate medical care for HIV increasingly requires the input of other specialist skills outside but associated with HIV – for example liver experts to manage co - existing hepatitis B and C – which means that it may not just be HIV

care that is required. Care of HIV infected children is a particularly specialised branch of medicine, with limited facilities for family care outside the larger clinical centres.

7. Doctors and other staff have often worked long and hard with patients to establish the drug routine and individual support necessary. Unanticipated relocation may jeopardise this provision and also threaten the patient-doctor relationship.

8. To make the situation viable for both patients and service providers advance warning of the dispersal of complex patients with adequate time is required to ensure that appropriate services are in place (e.g specialist translation). Clinicians regularly transfer patients between centres and given proper information such as the address to which a person is going and adequate time, safe transfer of care can be organised.

ASYLUM SUPPORT REGIONAL HEALTH CONTACTS

Region	Name	Contact Details	Postal Address
North West	Ian Macqueen	Ian.Macqueen@homeoffice.gsi.gov.uk Tel:(0161) 261 1252 Fax:(0161) 261 1323 Mob: 07717 701547	PO Box 191, 4 th Floor Concorde Offices, 4M Building, Manchester Airport, M90 3WZ
Scotland	Colin Mitchell	Colin.Mitchell2@homeoffice.gsi.gov.uk Tel:(0141) 419 1321 Fax:(0141) 419 1329	c/o IS Scottish Enforcement Unit, Festival Court 3, 200 Brand Street, Glasgow, G51 1DH
East of England	Deidre Wright	Deidre.Wright@homeoffice.gsi.gov.uk Tel: (01733) 847 817 Fax: (01733) 847 800 Mob: 07881 832 725	3 rd Floor East, Stuart House, St John's Street, Peterborough, PE1 1QF
West Midlands	Gill Pallett	Gill.Pallett@homeoffice.gsi.gov.uk Tel:(0121) 345 8011 Fax:(0121) 345 8096 Mob: 0779 694 1207	Chadwick House, Blenheim Court, Warwick Road, Solihull, Birmingham, B91 2AA
Greater London	Nick Farey	Nick.Farey@homeoffice.gsi.gov.uk Tel:(0208) 633 0881 Fax:(0208) 633 0896 Mob:07799 343 324	1 st Floor Quest House, 11 Cross Road, Croydon, CR9 6EL
South East & Central England	Gillian Brear	Gillian.Brear2@homeoffice.gsi.gov.uk Tel: (01304) 873 124 Fax: (01304) 873 133 Mob: 07818 013 273	Units 4&6 Whitfield Court, White Cliffs Business Park, Honeywood Road, Whitfield, Dover, CT16 3PX
East Midlands	Simon Addison	Simon.Addison@homeoffice.gsi.gov.uk Tel:(01332) 638 615 Fax: (01332) 638 290 Mob: 07717 300 861	Regus House, Herald Way, Pegasus Business Park, Castle Donnington, Derbyshire, DE72 2TZ

North East	Graham Fryer Geoff Laws	Graham.Fryer@homeoffice.gsi.gov.uk Tel:(0191) 376 2858 Geoff.Laws3@homeoffice.gsi.gov.uk Tel: (0191) 376 2861	Link House, Melbourne Street, Newcastle-upon-Tyne, NE1 2 JQ
Yorkshire and Humberside	Kirstie Barr	Kirstie.Barr@homeoffice.gsi.gov.uk Tel:(0113) 341 2037 Fax:(0113 341 2171	Waterside House, Kirkstall Road, Leeds LS4 2QB
South West	Teresa Aston	Teresa.Aston@homeoffice.gsi.gov.uk Tel:(01275) 815 303 Mob: 07879 848 868	Unit 1, Greystoke Business Centre, High Street, Portishead. Bristol, BS20 6PY
Wales	Stuart Dandy	Stuart.Dandy@homeoffice.gsi.gov.uk Tel: (02920) 504 775/504 681 Fax: (02920) 504 211 Mob: 07769 886 383	Floor 2, Regus House, Falcon Drive, Cardiff, CF10 4RU
Northern Ireland	Michelle McPhillips	Michelle.Mcphillips@homeoffice.gsi.gov.uk Mob: 07867 638 884	Room 514, 5 th Floor, Brookmount Buildings, 42 Fountain Street, Belfast, BT1 2EE