https://www.brushstrokessandwell.org.uk/nrpf-better-pathways

Better Pathways project: Briefing Paper 5 (March 2025)

NRPF and public health: needs, gaps, and best practice

1. Introduction: the Better Pathways briefing series

The Better Pathways five-part briefing paper series responds to current areas of challenge arising for cross-sector frontline practitioners who are supporting individuals and families with the No Recourse to Public Funds (NRPF) condition. Each briefing paper collates up-to-date information on legal definitions, policy changes, insights from academic research, shares reflections and good practice from frontline practitioners across the statutory and third sectors, and signposts to useful resources.

Each briefing ends with working recommendations to develop more supportive pathways to better outcomes for people with NRPF. The briefings can be used as helpful guides for frontline practitioners and as a continuous professional development tool to keep abreast of current NRPF issues from practice and research. The briefing paper series, as well as the Better Pathways Charter for NRPF Best Practice can be accessed at: https://www.brushstrokessandwell.org.uk/nrpf-better-pathways

This fifth briefing paper focuses on challenges and best practice in the area of access to health services for people with NRPF and includes primary research data carried out across the West Midlands region.

Key points from Briefing Paper 5:

- **Everybody in the UK is entitled to access NHS health care services**, regardless of their immigration status.
- Primary healthcare treatment in the form **of GP and nurse consultations are free to everyone.** However, a person may be charged for dental treatment, eye tests, prescriptions, and other additions.
- People on low incomes and those meeting certain eligibility requirements can be supported to access help with additional primary healthcare charges through the **HC2 certificate process.**
- A person (and their dependents) applying for 'leave to remain' or leave to enter the UK are required to pay an **Immigration Health Charge ('NHS surcharge').**
- People who are **not classed as 'ordinary residence'** and have not paid the NHS surcharge or do not have an exemption certificate are **chargeable for treatment.**
- **Chargeable treatment is considered in three categories: immediately necessary, urgent, and non-urgent, and cancer care is also considered under these categories.** Payment is required upfront for all types. Payment will be required for all treatment. Non-urgent care will not be provided unless payment is provided up front (treatment under the other types can be given before payment).
- **Barriers in access to healthcare for people with NRPF:** language and literacy; fear and distrust; financial poverty; cultural barriers; lack of awareness regarding entitlements to healthcare.
- **Barriers for healthcare professionals:** gaps in knowledge/training of NRPF statuses and bespoke support needs, recognising emotional abuse, cultural competency/communication; the need for systems-change such as joined-up cross-sector discharge plans and support from central Government for funding of specialist projects to address NRPF needs.
- **Best practice examples** include partnership working within sectors and cross-sector, including a case study of social prescribing for newly arrived migrants communities in Dudley.
- **Recommendations** are made for policymakers; NHS; cross-sector organisations.

2. Access to healthcare for people with NRPF

Equity of access to health care, irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status, is one of the seven underpinning principles of the National Health Service's (NHS) Constitution for England (Department of Health and Social Care [DHSC],

2023). The Constitution also comprises the core values of the NHS with 'respect and dignity', 'compassion' and 'everyone counts' amongst them.

The NHS, for a large part of its history, was considered comparably to other international healthcare systems and as an exemplar of universal healthcare, yet now many describe the NHS as being in a state of 'perma-crisis' (Anandaciva, 2023). Inevitably inequities to access to healthcare do exist for individuals and groups, in the context of the NHS and other health care systems around the world that are likely reflective of wider societal inequalities, and whilst governments are striving to address these inequalities, a clearer picture is required of the complexities for certain groups (Goddard & Smith, 2001).

Research commissioned by the Equality and Health Commission, for example, brought to the fore challenges for people seeking or refused asylum to exercise their human rights in accessing healthcare in England, Scotland and Wales (Nellums et al., 2018). Similarly, research has shown health challenges and access issues related to vulnerable migrants more widely resulting from their NRPF condition (e.g. Quy, 2017; Howard, 2024).

Whilst the nature and extent of these inequities are hard to gauge, one key point to examine is whether there exists equal access for equal need, and with this raises two key questions *'what is need? what is access?'* (Goddard & Smith, 2001: 1149): questions that this paper gives some insight to through the primary research carried out with lived experience groups and professionals in the West Midlands (see Section 6).

3. Policy context: access to primary and secondary NHS care for people with NRPF condition

Health treatment through the NHS is not classed as a public fund for immigration purposes. This therefore means that NHS treatment can be accessed by a person regardless of their immigration or NRPF status (NRPF Network, 2025a).

However, when advising people with the NRPF condition it is important to consider the type of treatment, whether this is primary or secondary health treatment, and to take account of a person's immigration status within the overarching NRPF umbrella as this determines whether a person is required to pay for some types of treatment.

3.1 Primary NHS healthcare

Primary care is delivered through GP practices, NHS walk-in centres, dentists, pharmacists and optometrists, and these services can be accessed by everybody, regardless of their immigration status (NRPF Network, 2025a). This also applies to people who are temporary visitors to the UK who are in the UK for more than 24 hours and less than three months (DHSC, 2025b). Primary healthcare treatment in the form of GP and nurse consultations are free to all. However, a person may need to pay for prescriptions, dental treatment, eye care

or additions such as wigs and fabric supports unless they are eligible to apply for an exemption.

EXEMPTIONS TO PRIMARY HEALTH CARE CHARGES

A person can apply for an exemption to these charges if they meet one of the following criteria:

- age 60 or over
- age under 16
- age 16-18 and in full-time education
- pregnant, or had a baby in the previous 12 months, and has a valid maternity exemption certificate
- holds a medical exemption certificate because they have a certain medical condition (these need to be checked against the NHS's list of applicable medical conditions)
- are on a low income (which meets the eligibility in the NHS Low Income Scheme – an income of below £16,000 for everyone or below £23,250 if living permanently in a care home)

HC2 certificate:

Anyone is entitled to apply for the HC2 certificate, regardless of their immigration status. A person would need to be supported to complete an HC1 form which will be assessed and if eligible they will receive an HC2 certificate for a time limited period to exempt them from payment. If a person with the NRPF condition is receiving support from a voluntary/community organisation, charity, or council they would need a letter to outline the support they are receiving (NRPF Network, 2025a).

3.2 Immigration Health Charge ('NHS Surcharge')

The Immigration Health Charge (IHS) (also known as the 'NHS surcharge') was introduced in 2015. When a person applies for 'leave to remain' or leave to enter the UK they will have been charged the IHS which, once paid, means they will be exempt from paying for secondary healthcare treatment, that is from the date the visa is granted until the date it expires. If this is not the case, a person will be asked to pay for any treatment upfront and may be denied treatment if they are unable to pay for it (NRPF Network, 2025a). People who have paid the IHS will also still need to pay for certain types of primary services, such as prescriptions, dental treatment and eye tests.

The IHS is required to be paid by a person who is applying for a visa or immigration application, under the following criteria: for more than 6 months, if applying outside the UK;

for any length of time if applying inside the UK (DHSC, 2024a). The IHS also applies to all family members seeking to enter / remain in the UK with the main applicant. It must be paid in full for each year, or part of a year that the applicant (and their dependents) is applying to stay for. Guidance from the DHSC (2024a, Section 7) states that:

> 'Failure to pay the IHS (except when an exemption from paying it applies, or when the Home Secretary waives, refunds or reduces it) will result in an immigration application being refused or considered invalid, or, if leave has been granted, that leave will be cancelled.'

3.3 Secondary NHS healthcare

SECONDARY NHS HEALTHCARE: 'ORDINARY RESIDENCE'

Secondary health care services are residence-based, meaning that a person must have 'ordinary residence'.

'Ordinary residence' is defined as someone who is 'lawfully living in the UK on a properly settled basis to be entitled to free healthcare' (OHID, 2014). The key factors are someone who is living in the United Kingdom:

- lawfully
- voluntarily
- for settled purposes as part of the regular order of their life for the time being, whether for a long or short duration (DHSC, 2022).

For further information regarding ordinary residence for **EU nationals, post-Brexit** please see Section 3.4 below.

The DHSC (2022) have created an ordinary residence tool with some guiding questions for healthcare professionals to support them in establishing whether someone is entitled to free secondary healthcare for the following groups:

- UK Nationals
- from 1 July 2021, EEA/Swiss Nationals with EUSS
- non-EEA/Swiss Nationals with indefinite leave to remain

Importantly, this states that **each patient must be considered on an individual basis with a sensitivity of care concerning their individual situation**, such as the fact that someone who is homeless will not have evidence of proof of address, or an individual may not be able to produce bank statements as they may not have a UK bank account but they could still be

ordinarily resident (DHSC, 2022). The tool can be accessed at the following link: https://www.gov.uk/government/publications/help-for-nhs-to-recover-costs-of-care-from-visitors-and-migrants/settled-purpose-tool

EXEMPTIONS FROM SECONDARY HEALTHCARE PAYMENT (SERVICES):

The NHS Migrant Health Guide outlines the services that are currently free irrespective of country of ordinary residence (as long as a person has not travelled to the UK for the purpose of the treatment), including:

- accident and emergency services (not including those in a person is admitted as an inpatient or required to have outpatient care).
- services provided for the diagnosis and treatment of some communicable diseases, including HIV, TB and Middle East Respiratory Syndrome (MERS).
- NHS services provided for COVID-19 investigation, diagnosis and treatment.
- services provided for diagnosing and treating sexually transmitted infections.
- family planning services (not including termination of pregnancy or infertility treatment).
- services for treating a physical or mental condition caused by torture, female genital mutilation, domestic violence or sexual violence.
- palliative care services provided by a registered palliative care charity or a community interest company.
- services that are provided as part of the NHS 111 telephone advice line (OHID, 2014).

EXEMPTIONS FROM SECONDARY HEALTHCARE PAYMENT (GROUPS):

The Guide also outlines the groups that are exempt from charging, including:

- refugees (people who have been granted asylum, humanitarian protection or temporary protection under the immigration rules) and their dependants.
- asylum seekers (people applying for asylum, humanitarian protection or temporary protection whose claims, including appeals, have not yet been determined) and their dependants.
- people receiving support under section 95 of the Immigration and Asylum Act 1999 from the Home Office.
- children looked after by a local council.
- victims, and suspected victims, of modern slavery or human trafficking, as determined by the UK Human Trafficking Centre or the Home Office, plus their spouse or civil partner, and any children under 18 provided they are lawfully present in the UK.
- prisoners and immigration detainees (OHID, 2014).

With regards a person whose application for asylum has been rejected, they may still be exempt from charge if they are supported:

- under section 4(2) of the Immigration and Asylum Act 1999 by the Home Office.
- by a local council under section 21 of the National Assistance Act 1948.
- under Part 1 (care and support) of the Care Act 2014 (OHID, 2014).

3.4 NHS healthcare for EU citizens following the Brexit transition period

The NHS Migrant Health Guide establishes that access to medically necessary healthcare is still available to **short-term visitors** from the European Union through the European Health Insurance Card (EHIC) scheme. However, short-term visitors from the EU who are not covered by the new UK-EU agreement on reciprocal healthcare (including former UK residents) may be charged for NHS treatment. For short-term visitors who are covered by bilateral healthcare agreements between the UK and countries outside the EU, including Norway, Iceland, Liechtenstein and Switzerland there are no changes to healthcare entitlements (OHID, 2014).

In terms of **longer-term visitors or those who are re-settling** in the UK there are some important changes. For citizens of the EU, Norway, Iceland, Liechtenstein and Switzerland who move to the UK from 1 January 2021 for more than 6 months, they will be required to pay the Immigration Health Charge as part of their visa application (ibid, 2014). For EU citizens who were living in the UK on or before 31 December 2020, they must apply to the

EU Settlement Scheme by 30 June 2021 to maintain their healthcare entitlements in the UK (see Better Pathways Briefing Paper 1 for more information on supporting people to apply for the EU Settlement Scheme).

3.5 Charging arrangements for different types of care: immediately necessary, urgent, and non-urgent

The regulations for the charging of overseas visitors distinguishes between urgent or immediately necessary care and non-urgent care. Importantly, the regulations state that failure to provide urgent or immediately necessary treatment because of someone's inability to pay (either if they are unable or unwilling), or if they are undergoing investigations into their charging status could be unlawful under the *Human Rights Act 1998* or the *Equality Act 2010*. Urgent or immediately necessary treatment must also go ahead even if the patient has not yet been informed of possible charges.

IMMEDIATELY NECESSARY CARE:

Immediately necessary care is any treatment which, in the opinion of a clinician, is needed to:

- save a patient's life
- prevent a condition from becoming immediately life-threatening
- prevent permanent serious damage from occurring

Immediately necessary treatment must also include all maternity services.

CHARGING FOR IMMEDIATELY NECESSARY CARE:

Treatment for immediately necessary care **should never be withheld on the basis of charging issues, even if the patient is unable or unwilling to pay upfront** (DHSC, 2024, Section 4).

URGENT CARE:

'any treatment which, in the opinion of a clinician, cannot wait until the person can be reasonably expected to leave the UK.'

This includes clinical and non-clinical considerations. Clinical considerations, for example, refer to: 'the pain or disability a particular condition is causing; the risk that delay might mean a more involved or expensive medical intervention being required: the likelihood of a substantial and potentially life-threatening deterioration occurring in the patient's condition if treatment is delayed until they leave the UK'. Non-clinical considerations refer to: 'whether they should reasonably be expected to leave the UK to receive those relevant services. The longer they are expected to stay, the greater the range of their treatment needs (including, for example, certain types of elective care) that are likely to be regarded as urgent'

CHARGING FOR URGENT CARE:

Treatment for urgent care **should never be withheld on the basis of charging issues, even if the patient is unable or unwilling to pay upfront** (DHSC, 2024, Section 4).

NON-URGENT CARE:

'Treatment that can wait until the date a patient can reasonably be expected to leave the UK.'

CHARGING FOR NON-URGENT CARE:

'Relevant bodies **must not provide non-urgent treatment until the estimated full cost of treatment has been paid in advance** of receiving treatment' (DHSC, 2024, Section 4).

With regards to the charging process and whether this has to happen upfront or not, the regulations (DHSC, ibid) state:

> 'Relevant bodies must still charge overseas visitors (unless exempt) and obtain upfront payment if it is possible and appropriate to do so without causing a delay and should continue to inform patients of potential charges at the earliest possible opportunity.'

Whilst NHS professionals have discretion as to whether to treat people without charging for urgent or immediately necessary treatment without an upfront charge, they do not have discretion on whether or not to levy a charge. In terms of retrieving debts, the regulations state:

> 'Debt collection should not begin until after a final invoice has been issued. They should invoice for any treatment provided and take steps to recover charges afterwards if it has not been possible to obtain payment beforehand. Charges cannot be waived or cancelled by relevant bodies' (DHSC, 2024, Section 4).

If a patient is destitute or at risk of destitution the regulations advise that if a professional is concerned about the welfare of a patient they should refer to their safeguarding team, and also engage support for the person experiencing vulnerability either within their organisation or externally. Importantly, a person should not be denied urgent or immediately necessary treatment if they are unable to pay upfront (DHSC, ibid).

The regulations further refer to the amendment to Immigration Rules following a public consultation by the Home Office in 2010, with the resulting outcome that the Home Office now has discretion to refuse immigration application from people with outstanding NHS debts (regardless of where in the UK the treatment took place) above a certain level. 'Qualifying debts' are debts relating to single or multiple invoices of:

- £500 or more that have been outstanding for 2 months or more (from date of invoice), if invoiced on or after 6 April 2016
- £1,000 or more (if invoiced between 1 November 2011 and 5 April 2016) (DHSC, ibid).

4.1 Spotlight: access to cancer care for people with NRPF

For people with the NRPF condition who need essential cancer treatment the situation is complicated. It is advised that people who are classed as overseas visitors contact the Overseas Visitors Team in the hospital who will explain the process and advise whether a person has to pay (Cancer Research UK, 2025).

Considering the differentiations between urgent, immediately necessary, and non-urgent care outlined in the above section is vital when advising people with NRPF who are chargeable for treatment. Cancer screening and treatment would still be chargeable if not ordinarily resident and decisions on where treatment falls between immediately necessary

and urgent are clinical and based on reasonableness of how long the patient could wait to stop something becoming life threatening. Cancer screening which is deemed not an immediately necessary treatment is likely to be ineligible for this group and they would be charged or advised to seek the screening outside of the UK.

For people who are eligible for an HC2 certificate this also covers cancer treatment and potentially covers additional support, such as special equipment needed or additions such as wigs. Some people with cancer can apply for a medical exemption certificate (MEC) in order to get free prescriptions associated with cancer. To do this they would need to collect an FP92A form from their GP surgery, and this will last for five years and can be renewed if still eligible. The medical exemption certificate also includes certain other conditions, for a full list see:

https://www.nhsbsa.nhs.uk/check-if-you-have-nhs-exemption/medical-exemption-certificates

For people who are classed as undocumented, for example, if they have had their asylum case refused or have overstayed their visa expiration date, they can still be supported to apply for an HC2 certificate and get support that way (but eligibility for the latter case depends on the type of visa they hold). Otherwise, they would be expected to pay for their treatment. It is also important to consider whether an individual who is not normally eligible for support, who has essential care and support needs due to their health needs to have a human right assessment under Section 21 (see NRPF Network, 2023 in Section 8 reference list) for full guide).

4.2 Spotlight: access to pregnancy care for people with NRPF

All women in the UK are entitled to NHS maternity care regardless of immigration status. However, whether or not a woman will be charged for that care depends on her immigration and residence status at the time she receives that care (Maternity Action, 2025). A woman should be entitled to free NHS maternity care at the time they receive the care if they meet one of the exemption criteria outlined above in Section 3.2 above. For a full list of exemptions in relation to NHS maternity care please see ‘Entitlement to NHS maternity care’ below:

https://maternityaction.org.uk/advice/no-recourse-to-public-funds-financial-support-and-housing/#Entitlement_to_NHS_maternity_care

For women in England and Wales who are more than 10 weeks pregnant or a parent/carer who has a child under the age of 4, the Healthy Start scheme can be a key source of support in buying health food and drink like fruit and milk, and to get free vitamin supplements

Since May 2021, the Healthy Start policy was extended to British children aged under 4 years old from families with NRPF, or families that do not have an immigration status (DHSC, 2024b). In such cases, families have been able to access Healthy Start benefits, where

eligible. The NRPF Network (2025) outlines the eligibility for the Healthy Start support, if a person meets one of the following criteria:

- They have at least 1 British child under 4 years old.
- They earn £408 or less per month after tax.
- They have NRPF.

If the mother is under the age of 18 they will be able to access the Healthy Start support, without the requirement of claiming certain benefits in order to qualify for this support (DHSC, 2024b).

5. Research – literature

A brief review of research literature on NRPF and health issues, conducted within the last ten years, brought to the fore some key themes.

(i) Fear, reluctance, and trust

Fear, reluctance and trust was a prevalent theme. In the Equality and Human Right Commission's report (Nellums et al. 2018), focused specifically on access to healthcare for people who were seeking asylum or had been refused asylum. Fear was primarily connected to concerns that medical information could be shared and become a stimulus for immigration enforcement. It was suggested in Nellums et al.'s report (2018) in connection to wider literature, that this fear and connection with deportation is stronger for those refused asylum. Evidence of fears connected to certain medical conditions was also found, with people seeking asylum concerned that particular conditions could have a detrimental impact on their asylum application, the latter a point that also interconnected with barriers from cultural beliefs and stigma. The report also referred to negative experiences of wider systems and institutions, such as racial discrimination and abusive behaviour, as impacting negatively on trust of healthcare services and professionals (ibid).

From a broader perspective with wider migrants with the NRPF condition, Odumade and Graham's (2019: 10) research also raised issues of a lack of trust in professionals, reluctance to seek support, which 'coupled with fear and financial pressures could leave people with NRPF at substantial risk of health-related difficulties.' Great Chapel Street GP surgery in London is part of the Safe Surgeries Network, run by Doctors of the World that recognises general practices that commit to taking steps to tackle the barriers faced by migrants in accessing healthcare (Howard, 2024) Two GP clinical leads in Howard's study from Great Capel Street raised trust issues in relation to highly vulnerable individuals, such as people experiencing homelessness, as well as particular cultural groups, for example Roma communities. Fear amongst homeless Roma in Howard's study was connected to fear of deportation and avoidance of all authorities due to changes in legislation in relation to Romanians no longer having an automatic right to stay in the UK as economic migrants (ibid).

(ii) Language and communication barriers

The Equality and Human Rights Commission's report referred to language and communication as a significant barrier for people seeking or refused asylum. The report highlighted the potential of misdiagnosis of conditions, or people not understanding medication instructions. Other concerns were around the combination of language barriers combined with cultural factors that were particularly challenging for women, such as women having to communicate domestic or sexual violence issues or sexual health issues through male interpreters or with male healthcare professionals (Nellums et al., 2018). Communication barriers was also evident in problems with signposting and key information, such as people knowing what they were entitled to (ibid).

(iii) Financial challenges and charging

In Nellums et al.'s (2018) report, financial challenges intersected with legislation and policy barriers, with evidence of confusion about charging systems for UK secondary healthcare and a lack of consistency in practice regarding people who had had their asylum case refused and required urgent treatment and cases of refusal to treat people. Similarly, and covering a broader spectrum of people with NRPF, in Quy's (2017) study access to secondary healthcare and the impact of legislative changes was raised as a key issue. Quy's (2017) study brought together broad data including Doctors of the World case notes, interviews with migrant service users, healthcare professionals and advocacy workers, and found that the combination of fears of reporting to the Home Office, combined with healthcare charging delayed access to secondary healthcare. Other impacts included detrimental consequences on newly arrived migrants physical, mental and social wellbeing, proposing that this added to an overall widening of health inequalities (ibid).

Additional costs connected to healthcare were also raised as a concern in Nellums et al.'s report (2018), that connected to poverty for people with the NRPF condition more generally. For example, problems paying for phone credit to make appointments, lack of money for public transportation to get to appointments, and the ability of pregnant women and people with particular health conditions to buy nutritious food.

(iv) Knowledge gaps from health professionals

Gaps In awareness of entitlements for people seeking asylum, was evident amongst professionals working across different healthcare settings, leading to inaccurate or inconsistent information or policies applied incorrectly (Nellums et al., 2018). In the same report barriers in relation to professionals included evidence of staff feeling 'unprepared for dealing appropriately with cultural differences, such as religious beliefs and stigmatised or complex issues such as women who have experienced female genital mutilation'.

Howard (2024) refers to a 2023 report from Pathway and Crisis in which two thirds of medical and healthcare professionals reported that people without proof of address had been refused access to GP services. The GP clinical leads also referred to this as a significant barrier amongst homeless communities who were being denied access to GP services due to

being asked for proof of address and two forms of ID. They further referred to secondary healthcare for people with NRPF as a 'hostile environment'(ibid). One of the GP clinical leads Dr Beale shared: "Yet in the primary care contract, surgeries are not in fact allowed to discriminate on the basis of not being able to produce a proof of address", and referred to a sign in Great Chapel Street's reception area that reads: "It doesn't matter what your legal status is, you are entitled to register here." (Howard, 2024: 3).

6. Primary research findings: Better Pathways focus groups

As well as revisiting the four focus groups with people with NRPF lived experience carried out at the start of the project between August to October 2023, in January and February 2025 the Better Pathways research team conducted six additional lived experience focus groups with service users in Coventry (Coventry Refugee and Migrant Centre), Sandwell and Birmingham (Brushstrokes Community Project and four contingency hotels housing single males seeking asylum) specifically focused on the topic of health and NRPF. Additionally in early 2025, two online focus groups and two online interviews were carried out with ten public health professionals across the NHS, statutory and voluntary community sector (VCS) in the West Midlands.

Many of the themes were crosscutting across the lived experience and health professionals' group, with the main themes summarised below.

6.1 Health barriers for people with NRPF status and good practice to mitigate barriers

(i) Education, Language and Literacy

One health professional discussed the need to start with consideration of three key barriers, **education, language, and literacy,** elaborating further:

> 'If a person comes from the context of having low formal educational experiences, it will be much harder for them to make choices for their health. If people don't have the language it will be much harder for them to express their needs. If a person has low levels of literacy in terms of reading and writing they will not be able to read things like leaflets or the written translations on tools such as Google Translate. People with such needs are at a higher risk of mental health issues and disease' (NHS social prescribing link worker, Dudley).

Similarly, two professionals working in VCSO organisations also discussed the barrier of health literacy and the detrimental consequences this could have on people missing important diagnoses or accessing essential health information. One VCSO professional raised the issue of how potentially dangerous this could be in cases of cancer or other critical conditions that require specialist treatment, this includes the risk of people missing out on preventative screenings if they are not registered with a GP, such as mammograms or prostate cancer checks at a certain age as well as essential treatment:

> ‘at the moment there’s an exclusion of people potentially because of having NRPF, and if they're undocumented they might not be registered with a GP, so they're not going to be picked up in that normal sweep of cervical cancer, bowel cancer screenings…the GP letters that you get through when you become a certain age so, they're going to miss out from that. But also because it's speculative testing there's a group of people that are not entitled to that…’ (Project Manager, Brushstrokes).

One professional spoke of the need for urgent improvements in accessible modes of communication for essential information:

> ‘Clients who are given information sheets in English rather than their first language.... is something I hope changes soon regarding the NHS having to provide better health literacy...we find that people miss out on understanding a diagnosis or important health information and that supportive information given to them has not been understood. Our clients collect NHS letters and cannot establish what is important and what is not so important’ (Health advisor, Wolverhampton RMC).

Within health literacy more widely, digital literacy was also raised as an important concern with the need for positive action to support both the understandings of patients but also of NHS professionals so that appropriate systems changes could be activated. Two participants from the health professionals group discussed some of the issues they viewed in terms of digital access and general communication barriers which had a knock-on effect on the way that missed appointments were being recorded on NHS systems, without any details of the nuances of why this was happening:

> ‘The NHS has gone digital and a lot of work needs to be done for migrants and the whole population for this digital transition. I see a lot of problems arising from this. For example, not having digital access so being unable to view appointment details, or not understanding how to open an email or a link. And this then becomes categorised as a ‘did not attend’ without any understanding from professionals as to why this happened’ (NHS social prescribing link worker, Dudley).

> ‘Many new migrants are scared to make a phone call so if that’s the only way to book an appointment it is already a barrier for them as they need to be able to communicate what they want...if they are late they don’t understand what happened’ (NRPF advisor, Brushstrokes).

For lived experience individuals, these barriers manifested in different ways. Two participants described situations of distress caused by professionals shouting at them when they had accessed accident and emergency services with their children and were told it was not deemed an emergency. For others this was caused by a lack of understanding of the processes around UK healthcare, such as how to make a GP appointment or how to use the NHS app to order a repeat prescription.

In terms of good practice to overcome education, language and literacy barriers, two examples were shared from NHS professionals from Dudley (see Section 6.3 for full case study of one example). One professional described the work her and her team were doing to improve signposting and awareness of health information internally within the NHS as well as outward-facing information:

> "a lot of what we're trying to do is making sure that people know how to access health, what they can access. So, I work on a website. And also, we've got a Dudley specific network group that we've recently started and so I support our DCBs [Data Coordination Boards] with our voluntary services in Dudley" (NHS public health improvement practitioner, Dudley).

(ii) Lack of awareness of healthcare rights: migrants with NRPF and professionals

Several of the lived experience participants shared that they were not aware that they could access free NHS primary healthcare when they first came to the UK. Three participants from Ghana, Nigeria, and Benin who had come to the UK on visitors visas initially, expressed that this was due to them assuming they were not eligible to access healthcare. This was combined with assumptions based on their home country where people do not have to register first, and rather would go straight to a hospital when sick walk into a hospital and be seen, as long as they could pay for the treatment.

Four participants, two of whom were undocumented and two who had previously been, shared that they had not gone to the GP due to fear, for example:

> "To be honest I was scared because I was an overstayer….and I was thinking where am I going to go now where they won't stop me?" (lived experience participant, Coventry).

> "I didn't get nothing at all for many many years because I was scared because I'm an overstayer. I mean in the pandemic I had a lot of tooth pain and I pulled my tooth out myself and it was so horrible and painful, and then someone told me to come here and get help through the HC2 form and I get help with the doctor, dentist, and eye optician" (lived experience participant, Wolverhampton).

Four women shared mixed experiences of care whilst pregnant: two positive and two less so. Two women classed alluded to a reduced experience of 'gatekeeping' when they became pregnant:

> "When you go to the GP the first thing they ask for is your ID and if you don't have that they can't do anything. But when you are pregnant things are different" (lived experience participant, Coventry).

> "Yes when I was pregnant they didn't ask for anything….it depends on the receptionist….before I got pregnant I had no access to medical care" (lived experience participant, Coventry).

One woman described a lack of signposting to support from her GP when she was pregnant and a distressing experience when she went into labour. Another woman described a distressing situation where she was told she would be unable to deliver her baby due to high blood pressure and was refused a scan due to not being able to pay for it and was given the number for an abortion clinic.

In terms of good practice in this area of communicating migrant rights, some of the VCSO participants shared the way that they were supporting people to access wide forms of support, and through this making people aware of their entitlements and working to reduce inequalities. This included supporting people with the HC2 certificate process:

> "Clients that have NRPF need supporting with HC2 Certificates to access Health services, such as dental, Opticians, and to obtain their medicines. I help everyone to register with GP Surgeries. I cancel fines from hospitals, and fines from other penalties such as environmental penalties like street littering. I also help with Healthy Start support…as well as mobile phones for people who have medical issues and need to make contact with their surgery. I also support clients to loan a laptop to reduce digital inequalities .... " (Health advisor, Wolverhampton RMC).

Another VCSO professional referred to similar support they provided for newly arrived migrants living in hotels:

> "much of our work is also around helping all migrants to understand their entitlement to health services and where to access health services that are appropriate to their conditions, and to reduce the potential of them going straight to Accident and Emergency. So, we'll help with GP registration, help with specialist referral. We have some kind of mental health counselling provision as well on site and some therapeutic interventions too, as well as health awareness sessions with guests such as cancer awareness sessions" (Project Manager, Brushstrokes).

Another professional currently supporting people living the contingency hotels also shared the way people were supported by SERCO staff at the hotel to book GP and dentist appointments, taxis for transportation, as well as booking interpreters at the GPs if necessary.

(iii) Health issues directly connected to NRPF condition

In one of the health professionals' focus groups, a tuberculosis (TB) nurse shared the connections they saw between the poor housing conditions and vulnerability to exploitation that came with having NRPF as directly impacting the increased potential of people getting TB:

> "It's important to understand that TB is often a consequence of complications and social complications that they're in due to their NRPS status. So they're on social housing, their lack of access to nutrition, they're working in sort of unsanctioned

accommodate workplaces that have a very high turnover of staff. And they often have very little documentation which makes TB tracing and contact tracing impossible in those situations…. We can't effectively contact trace that population because they aren't actually aware of the full details of the people they've been sharing accommodation with….so it often allows TB to spread quite freely within this this cohort of people" (TB nurse, Sandwell).

The mental health impacts of having the NRPF status were shared across the lived experience and professionals' focus groups. For example, the lengthy waiting times combined with uncertainties and worry associated with the immigration process were highlighted by lived experience participants as having a detrimental impact on their mental health:

> "I was really depressed because of the waiting time, and nothing I could do just wait" (lived experience participant, Coventry).

> "I had a lot of terrible headaches. The waiting period is a lot of stress for us because we don't know what the answer will be. I got a lot of headaches, depression. And even when I got status they initially continued due to the housing issues. I felt scared because I have health problems and was worried about where I would be housed" (lived experience participant, Coventry).

> "We wait and wait…I walked ten countries to get to here… We have family to support back home….and not having work permission and no income we can't support them….we didn't come to this country to sleep and eat, we came to improve our lives and when we have no right to education or work, life is so meaningless…." (lived experience hotel participant Sandwell, – translated from Farsi).

Two participants referred to the impact the worry had on their sleep:

> "I've been on medication for depression for almost three years now and every day I take six different medications and at night I have to take some, the doctors told me to take three sleeping tablets but sometimes I think three is too much...sometimes I take one or two. I can't sleep…and it affects my mental health" (lived experience participant, Sandwell).

> "I worry a lot and I can't sleep day or night" (lived experience hotel participant Sandwell, – translated from Farsi).

One professional discussed the detrimental impact of isolation as a result of people's living situations on mental health, and alluded to the importance of the GP as a key contact person in the preventative journey to slow down the potential of mental health issues exacerbating further:

> "If a person has been placed in a community where they do not know anyone and do not speak the language they will start to become very isolated. And there may be

services in the community but they might not know where they are because they have not spoken to anyone. So GPs in our community have become a source of support for these essential needs and are often the first point of contact for isolated people" (NHS social prescribing link worker, Dudley).

One of the lived experience participants living in one of the contingency hotels, shared their experience of being relocated, talking in positive terms about the temporary community that was cultivated in the hotels but how this then disappeared when they were moved and faced another period of uncertainty:

> "Another big problem for everyone is normally after a few months people get their dispersal information, and normally it's quite far so in that time in the hotel you've been going to a college or making some friends, creating a bit of a community, mosque, church, and suddenly they send you to a city six or seven hours away and you have to start all over again" (lived experience hotel participant Sandwell, – translated from Farsi).

(iv) Cultural beliefs and understandings of mental health

Continuing the theme of mental health, several of the health professionals referred to barriers that emanated from diverse cultural beliefs or ways of life, such as on the topic of immunisations during the COVID-19 pandemic. For example, one professional referred to specific barriers connected to Gypsy, Roma and Travelling communities:

> "Because they're a population that moves around a lot…it's trying to get the letters out to them and knowing where to send those letters…And also in terms of things like immunisations…and this is with the Gypsy Rama Traveller community as well. they're very much against the immunisations. Apparently, there was a Pope in the 1970s that said, not to have immunisation and they're still very, very much of that opinion" (NHS public health improvement practitioner, Dudley).

Two professionals referred to cultural beliefs around domestic violence, in terms of differences in how violence is conceptualised and in terms of willingness to be examined:

> "Domestic violence is also understood differently in different cultures: for example, women might put up with it for a long time because they have a different understanding of violence and then by the time they come to seek help it has been going on so long that they may have severe depression or anxiety or having suicidal thoughts" (NHS social prescribing link worker, Dudley).

> "In terms of domestic violence, it's really difficult to convince those ladies to get the treatment they required. So sometimes they're happy to see the doctor, but they're not letting doctor examine them properly" (NRPF advisor, Brushstrokes).

In relation to the latter quote and intimate health examinations, one of the NHS professionals referred to the way that this was considered taboo to discuss in many cultures and how barriers often came from within the community itself:

> "These are the sorts of screenings that are very personal and intimate.
> And it might be that with some of the cultures that they don't want that their women to go and do this" (NHS public health improvement practitioner, Dudley).

Sharing an example of good practice in this area, one professional discussed the need to carefully adapt her language accordingly when discussing such issues:

> "People know what mental health is but they have different understandings of it, based on their religious or other beliefs. They often will not seek support or want to talk about it as find terms such as 'depression' and 'mental health' as labelling. I'm a Mental Health First Aider. I have to be very sensitive in how I talk about it. The language must be sensitive to the individual person so that they understand it from a stress perspective. If a person has depression or anxiety, it is better to refer to it in terms of stress and discuss what activities they could do to manage stress" (NHS social prescribing link worker, Dudley).

(v) Poverty and NHS Charging

The financial impacts of NRPF on overall wellbeing was a key theme that was shared across all of the focus groups. One NHS professional summarised the issues as follows:

> 'Immigration is a determinant of health. People with NRPF are more vulnerable to poverty and if people do not documents this restricts people's access to employment, financial support, housing, some education. From a public health point of view, when these needs are not met people will worry, become anxious. We see a lot of social related anxieties caused by poverty, homelessness, poor housing/living conditions that are not appropriate for their needs' (NHS social prescribing link worker, Dudley).

Another professional, who also came from a lived experience of having previously had NRPF, discussed the 'vicious cycle' of poverty that means that you cannot afford good quality nutritious food, which in turn impacts on mental wellbeing:

> "I was struggling to pay for everything, combined with the knock-on effect of stress…..I couldn't afford good food so wasn't eating properly. I think with mental health it's a slow process that's still ongoing….you can get into a bit of a trap so if not eating well and not able to look after yourself properly and then you put on weight…it's harder to get out of than it is to get into" (Health professional, Coventry RMC).

NHS charging was a significant theme across both lived experience and professionals' groups. Amongst the lived experience groups at the start of the project, challenges in relation to international students were specifically raised, such as the additional costs for prescriptions and ambiguities/inconsistencies in terms of the NHS health surcharge:

"Sometimes we don't need to go or don't need any surgery but still we have to pay in advance for a service that we may or might not use…and even after making such payments for the healthcare, it's really very difficult to connect to the GP and to get an appointment when it is needed. If I'm sick the medicines they will prescribe and I then have to go and buy from some place. So I've already paid for the healthcare why am I paying for the medicines, it should all come within it? These are the basic medicines. It can come to around £700 a year for the medicines alone. If I'm not using the health service at all that money is totally wasted, if I am using it it's just the consultations I'm getting free, the medicines I'm buying" (lived experience participant, Birmingham).

"The advance fees is one thing and then there are the fees for the six month phases….recently I extended my visa because my course wasn't over and it was 7 months and I had to pay for an entire year of the NHS, and it wasn't just me it was my dependents as well. And again, that is the same visa, my friend was also applying, he also had an extension of 7 months but he just paid 6 months so it was like depending on case to case they are saying which is unfair. I have to pay £500 per person and my friend didn't. Fees should therefore be calculated on a monthly basis and be standard for everyone" (lived experience participant, Birmingham).

The fees had also been a challenge for several participants who were not on international student visas. Some had received bills when they were going through the asylum process and had been supported to contact the hospital to explain their situation and to access a HC2 certificate. Another woman who was now undocumented was shared her experience of having to previously work extensive hours per week and not see her children in order that she could pay the instalments from the NHS, and shared that she was now unable to work due to having high blood pressure and mental health issues:

"My son is a type-1 diabetic…he was in Sandwell hospital for two or three weeks and his total amount came to £6500….so every month I have to pay in instalments….and then when I had my daughter and had a C-section the total amount with my son and daughter is over £17,300… I can't work now because of my mental health and high blood pressure and have to look after my son but still I am paying. I am overstayer at that time" (lived experience participant Sandwell – translated from Punjabi).

Another participant on a spouse visa, shared her experience (through a translator) of expenses of £4,300 as a result of having her baby prematurely. Due to depression she was unable to work and her husband and her and the baby have been living in shared accommodation for five years and are still paying off the fees.

Professionals in the focus groups also raised concerns around the fear that the bills created, which impacted on people receiving essential treatment such as cancer care, and potentially self-excluding from maternity care due to fear of having to pay for treatment and tests:

> "I've seen clients come in with those bills. And they are told if they don't pay the bills it can influence your Home Office decision. So that will scare people with NRPF to go in and access healthcare because they think if I have a bill I can't pay they're going to kick me out of the country" (Health professional, Coventry RMC).

> "There's a question then in terms of cancer treatment…obviously with cancer, you can't necessarily tell how long treatment is needed for, so you're leaving people in a worse situation saying you've got this, but actually we're not going to treat you because it's not an urgent issue at the moment or it is an urgent issue and we're going to but you're going to have to pay for it" (Project Manager, Brushstrokes).

One professional raised multi-layered concerns about the impact of the charging system on children, as well as on people's ability to gain citizenship which in turn placed more pressures on the systems that were already under immense pressures:

> "For children with NRPF there's a conflict between withholding treatment until payment is made and what is in the best interests of the child? Also, NHS debts are going to be a barrier for those with NRPF to resolving their immigration status, with consequential impacts on Local Authorities / Children's Trusts" (Project Manager, Brushstrokes).

Another issue raised across both groups was regarding costs for essential letters. One lived experience participant had had to pay £60 per letter for her and her two children. One professional raised ethical concerns around this charging process:

> "They are taking advantage because they know that this letter is very important for immigration purposes and they charge for the letter. The thing is here if you are an overstayer the only record of confirming your residence in the UK will be your doctor and that can be accessed by anyone, by the human rights, and they know you need it" (NRPF advisor, Brushstrokes).

6.2 Barriers for health professionals supporting people with NRPF status

(i) Gaps in knowledge regarding NRPF and migrants' entitlements combined with system complexities

Specific barriers for health professionals also emerged from the focus groups. Two lived experience participants explained that they had tried to access the GP but had been prevented by the receptionist due to overstaying their visa, alluding to this role as acting in a gatekeeper capacity:

> "I did try once in 2014 [to access GP services], but they asked for my current passport and my passport had already expired and I was an overstayer. So I couldn't do it. I don't think it's everyone who can access it unless you tell me otherwise" (lived experience participant, Coventry).

> “When I went that the receptionist didn’t even ask me my symptoms, just said in order to register me she’d have to see my passport. And being an overstayer I didn’t have it to show her” (lived experience participant, Coventry).

This point was also reiterated by two health professionals who discussed a gap in understanding by some NHS staff as to the entitlements of migrants with NRPF:

> “I think one of the things for sometimes for frontline health professionals, there is still a confusion about what NRPF means…and it can often be interpreted as you're not entitled to healthcare” (VCSO Project Manager, Sandwell).

> “I think there are some doctors, nurses, receptionists who don’t know….the receptionists tend to be the gatekeeper…and asks for your symptoms….I don’t know that they are all aware that anyone can access the care” (Health professional, Coventry).

With regards women with NRPF who are victims of domestic violence, one professional highlighted potential gaps for some GPs and nurses in awareness of the signs of emotional abuse, as well as gaps in communicating to women essential details about their medication:

> “They [primary health care professionals] do have a good understanding of physical abuse but we are finding gaps in their understanding of emotional abuse – e.g. how it can affect them mentally, how she can get confused with dates, confused with events that occurred connected to the violence…..We are also finding they are often missing diagnoses around depression and severe anxiety and often prescribing medication for things like sleeping but the women don’t understand how to take them properly” (NRPF professional, Birmingham & Solihull Women’s Aid).

Two health professionals alluded to feeling overwhelmed at the ever-changing eligibility criteria and policies that makes it challenging to keep up with and to support people with NRPF who are in the same position of not knowing their entitlements, and for those that do not have documentation this becomes even more challenging:

> “It's just such a moving feast all the time that I can't stay on top of it, and I just can't wrap my head around it sometimes. And people that are in this situation, they don't know what their situation is exactly. So, it's really difficult just to get to the bottom of it all the time. I just really struggle so much with it” (NHS public health improvement practitioner, Dudley).

> “So the only experience we've got with NRPF is sort of lived experience with having a case-by-case basis, I don't think we've had any sort of formal training or any other way to understand it. And very often there's no document to check and when there's no documentation to check and they're actually not aware themselves, it's very difficult to know” (TB nurse, Sandwell).

Evidence of this was also clear during the focus group when two of the health professionals shared that they did not know that transport costs could be reclaimed through the HC2 certificate process, shared by another health professional. Another participant from the professionals' group, in relation to the same point, discussed that the complexities of the systems were challenging for both professionals and therefore this was exacerbated to a much greater degree for patients:

> 'And with the HC2 you can claim refund for transport but the process of doing that is complicated, accessing the form, printing it, filling it out, providing receipts, sending it back – and it's the complexities of the systems that is not straightforward…..there's a lot of bureaucracy involved and that's a huge barrier' (NHS social prescribing link worker, Dudley).

(ii) Funding constraints

Participants from the professionals group referred to what ongoing funding constraints across the VCSO sector, statutory sector and the NHS looked like in practice. For Coventry RMC, one important way they had supported people with NRPF who were experiencing health challenges due to poverty was through support with bus tickets to get to appointments and subsistence contributions:

> "We now can't give bus tickets regularly because the funding has gone. And now we only can give half as much subsistence support as we used to (now £10 a week) and we're due to run out of it in a few months" (Health professional, Coventry RMC).

Another way that funding constraints were evident was a lack of access to interpreters in GP services for women with NRPF who are victims of domestic violence, as one professional shared:

> "We are finding that many GPs are not being able to provide interpreters so then the woman have a lack of confidence to call the GP or to go in person to the GP because she knows because of her language barrier she won't be able to explain herself" (NRPF project professional, Birmingham & Solihull Women's Aid).

(iii) The need for systems-change

Expanding on the issue of funding constraints in the form of lack of human and other resources, many of the professionals shared examples of the need for a large macro system-change approach in order to address the scale of the issues. One of the local government professionals considered the lack of funding for specialist support projects on NRPF given the large numbers of people who have the condition and the need for much more responsibility and support from central government to break a bigger cycle of poor health and poverty:

> “I think the government needs to take more of a responsibility. How are we supporting those individuals? Because at some point they are going to have some sort of accident or they are going to deteriorate because they're not getting the right healthcare or dental care or GP support so they are that they are going to deteriorate. But what are we doing as a system? It's not just one person's responsibility. It should be everyone's responsibility, but I don't think we’re all joined up together” (Operational Head, Sandwell).

Many of the examples raised connected to lack of availability of accommodation. One voluntary sector professional explained the unrealistic expectations on them to fill the gaps that were not being provided by local government:

> “The first point of contact when people get their leave to remain status after having NRPF is to go to the Council because they are now entitled to a house and other support, but then the Council gives them a letter telling them to come here….because the Council won’t house them if they are lower priority. But then we can’t…..” (Health professional, Coventry RMC).

Additional issues connected to funding cuts and housing were raised by three of the NHS professionals, in relation to appropriate discharge pathways for patients:

> “We do get quite a lot of NRPF patients get admitted and we do have quite a few patients who have extended stays on the ward and we’ve no exit plan for them at all. I have had previous conversations with local authority about you know their input in terms of, are they responsible for supporting with accommodation and so forth. But the only time I'm aware that the local authority can support with NRPF is when someone's Section 117 eligible and they have social needs. And I have approached the Home Office directly regarding a couple of patients and their advice to me was unless the patient is going to actively opt for deportation there's nothing that they can do” (Discharge Coordinator, Mental Health, Sandwell)

> “So although there was money available to sort the accommodation [for people on the TB pathway], actually there's still no one that was willing to house these individuals, the local authority had no responsibility to provide them with social housing, and we had to come up with a way of how local authority housing department would engage with third party landlords to sort of facilitate them, to be housed” (TB nurse, Sandwell).

For one NHS professional, there had been a shift in previous support in the discharge pathway due to changes with social workers, presumably due to capacity issues:

> “The social workers in Dudley are no longer in the hospitals and this is where the problem comes. So, before COVID, you had social workers actually based in the hospital, and they'd go in and make sure that a housing assessment was done and a

document would be sent to the housing team to tell them that this person is being released to them with all their information in order to house them appropriately…but now people are just turning up" (NHS public health improvement practitioner, Dudley).

6.3 Best practice in supporting access to health for people with NRPF

As well as bringing to the fore current challenges from the perspectives of lived experience individuals and frontline professionals, a key element of the Better Pathways project is to cultivate a culture for sharing cross-sector best practice so that peer support can be developed and statutory departments and VCSOs across the West Midlands can learn from examples of where practice is working well under constrained resources.

As well as the examples of best practice discussed so far, some further examples were shared by the lived experience participants, and a more in-depth case study of best practice shared by one of the NHS professionals in Dudley.

(i) Examples shared by lived experience group

One of the Sandwell lived experience participants discussed the positive primary health care experiences he had received whilst destitute in Birmingham before applying for asylum, and whilst he was living in a hotel in Birmingham before then being housed in Wolverhampton. During this time, he was signposted to access GP services and nursing support at the Birmingham Homeless Health Exchange, a responsive NHS General Practice services (GP), designed to meet the needs of people who are homeless or in unstable accommodation (https://www.birminghamhomelessexchange.co.uk/). Describing his experience he shared:

> "I have a lot of serious medical conditions and have to see a lot of GPs and consultants regularly. The best experience I've had was in Birmingham at The Exchange….when I was on crutches the nurses there looked after me, and when I went there I had no money for a bus ticket or taxi and they helped me and booked a taxi to take me back to the hotel. I saw a difference in how they speak to you and how they explain it to you, they always made sure you were happy before you left…" (lived experience participant, Sandwell).

One of the Coventry lived experience participants also shared an example which had made a positive different to her overall mental wellbeing and physical health as it had enabled her to mix socially with new people, whilst learning ways to cook in healthy and nutritious ways:

> "It was a project called Fusion Through Cultures through an organisation called Brighter Moments….it was a special group for women who were undocumented and we come together every Wednesday morning when we'd dropped off our child at nursery….they gave us a lot of African food to share for those of us who didn't have papers and I did volunteering with them too. We did some cooking together and they had nutritionist that would come and tell us about healthy eating" (lived experience participant, Coventry).

(ii) *Strong partnership working to provide bespoke NRPF support*

Where practice was working well there were strong partnerships between statutory services, the NHS, and the voluntary and community sector. This is the case, for example, with the TB team at Sandwell NHS Trust who have close partnerships with Brushstrokes charity for immigration and wider advice. Similarly, the mental health team in Sandwell NHS Trust, who have close partnerships with Brushstrokes charity as well as the Operational Head of acute hospitals at Sandwell City Council who overseas mental health and people who have been discharged from hospital into different provisions. Regarding the importance of this, one voluntary sector professional shared:

> "Certainly from my perspective as a voluntary sector organisation, there's a level of willingness to work in partnership and an appetite to develop solutions and work collaboratively" (Project Manager, Brushstrokes).

A similar example was shared in the voluntary community sector, with an NRPF project and partnership established to support women who were victims of domestic violence, including: Birmingham and Solihull Women's Aid who operate a helpline and daily drop-in centre for women, Roshni (a refuge and domestic violence specialist charity), Baobab (a charity specialised in asylum support), British Red Cross (providing additional financial support for women with NRPF who have applied for the Domestic Violence Concession), Refugee and Migrant Centre (specialist immigration advice with multilingual case workers), and the Central England Law Centre (for access to solicitors). A professional from Women's Aid charity stressed the importance of supporting the women who accessed their services to empower themselves and the ways in which they supported them to consider different options and to make appointments independently as they found that often women who are victims of domestic violence have never put themselves and their own needs first before.

(iii) Case study of best practice: connecting newly arrived migrants to health and wellbeing activities and services through social prescribing

A case study of best practice is presented below, following an interview with Grace Namwanje, a social prescribing link worker for migrant communities in the Dudley and Netherton NHS Primary Care Network. A well as describing how her role works, Grace also shared evidence of the benefits they were seeing across the PCN as a result of the creation of this unique role.

How does your role work?

"As part of the PCN, I support migrant patients already registered with the NHS and support to register and integrate new patients with limited digital and literacy skills to be linked to community services.

Here's an overview of my role:

Patients typically begin by consulting their GP. If the GP identifies social support needs—such as challenges related to loneliness and isolation, mental health, immigration, long term illnesses, or socioeconomic factors—they refer the individual to the migrant social prescribing service.
Those referred often come from diverse migrant backgrounds, including refugees, asylum seekers, undocumented individuals, EU citizens, and international workers and students.

With translation support, I conduct an in-depth, one-on-one consultation to understand 'what matters' which includes priorities, challenges, and goals. This assessment covers areas like language barriers, income stability, food insecurity, employment, housing, social isolation, physical/mental health, and immigration status. Collaboratively, we create a personalised plan with the patient to address their needs. This may involve connecting them to services such as support with hospital appointments, transport, understanding hospital letters, booking blood tests or referrals to mental health programmes (e.g., Talking Therapies), linking to food banks, ESOL classes (e.g., through colleges, neighbourhood learning centres, Brushstrokes), or legal advice (e.g., Refugee Migrant Centre), facilitating access to group activities (gardening and creative clubs, exercise classes, computer skills workshops) to foster social inclusion.

After approximately six weeks, we review progress using the ONS4 well-being scale. This tool measures changes in the individual's perceived life satisfaction, happiness, anxiety levels, and sense of control, providing tangible insights into their journey. By bridging clinical care with community resources, the role aims to empower individuals to navigate systemic barriers and improve their overall well-being."

What are the benefits of this role for newly arrived migrants?

- **Bridging the Gaps**

"This role addresses systemic barriers that contribute to poor health outcomes among migrants. Providing targeted support to non-English speakers has reduced NHS costs by minimising missed appointments (a significant financial cost) and streamlining care (e.g., reducing the need for multiple translator-supported appointments if patients access language classes). It also empowers migrants to navigate the NHS, ensuring they understand how to access services, adhere to appointments, and advocate for their needs.

It alleviates pressure on GPs by addressing the social determinants of health (e.g., immigration, housing, employment, and education) that often underlie medical visits, allowing clinicians to focus on clinical care.

Through partnerships with local organisations in the Dudley borough and across the West Midlands like Refugee Migrant HUB, Dudley CVS, Dudley Housing Refugee Inclusion Team, Dudley Public Health Centre For Equality Diversity, Halesowen Welcome Group, Provision House, Black Country Food Bank, baby banks, legal aid, various faith groups, Hope Project, Refugee Action, Baobab Women's Project, Brushstrokes Community Project, transport companies, the role builds inclusive ecosystems of support for migrants."

- **Connection and Community**

"Through social prescribing, a dedicated community hub at CreArt Collective Centre in Dudley was strengthened; weekly drop-in sessions, providing practical assistance such as booking medical appointments (blood tests, prescriptions), securing food vouchers, education support-offering language and digital skills guidance, former service users become volunteers, leveraging their language skills and lived experience to guide newcomers. This creates social opportunities that combat isolation through group activities (e.g., community projects, skill-building workshops) and skill development; volunteers gain work experience, confidence, and leadership abilities and mental health benefits as group-based activities and communal support significantly improve emotional well-being, reducing reliance on clinical services for non-medical issues.

The role has contributed to breaking cycles of isolation and dependency by connecting migrants to community networks and tailored resources. This role, hence, prevents recurrent crises and builds long-term resilience. For example, migrants on my caseload have gained knowledge, skills, and social ties to navigate systems independently and strengthened trust in community and public services, ensuring equitable access and fostering a sense of belonging.

In conclusion, this role turned previously scattered community services into full and connected support. It helps people to stay healthier, learn to help themselves, and brings communities closer together."

What are the benefits of this role for newly arrived migrants?

- **Identifying Needs & Advocating for Change**

"By tracking referrals, we spot gaps in local services and push for solutions. For example, when we saw high demand for immigration support, we worked with charities like the *Refugee and Migrant Centre* and *Brushstrokes* to bring Dudley community ESOL classes, legal advice, and job help. Now, we're using data on loneliness and isolation to advocate for more group activities (e.g., active classes, and social clubs) so people can connect faster.

We act early. Instead of waiting 4-6 months (when stress from isolation often starts), we connect migrants to support as soon as they register. This prevents problems before they grow.

Boosting confidence is essential for accessing services. Many people arrive feeling hopeless or unmotivated due to traumatising experiences; by linking them to activities and services, they gain skills, friendships, and purpose.

Poverty often blocks access to care and activities. To fix this, we have partnered with public services like *West Midlands Combined Authority* to offer free or reduced travel for appointments, classes, or well-being activities, ensuring no one misses help because they can't afford a bus ticket.

Social prescribing helps patients by bridging the gap between services and people; many services exist, but migrants struggle to find or use them. Social prescribers act as the "link," guiding people through complex systems. We focus on practical issues others might ignore (e.g., transport, bills, energy, overcrowding, social networks, food, clothing, mould, or lack of digital skills) and dig deep to solve what truly matters to each person.

- **Why It Works:**

It is a unique NHS approach: social prescribing does not just treat symptoms. It tackles root causes (like loneliness, poverty, or confusion about systems). It builds trust, as migrants know they have a dedicated person to turn to, reducing fear and stress. Newly arrived migrants feel supported, connected, and empowered to rebuild their lives faster, healthier, and with hope."

6.4 Better pathways to better health outcomes: recommendations

The lived experience and professional participants in the focus groups were asked to share their thoughts on how pathways to health could be improved for people with the NRPF condition. In the spirit of co-production that has underpinned the whole Better Pathways project these suggestions from the groups are our collaborative recommendations:

Recommendations for Department for Health and Social Care:

- **Policy gap: children with NRPF whose parents/carers are chargeable for treatment**

  Consideration is required in a change of policy regarding children who require healthcare treatment and whose parents/carers are liable to be charged as children may be withheld treatment due to fear/worry about debt accumulation.

- **Policy gap: NHS debts as barrier to immigration case**

  Consideration is required in a change of policy regarding people with NRPF with NHS debts. The opportunities of people to secure their visa status/ citizenship should not be penalised due to NHS debts as this will exacerbate further the cycle of poverty and ill health and add financial pressure to Local Authorities and Children's Trusts. People should be supported to have a payment plan set up and the Government should consider having accessible loans for people who have had NRPF status, as well as potentially waiving fees connected to children.

Recommendations for National Health Service:

- **Professionals' training gap: cultural competence / trauma-informed practice**

Cultural competence was shared as a key skill for professionals to be able to support migrants in the most appropriate and respectful way. This forms part of a trauma-informed approach to practice, understanding that people come from experiences of trauma and to understand the importance of sensitive and empathetic communication, and the use of appropriate language that is culturally sensitive. An essential aspect of this is for professionals to have awareness of barriers, such as a lack of digital literacy or digital access that some people have, in order that they suggest alternative more appropriate access modes.

- **Professionals' training gap: NRPF awareness for professionals**

More training or supportive communication is needed across multiple sectors to educate professionals to understand the nuances of the NRPF umbrella and the bespoke needs within this wide typology (see for example Better Pathways briefing paper 4: https://www.brushstrokessandwell.org.uk/nrpf-better-pathways).

- **Professionals' training gap: emotional abuse**

More training is required for health professionals on recognising and understanding signs of emotional abuse for people who are victims of domestic violence.

- **Resource gap: quick up-to-date reference guides for professionals**

There is a need for signposting for professionals for up-to-date, accessible reference guides to help them better support people with NRPF to access the health services they are entitled to. This could be incorporated as a refresher activity into monthly staff meetings and peer sharing to ensure that colleagues are aware of up-to-date resources (see resource list in Section 5.5 for some key resources).

- **Resource gap: traffic light colour-coded system**

As part of a bigger piece of public health awareness work, it was suggested that a traffic light system in the NHS for letters and emails could provide essential support for people facing language, literacy and/or education barriers through a colour-coding process to reduce the chance of people missing important diagnoses, essential treatment and preventative healthcare.

Cross-sector recommendations:

- **Systems-change gap: improve discharge pathway processes through cross-sector partnerships**

Professionals across sectors shared the need for local areas to come together to look at discharge pathways for NRPF both for physical healthcare needs, mental health, and communicable disease.

- **Professionals and NRPF lived experience groups training gap: digital literacy support**

There is a critical need for funding to better support people with NRPF to become proficient with digital literacy skills to access NHS digital, and training to support professionals to better support newly arrived migrants in this area. VCSOs offering ESOL classes could prioritise this as a key component where possible, e.g. input on health language and literacies.

- **Voluntary sector organisations**

Gather best practice suggestions about how to resolve NHS debts/charges for individuals with NRPF, such as courses to support with financial literacy (e.g. https://themoneycharity.org.uk/media/Community-Financial-Wellbeing-Workshops-Guide.pdf)

- **Professionals' awareness gap: health activity initiatives for people with NRPF**

Many City Councils and other health providers offer free swimming and exercise classes for people on low incomes, or who are asylum seekers or refugees but there is a lack of awareness of this amongst lived experience groups and professionals. Better signposting to such schemes could be provided by VCSOs, NHS, schools and libraries, and City Councils' City of Sanctuary websites. For examples of such schemes in Birmingham see:

- https://www.birminghamleisure.com/be-active-passport-to-leisure/
- https://www.better.org.uk/supported-membership-scheme

Helpful resources

❖ **Resources for professionals to increase awareness of entitlements:**

- **Doctors of the World (2021)**

https://www.youtube.com/watch?v=LVcCNGrxau8

This animation explains the entitlements to NHS services and to vaccination for migrants in England and is aimed at healthcare professionals who support migrants in their practice.

- **National Health Service guides:**

For the full list of exemptions in NHS charging, see: https://www.gov.uk/healthcare-immigration-application/who-needs-pay

For the NHS Migrant Health Guide see: https://www.gov.uk/guidance/nhs-entitlements-migrant-health-guide

- **Access to primary healthcare for migrant children, young people and families:**

The Coram Children's Legal Centre have produced a helpful fact sheet as part of their Migrant Children's Project:

https://www.childrenslegalcentre.com/wp-content/uploads/2017/05/Access-to-primary-healthcare-May.2017.final_.pdf

- **Access to loans for cancer treatment**

https://www.macmillan.org.uk/cancer-information-and-support/impacts-of-cancer/benefits-and-financial-support/grants-and-loans

https://www.cancerresearchuk.org/about-cancer/coping/practically/financial-support/what-benefits-can-i-claim

- **Hospice and palliative care for people with NRPF – a toolkit**

'This resource is aimed at professionals working across the palliative care sector and in migrant centres and related organisations. This very helpful toolkit will enable professionals to support people in their role as family carers helping someone to die well while facing the additional challenge of having no access to the welfare safety net, due to restrictions placed on them as part of their immigration status.'

https://www.stchristophers.org.uk/nrpf-guide

❖ **Signposting for NRPF lived experience groups:**

- **Doctors of the World's Patient Clinic:**

https://www.doctorsoftheworld.org.uk/patient-clinic/

'If you're having problems signing up with an NHS family doctor (GP) and/or getting healthcare our team can give you free and confidential support – whatever your immigration status and wherever you live in the UK.'

- **Doctors of the World's Translated Health Information:**

https://www.doctorsoftheworld.org.uk/translated-health-information/?_language=

Downloadable fact sheets in multiple languages on multiple health topics including:

COVID-19 information for migrants; EU Citizens Healthcare Entitlement; Flu Vaccination Winter; GP Access Card; HIV in the UK: video guides for migrants; How to register with a GP and book a vaccine; Keeping young people healthy; Navigating the NHS and right to healthcare; Oral Health Guidance for migrants; Right to hospital care; Vaccine confidence toolkit; Wellbeing guidance

- Maternity Action

-free advice helpline with legal advisers.

-legal information sheets on 'am I entitled to NHS maternity care?'; 'what to do if you've been charged – your rights' 'Your rights if you're an EU or EEA national'

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