

Health Needs Assessment of Migrant Workers in Devon

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1. Foreword

- 1.1 For the purposes of this report the term 'migrant workers' has been used to define what is a very heterogeneous group, which can be classified in many different ways. The definition in this report however is that agreed and adopted by the Devon Migrant Worker Task Group in their scoping report 2007³.
- 1.2 Nationally 82% of migrants¹ from the Accession 8 member states that joined the European Union in 2004 were said to be aged between 18 and 34 years and being young are seen to be unlikely to need significant levels of health care. Overall 85% of migrants, from European and non European countries are aged between 15 and 44 years and tend to have general health needs similar to individuals of equivalent age and sex as the indigenous United Kingdom population². Inward migration has the potential to be hugely beneficial to society. Migrant workers actively contribute to economic prosperity, they are often highly educated, and inward migration helps to balance the demographics.
- 1.3 Studies¹ have shown there are inequalities in health and health outcomes amongst migrant workers which need to be addressed. Health inequalities are linked to their ability or not to speak English, which then impacts on their employment opportunities and income levels. The relationship between poverty and poor health is well understood. Other factors that impact on health outcomes are linked to difficulties in understanding the process to access work and public services, the impact of racism, local prejudices and a lack of understanding within communities of different cultural norms.
- 1.4 There is national evidence to show that migrant workers often fail to register with primary care thus leading to poor immunisation and screening uptake rates. Migrant workers make more use of Accident and Emergency departments, experience more work related accidents (linked to poor or a lack of understanding of health and safety training⁶ or the employer failing to ensure migrant workers are trained in health and safety in the workplace and female migrant workers can present at maternity services later in their pregnancy. The prevalence of some mental health problems can be greater than the community as a whole. This is in part exacerbated by social isolation, racism, language barriers as well as lack of access to religious and cultural support.
- 1.5 Prejudices may include inappropriate concerns about the impact of migrant workers on the prevalence of some infectious diseases. A lack of suitable and secure accommodation can lead to overcrowding or homelessness. The impact of poor housing on health and wellbeing is also well understood and must be addressed.
- 1.6 Currently at both a national and a local level there is a lack of quantitative data to reliably inform strategic commissioners of the services that need to be put in place to improve health outcomes and reduce health inequalities. The need for better data has been recognised nationally and work is in place to address this. In the meantime the Devon Migrant Worker Task Group has the ability to encourage and support data sharing to enhance and influence commissioning decisions. Hospitals now record ethnicity and local general

practitioners under a Directly Enhanced Service have also agreed to code ethnicity.

- 1.7 The Community Development Worker team employed by Devon Primary Care Trust has a role as a bridge between black and minority ethnic communities and the health services. Part of their remit is to collate evidence of gaps in services and to make recommendations to commissioners of ways in which to improve services. Qualitative evidence is fed back to Patient Advice and Liaison Service and commissioners.
- 1.8 At a local level there are examples of good practice, for example a DVD in three languages on how to use and access emergency services, drop-in centres and a 'Welcome' pack including information on health. Community Development Workers have visited some English for Speakers of other Languages (ESOL) classes in North Devon to enhance knowledge on health and access to services, including providing information about local services and how to register. A series of workshops for migrant workers around themes including health, which explain how the system works in the United Kingdom, have also been delivered by a Community Development Worker. The 'Welcome' pack should include information on the role of the Patient Advisory Liaison services.
- 1.9 Commissioners on the other hand still lack adequate data to be able to satisfactorily assess the health needs of this specific community and assure themselves that any inequalities in access to health care are being addressed.
- 1.10 The recommendations in this report are based on the evidence of what works and I believe that the Devon Strategic Partnership is the appropriate multi-agency body to consider the recommendations contained within this report and performance manage the implementation of them through the work of the existing Devon Migrant Worker Task group.

2. Executive Summary

- 2.1 Whilst human migration has taken place for centuries there has been an increase in world wide mobility in recent decades. Migration has the potential to be hugely beneficial to society. Migrant workers actively contribute to economic prosperity, they are often highly educated, and inward migration helps to balance the demographics (migrants typically being young adults).
- 2.2 Overall 85% of migrants, from European and non-European countries are aged between 15 and 44 years and tend to have general health needs similar to individuals of equivalent age and sex as the indigenous United Kingdom population².
- 2.3 Migrant workers are a very heterogeneous group and can be classified in many different ways, for example by nationality, country of origin (which could be country of birth or country of last residence), ethnicity, language or religion. For the purposes of this report the term 'migrant worker' instead of 'economic migrant' will be used.

- 2.4 Characteristics of most migrant populations at a national level³ are that they are:
- generally young, at the younger end of the working age spectrum, with a high proportion of men – typical age 25-34 years⁶ (endorsed by local housing needs assessment report¹)
 - commonly have language difficulties and almost always a lack of cultural understanding about the UK
 - polarised in terms of educations and skills. Many may be well educated but because of language or non-recognition of qualifications are not allowed to work or work below their skills. Others are unskilled and the middle levels are not well represented.
- 2.5 The South West was one of the regions considered to be a high net migration area in 2006 and was in the top three areas in the UK for migrants from Poland, Lithuania and Slovakia in particular² but migration from these Eastern European A8 states has declined sharply during the second half of 2008.
- 2.6 At a local level a Devon Migrant Worker Task Group exists and has identified eleven objectives⁵ for their work, summarised in Appendix 5.
- 2.7 Section 7 of the report describes the inequalities in health that have been found in national studies and despite the lack of quantitative data locally there is no reason to believe that the same inequalities in health are also experienced locally. These include difficulties in accessing health services in particular primary care leading to inappropriate use of some secondary care services and poor access to some public health programmes. A higher prevalence than the community as a whole of some mental health problems exacerbated by racism, social isolation, language and cultural issues and a later presentation in maternal care which can impact on the health of the mother and child.
- 2.8 There is evidence of effective practice pertinent to but not exclusively researched for migrant workers (see Section 8) that should be implemented across Devon in a uniform way and audited as part of an agreed audit programme by providers and reported to commissioners (See Section 10). There are also examples of good practice locally that should be evaluated and if found to be effective should be supported on a long term basis.
- 2.9 The recommendations contained in section 11 have received support from those who have responded during the two week consultation phase. The recommendations cover interpretation issues, intelligence, access to services, training, protocols and evaluation. As a principle migrant workers should routinely be engaged and involved in taking forward the recommendations outlined in this report
- 2.10 The draft report has been widely circulated to a range of organisations and individuals for comment and amendments – see Section 13 acknowledgements.

¹ The Housing Needs of Migrant workers in Devon Involve – The Anglo-Polish Organisation of Tiverton April 2008

² Analysis of the latest data on migration trends May 2009 update Equality South West

- 2.11 The Devon Migrant Worker Task Group is well placed to take forward the recommendations and hold organisations to account (see Section 10). The Task Group may wish to review its membership to ensure it has the right skill mix to drive forward the recommendations. This is particularly pertinent for those concerning service reviews and to consider its reporting mechanism to the Devon Strategic Partnership given the remit of the Stronger Communities and Health Improvement Group.

3. Introduction

- 3.1 Whilst human migration has taken place for centuries there has been an increase in worldwide mobility in recent decades. Migration is considered one of the defining global issues of the early 21st century as more and more people are on the move today than at any other point in human history, given the ease of modern communications and the growing globalisation of trade and business.
- 3.2 Migration has the potential to be hugely beneficial to society. Migrants fill skills gaps in sectors ranging from agriculture, hospitality to science so migration is seen to be a positive, essential and inevitable component of the economic and social life of every country.
- 3.3 Migrant workers actively contribute to economic prosperity, they are often highly educated, and inward migration helps to balance the demographics. The majority of migrants are young, fit, considered to be healthy, have no dependants and have come here to work or study. Some though do have a greater susceptibility to certain problems and disease than the rest of the population, i.e. some migrant workers can be quite poorly paid and at a greater risk to high accident rates and injuries from lifting and handling. The prevalence of certain mental health problems is higher than in the community as a whole. In the work environment some migrant workers complain of physical attacks verbal and abuse and regular abuse can lead to mental health problems.
- 3.4 There are felt to be some negative impacts on health services due to migration, in relation to greater use of Accident and Emergency services instead of general practice and increased use of maternity services, often late making planning difficult. There is also an increased demand for mental health services for those migrants who have experienced abuse, social isolation and discrimination.

4. Background / Context

Purpose of a HNA

- 4.1 The National Institute for Health and Clinical Excellence (NICE) describes a health needs assessment as a systematic method for reviewing the health needs of a particular population leading to agreed priorities and resource allocation which will lead to improved health, improved access to healthcare and reduced health inequalities. This report will focus on the health needs of migrant workers.
- 4.2 The objective of this health needs assessment is to:
- raise the profile of the health needs and current health inequalities of migrant workers in order to inform and influence commissioners
 - describe what is currently understood about the health needs of this client group
 - determine what the gaps in information are and make recommendations to improve local understanding of health needs
 - to make recommendations to improve health and access to health care for migrant workers.

Definition

- 4.3 Migrant workers are a very heterogeneous group and can be classified in many different ways, for example by nationality, country of origin (which could be country or birth or country of last residence), ethnicity, language or religion. An important further classification is the legal status of the migrant as this can affect their right to access health care in the United Kingdom. National classifications of 'migrants' can include asylum seeker, refugee, refused asylum seeker, migrants from Europe (especially the new EU accession states; the Accession 8), migrants from outside Europe (the highly skilled migrant programme), students and others due to marriage, family or short term visitors³. Figure 1 below summarises current United National migrant definitions.

Figure 1: UN Migrant Definitions⁴

Students: a large group which includes people of any age moving to another country for the purpose of full time study.

Economic migrants: people leaving their usual place of residence to improve their quality of life. This may include long-term migrants or short-term seasonal workers.

Frontier worker are migrants who retain their usual country of residence but work in a neighbouring state returning daily or weekly.

³ New Arrivals in North East England: mapping migrant health and NHS delivery. North East Public Health Observatory June 2008.

⁴ Migrant Health infectious diseases in non UK born populations in England, Wales and Northern Island a baseline report Health Protection agency 2006

Asylum seekers: people with a fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinions, who enter a country and claim asylum under the 1951 Geneva Convention. Once the fear has been proven to be well founded, the claimant is granted refugee status.

Irregular migrants (or undocumented or clandestine): migrants without legal status owing to illegal entry or the expiry of their visa.

Displaced persons: people fleeing an armed conflict or escaping natural or man-made disasters or their effects. This term primarily covers persons displaced within the borders of their country of origin (i.e. internally displaced persons) who would not come under the 1951 Geneva Convention.

Source: Nygren-Krug, H (Ed). International Migration, Health & Human Rights. 2003. http://www.who.int/hhr/activities/en/intl_migration_hhr.pdf

- 4.4 The Devon Migrant Worker Task Group in their scoping report⁵ agreed to a different definition and incorporated their definition in their terms of reference: Their definition is as follows:
- 4.5 *“Migrant workers can be defined as those who travel to another country for the primary purpose of seeking or carrying out work and usually with the intention of returning to their country of origin. The term ‘migrant workers’ therefore refers to international migrant workers – people who come to Britain from another country including Europe, who come primarily to earn a living (whether this is through a legal or illegal / exploited arrangement) rather than to seek asylum, and therefore people who are ‘economic’ migrants”.*
- 4.6 For the purposes of this report the term ‘migrant worker’ rather than ‘economic migrant’ will be used throughout.

National Policies

- 4.7 The challenges and benefits of migration are highlighted in recent reports published in June 2008⁶ and March 2009⁷ respectively. New migrants to the United Kingdom (UK) over the past five years are now estimated to make up around 3% of the total UK population, whereas approximately 7% of the UK population are born abroad, this equates to 57,654 people in Devon. Poland has taken over from India as the most common non-British country of citizenship for migrants entering the UK⁸ and this is reflected in local figures for Devon albeit the changing economic climate is seeing a downward trend in new migrant arrivals from some countries.
- 4.8 Nationally 82% of migrants from the new European member states i.e. the 2004 Accession Eight (A8) are said to be aged 18 to 34 years and being young are seen to be unlikely to need significant levels of healthcare⁶. The

⁵ Migrant workers scoping the issues for Devon Community Council Devon April 2007

⁶ Managing the impacts of migration: a cross government approach Communities and Local Government June 2008

⁷ Managing the impacts of migration: improvements and innovations Communities and local government March 2009

⁸ Safety and migrant workers a practical guide for safety representatives, 1 in 5 a fair deal for vulnerable workers TUC June 2007

Accession 8 countries include: Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovak Republic, and Slovenia plus Malta and Cyprus (not Accession 8 countries) and in 2007 two more A8 countries were added i.e. Bulgaria and Romania.

- 4.9 British citizens emigrating abroad tend to be older than immigrants so the overall pattern of migration has a positive effect on the proportion of people in the UK who are in work and paying taxes. Since 1998 migration at a national level has been the principle component of population change overtaking natural change through births and deaths⁹.
- 4.10 The Government has recognised the need for better data to assist national and local planners to understand change and plan for the needs of migrant workers in the future. The Office of National Statistics (ONS) is currently undertaking a major programme of work to further improve population and migration estimates and projections; see **Figure 2** below.

Figure 2: Improving Data Collection on Population Estimates⁶

A comprehensive cross-government programme of work led by the Office of National Statistics is underway to improve population and migration statistics, including those at the local level. The programme involves:

- improvements to surveys
- better data sharing
- the use of a range of administrative data sources
- the development of local indicators.

- 4.11 The general issues facing migrants / new arrivals nationally³ can be summarised as:
- interpretation and translation – without good services migrants find public services such as the NHS hard to access and hard to use. Locally ‘Multilingua’ interpreters are reporting that some General Practitioners are unwilling or unable to supply an interpreter even when the patient requests them. Some do not get the service or help they require because they cannot speak the language. It has been said that those migrant workers who do not speak English avoid going to the doctor until their health problems become acute. This not only impacts on the health outcome of the migrant workers but also on the overall costs of health care
 - housing – many migrants have difficulty finding adequate and secure housing and some migrant workers are poorly housed in over crowded accommodation sometimes in temporary structures on the work site itself (agricultural workers)

⁹ Estimating the scale and impacts of migration at the local level Institute of Community Cohesion Local Government Association November 2007

- legal support can be an issue for Migrant Workers e.g. issues around a lack of resource to public funds for non-registered migrants or migrant workers from Accession 8 countries who have not been working in the United Kingdom for 12 months. The lack of resources can prevent them from receiving appropriate residential mental health services, housing, benefits etc which can lead to poverty, homelessness and poorer health outcomes.
- discrimination and abuse - racial harassment and prejudice are often the top issues Community Safety Partnerships are tackling nationally and this is mirrored locally. In Devon there is Local Area Agreement (LAA 35 re prejudice and hate crime) in place and whilst racist offences have decreased yearly in number and proportion (from a reporting point of view), racist offences (mostly harassment) are still the highest offences in hate crime. Furthermore such a trend is not necessarily concrete evidence of a decrease in the number of racist incidence but may be indicative of low levels of trust and confidence often fuelled by previous negative contact with such statutory agencies and a subsequent reluctance to report incidents. When victims do not get the support they need they may not be bothered the next time to report as the reporting procedure is very time confusing especially when it does not lead anywhere. The victims, mainly men (60% men) fall in the 35 to 44 year age group and the ethnicity of victims are mostly African-Caribbean, followed by white European and then Asian, with all offenders classified as white European. Reports of racist incidents in Devon County Council primary and secondary schools are also prepared but most victims do not disclose their nationality. However, where they do disclose their nationality, most are European followed by African
- education and skills – language, cultural awareness and health and safety in the workplace can all represent local challenges
- income and poverty - many migrants are living on or below the poverty line with direct and negative impacts on health. They can suffer from poor nutrition, respiratory problems, skin problems and other health issues associated with poor housing and overcrowding. They can experience greater susceptibility to certain problems such as a greater risk to high accident rates and injuries from lifting and handling⁸ plus higher rates of certain diseases than the rest of the population. Some migrant workers on top of being quite poorly paid can be further penalised by their employers taking large cuts from their pay for accommodation and other benefits. Some employers make use of the migrant workers but do not provide them the services they would provide for English counterparts. Migrant workers can be unable and unwilling to make a complaint for fear of losing their jobs
- employment, including employment in the NHS. Migrant workers contribute to economic prosperity and are often highly educated. Inward migration helps to balance the demographics (migrants typically being young adults) but they can also be quite poorly rewarded. Migrants who are fluent in English tend to be able to earn more.²³ The NHS as a major employer creates demand for workers at all levels from very low skilled to the highest skill levels⁶. The NHS benefits from the provision of qualified staff at low cost outlay and graduates increase the diversity of

the population. An ethnic profile for Devon Primary Care trust is given later in this report in Section 6.

- 4.12 National evidence suggests that public services would struggle without the contribution of migrant workers who fill gaps in sectors such as care work. In health care nationally 17% and in social care nationally 18% of workers⁶ are from overseas.
- 4.13 There are felt to be some negative impacts on national health services due to migration, for example greater use of Accident and Emergency Departments instead of general practitioners (GPs) working in primary care because anecdotally some migrants fail to register or are turned away from services by front-line staff who do not understand the eligibility criteria. Community Development Workers locally have been informed of incidences whereby front-line staff asked migrant workers for 6 months worth of pay-slips to prove their eligibility to health-care despite there being no requirement for migrant workers to be working to receive NHS services.
- 4.14 There is said to be an increased use of maternity services, often with a late booking making care planning more difficult. This can increase costs on the NHS as well as being bad for public health⁶. There is also an increased demand for mental health services for those migrants who have experienced abuse, social isolation and discrimination (Recommendation).

Recommendations

- 4.15 To review the process currently used by migrant workers when registering with a GP practice with the aim to improve access to primary care services. To make recommendations to address any issues pertinent to access to interpreters, the opening times of surgeries and the time to travel from rural employment. To develop if necessary a protocol to improve the registration process and ensure this is adopted across all GP practices in Devon.
- 4.16 To review current maternity services provision across Devon with the aim to ensure that there is a proactive outreach service available that targets high risk women. To routinely monitor access by ethnicity. To undertake a joint strategic needs assessment around health inequalities in maternal health and infant mortality.
- 4.17 To review access to mental health services, including drugs and alcohol services, in the community, primary and secondary care with the aim to ensure timely access that meets ethnic needs and addresses cultural and language needs

Legislative Framework

- 4.18 The United Kingdom Border Agency (UKBA) provides information for persons seeking to enter or remain in the UK for employment purposes. It also provides regular updates on the national shortage occupational list for work permits and is the agency with the responsibility to crack down on the illegal jobs that lure illegal immigrants to come to the UK.

- 4.19 In accordance with European Union (EU) regulations¹⁰, European Economic Area (EEA) nationals are free to live in any European Economic Area country, and are able to enter the UK to visit and seek employment without work permits. The workers registration scheme introduced in 2004 picks up residents from the Accession 8 states already listed, plus two more countries added in 2007 Bulgaria and Romania. The Workers Registration Scheme is closely work related and should effectively be a sub set of National Insurance number registrations (NINOs). People from Bulgaria and Romania do not have the right to work and are required to apply for an Accession Workers card or enter under the Seasonal Agricultural Workers Scheme (SAWS).
- 4.20 Migrant workers with an entitlement to work in the UK have the same rights and protection⁶ as workers as the existing population. Migrant workers from Accession 8 countries have limited access to benefits until they have worked in the UK for at least 12 months continuously. General practitioners who do not fully understand eligibility criteria may be putting unnecessary barriers for migrant workers to access primary health care thus diverting them inappropriately to secondary care.
- 4.21 Legislation governing immigration from outside the EEA has recently undergone extensive revision and in 2008 the Government launched the phased introduction of an Australian style points based system (PBS)¹⁰. Under this new system migrants are required to pass a point's based assessment before they are given permission to enter or remain in the UK.

Regional Strategies

- 4.22 The South West was one of the regions considered to be a high net migration area in 2006 and was in the top three areas in the UK for migrants from Poland, Lithuania and Slovakia in particular¹¹ but migration from these Eastern European Accession 8 states has declined sharply during the second half of 2008. According to worker registration scheme figures inflows of Accession 8 migrants have fallen between 2007 and 2008 in all county and unitary authority areas although there is some variation in the level of decline. Work permit approvals for non Eastern European Accession migrants plus Bulgarians and Romanians increased in the south west between 2007 and 2008 but this might reflect the urgency of employers to avoid recourse to the points based system that came in during 2008. Just over 50% of points based sponsors are located in hospitality and catering, care, health and education.
- 4.23 Local research⁵ into migrant workers found that in Cornwall 74% of employers surveyed felt that there would be a negative impact on their business if they could not employ migrant staff. Anecdotal evidence suggests some businesses are largely dependant on the contribution of migrant labour.
- 4.24 A recommendation from a report currently out for consultation produced by the south west Regional assembly scrutiny panel¹⁰ is that the South West Observatory should co-ordinate a region wide approach to capture, analyse and share data and intelligence on migrant workers. Other recommendations include better access for migrants to English language training (migrants who speak good English are able to get better paid work), encouraging employers

¹⁰ Migrant Workers in the South West – final report and recommendations of the regional scrutiny and review panel South West Regional Assembly Scrutiny March 2009

¹¹ Analysis of the latest data on migration trends May 2009 update Equality South West

to progress migrants workers into vacancies commensurate with their skills, promote the integration of action to address the needs of migrant workers into local area agreements all of which should have a positive impact on migrants health.

4.25 Equality South West (ESW) is a registered charity and England's first regional equality and diversity body. It is supported by the South West Regional Development Agency, the Government Office for the South West, the South West Regional Assembly, South West Forum and the South West Trade Union Congress. The aim of the charity is to tackle discrimination on the grounds of age, disability, gender, race, religion or belief, sexual orientation and transgender. They support the dedicated regional networks for each of these seven strands and work with other groups including migrant workers. The Equality South West Migrants workers project, funded by the South West Regional Development Agency for two years, has been running for six months. The project has four main objectives:

- a better understanding of the trends in migration and the impact and implications this has for the sustainability of businesses in the region
- better skills training provision for migrant workers
- employers are equipped for the task of employing migrant workers and are using best practice
- a better co-ordinated public sector response to the issue at a regional level.

To date the work has included the development of a regional action plan, input into a regional scrutiny review, on-going research, and support to networks and staging of events¹².

Local Strategies

4.26 In April 2007 the Community Council for Devon produced a scoping report⁵ on the issues facing migrant workers in Devon. The report attempted to understand the numbers involved, describe examples of good practice locally and across the region as well as the benefits and challenges facing migrant workers and employers locally.

4.27 A Devon Migrant Worker Task Group exists and its terms of reference and membership are listed in Appendix 4. The group has identified eleven objectives⁵ for their work which are summarised below and detailed in their project plan and map of current initiatives attached as Appendix 5a & 5b.

- **Strategic Leadership.** Strategic leadership and championing of the issue of Migrant workers by the Devon Strategic Partnership (DSP).
- **Participation.** Empowerment and support to Migrant workers to enable ongoing engagement in project plan.

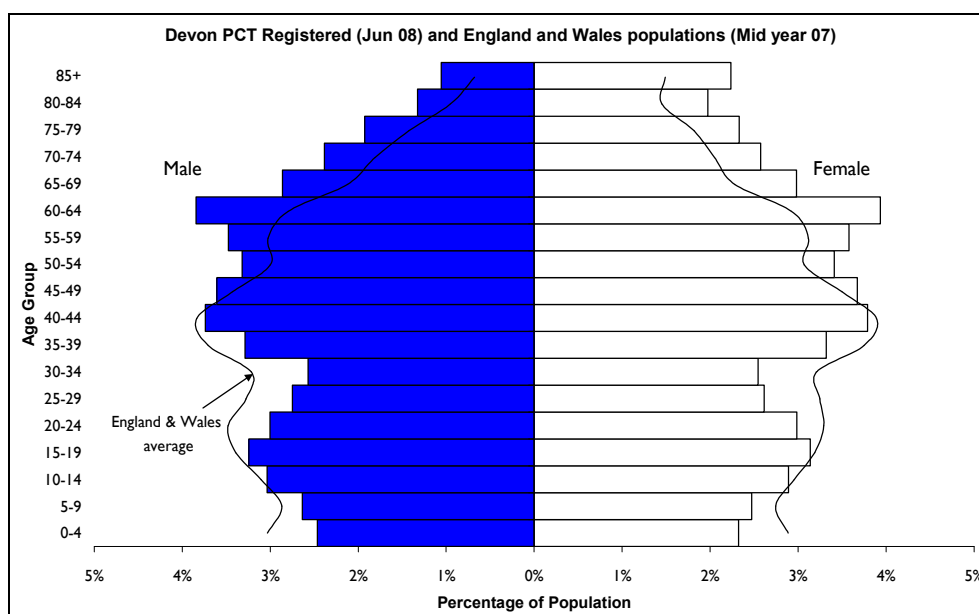
¹² Equality South West Newsletter Issue 9 , Equality South West Stronger Together December 2008

- **Evidence Base.** Improved data and information on the issue of Migrant workers
 - **A Welcoming Devon.** Develop a 'Welcome pack' for migrant workers in a variety of languages which covers basic information on rights and services
 - **Myth Busting.** Develop a 'fact and myth buster guide' in A4 form on migrant workers
 - **Community Cohesion.** Development of a programme of community 'Welcome events' designed to: a. provide advice and information to Migrant workers, b. bring together Migrant workers and 'settled' population
 - **Capacity Building.** Development of a Migrant Worker Network
 - **Compliance (Public sector).** Evidence of "compliance" with Race Equality duties
 - **Compliance (Private sector).** Evidence of "compliance" in housing and employment.
- 4.28 Examples of cross boundary good practice include the development and launch of a DVD providing advice to migrant workers on accessing emergency services. Devon and Cornwall police, working alongside Cornwall Fire and Rescue Service, the South West Ambulance Trust and Amber initiatives (a migrant worker organisation) worked collaboratively to produce the information in three languages English, Russian and Polish. A 'Welcome' pack with a section on health is also available and further work in six languages is in hand.
- 4.29 The Community Development Worker team employed by Devon Primary Care Trust have a role as a bridge between Black and Minority Ethnic communities and the health services. Part of their remit is to collate evidence of gaps in services and to make recommendations to commissioners of ways in which to improve services. Qualitative evidence is fed back to Patient Advice and Liaison Service and commissioners. Community Development Workers have helped to develop community support groups across Devon: e.g. Polonica, a Polish community group; Spectrum, a group for mixed heritage families; International Women's Group; International Ilfracombe, and Bideford Bay mutual support groups for bilingual families.

5. Demography & Population Projections

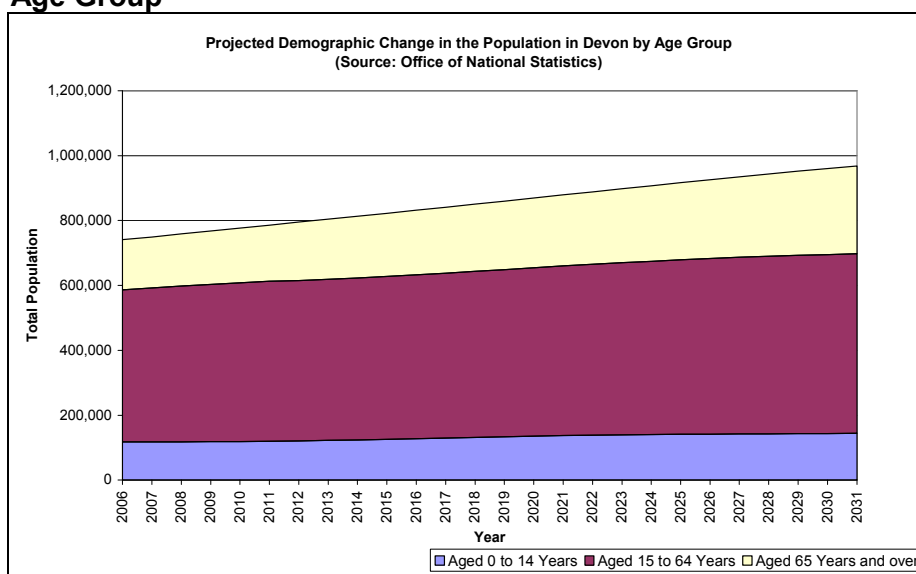
- 5.1 The GP registered population of Devon Primary Care Trust totalled 755,601 as of 30th June 2008 of which 386,043 were female and 369,558 were male. A graphical representation (population pyramid) further breaking the population down by sex and age band is shown in Figure 3 along with a second graph, Figure 4, showing population projections up until 2029.

Figure 3: Devon Primary Care Trust Registered (Jun 08) and England and Wales Populations (Mid year 07)



Population Projections

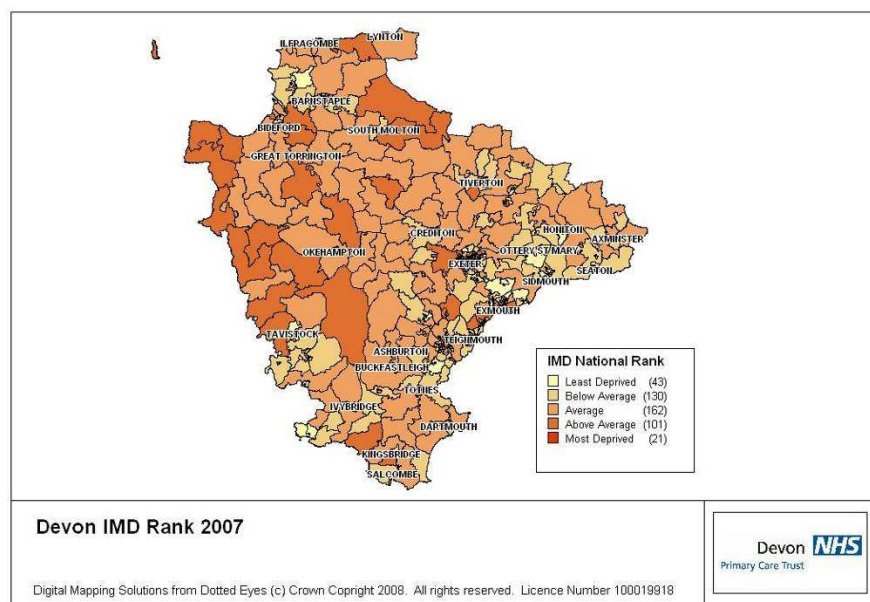
Figure 4: Projected Demographic Change in the population in Devon by Age Group



- 5.2 Projections for the population change across Devon between 2006 and 2031 suggest that the overall population will increase from 741,000 to 967,900. The 0 to 14 years and 15 to 64 years age groups are forecast to increase by around 20% with larger increases, of 75% and 85%, being anticipated in the over 65 and 75 population. By 2031 forecasts suggest that there will be 270,500 people over the age of 65 years and 146,600 over the age of 75 years.
- 5.3 There is a low ethnic mix, with the latest figures for Devon indicating 97.4% of the population are white, the majority British with only 2.7% of those being from other white groups. The proportion of people from Mixed, Asian, Black, Chinese or other ethnic grouping is very low.

- 5.4 Variations in the levels of multiple deprivation, by lower super-output area in Devon are shown below. The most deprived areas can be found in parts of Exeter and North Devon.

Figure 5: Map Showing Indicators of Multiple Deprivation in Devon



- 5.5 Growth in migrant workers has been affected by the changing size of the European Union (EU). New and additional migrants from European Union, who have the right to reside and work in other European Union states were expanded in 2004 when the Accession 8 states were added. Malta and Cyprus also came on board in 2004 but are not part of the Accession 8. In 2007 two more countries, Bulgaria and Romania, were added to the European Union. Work areas have included agriculture, hotel and catering and health and social care. Inward migration from some countries has started to decline during 2007 partly due to the economic downturn.
- 5.6 Whereas nationally there is much discussion about the inadequacy of information on migrants to assess accurately current needs, there are data sources that can help build up a reasonable picture of local needs. Sources include:
- 2001 UK census
 - national insurance numbers (NINO) issued – good for estimating economic migrants
 - worker registration scheme for Accession 8 migrants only plus Bulgaria and Romania including data collected under the Seasonal Agricultural Scheme (SAWS). Accession 8 workers frequently work as: factory

workers, warehouse operatives, packers or kitchen and catering assistants¹³

- higher Education Statistics Agency (HESA) conducted a count of students whose country of usual residence is outside the UK. Counts the student but not the dependent
- pupil level annual school census (PLASC)
- 1st GP registration of new arrivals - NHS central (GP) register Flag 4; i.e. a person registering with a GP whose previous address is outside the UK can potentially count the number of migrants but weakness is that not all migrants register and other leave the area without informing the practice
- death registration (country of birth is recorded)
- birth registration (origin of mother is recorded)
- electoral registers (ER) record nationality as EU citizen can vote in local elections
- labour Force Survey (LFS)
- UK Border Agency (UKBA) where the asylum seeker is being supported by the agency. Primary Care Trusts are given the information where they are in a dispersal area
- health Protection agency hold information on new arrivals notified through Port Health screening - in particular TB
- local data housing needs assessment.

5.7 Despite the difficulty in obtaining definitive statistics, available statistics had indicated an increasing number of economic migrant workers in Devon, the rate of increase had been accelerating since 2001/02 and was estimated in 2005/06 as 5960, an increase of 50% on the previous year. More recent data¹⁴ suggests that migration from the Accession 8 states to the south west has declined sharply across the south west during the second half of 2008. Workers registration scheme incoming migration figures from July to September 2008 was almost 50% lower than the same period in 2007, whilst the figures for October to December were 35% lower than the final quarter of the previous year, again across the south west as a whole.

5.8 Work permits from non European Economic Area, plus Bulgaria and Romanians increased from 4825 to 5360 across the south west between 2007 and 2008, with significant increases in work permit approvals in 2008 in health and medical services particularly among senior carers, food processing, entertainment and leisure services. Seasonal agricultural workers scheme (SAWs) declined by 2.5% from 2007 to 2008. Migrant workers are

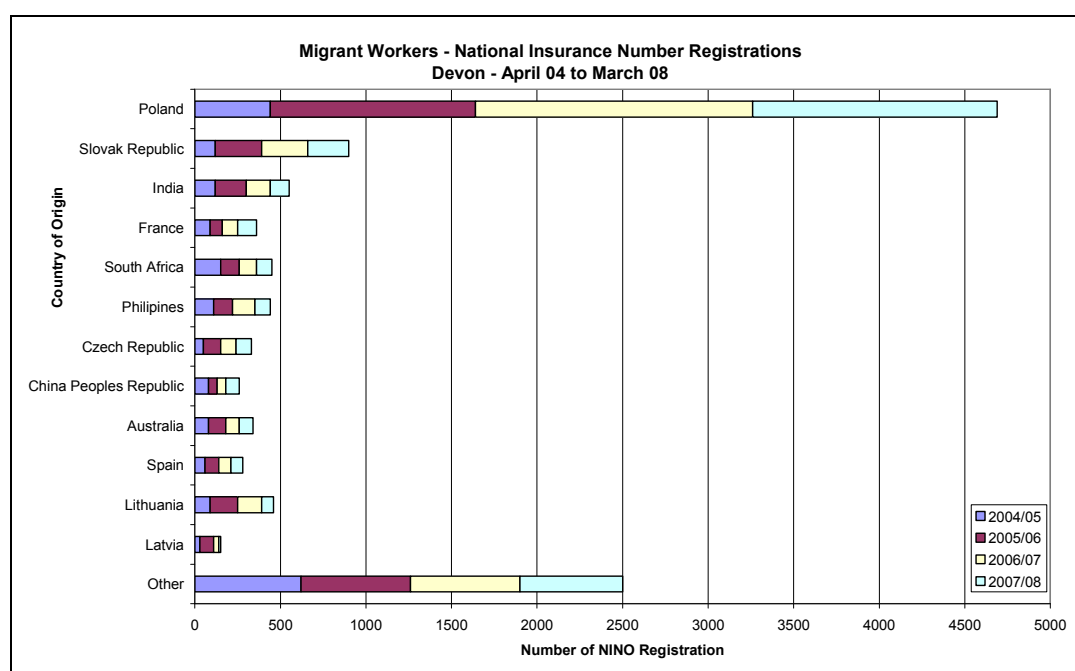
¹³ Migrant workers from the EU Accession countries – a demographic overview of those living and working in England and Wales and a comparison of infectious disease and immunisation rates in the Accession countries with those in the UK Health Protection Agency December 2008

¹⁴ Analysis of the latest data on migration trends – May 2009 update Equality South West

often transitory especially when working in rural areas or areas where there is seasonal employment (tourist industry)

- 5.9 273 employers in the south west registered as sponsors under the point based system (PBS and just over 50% of PBS sponsors are located in hospitality, catering care health and education. The highest concentrations of PBS sponsors are in Bristol, Gloucestershire and Swindon.
- 5.10 A National Insurance number is a unique number used to record a person's National Insurance contributions and to claim social security benefits. People entering the United Kingdom (UK) to work have to apply for a National Insurance number through the local Jobcentre Plus office, Jobcentre or social security office.

Figure 6: Migrant workers National Insurance Registrations Devon April 2004 to March 2006

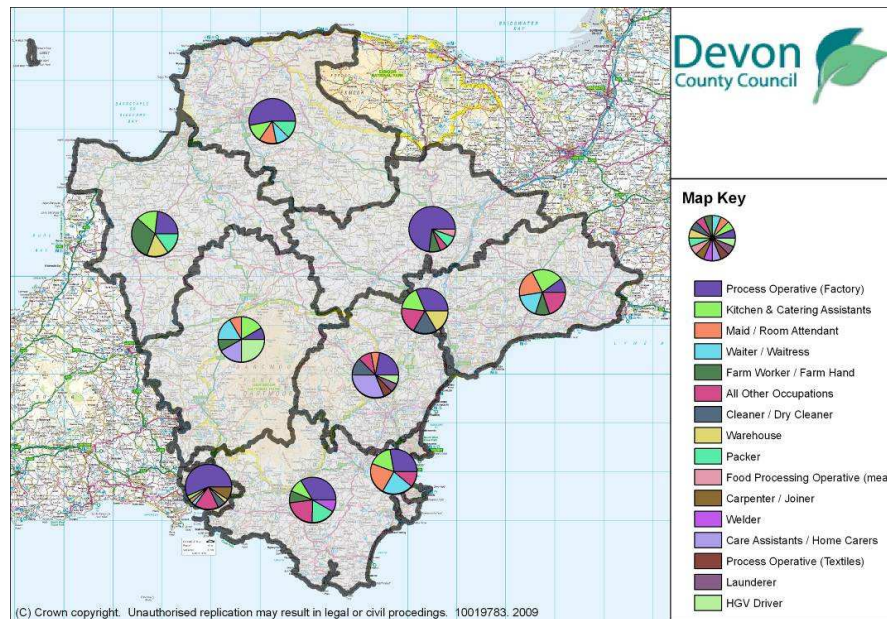


- 5.11 The largest numbers of National Insurance Number (NINO) registrations were from people from Poland. There are limitations on most data sets including the national insurance registration number because it does not capture those who do not convert a temporary National Insurance Number to a permanent one, allow for delays in registering or for those who return home .
- 5.12 The Workers Registration Scheme introduced in 2004 applies to applicants from the Accession 8 countries. These are the eight new countries that joined the European Union on 1st May 2004. Migrant Workers from the Accession 8 countries have the right to work but have to register with the Home Office under the Worker Registration Scheme (WRS), within one month of employment. People from Bulgaria and Romania do not have the automatic right to work in the UK but can register under the Worker Registration Scheme or the Seasonal Agricultural Workers scheme. Worker Registration Scheme registrations in Devon have dropped from a total of 2075 in 2007 to 1270 in 2008. There are limitations once again in these figures because the data only measures inflows of migrants not outflows. Some workers are

exempt from registration including those who are self employed and the data does not pick up inflows of migrants to the county where the worker has already registered in another part of the United Kingdom.

- 5.13 Figure 7 below provides a graphic presentation of the main employment sectors for migrant workers in Devon and the author of this report is indebted to Devon County Council for the use of this map

Figure 7: Main Employment sectors for Migrant Workers in Devon (Devon County Council)



- 5.14 Other data sources include the proportion of children attending school whose first language is not English. The proportion of pupils in Local Authority Maintained Schools whose first language is not English is as follows:

Primary 2.8% Secondary 2.7% Special 1.6%
Source: DCSF School Census 15/1/09

- 5.15 A 2002 survey identified that there were over 40 different languages spoken by pupils in Devon Schools. One of the features of Devon is the isolated bi-lingual learner i.e. a single child may be the only representative of a particular language or ethnic background in a class or school. Families themselves represent a wide range of backgrounds and circumstances including:

- hotel & catering businesses
- university students
- hospital staff
- various company employees
- refugees and asylum seekers

- 5.16 Many families live in Exeter, however, a large number are scattered throughout the county, primarily in rural areas. Devon County Council produces a leaflet¹⁵ for parents of children with English as an additional language on the additional language services.
- 5.17 The number of courses run on English for speakers of other languages (ESOL) varies according to demand and there does not appear to be one central department who collates the information on the number of courses run across Devon over a given period. As with many data sources there are limitations which make accurate estimates of the number of migrant workers at any one time difficult to accurately define.
- 5.18 The Community Development Worker team employed by Devon Primary Care Trust have a role as a bridge between Black and Minority Ethnic communities and the health services. Part of their remit is to collate evidence of gaps in services and to make recommendations to commissioners of ways in which to improve services. Qualitative evidence is fed back to the Patient Advice and Liaison Service and commissioners.
- 5.19 The English@Work in Devon project launched in 2008 aims to ensure that migrant workers work safely and are able to communicate in basic English thereby boosting the impact migrant workers can make to the economy. The project has been funded by Devon Renaissance, the Learning and Skills Council and the European Social Fund. The project offers subsidised training within the workplace for groups of workers or can provide access to a DVD based independent learning project for smaller numbers. The 20 hour course covers topics in basic language skills and communication at work.
- 5.20 There are around 2,000 international students from over 100 different countries studying with Exeter University alone apart from students from other universities or colleges of further education whose studies might involve a placement in Devon. International students may also reside with their families. The schools and general practices surrounding the University like Stoke Hill and St Sidwells and Mount Pleasant Health Centre include overseas families.
- 5.21 The Safeguarding Children Board for Devon does not hold data on children of migrant workers but an officer is currently working on an improved data set for children. It is not clear if the Safeguarding Board for Adults monitors vulnerability amongst migrant workers but local hate crime statistics would suggest racism is the largest category of hate crime and largest contributor to prejudice based on race. See Section 4 paragraph 4.11.
- 5.22 Local Authorities have a responsibility to provide housing and benefits. Some migrant workers from the Accession 8 countries have limited access to benefits and cannot usually claim benefits unless they are registered in the country and residence and have worked continuously for at least 12 months in the United Kingdom.
- 5.23 Information on the changing profiles of migrant workers form part of the responsibility of organisational Equality and Diversity leads within the National Health Service (NHS) local organisations. Workforce reports are published and reported to respective boards. Devon Primary Care Trust provides a

¹⁵ Welcome to the Devon English as an Additional Language Service (EAL), Information for Parents of Children with English as an Additional Language, Devon County Council

breakdown of major ethnic categories in terms of new staff, current staff and leavers and this is summarised in figures 8, 9 and 10 below;

Figure 8: Starters & Leavers by Ethnicity Information taken from Devon PCT Workforce Diversity annual Report 1st April 2008 – 31st March 2009

Ethnic Origin	Starters						Leavers					
	Quarter 4 08/09			Variation Q4 – Q1			Quarter 4 08/09			Variation Q4 – Q1		
	Head count	FTE	Head count %	Head count	FTE	Head count %	Head count	FTE	Head count %	Head count	FTE	Head count %
White / British	144	62.6	80.9%	-44	-28.56	5.09%	107	62.75	86.99%	-199	-11.78	10.45%
European	0	0	0	-3	-1.12	-0.1%	2	1.80	1.62%	0	0.80	1.12%
BME & Irish	7	4.3	3.93%	-5	-2.21	-2.02%	5	3.50	4.06%	-1	1.6	1.42%
Not Disclosed	19	7.35	10.67%	-1	-0.24	0.87%	9	6.03	7.32%	-67	-1.09	-11.97%
Undefined	8	2.29	4.49%	-15	-2.30	-3.04%	0	0	0%	-4	-1.48	-1.02%

Figure 9: Devon PCT by Ethnicity - Information taken from Devon PCT Workforce Diversity annual Report 1st April 2008 – 31st March 2009

Employees	Quarter 1 08/09			Quarter 4 08/09			Variation Quarter 1 to Quarter 4		
Ethnic Origin	Head count	FTE	Head count %	Head count	FTE	Head count %	Head count	FTE	Head Count %
White/ British	3221	2375.76	87.39%	3427	2483.16	86.61%	206	107.4	-0.78%
BME & Irish	41	33.57	1.11%	47	39.81	1.21%	6	6.24	0.10%
European	59	44.18	1.60%	62	46.07	1.58%	3	1.89	-0.02%
Undefined	46	35	1.25%	79	51.85	2.01%	33	16.85	0.76%
Not Stated	319	233.27	8.65%	342	258.08	8.64%	23	24.81	-0.01%

Figure 10: Recruitment by Ethnic Origin - Information taken from Devon PCT Workforce Diversity annual Report 1st April 2008 – 31st March 2009

Employees	Quarter 1 08/09			Quarter 4 08/09			Variation Quarter 1 to Quarter 4		
Ethnic Origin	Applications	Shortlisted	Appointed	Applications	Shortlisted	Appointed	Applications	Shortlisted	Appointed
White/ British	73.2%	84.5%	94.3%	80.2%	86.4%	90.2%	7.0%	1.9%	-4.1%
BME & Irish	20.5%	10.3%	2.4%	13.7%	9.1%	4.8%	-6.8%	-1.2%	2.4%
European	5.5%	4.4%	2.9%	5.1%	3.7%	3.7%	-0.4%	-0.7%	0.8%
Undefined	0%	0%	0%	0%	0%	0%	0.0%	0.0%	0.0%
Undisclosed	0.8%	0.8%	0.6%	1.1%	1%	1.2%	0.3%	0.2%	0.6%

- 5.24 There is a Public Service Agreement (PSA 15) in relation to equality and diversity, including ethnicity, now that this is a formal duty of all public organisations. Ethnic coding is a requirement of all hospital care and more recently has been accepted by the majority of general practices in Devon as part of a directly enhanced service but the coding systems between primary and secondary care are not fully compatible.
- 5.25 **Recommendation:** Public, private and voluntary organisations in Devon should agree a process for sharing current intelligence to improve our understanding of migrant worker's health needs, thus aiding commissioning and monitoring the improvements to meet these needs.

6. Prevalence, Epidemiology & Impact on Health

- 6.1 It has been estimated that 85% of migrants are aged between 15 and 44 years⁴ and tend to have general health needs similar to individuals of equivalent age and sex as the indigenous UK population. Issues of poor and cramped accommodation, low income, social isolation, abuse, racism and discrimination, however, also have a negative impact on health.
- 6.2 The characteristics of most migrant populations at a national level³ are that they are:
- generally young, at the younger end of the working age spectrum, with a high proportion of men – typical age 25-34 years⁶ (endorsed by local housing needs assessment report¹⁶)
 - commonly have language difficulties and almost always a lack of cultural understanding about the UK
 - polarised in terms of educations and skills. Many may be well educated but because of language or non recognition of qualifications are not allowed to work or work below their skills. Others are unskilled and the middle levels are not well represented.
- 6.3 Migrants have a range of health needs reflecting the diversity of the group but they are affected by three key determinants⁴:
- their individual characteristics – age, sex and ethnicity
 - their country of origin and the circumstances for migration
 - the socio-economic conditions of the host country.
- 6.4 A summary of the key findings from the local housing needs assessment¹⁶ that impact on health include;

¹⁶ The Housing Needs of Migrant workers in Devon Involve – The Anglo-Polish Organisation of Tiverton April 2008

- migrant workers tend to move into temporary accommodation when they first arrive in Devon and most Migrant workers in Devon live in the private rented sector
- issues of overcrowding is improving although some Migrant workers report poor and very poor housing conditions that are closely linked to poor physical and mental health
- a lack of secure housing when their accommodation is linked to their employment leading to homelessness can lead to despair and mental health issues
- there is still a lack of information about their rights and where they can go for help and a lack of practical language support
- many migrant workers experience racial discrimination, some of which is exacerbated by a lack of language ability. Local data on hate crime has shown that the victims, mainly men (60% men) fall in the age 35 to 44 years age group and the ethnicity of victims are mostly African - Caribbean followed by white European and then Asian with all offenders classified as white European. Reports of racist incidents in Devon County Council primary and secondary schools are also prepared but most victims do not disclose their nationality but where they do most were European followed by African. Overall it is felt that racial discrimination incidents remain under reported.

7. Health Inequalities

7.1 The report published in June 2008³ by the North East Public Health Observatory described the health issues affecting new arrivals under six key headings:

- Primary Care
- Mental Health
- Secondary Care
- Infectious Diseases
- Public Health
- Access and Payment

Primary Care

7.2 The following health needs were identified in primary care:

- mental health issues, including post traumatic stress disorder (PTSD), the consequences of trauma and rape, and isolation

- sexual health issues, including Sexually Transmitted Infections (STIs), Human Immunodeficient Virus (HIV) and unwanted pregnancies
- lack of, or incomplete, screening and immunisations – covering a wide variety of checks from communicable disease, cervical screening, breast screening, hearing and eye checks
- poor dental health and difficulties in accessing dental care
- poor nutrition and consequences such as vitamin deficiencies
- skin diseases and parasitic diseases
- musculoskeletal problems, particularly of the feet – sometimes from travelling
- behavioural health problems – drug misuse (especially opiates), domestic violence, alcohol misuse, and a higher prevalence of smoking linked to cheaper tobacco costs in their home countries. Locally it is felt that there is a lack of provision of drugs and alcohol services to meet the needs of migrant workers. Multilingual has been used on many occasions for drug misuse cases and this seems to be a growing problem especially among the Eastern European men
- hypertension, H. pylori and diabetes were found in higher rates and earlier onsets.

Mental Health

- 7.3 Problems of anxiety and depression, suicidal thoughts and action and the impact of repeated racial abuse. These problems are then exacerbated by social isolation, racism, language barriers, lack of access to English for speakers of other languages as well as lack of access to religious and cultural support and bureaucratic processes in accessing work and public services.
- 7.4 Local research conducted by the Hikmat group in Exeter showed that whilst the majority of Muslim elders in Exeter were registered with a general practitioner they did not feel they could talk to their General Practitioner due to communication difficulties related to culture and cultural understanding. This can in turn adversely affect referrals to secondary services including mental health provision. Discussing mental health problems can be difficult enough in one's first language, without adding the cultural inhibitions and language barrier problems. NICE guidance summarised in Appendices 8 & 9 provides guidance on effective practice.
- 7.5 **Recommendation:** To review access to mental health services, including drug and alcohol services in the community, primary and secondary care with the aim to ensure timely access that meets ethnic needs and addresses cultural and language needs
- 7.6 It is important to realise the value of, and to put in place, Equality and Diversity training for those working with migrant workers. Consideration needs

to be given as to how migrant workers can be involved in the designing and assist in the delivery of the training.

- 7.7 **Recommendation:** To ensure Equality and Diversity training programmes address the issues that concern migrant workers with the aim of improving knowledge and understanding and reduce discrimination and prejudices.

Secondary Care

- 7.8 Acute Trusts are able to identify chargeable patients, which have a partial overlap with migrants. They can sometimes pick up the issues from their Equality and Diversity work and the number who may use their interpreting services.

- 7.9 Acute hospital services likely to be heavily used include:

- accident and emergency (A&E) – especially when registration with General Practitioners is low, partly due to the nature of migrant worker employment, their lack of understanding of the process or by barriers put up by the general practice itself. It is more likely to be the case that people report to Accident and Emergency departments following accidents and when experiencing acute medical illness
- sexual health clinics – either referred through from primary care or possibly presenting directly
- maternity – there is an increase in the number of births nationally after a decline, which is felt to be primarily because of increased rates in mothers born overseas. The average age of migration coincides with child bearing age
- infectious disease – such as Tuberculosis, Blood Born Viruses and HIV are reported to the Health Protection Agency and so there should be record, but the numbers may be too small to present and guarantee anonymity. Whilst numbers are not high they are higher in some sub groups of the migrant population than in the general population, although lack of good demographic information makes rates difficult to interpret.

Recommendation Interpretation

- 7.10 There would be a benefit if a joint agency policy could be developed as the need for interpreters and translators has been raised by both primary and secondary care and a cross agency approach should be considered to address these needs. Consideration should also be given to supporting opportunities to employ or fast track bilingual health care workers.

Infectious Diseases

- 7.11 Some migrants come from parts of the world which have high rates of certain diseases, and an awareness of what these diseases are, who may need to be screened and other arrangements for proper control are important. A lack of understanding however can lead to prejudices and inappropriate concerns about the impact of the prevalence of some infectious diseases. Whilst there

is little evidence to suggest the general population is at risk of acquiring diseases from migrants, people in their immediate family and community, often first and second generation migrants may be⁴. Some screening is done for Tuberculosis on new arrivals shortly after entry, see Appendix 2¹⁷.

- 7.12 **Recommendation** to ensure there is an agreed protocol in place between Devon Primary Care Trust and the local Health Protection Team to clarify roles and responsibilities if health screening is required amongst migrant workers.

Public Health

- 7.13 Smoking levels can be quite high amongst European Union migrant workers where prices of tobacco products are cheaper so local public health programmes need to target these vulnerable groups. There may also be problems with sexual health, alcohol misuse, poor diets and difficulty adapting to local produce partly due to income and availability and social pressures which can impact upon one's life such as racism, discrimination, poor housing etc.
- 7.14 Children of migrant workers often have to support their parents on many different levels, from learning English to helping the parents to cope with the pressures. Improving access to health services and increasing social support for the parents and children can reduce the levels of stress and consequently unhealthy coping strategies such as smoking and alcohol dependency. Locally there are plans in place to organise counselling training courses for bilingual community members. The courses will focus on motivational interviewing techniques to assist the individuals who are considering developing healthier lifestyles.
- 7.15 **Recommendation** to improve access to public health programmes (smoking, obesity, sexual health, drug and alcohol misuse) they need to be designed to address cultural and language differences and the use of social marketing tools may help.

Access and Payment

- 7.16 Everyone who lives in the UK can access public services. Migrant workers have access to schools and NHS treatment. Schools are open to all children residing in the UK, including those from migrant workers families. Entitlement to free health services is based on whether a person is considered to be 'ordinarily resident'; i.e. on a lawful and settled basis in the UK and not on nationality.
- 7.17 Migrants who come to the UK to work are entitled to register with a GP practice and to receive free hospital treatment. Concerns have been raised that migrants are failing to register with GPs and to access primary healthcare. Apart from the impact on public health and the increased demands of Accident and Emergency (A&E) there is a knock on effect on other hospital care, which imposes greater costs on the NHS as well as being

¹⁷ National Institute for Health and Clinical Excellence, Clinical Diagnosis and Management of Tuberculosis and Measures for its prevention and Control Clinical Guideline No. NICE Guidelines 33, March 2006

bad for public health. Some areas are using Personal Medical Services (PMS) to deliver health services to their communities.

- 7.18 Access to healthcare however is difficult for many migrants for a number of reasons, including language and lack of understanding as to how services operate. There are practical difficulties, e.g. long hours in rural areas not necessarily being conducive to finding and registering with a GP, alongside anecdotal reluctance amongst some GPs to register foreign born new residents.
- 7.19 The Devon Primary Care Trust Community Development worker team is rolling out a training programme called 'Every Patient Matters; Welcoming Patients from BME Backgrounds into your Surgery' which is available to front-line staff at GP surgeries. So far this has been delivered to the St Thomas Medical Group, Whipton Surgery, Heavitree Surgery and South Lawn Surgery. Locally it has also been observed that some migrant workers go back to their home country to access specialist health services, i.e. maternity check ups, dentistry and other tests because of the familiarity of the services and the approach to treatment.
- 7.20 **Recommendation** to review the process currently used by migrant workers when registering with a GP practice with the aim to improve access to primary care services. To make recommendations to address any issues pertinent to, access to interpreters, the opening times of surgeries and the time to travel from rural employment. To develop if necessary a protocol to improve the registration process and ensure this is adopted across all GP practices in Devon.

8. Evidence of Effectiveness

Community Engagement

- 8.1 The National Institute for Health and Clinical Excellence (NICE) Public Health Guidance No.9¹⁸, published in 2008, entitled 'Community Engagement to Improve Health' is summarised in Appendix 1.
- 8.2 There is a consensus of opinion of the value of community outreach health projects undertaken in partnership with the voluntary sector and local migrant organisations but a major obstacle concerns the short-term nature of many projects. While evaluations are overwhelmingly positive and indicate significant health gains, the majority of projects run for between one and three years, with a risk that the health improvement will be lost once they finish.
- 8.3 A summary of evidence based recommendations underpinned by dedicated long term funding include:
- peer educators programmes

¹⁸ Public Health Guidance No9, Community Engagement to improve health, National Institute for Health and Clinical Excellence, February 2008

- specialist health visitor / health worker, community development worker posts
- information to cover the key topics identified by migrants themselves²³ including information to support them to access healthcare, to help them to understand medication and health and safety at work information and training supported with interpreters

8.4 **Recommendation.** The Devon Migrant Worker Task Group should evaluate their current work streams and projects that are currently being commissioned to ensure resources are being used effectively and efficiently and make the case for mainstream funding where there is evidence of improved outcomes.

Infant mortality

8.5 The National Health Service Implementation plan for reducing health inequalities in infant mortality a good practice guide is summarised in Appendix 7. The guidance recognises the importance of good quality early years NHS services such as maternity and health visiting can offer to ensure a crucial opportunity to nip in the bud health inequalities that will otherwise become entrenched and last a lifetime¹⁹. The good practice guidance outlines actions for both commissioners and providers in the development of local services.

8.6 **Recommendation:** To ensure the full implementation of the National Health Service Implementation plan for reducing health in-qualities in Infant Mortality a good practice guide summarised in Appendix 7²⁰. This includes:

- raising awareness of health–inequalities in the Director of Public Health Annual report,
- giving priority to evidence based interventions that will help ensure delivery of the targets such as improving access to maternal care (as measured by PSA maternity indicator - a set of full health and social care needs, risks and choices by 12 completed weeks of pregnancy), improving services for Black and Minority Ethnic (BME) groups
- gathering and reporting on improved data on maternity and paediatric activity (including breast feeding rates at 6 to 8 weeks (PSA 12), infant screening, immunisations).To note that the Department of Health is working with the NHS Connecting for Health and the Information Centre to develop a maternity data set towards the end of 2009
- provision of high quality primary care, midwifery, obstetric, neonatal and health visitor care including proactive identification of ‘at risk’ women, provision of maternity care in community settings, promotion of early access to maternal care, antenatal screening help with nutrition for women on low incomes and neonatal screening

¹⁹ Health Inequalities third report of session 2008/09 House of Commons Health Committee February 2009

²⁰ Identifiable Actions to Reduce the 2002-04 gap in infant mortality, Implementation plan for reducing health inequalities in infant mortality: a good practice guide, Department of Health, December 2007

- encouraging ownership of the target through effective performance management.

8.7 **Recommendation:** To review current maternity services provision across Devon with the aim to ensure that there is a proactive outreach service available that targets 'at risk' women. To routinely monitor access by ethnicity. To undertake a joint strategic needs assessment around health inequalities in maternal health and infant mortality.

Mental health

8.8 National Institute for Health and Clinical Excellence (NIHCE) Clinical Guidelines for managing Depression (no. 23)²¹ and Anxiety (no.22)²² in primary secondary and community care (amended in 2007) is summarised in Appendices 8 and 9. **Recommendation:** to ensure the full implementation of the clinical guidelines for managing depression and anxiety summarised in Appendix 8 & 9

Information

8.9 Evidence gathered from national focus groups regarding key information requirements for new migrants²³ highlighted 20 information subject areas to be included in local information resources and they are summarised below.

Figure 11: Twenty Information Subject Areas to be included in Local Information Resources

Getting a job	Discrimination
English language learning	Racial harassment
Where to get advice and information	Rights to bring your family to the UK
National insurance and tax	School places
Rights at work	Family services
Welfare benefits and social security	Housing –overcrowding and repairs
Rights to live and work in the UK	Homelessness
Doctors	Interpreters
Adult education and training	Money, bank accounts, credit debt
Housing in the UK	Trade unions

8.10 **Recommendation:** these topics should be covered in the future review of 'Welcome' packs and information on the Patient Advisory Liaison service should be included.

²¹ National Institute for Health & Clinical Excellence (NIHCE) Clinical Guideline 23, Depression: Management of Depression in Primary and Secondary Care (amended) May 2007

²² National Institute for Health and Clinical Excellence (NIHCE) Clinical Guideline 22, Anxiety (amended) Management of Anxiety (panic disorder, with or without agoraphobia and generalised anxiety disorder) in Adults in Primary, Secondary and Community Care (amended) Issue April 2007

²³ Integrating new migrants –communicating important information: A Guide for Local Authorities 11 Improvement and Development Agency for local government January 2008

9. Current Commissioning

- 9.1 The author of this report has not found any specific examples of health care commissioning specifically relevant to the health needs of migrant workers. Performance reporting to NHS Boards on compliance with ethnic coding and workforce reports are examples of performance monitoring, but there is insufficient reporting to assure equality of access to health care services and optimum health outcomes for migrant workers.
- 9.2 The recommendations in section 11 of this report aim to improve assurance for the NHS and key partner agencies of the Devon Strategic Partnership.
- 9.3 A bid for the Migrant Worker Impacts Fund draft application has been made and has secured £460K of national funding.

Primary Care

- 9.4 The majority of general practices in Devon have agreed to code ethnicity on current and new patients as part of a Directly Enhanced Service and this should improve our local understanding of migrants health needs albeit practices would require additional funding before any detailed reports could be extracted. There are 17 ethnic categories that could be coded, but there are different hierarchical sub sets across GP computer systems and it is understood that the ethnic codes do not mirror those used in secondary care.
- 9.5 People can access health care via the walk in centre on site at the Royal Devon and Exeter NHS Trust and Sidwell Street, if they are not registered with a GP. An audit should be undertaken to ensure there is no restriction on access to primary care.

Secondary Care

- 9.6 There is a requirement to code ethnicity within secondary care and levels of compliance should be monitored by the Trust Boards and commissioners. Some NHS Trusts provide interpreting services for both planned and emergency attendances. This can include local interpreters able to offer telephone support and face to face on occasion even when patients do not arrive for a pre-planned appointment. In addition some trusts provide written information in a range of languages e.g. North Devon Healthcare Trust in Polish, whilst the Royal Devon and Exeter NHS Foundation Trust also provides an advocacy service.
- 9.7 NHS Trusts equality and diversity leads are responsible for developing and implementing effective strategies and NHS Boards should receive regular reports on progress.
- 9.8 Currently there is no routine monitoring of access to services by ethnic grouping, but this should be included as part of any service review.

Local Partnerships

- 9.9 Details of the Devon Migrant Worker Task Group current objectives and work plan have already been detailed in Section 4 and are summarised in Appendix 5a & 5b.

- 9.10 Migrant worker officers based at Devon Race Equality Council and Community Council of Devon support drop in centres, provide a 'Welcoming' pack, and enable Migrant Workers to access training they request and health would be one if requested.
- 9.11 In addition Devon Primary Care Trust employs Community Development Workers who have undertaken extensive work with the local community. Some examples of the work they have undertaken or are engaged with have been already described earlier in this report.

10. Performance Monitoring

- 10.1 There are a range of targets nationally prescribed and / or locally agreed that provide evidence over time of improvements in health and reductions in health inequalities. Performance against these targets is monitored by a range of organisational boards and strategic partnerships
- 10.2 The Devon Stronger Communities and Health Improvement Group needs to agree the mechanism, frequency and process of performance monitoring the vast range of indicators that it should use to ensure progress on addressing the health inequalities highlighted in the report and the recommendations outlined. Summary reports can regularly be presented to the Devon Strategic Partnership. The indicators outlined below offer a summary of, but not an exhaustive list of the relevant and potential targets that currently exist.
- 10.3 **Public Service Agreements (PSA 15)** is set to address the disadvantage that individuals experience because of their gender, race, disability, age , sexual orientation, religion or belief.
- 10.4 **National Indicator 120** all age all cause mortality rate per 100,000 population i.e. by 2010 increase the average life expectancy at birth in England to 78.6 years for men and to 82.5 years for women.
- 10.5 **Infant mortality** – to reduce inequalities in health outcomes by 10% by 2010 as measured by infant mortality and life expectancy at birth. This target is underpinned by the following objective: starting with children less than one year by 2010 to reduce by at least 10% the gap in mortality between the routine and manual group and the population as a whole.

Devon Local Area Agreements

- 10.6 Local Area Agreements (LAAs) are three year agreements between a local area and central government. Local Area Agreements describe how local priorities will be met by delivering local solutions and bring together partners from the public, private and voluntary sectors with the aim of providing services in a more joined up way.

- **Strong and Inclusive Communities**

- LAA15a - work towards the economic inclusion and social integration of vulnerable population

- LAA 35 - prejudice and hate crime - increase levels of reporting and maintain victim satisfaction
- **A Growing Economy**
 - LAA 14 - provide coordinated support to unlock the economic potential of Devon's most disadvantaged communities
 - LAA15b - work towards the economic inclusion and social integration of vulnerable populations
 - LAA 17 - develop and harness skills to achieve a competitive economy
- **Homes and Housing**
 - LAA27 - improve housing options for the homeless and vulnerable clients
- **Health and Wellbeing**
 - LAA30 – promote health and reduce health inequalities.

Public Health Targets

- 10.7 Targets expressed within the National Health Service operating framework's vital signs i.e. those that are national priorities for local delivery for improving health and reducing health inequalities. These include reductions in circulatory disease and cancer mortality, reductions in the prevalence of smoking, obesity, teenage conceptions and sexually transmitted infections. Improvements in breast feeding rates, the proportion of pregnant women who are assessed for health and social care needs by 12 completed weeks of pregnancy, increased childhood immunisation rates, uptake of screening programmes and the number of drug users in effective treatment as well as a reduction in the suicide and undetermined injury rates.

Others

- workforce reports to NHS Boards

Standards for Better Health

Seventh Domain Public health

- 10.5 **C22** - Health care organisations promote, protect and demonstrably improve the health of the community serviced and narrow health inequalities by:
- a) co-operating with each other and with local authorities and other organisations

- b) ensuring that the local Director of Public Health's Annual report informs their policies and practices and
 - c) making an appropriate and effective contribution to local partnership arrangements including local strategic partnerships and crime and disorder reduction partnerships.
- 10.6 **C23** - Healthcare organisations have systematic and managed disease prevention and health promotion programmes which meet the requirements of the National Service frameworks and national plans with particular regard to reducing obesity through action on nutrition and exercise, smoking, substance misuses and sexually transmitted infections

Third Domain Governance

- 10.7 **C7e** - Healthcare organisations should enable all members of the population to access services equally and offer choice in access to services and treatment equitably. They should challenge discrimination, promote equality and respect human rights

11. Recommendations

- 11.1 Migrant workers and their dependants are entitled to the same high quality health care services as the rest of the local population, albeit they may require additional assistance in the form of interpretation and translation services and support if they are to gain the maximum health benefit.
- 11.2 As a principle migrant workers should routinely be engaged and involved in taking forward the recommendations outlined in this report. The author of the report has been advised that not all migrant workers have easy access to the web so in order for maximum participation alternative methods need to be put in place.
- 11.3 These recommendations have not been prioritised but they have been supported by those who contributed to this report or commented on the draft.

Interpretation / Information

- 11.4 The need for interpreters and translators has been raised by both primary and secondary care and a cross agency joint protocol should be developed and agreed to address these needs. Consideration should also be given to supporting opportunities to employ or fast track bilingual health care workers.
- 11.5 Review the topics covered in the 'Welcome' packs to ensure that they are in line with the top 20 topics in Figure 11 and include details on how to contact the Patient Advisory and Liaison Service. Information must be readily available in a range of languages to reflect the local demography

Intelligence

- 11.6 Public, private and voluntary organisations in Devon should agree a process for sharing current intelligence to improve our understanding of migrant worker's health needs, thus aiding commissioning and monitoring the improvements to meet these needs.

Access to Services

- 11.7 To review the process currently used by migrant workers when registering with a GP practice with the aim to improve access to primary care services. To make recommendations to address any issues pertinent to access to interpreters, the opening times of surgeries and the time to travel from rural employment. To develop if necessary a protocol to improve the registration process and ensure this is adopted across all GP practices in Devon
- 11.8 To review current maternity services provision across Devon with the aim to ensure that there is a proactive outreach service available that targets 'at risk' women. To routinely monitor access by ethnicity. To undertake a joint strategic needs assessment around health inequalities in maternal health and infant mortality.
- 11.9 To review access to mental health services, including drug and alcohol services, in the community, primary and secondary care with the aim to ensure timely access that meets ethnic needs and addresses cultural and language needs.
- 11.10 To improve access to public health programmes (smoking, obesity, sexual health, drugs and alcohol misuse) they need to be designed to address cultural and language differences and the use of social marketing tools may help.

Training

- 11.11 To ensure Equality and Diversity training programmes address the issues that concern migrant workers with the aim of improving knowledge and understanding and reduce discrimination and prejudices.
- 11.12 To ensure all staff receive training in the skills to work with interpreters.

Protocols and Guidance

- 11.13 To ensure there is an agreed protocol in place between Devon Primary Care Trust and the local Health Protection Team to clarify roles and responsibilities if health screening is required amongst migrant workers.
- 11.14 To ensure the full implementation of the National Health Service Implementation plan for reducing health inequalities in Infant Mortality a good practice guide. Summarised in Appendix 7.
- 11.15 To ensure the full implementation of the clinical guidelines for managing depression and anxiety summarised in Appendix 8 & 9.
- 11.16 To develop and agree a joint agency protocol on the use and availability of interpreting services.

Evaluation and Audit

- 11.17 The Devon Migrant Worker Task Group should evaluate their current work streams and projects that are currently being commissioned to ensure resources are being used effectively and efficiently and make the case for mainstream funding where there is evidence of improved outcomes.
- 11.18 An audit should be undertaken to ensure there is no restriction of access to primary care walk-in centres.

12. Conclusions

- 12.1 Accurate figures on the numbers of migrant workers as a proportion of the working population are hard to calculate with any degree of accuracy given the complexity of definitions and cross government agency data sources. The numbers of migrant workers coming from the Accession 8 states were accelerating between 2001 to 2002 and 2006 to 2007¹³ but are now showing nationally, within the south west region (including Devon) a decline, amongst some but not countries in Europe, given the economic downturn.
- 12.2 Migrant workers contribute to economic prosperity and national evidence suggests that public services would struggle without the contribution of migrant workers to fill skilled and unskilled labour shortage gaps including those in health and social care. Local business people have also expressed a view that without migrant workers some of their businesses would collapse.
- 12.3 Information from national and local research suggests that migrant workers, working and living in Devon, currently experience inequalities in health leading to poorer health outcomes. These inequalities include failing to register with and poor access to primary care, late presentation with maternity services, a higher prevalence of mental ill health and work related injuries leading to a greater use of secondary services. Community Development workers and Patient Advisory Liaison Officers have reported incidences of migrant workers being turned away from some GP surgeries because the staff had not understood eligibility criteria.
- 12.4 The inequalities are exacerbated in part by language difficulties, problems in accessing work and other public services, lower incomes, poor housing, as well as the negative impact of racism and prejudice.
- 12.5 Migrant workers are not a highly visible group in terms of health service commissioning, albeit this is being addressed nationally and steps are in place locally that should improve intelligence. The National Health Service working in partnership with other public, private and voluntary services has a clear role in reducing health inequalities and evidence based urgent and sustained action must be taken if existing health inequalities are to be reversed. There is some evidence based action that should be taken to improve health outcomes and narrow the existing health inequalities gap.
- 12.6 The Devon Migrant Worker Task Group is well placed to take forward the recommendations and hold organisations to account (see Section 10). The Task Group may wish to review its membership to ensure it has the right skill

mix to drive forward the recommendations. This is particularly pertinent to those concerning service reviews and to consider its reporting mechanism to the Devon Strategic Partnership given the remit of the Stronger Communities and Health Improvement Group.

13. Acknowledgements

- 13.1 The Public Health Directorate of Devon Primary Care Trust has led in the production of this health needs assessment of Migrant Workers.
- 13.2 The author of the report however, is indebted to people from a number of organisations across the south west region. All have freely given up time and offered support, advice and expertise. The list below details those who contributed to the initial draft and / or who commented on it. Their comments have informed the final version of this report.
- 13.3 The author of the report takes full responsibility for any inaccuracies.

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14. List of Figures

1	UN Migrant Definitions ²⁴
2	Improving Data Collection on Population Estimates ⁶
3	Devon Primary Care Trust Registered (Jun 08) and England and Wales Populations (Mid year 07)
4	Population Projections
5	Map Showing Indicators of Multiple Deprivation in Devon
6	Migrant workers National insurance registrations Devon April 2004 to March 2006
7	Main Employment sectors for Migrant Workers in Devon (Devon County Council)
8	Starters & Leavers by Ethnicity - Information taken from Devon PCT Workforce Diversity annual Report 1 st April 2008 – 31 st March 2009
9	Devon PCT by Ethnicity - Information taken from Devon PCT Workforce Diversity annual Report 1 st April 2008 – 31 st March 2009
10	Recruitment by Ethnic Origin - Information taken from Devon PCT Workforce Diversity annual Report 1 st April 2008 – 31 st March 2009
11	20 Information Subject Areas to be Included in Local Information Resources ²³

²⁴ Migrant Health infectious diseases in non UK born populations in England, Wales and Northern Island a baseline report Health Protection agency 2006

15. Appendices

APPENDIX 1	National Institute for Health and Clinical Excellence (NIHCE), Community Engagement to Improve Health, Public Health Guidance No.9 ¹⁸
APPENDIX 2	National Institute for Health and Clinical Excellence Clinical Diagnosis and Management of Tuberculosis and Measures for its Prevention and Control Clinical Guideline No. NICE Guidelines 33, March 2006 ¹⁷
APPENDIX 3	Implementation plan for reducing health inequalities in infant mortality: A summary of evidenced based interventions that will help deliver the target include;
APPENDIX 4	Devon Migrant Worker Task Group – Terms of Reference
APPENDIX 5A	Devon Migrant Worker Task Group Project Plan
APPENDIX 5B	Migrant Worker Initiatives in Devon – Mapping Document October 2008
APPENDIX 6	Devon Migrant Worker Task Group Circulation list.
APPENDIX 7	Identifiable Actions to Reduce the 2002-04 Gap in Infant Mortality, Implementation Plan for Reducing Health Inequalities in Infant Mortality: A Good Practice Guide, Department of Health, December 2007 ²⁰
APPENDIX 8	National Institute for Health and Clinical Excellence (NIHCE) Clinical Guideline 23, Depression: Management of Depression in Primary and Secondary Care (amended) May 2007 ²¹
APPENDIX 9	National Institute for Health and Clinical Excellence (NIHCE) Clinical Guideline 22, Anxiety (amended) Management of Anxiety (panic disorder, with or without agoraphobia and generalised anxiety disorder) in Adults in Primary, Secondary and Community Care (amended) Issue April 2007 ²²

APPENDIX 1

National Institute for Health and Clinical Excellence (NIHCE), Community Engagement to Improve Health, Public Health Guidance No.9¹⁸

The recommendations in summary are

Prerequisites for success:

- coordinated implementation of the relevant policy initiatives
- a commitment to long-term investment
- openness to organisational and cultural change
- a willingness to share power, as appropriate, between statutory and community organisations and the development of trust and respect among all those involved

Infrastructure to support practice on the ground includes:

- support for appropriate training and development for those working with the community – including members of that community
- formal mechanisms which endorse partnership working
- support for effective implementation of area-based initiatives

Approaches to support and increase levels of community engagement

- provision of appropriate training and development to help improve communications between the local community and service providers and may attract more people to community groups. (For example, by offering the opportunity to gain new skills and potential employment in the health and 18 social care sectors.)
- partnerships (both between sectors and with the local community) and local input into area-based initiatives and regeneration activities are essential to ensure community engagement activities are coordinated and reflect the community's views.
- 'agents of change' and a range of other approaches can be used to encourage local communities to become involved in health promotion activities and area-based initiatives to address the wider social determinants of health.

Evaluation

- improving the quality of evidence is a continuing process. Better evaluation processes are needed to increase understanding of how community engagement and the different approaches used impact on health and social outcomes.

APPENDIX 2

National Institute for Health and Clinical Excellence Clinical Diagnosis and Management of Tuberculosis and Measures for its Prevention and Control Clinical Guideline No. NICE Guidelines 33¹⁷

Key priorities for Implementation

The following recommendations have been identified as priorities for implementation:

Management of Active TB

A 6-month, four-drug initial regimen (6 months of isoniazid and rifampicin supplemented in the first 2 months with pyrazinamide and ethambutol) should be used to treat active respiratory TB in:

- adults not known to be HIV-positive
- adults who are HIV-positive
- children

This regimen is referred to as 'standard recommended regimen' in this guideline.

Patients with active meningeal TB should be offered:

- a treatment regimen, initially lasting for 12 months, comprising isoniazid, pyrazinamide, rifampicin and a fourth drug (for example, ethambutol) for the first 2 months, followed by isoniazid and rifampicin for the rest of the treatment period
- a glucocorticoid at the normal dose range:
 - adults – equivalent to prednisolone 20–40 mg if on rifampicin, otherwise 10–20 mg
 - children – equivalent to prednisolone 1–2 mg/kg, maximum 40 mg with gradual withdrawal of the glucocorticoid considered, starting within 2–3 weeks of initiation.

Improving Adherence

Use of directly observed therapy (DOT) is not usually necessary in the management of most cases of active TB. All patients should have a risk assessment for adherence to treatment, and DOT should be considered for patients who have adverse factors on their risk assessment, in particular:

- street or shelter-dwelling homeless people with active TB

- patients with likely poor adherence, in particular those who have a history of non-adherence

The TB service should tell each person with TB who their named key worker is, and how to contact them. This key worker should facilitate education and involvement of the person with TB in achieving adherence.

New entrant screening

New entrants should be identified for TB screening from the following information:

- port of Arrival reports
- new registrations with primary care
- entry to education (including universities)
- links with statutory and voluntary groups working with new entrants

BCG Vaccination

Neonatal BCG vaccination for any baby at increased risk of TB should be discussed with the parents or legal guardian.

Primary care organisations with a high incidence of TB should consider vaccinating all neonates soon after birth.

APPENDIX 3

Implementation plan for reducing health inequalities in infant mortality²⁰- A summary of evidenced based interventions that will help deliver the target include;

- Reducing the prevalence of obesity in the routine and manual (R&M) group by 23% to the current levels in the population as a whole
- Meeting the national target to reduce smoking in pregnancy from 23% to 15% and meeting this target in the R&M group
- Reducing sudden unexpected death in infancy (SUDI) by persuading 1 in 10 women in the R&M group to avoid sharing a bed with their baby or putting their baby to sleep on its front
- Achieving the teenage pregnancy strategy to reduce the under-18 conception rate in the R&M group by 50% compared with the 1998 levels
- Meeting the child poverty target to halve the number of children in relative low income households between 1998-99 and 2010-11 by increasing the income in the R&M group by an average of 18%
- Reducing housing overcrowding in the R&M group through the effect on reducing SUDI
- Promoting early antenatal booking among disadvantaged groups

APPENDIX 4

Devon Migrant Worker Task Group - Terms of Reference

Background

Migrant workers can be defined as those who travel to another country for the primary purpose of seeking or carrying out work and usually with the intention of returning to their country of origin. The term 'migrant workers' therefore refers to international migrant workers – people who come to Britain from another country including Europe, who come primarily to earn a living (whether this is through a legal or illegal/exploited arrangement) rather than to seek asylum, and therefore people who are 'economic migrants'.

1. Aim

To provide leadership and a coherent approach to the issue of migrant workers in the County. To deliver this in a way that is empowering and supportive to the migrant worker population.

2. Objectives

- i To identify current work and data in order that gaps in services can be recognised and addressed.
- ii To identify the barriers that exist in providing equality of service to migrant workers and develop solution to overcome these.
- iii To develop a migrant worker multi agency action plan for Devon.
- iv To develop resources, initiatives and policy, such as a 'Welcome Pack' (which will outline the services available and the means of access), myth buster (to ensure that the positive role of migrant workers in Devon's communities is not overlooked) and agreed ways of working.
- v To seek sources of funding to aid work whether through statutory, charitable or private sector sources

3. Outcomes

- i Improved outcomes for migrant workers (better information about rights; more widespread adoption of good practice amongst employers and landlords)
- ii A more co-ordinated response to migrant worker issues, ensuring that the right people are involved

- iii Improved understanding and awareness of migrant worker issues amongst partners in both statutory and voluntary sectors

4. Accountability

The Devon Migrant Worker Task Group will report to the Devon Strategic Partnership (DSP) through Common Ground, the Devon wide social inclusion body.

5. Membership

Public, private and community / voluntary sector organisations and migrant worker representatives. Please attached list.

6. Roles of member representatives:

- i To represent their organisation(s) and maintain two-way dialogue, reporting back to their organisation(s).
- ii To participate in decision making and actioning of tasks.
- iii To share ideas and information.
- iv To be supportive and give constructive criticism in order to aid improvement.
- v To participate in learning and development programmes to develop skills and knowledge, and share any learning with group members.
- vi Network outside of formal meetings to advise each other over problems and issues.
- vii To disseminate information regarding the work of the group to local partners, both geographic and thematic

7. Relationship to other bodies

The Devon Migrant Worker Task Group recognises and values the role, operational style and priorities of all bodies with which it works. It will at all times seek to engage openly and frankly with all partners.

8. Style

The Devon Migrant Worker Task Group will adhere to the statement of inclusion adopted by the DSP (appendix 1). It will treat all its members with dignity and respect and value all contributions.

9. Administrative and Support arrangements

Support for the administration and facilitation of the Migrant Worker Devon Migrant Worker Task Group for the first three meeting will be provided by the Community Council of Devon. It is envisaged that the group will initially meet every 4-6 weeks.

10. Resources

Such resources as are secured by the partnership will normally be deployed through one of its members and will be subject to proper financial process and will be transparently managed.

11. Review

A review of the Devon Migrant Worker Task Group will occur after three months and annually there after.

Appendix 1 Devon Strategic Partnership Statement of Social Inclusion

1. “Strategic Partnerships are set up to develop and deliver community strategies and action plans with which local authorities and their partners can promote or improve the economic, social and environmental wellbeing of their areas, and contribute to the achievement of sustainable development in the UK.
2. The purpose of the Devon Strategic Partnership is to improve the quality of life of people in Devon by ensuring that the work of all agencies and groups has the needs of local people at its core, promoting and upholding the human rights of everybody in Devon, including asylum seekers, refugees, students and tourists.
3. The Devon Strategic Partnership actively promotes equality under the law without discrimination based on: ethnic, racial or national background or origins; skin colour; nomadic lifestyle; sex; gender or gender status; age; mental or physical disability or difference; sexual orientation or behaviour; partnership or family status; financial or employment status; political, personal or religious beliefs or opinions (so long as those beliefs or opinions are not in themselves incompatible with the rest of this paragraph); or any other unfair basis of discrimination.
4. The Devon Strategic Partnership is taking action to become a regional and national example of excellence in the field of social inclusion. It values the broad diversity of all the individuals and communities that enrich Devon, past, present and into the future. The Partnership is committed to meeting the needs of individuals and their communities and celebrates the knowledge, perspective, expertise and enthusiasm that they bring to the county. We are working to ensure that all groups, particularly minority groups, are secure, respected, valued and equal members of the Partnership and the whole community of Devon”.

APPENDIX 5A

Devon Migrant Worker Task Group Project Plan

Objective	Outcome	Key Partners required	Tasks	By when
1. Strategic leadership. Strategic leadership and championing of the issue of Migrant workers by the Devon Strategic Partnership (DSP).	Cohesive strategic approach prioritised in the Sustainable Community Strategy and Local Area Agreement with resources to follow.	Devon Strategic Partnership Executive board and members of the Devon Migrant Worker Task Group. Potential lead. Devon County Council (DCC).	a. Establish strong political leadership on the issue, in terms of elected member or MP. b. Identify lead Organisation and Officer, with appropriate capacity, from amongst DSP Partners c. Facilitation of Devon Migrant Worker Task Group and key project areas e.g. Welcome Pack. d. Ongoing Liaison with Equality Strategy and Scrutiny Group and other appropriate Devon Strategic Partnerships and Devon Migrant Worker Task Groups. e. Linkage with Regional Assembly and EU General Framework directive on migrant workers (September 2007)	June 2007
2. Participation. Empowerment and support to Migrant workers to enable ongoing engagement in project plan.	Well designed, user led services that are 'fit for purpose'.	Devon Migrant Worker Task Group members, (particularly representatives from the Community Voluntary Sector, employers and Equality and	a. Consultation with Migrant workers both through specific pieces of work and ongoing dialogue. b. Close liaison with Community and Voluntary Sector initiatives, esp. BME organisations and rural advocates such as Community Council of Devon (CCD).	Ongoing

Devon Migrant Worker Task Group Project Plan

Objective	Outcome	Key Partners required	Tasks	By when
		Participation officers) Potential lead. Devon Association of Councils for Voluntary Services		
3. Evidence base Improved data and information on the issue of Migrant workers	Ensure strong evidence baseline to work from on what is often an emotive subject.	Initial report by Devon Migrant Worker Task Group , collated by Community Council of Devon Potential lead. CCD	<ul style="list-style-type: none"> i Production of brief report, (collated by CCD) giving a rapid appraisal of existing information, in terms of activity and identifying any gaps in provision. Key sources include: Devon County Council, Government Office South West, South West Regional Development Agency, Home Office, SLIM, TUC, DEFRA, CAB, Devon Primary Care Trust and DREC. ii Identification of gaps in data and activity. iii Establish role of SW Observatory in research. iv Commissioning of further work, e.g. forecasting future demographics. v Establish performance indicators to measure success and 	Initial report by May 2007

Devon Migrant Worker Task Group Project Plan

Objective	Outcome	Key Partners required	Tasks	By when
			achievements of the Task group work plan.	
4. A Welcoming Devon Develop a 'Welcome pack' for migrant workers in a variety of languages which covers basic information on rights and services.	Migrant workers who are aware of their rights and responsibilities and who are able to access local services.	Devon Migrant Worker Task Group , to be collated by the Community Council of Devon Potential lead DCC	a. Develop Welcome Pack utilising existing good practice. b. Pilot pack with Migrant workers for Devon in plain English ensuring it covers key points of law and service provision c. Task group to consider and make recommendations for its distribution and publication. d. Identify funding for printing e. Canvass local business, who benefit from migrant workers, for financial support. f. Explore web based access. g. Identify 'owner' for the pack.	June 2007
5. Myth busting Develop a 'fact and myth buster guide' in A4 form on migrant workers.	Informed and reasoned public debate confronting misinformed and often racist propaganda disseminated by extremist organisations	Migrant Worker Devon Migrant Worker Task Group members, particularly TUC, Devon and Cornwall Police and Business link	a. Develop a leaflet 'for Devon' utilising existing good practice. b. The Leaflet will be suitable for educating staff, stakeholders and councillors of local services and available to the media. c. Task group to consider and make recommendations for its distribution and publication.	Leaflet production June 2007

Devon Migrant Worker Task Group Project Plan

Objective	Outcome	Key Partners required	Tasks	By when
		Potential lead TUC		
6. Community Cohesion Development of a programme of community 'Welcome events' designed to: a. provide advice and information to Migrant worker, b. bring together Migrant worker and 'settled' population.	Stronger and inclusive communities better placed to maximise the skills and talents of new and existing residents.	Employers, Com/vol sector partners, for example DREC, Neighbourhood beat managers, Schools and Faith groups. Potential lead CCD	a. Understand, acknowledge and address peoples concerns about migration. b. Develop a portfolio of resources e.g. photo exhibition. c. Link to existing festival e.g. Respect (Exeter / Barnstaple/ Plymouth) d. Identify funding to initiate and support community events across the County, both urban and rural. e. Maximising opportunities presented by using community venues, food and culture. f. Explore linkage with other communities of interest e.g. Gypsy and Travellers.	Ongoing
7. Capacity building Development of a Migrant Worker	Empowered and informed Migrant workers.	Community Voluntary sector, Business, Devon	a. Evidence potential and need for Migrant Worker Network. b. Liaise with existing initiatives e.g. Migrant Worker Officer,	Sept 2007

Devon Migrant Worker Task Group Project Plan

Objective	Outcome	Key Partners required	Tasks	By when
Network.		Equality Partnership. Potential lead Exeter CVS	Exeter CVS	
8. Compliance (Public sector) Evidence of “compliance” with Race Equality duties.	Organisations meeting legal obligations and ensuring protection of Migrant workers.	Public agencies, Potential lead. Devon Equality Partnership	<ul style="list-style-type: none"> a. Consider implications in Equality Impact Assessments. b. Identify whether agencies are considering these issues in their equality scheme. c. Engage with Migrant workers to identify issues d. Look at complaints e. Develop joint agency approaches to enforcement. f. Explore Responsible Employers Scheme. g. Consider implications of compliance, e.g. greater demands on interpretation services. h. Address demands placed upon service provision e.g. libraries. 	Ongoing

Devon Migrant Worker Task Group Project Plan

Objective	Outcome	Key Partners required	Tasks	By when
9. Compliance (Private sector) Evidence of “compliance” in housing and employment.	Ensure safe conditions and dwellings.	Devon and Somerset Fire and Rescue, Housing, Local Authorities, Police, Ed, Police. Potential lead Devon and Somerset Fire and Rescue.	a. Research of good practice from elsewhere. b. Identification of representatives from each organisation to take part in joint inspections. c. Pilot safety inspections d. Develop Responsible Employers Scheme	Pilot by March 08
10. Learning and skills Development of improved Learning provision of EOSL.	Increased ESOL provision tailored to Migrant workers needs and LSC funding regimes.	Devon and Torbay Learning Partnership (DTLP) Devon Economic Partnership, Learning and Skills Council, Community Voluntary sector, Businesses, delivery organisations. Potential lead DTLP	a. Dissemination and development of work initiated by English @Work in Devon (adults). b. Analysis of current provision for children. c. Increased capacity for the delivery of ESOL throughout the County.	Nov 2007

Devon Migrant Worker Task Group Project Plan

Objective	Outcome	Key Partners required	Tasks	By when
11. Stronger and inclusive communities Increased Support to Faith and Community and Voluntary sector organisations	Community and Voluntary Sector Organisations better equipped to meet the needs of Migrant Workers	Devon Faith Forum and Community and Voluntary Sector. Potential leads Devon Consortium and Devon Faith Forum	a. Identify need b. Recognise and share good practice c. Address current gaps in provision. d. Secure funding	TBC

Project plan to be reviewed 6 monthly.

APPENDIX 5B

Migrant Worker Initiatives in Devon – Mapping Document October 2008

Examples of current Migrant Worker initiatives in Devon as highlighted in 2007 Scoping Report

This mapping document shows a snapshot of the current Migrant Worker Initiatives in Devon as of October 2008. The table shows 25 initiatives working across the whole of Devon and several in different districts: Exeter – 8; East Devon – 2; Mid Devon – 3; North Devon – 1; Plymouth – 2; South Hams – 2; Teignbridge – 1; Torbay – 1

Contact for more information on initiatives is: Community Council of Devon info@devonrcc.org.uk

Data Source / Location	Comment	Area Covered
Amber Initiatives	Amber Initiatives is non-for-profit, community-based company. The mission of the company is to contribute to society through the assisting of migrant worker community and the host community. The principal activity is Information, Advice and Guidance service: Employment, Housing, Finance and Benefit advice, Education and Health-related advice. Amber has expanded its service delivery capacity over the past year to include 3 new programmes and services: Safer Community Programme, 'Resettlement Project: Towards Integration', and Community Forum. Translation service. Their website is available in 4 languages and they have a telephone advice line (Polish, Russian and Lithuanian) for those who cannot get to one of the drop in centres.	Devon and Cornwall
Devon Faith Forum	Local focus of social identity and gathering for some groups of Migrant Workers. The response / support provided depend on local capacity.	Devon
Devon Tourism Skills Network www.discoverdevon.com/trade	Have created a website for whole of SW for people working the Tourism Industry in Polish and Portuguese. Individual pages for each county, and also a general section including health / work / bank accounts etc. Due for Launch mid October	Devon
Devon Drivers Centre	A leaflet has already been produced in Polish about traffic laws etc. Further work being done.	Devon
English@Work	'English@Work' Learning Providers in Exeter & Heart of Devon. Work related & relevant short courses negotiated with employers. Currently delivering 3 courses, and negotiating another 15. (01/10/08)	Devon
University of Exeter, Skills and Learning Intelligence Module (SLIM)	Migrant worker research hub linking into SW Observatory.	South West

Data Source / Location	Comment	Area covered
ESOL	English as a Secondary Language, delivered through out the County from learning and training organisations.	Devon
Safer Devon Cohesion Project	Amble Skuse and Richard Anderson are working to establish 6 'hubs' for the MW community across Devon. Amble is looking at North / Mid / Teignbridge and Torridge and Richard is Exeter, East Devon, West Devon, and South Hams.	Devon
DSP Migrant worker Welcome pack	Pack giving guidance and signposting on key issues such as finance, health, emergency services, working in the UK etc. Currently available in Polish and English. http://www.devonsp.org.uk/migrantworkers/index.html Review happening with revised pack available towards end of 2008 with several more languages.	Devon
Devon Migrant Worker Task Group	Please see appendix 6 for membership	Devon
EAL	English as an Additional Language. Work in schools supporting children and young people whose first language is not English. Skin Deep resource pack for teachers addressing issues of racism, mixed heritage, cultural stereotyping and bullying, based on real-life experiences. Students' book, teachers' book and CDrom. Suitable for Key Stage 2 & 3. http://www.devon.gov.uk/eals-skindeepflyer.pdf	Devon
Devon Inclusive Housing Project (DHIP)	Advice for people from ethnic minority backgrounds who are homeless or threatened with homelessness (covers the whole of Devon)	Devon
Shops	A number of small retail outlets with a particular focus on the Polish and other communities. Local focus of social identity and gathering for some groups of Migrant Workers. The response / support provided depend on local capacity. <ul style="list-style-type: none"> • Laina Howe - Costcutters – Tiverton • Bartholomew street, Exeter • Union Street, Plymouth • U Anety, North Hill, Plymouth • Kasia & Tomek, Devon Square, Newton Abbot 01626 367776 • Polski Sklep, Lucius Street, Torquay 01803 389212 • Polish store, Bear Street, Barnstaple 	Devon

Data Source / Location	Comment	Area covered
Devon Race Equality Council	Offers a range of services including: Specialist advice on racial discrimination, support for isolate and vulnerable children, advice and support for Gypsy / Traveller community, training on equality and diversity for voluntary, statutory and private sector organisations, advice and support public bodies on policies and on community engagement. Migrant Workers officer – Richard Anderson, funded by Safer Devon partnership for 'hub' project.	Devon
Devon Citizen Advice Bureaus	Advice and information points. Particular focus on disseminating Welcome packs and collating research for Migrant Worker research group information. Have very useful booklet on Benefits.	Devon
Devon County Council Migrant worker group	Internal DCC group for dissemination and actioning on the issue of migrant workers.	Devon
Fata He	Umbrella organisation for BME individual and groups, and works closely with other local, sub-regional and regional organisations.	Devon
Mosaic	Helps women and families from minority communities come together to develop self help groups. Helps groups develop a programme of social and educational activities. Project worker can offer advice and guidance or referrals on issues such as English language courses, mental and physical health, domestic violence, schools and children's education.	Devon
Multilingua	Exeter based interpreting and translation agency. Interpreting for public services – including courts, specialist interpreting, translation by request, face to face interpreting, accredited training courses in 'community interpreting', training for organisations – Working with Translators.	Devon
The Monitoring Group (TMG)	Delivering support to victims of racial harassment and violence. Casework services which provide legal, practical and emotional support, advocacy and advice. Also outreach and development with BME communities, training around best practice with front line agencies in the voluntary and statutory sector and monitors the compliance of authorities to community safety legislative drives.	Devon
Ujima	Provide direct support for groups & networks, Identifying the need for and supporting the development of new projects / groups / networks, promoting and enabling community development by supporting BME communities at a strategic level, helping to provide appropriate accountability to a range of stake holders, ensuring all work is carried out in accordance with accepted standards of good practice.	Devon

Data Source / Location	Comment	Area covered
Devon United Women	Devon United Women works to empower women , especially those from minority ethnic backgrounds	Devon
Pawel Szczepanowski	Polish Newspaper...Latawiec.....	Devon
ISCA migrant network	Magda Kosclelak and Rafal Szymanski run a Polish Support Group in Exeter, St Sidwell's Centre, they are run every other Sunday between 10am and 1pm.	Exeter
Polonica	A new Polish voluntary organisation in Exeter. Exeter Polish Association POLONICA. The launch is planned at the end of Nov.	Exeter
UJIMA Project	Supporting BME communities in Exeter	Exeter
Exeter CVS	Mapping and support for migrant workers in Exeter & Area, initially funded up to 2007. Now have a Human Rights Officer.	Exeter
Portal Informacyjny Polaków w Exeter	Polish language website and newsletter for Exeter	Exeter
Olive Tree Project	Advice and support for the Black and Minority Community, including Migrant Workers.	Exeter
DRIVE	Based at Exeter CVS, DRIVE aims to encourage, support and recruit volunteers from BME backgrounds to volunteer in our local communities.	Exeter
Mid and East Devon Community Safety Partnership	Migrant Workers covered as part of wider remit. Production of information leaflet – 'Welcome to East & Mid Devon' in 2007.	Mid and East Devon
Anglo Polish Organisation	Bringing together Migrant Workers from around the Mid Devon area, the organisation provides a social focus as well as offering a range of services to both individuals and to organisations. - Language Tuition - Advice, guidance and practical support for Polish speakers, - Translation and interpreting services - Anglo polish Saturday school.	Devon
Devon LINK	The Devon Local Involvement Network is for the public of Devon to have their say about the provision of health and social care in Devon. Migrant workers may well want to feed in their experience of Local services.	Devon
Catholic Churches with Mass in Polish	TORQUAY – Abbey Road; TQ2 5NJ; every first Sunday of the month at 4pm, WEYMOUTH, every second Saturday of the month 7pm , Saint Augustine DT4 7Z, TIVERTON EX 16- 4HJ; ST JAMES; 40 Old Road; 4.30pm, 3rd Sat of the month, Cornwall, 3rd Sunday of the month, 5pm, Redruth TR15-3AA; BARNSTAPLE last Saturday of the month, ST. MARY's Higher Church Street; EX32-8JE, PLYMOUTH every last Sunday of the month, cathedral PL1 5HW, mass at 3pm, CULLOMPTON first Saturday of the month, 7pm ST Boniface Church EX15 1EW, EXETER Second Sunday of the month – 4pm (confession at 3.30pm) CHURCH: The Sacred Heart; 25 South Street.	Devon

Data Source / Location	Comment	Area covered
Northern Devon Migrant worker group	WPC Shaunagh Cobb, Emily Poyner – Diversity N Devon District Council, Terrena Howse – North Devon Healthcare NHS trust, Maja Lelandais, Devon PCT, Julie Dixon – Diversity officer Devon and Cornwall Police, Jay Chapman – TVS & Grassroots project, Dawn Milner - TVS, Tony Makin – HSE, Ali Bod – DCC, Des Brailey – NDC, Mark Searle – DSFRs, Alan Coxon – DSFRs, Paul Chaimberlain – DSFRS, David Rolls – CCD, Amble Skuse – CCD, Liz Crone - EAL, David Wright – SDP, Peter Yensen – GLA, Ian Hobbs – DCC, Magda Koscielak – PCT, Ian Smart – DREC, Becky Keeling – Devon LINK.	North Devon
Plymouth City Council	Myth Buster. PCC are planning a 'transient communities' welcome pack which will include Migrant Workers, Gypsies and Travellers etc.	Plymouth
South Hams District Council	2007: Funding secured from Language Energy Park (section 106) to produce a Welcome Leaflet specifically for Language Energy Centre Migrant Workers (construction sector) together with funding for CAB officer advice sessions and community awareness days.	South Hams and Plymouth
South Hams Strategic Partnership – Migrant Workers Working Group	Last met 2006	South Hams
Herald Express	Weekly column written by Polish journalist, also available as PDF download on web. - http://i.thisis.co.uk/274137/binaries/polishpage.pdf	Teignbridge
Devon Partnership Trust.	Magdalena Wood. One of 7 BME Community Development Workers across the County working around wellbeing and mental health issues. Magda has a particular focus on Migrant workers. Torbay / Exeter, East and Mid.	Torbay / Exeter, East and Mid
Global Centre	Cultural Champions - A Cultural Champion is a Devon resident from another culture or religion, who comes into the classroom (or other space) to give pupils an authentic, personal view of their culture. In this way, Devon children and adults can learn about other cultures and people that live here, broadening their minds and breaking down barriers.	Devon
PolishLingua	Mid-Devon based community interpretation and translation service (offered through the Anglo-Polish Organisation) specialising in Polish/English language communications. Interpreters are migrant workers themselves who have received accredited training to carry out interpretation and translation for public services.	Devon

APPENDIX 6

DEVON MIGRANT WORKER TASK GROUP MEMBERSHIP (Current June 2009)

Contact for members is via: COMMUNITY COUNCIL of DEVON
info@devonrcc.org.uk

Age Concern Devon
Amber Initiatives
Anglo-Polish Organisation
Campaign for National Parks
CCD
CISCO
Community Council of Devon
Cornwall County Council
Devon & Somerset Fire & Rescue
Devon Adult & Community Learning
Devon and Cornwall Police
Devon County Council
Devon Local Involvement Network
Devon PCT
Devon Strategic Housing Group
Devon Workers Rights Unit
English @ Work Project
Equality South West
Exeter City Council
Exeter Community Initiatives
Exeter CVS
GOSW
Health and Safety Executive
Lloyds TSB
Mid Devon District Council
North Devon District Council
Plymouth city council
Royal Devon & Exeter NHS Foundation Trust
South Hams District Council
SWRDA
Teignbridge District Council
Torridge District Council
TUC
TUC - Union Learn
University of Exeter

Identifiable Actions to Reduce the 2002-04 Gap in Infant Mortality²⁰

What would Work

Reducing conceptions in under-18s in the R&M group by 44% to meet the 2010 target

1.0

Reducing overcrowding in the R&M group, through its effect on SUDI

1.4

Targeted interventions to prevent SUDI by 10% in the R&M group

1.4

Reducing rate of smoking in pregnancy by 2 percentage points by 2010

2.0

Reducing the prevalence of obesity in the R&M group to 23%

2.8

Meeting the child poverty strategy

3.0

Immediate actions

Optimising preconception care

Early booking

Access to culturally sensitive healthcare

Reducing infant and maternal infections

Long-term actions

Improving infant nutrition

Improving maternal educational attainment

Actions / Interventions

Targeted prevention work at-risk teenagers and targeted support for pregnant teenagers and teenage parents

Increase the supply of new social housing; pilot innovative approaches to making temporary social stock permanent; encourage better use of housing stock

Maintain current information given to mothers and target the Back to Sleep campaign and key message to the target group

Smoking cessation as an integral part of service delivery for the whole family during and after pregnancy

Support the contribution LAAs can make to tackling obesity

Develop plans to implement NICE obesity guidance with a focus on disadvantaged groups

Develop plans to help women with a BMI of over 30 to lose weight by providing a structured programme of support

Help lone parents into work

Ensure that people stay in work and progress in their jobs

Develop a family focus in DWP's work with all parents

Tax credit measures

Provide comprehensive preconception services

Provide advice / support for at-risk groups within the target group e.g. BME groups

Increase direct access to community midwives

Provide 24/7 maternity direct line for advice and access

Implement NICE antenatal and postnatal guidelines

Health equality audit of women booked by 12 weeks and more than 22 weeks gestation

Commissioners and maternity service providers agree improvement plans in contract

Improve uptake of immunisation in deprived population

Implement Baby Friendly standard

APPENDIX 8

National Institute for Health and Clinical Excellence (NIHCE) Clinical Guideline 23 (amended) 2007, Depression: Management of Depression in Primary and Secondary Care²¹

Key priorities for implementation

Screening in primary care and general hospital settings

- Screening should be undertaken in primary care and general hospital settings for depression in high-risk groups – for example, those with a past history of depression, significant physical illnesses causing disability, or other mental health problems, such as dementia.

Watchful waiting

- For patients with mild depression who do not want an intervention or who, in the opinion of the healthcare professional, may recover with no intervention, a further assessment should be arranged, normally within 2 weeks ('watchful waiting').

Antidepressants in mild depression

- Antidepressants are not recommended for the initial treatment of mild depression, because the risk–benefit ratio is poor.

Guided self-help

- For patients with mild depression, healthcare professionals should consider recommending a guided self-help programme based on cognitive behavioural therapy (CBT).

Short-term psychological treatment

- In both mild and moderate depression, psychological treatment specifically focused on depression (such as problem-solving therapy, brief CBT and counselling) of 6 to 8 sessions over 10 to 12 weeks should be considered.

Prescription of a Selective Serotonin Reuptake Inhibitor (SSRI)

- When an antidepressant is to be prescribed in routine care, it should be a selective serotonin reuptake inhibitor, because selective serotonin reuptake inhibitors are as effective as tricyclic antidepressants and are less likely to be discontinued because of side effects.

Tolerance and craving, discontinuation/withdrawal symptoms

- All patients prescribed antidepressants should be informed that, although the drugs are not associated with tolerance and craving, discontinuation/withdrawal symptoms may occur on stopping, missing doses or, occasionally, on reducing the dose of the drug. These symptoms are usually mild and self-limiting but can occasionally be severe, particularly if the drug is stopped abruptly.

Initial presentation of severe depression

- When patients present initially with severe depression, a combination of antidepressants and individual CBT should be considered as the combination is more cost-effective than either treatment on its own.

Maintenance treatment with antidepressants

- Patients who have had two or more depressive episodes in the recent past, and who have experienced significant functional impairment during the episodes, should be advised to continue antidepressants for 2 years.

Combined treatment for treatment-resistant depression

- For patients whose depression is treatment resistant, the combination of antidepressant medication with CBT should be considered.

CBT for recurrent depression

- CBT should be considered for patients with recurrent depression who have relapsed despite antidepressant treatment, or who express a preference for psychological interventions.

NICE Guideline – depression (amended April 2007)

APPENDIX 9

National Institute for Health and Clinical Excellence (NIHCE) Clinical Guideline 22 (amended) Issued April 20007, Anxiety (amended) Management of Anxiety (panic disorder, with or without agoraphobia and generalised anxiety disorder) in Adults in Primary, Secondary and Community Care²²

Key priorities for implementation

General management

- Shared decision-making between the individual and healthcare professionals should take place during the process of diagnosis and in all phases of care.
- Patients and, when appropriate, families and carers should be provided with information on the nature, course and treatment of panic disorder or generalised anxiety disorder, including information on the use and likely side-effect profile of medication.
- Patients, families and carers should be informed of self-help groups and support groups and be encouraged to participate in such programmes where appropriate.
- All patients prescribed antidepressants should be informed that, although the drugs are not associated with tolerance and craving, discontinuation/withdrawal symptoms may occur on stopping or missing doses or, occasionally, on reducing the dose of the drug. These symptoms are usually mild and self-limiting but occasionally can be severe, particularly if the drug is stopped abruptly.

Step 1: Recognition and diagnosis of panic disorder and generalised anxiety disorder: the diagnostic process should elicit necessary relevant information such as personal history, any self-medication, and cultural or other individual characteristics that may be important considerations in subsequent care. (See also 'Which NICE guideline?' page 4.)

Step 2: Offer treatment in primary care: There are positive advantages of services based in primary care practice (for example, lower drop-out rates) and these services are often preferred by patients. The treatment of choice should be available promptly.

Panic Disorder

- Benzodiazepines are associated with a less good outcome in the long term and should not be prescribed for the treatment of individuals with panic disorder.
- Any of the following types of intervention should be offered and the preference of the person should be taken into account. The interventions that have evidence for the longest duration of effect, in descending order, are:
 - psychological therapy (cognitive behavioural therapy) (CBT)

- pharmacological therapy (a selective serotonin reuptake inhibitor [SSRI] licensed for panic disorder; or if an SSRI is unsuitable or there is no improvement, imipramine^a or clomipramine²⁵ may be considered)
- self-help (bibliotherapy – the use of written material to help people understand their psychological problems and learn ways to overcome them by changing their behaviour – based on cognitive behavioural therapy principles).

Generalised Anxiety Disorder

- Benzodiazepines should not usually be used beyond 2–4 weeks.
- In the longer-term care of individuals with generalised anxiety disorder, any of the following types of intervention should be offered and the preference of the person with generalised anxiety disorder should be taken into account. The interventions that have evidence for the longest duration of effect, in descending order, are
 - psychological therapy (cognitive behavioural therapy) (CBT)
 - pharmacological therapy (a selective serotonin reuptake inhibitor) [SSRI]
 - self-help (bibliotherapy based on cognitive behavioural therapy principles).

Step 3: Review and Offer Alternative Treatment: if one type of intervention does not work, the patient should be reassessed and consideration given to trying one of the other types of intervention.

Step 4: Review and Offer Referral from Primary Care: in most instances, if there have been two interventions provided (any combination of psychological intervention, medication, or bibliotherapy) and the person still has significant symptoms, then referral to specialist mental health services should be offered.

Step 5: Care in Specialist Mental Health Services: Specialist mental health services should conduct a thorough, holistic, re-assessment of the individual, their environment and social circumstances.

Monitoring

- Short, self-complete questionnaires (such as the panic subscale of the agoraphobic mobility inventory for individuals with panic disorder) should be used to monitor outcomes wherever possible.

²⁵ Imipramine and clomipramine are not licensed for panic disorder but have been shown to be effective in its management.