



UK Visas  
& Immigration

# Healthcare Needs and Pregnancy Dispersal Policy

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**This document provides instruction to staff dispersing asylum seekers/failed asylum seekers and their dependants who have healthcare needs, or who are pregnant or new mothers.**

# Table of Contents

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## Table of Contents

Application of this instruction in respect of children and those with children

### Chapter 1 – Scope

### Chapter 2 - Health Entitlement for Asylum Seekers and Failed Asylum Seekers

#### 2.1 HC2 certificates

#### 2.2 HC1 Form

### Chapter 3 – Identifying Healthcare Needs during the Asylum Process

#### 3.1 Registering an asylum claim (Port/Local Enforcement Office/Asylum Intake Unit action)

#### 3.2 Routing of applicants to Initial Accommodation

#### 3.3 What to do if a scheduled medical event has been booked prior to routing to Initial Accommodation

#### 3.4 Notifying Initial Accommodation providers

#### 3.5 Notifying Initial Accommodation Healthcare Teams by the

#### 3.6 Initial Accommodation Team

#### 3.7 Initial Accommodation Site Health Check

### Chapter 4 – Dispersal: Consideration of Healthcare Needs

#### 4.1 Applying for Asylum Support

#### 4.2 Prioritising Applications

#### 4.3 Dispersal requirements and healthcare needs

#### 4.4 Role of the Asylum Support Medical Adviser

#### 4.5 Referring cases to the Asylum Support Medical Adviser

#### 4.6 Considering Medical Evidence

#### 4.7 Representations from NHS Clinicians or NHS Health Professionals

#### 4.8 Requesting Detailed Medical Information from Treating Clinicians

#### 4.9 Determining the nature of accommodation required

#### 4.10 Location of accommodation

#### 4.11 Dispersal: Criteria for deferral or selective dispersal on health grounds

#### 4.12 Deferred dispersal from IA

#### 4.13 Requests from applicants to delay dispersal on grounds of ill health

#### 4.14 Notifying Initial Accommodation Healthcare Teams

#### 4.15 Effective Handover of Health Care

#### 4.16 Severe or Complex Healthcare Needs

#### 4.17 Relocation to Alternative Asylum Support Accommodation

### Chapter 5 - Arranging Dispersal Accommodation

- 5.1 Informing the dispersal accommodation provider of healthcare needs and sourcing property
- 5.2 Notifying Initial Accommodation Healthcare Teams
- 5.3 Notifying Clinical Commissioning Groups / Health Boards / Health Care Trusts
- 5.4 Failure to Travel
- 5.5 Unsuited Accommodation
- 5.6 Requesting the provision of section 4 accommodation

## **Chapter 6 - Role of Dispersal Accommodation Provider**

- 6.1 Registering with a GP
- 6.2 Timescales for registering with a GP
- 6.3 Briefing of applicants by the Dispersal Accommodation Providers
- 6.4 Urgent health need
- 6.5 Providing assistance to attend medical appointments where the supported person has a visual impairment
- 6.6 Dispersal Accommodation Provider – When to contact the Clinical Commissioning Group (or local equivalent)
- 6.7 Dispersal Accommodation Provider – Contract Compliance

## **Chapter 7 - Further guidance on specific healthcare needs**

- 7.1 HIV – Dispersal Guidelines
  - 7.1.1 Confidentiality
  - 7.1.2 HIV – Further Information
- 7.2 Tuberculosis – Dispersal Guidelines
  - 7.2.1 TB – Further Information
- 7.3 Mental Health – Dispersal Guidelines
  - 7.3.1 Applicants not yet in receipt of treatment
  - 7.3.2 Behaviour that suggests drug abuse
- 7.4 Pregnancy / New Mothers - Dispersal Guidelines
  - 7.4.1 Risks during pregnancy
  - 7.4.2 General background information on pregnancy
  - 7.4.3 Confirmation of Pregnancy
  - 7.4.4 The Late Stages of Pregnancy
  - 7.4.5 Dispersing asylum seeking women who are pregnant on arrival in the UK
  - 7.4.6 Dispersing pregnant asylum seeking women who have been residing in the UK for some time
  - 7.4.7 Pregnant women with HIV
  - 7.4.8 Other high risk pregnancies
  - 7.4.9 Miscarriage or still birth
  - 7.4.10 Termination of pregnancy
  - 7.4.11 Additional Financial Support

## **Appendix A - Initial Accommodation Healthcare Team Contact**

## **Appendix B - Criteria for Deferred Dispersal on Health Grounds Flowchart**

## **Appendix C - Glossary**

## **Document Control**

## **Change Record**

### **Application of this instruction in respect of children and those with children**

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

Officers must not apply the actions set out in this instruction either to children or to those with children without having due regard to Section 55. The Home Office instruction 'Arrangements to Safeguard and Promote Children's Welfare in the Home Office' sets out the key principles to take into account in all activities where child/children are involved.

Our statutory duty to children includes the need to demonstrate:

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

## Chapter 1 – Scope

This document provides guidance for Home Office staff responsible for dispersing asylum seekers/failed asylum seekers and their dependants who have health needs, following an application for asylum support under the Immigration and Asylum Act 1999 (“the 1999 Act”).

This instruction applies to the provision of support under sections 4, 95 and 98, unless otherwise stated. It seeks to reflect Home Office healthcare processes with regards to the provision of asylum support to asylum seekers and failed asylum seekers with healthcare needs for the whole of the United Kingdom. However, there may be regional variances in the processes specified in this instruction.

In this instruction, the term “caseworker” will be used to refer to the Home Office staff responsible for carrying out the support function. Asylum caseworkers will be specified where they must carry out a specific function. Asylum caseworkers and asylum support caseworkers **must** ensure that they share any relevant information which may affect dispersal or the ability of the asylum seeker or failed asylum seeker to attend a Home Office event, such as a reporting event.

This instruction does not cover asylum seekers or failed asylum seekers who require specialist accommodation and support which cannot be provided by Home Office accommodation. Local Authorities in England are obliged to provide suitable residential accommodation under section 21 of the Care Act 2014 where an individual has a care need which requires some additional help over and above the provision of accommodation, for example, assistance with personal care or household tasks. Local Authorities in Wales are currently obliged to provide this assistance under section 21 of the National Assistance Act 1948 (“the 1948 Act”), but from April 2016 will be obliged to provide this assistance under Part 4 of the Social Services and Well-being (Wales) Act 2014. In Scotland the power to provide suitable accommodation is set out under section 12 of the Social Work (Scotland) Act 1968 (“the 1968 Act”), instead of under section 21. These cases should be referred to the Local Authority Social Services Department for a Community Care Assessment. For guidance on dealing with such cases, please see the asylum support policy on Asylum Seekers with Care Needs.

[Back to contents](#)

## Chapter 2 - Health Entitlement for Asylum Seekers and Failed Asylum Seekers

Information on eligibility for free National Health Service (NHS) healthcare for people in selected immigration categories is set out in the table of entitlement to National Health Service (NHS) treatment, which can be accessed via the following link: <https://www.gov.uk/government/news/guidance-on-providing-nhs-treatment-for-asylum-seekers-and-refugees>

### 2.1 HC2 certificates

Asylum seekers supported under Section 95 of the 1999 Act qualify for an HC2 certificate. An HC2 certificate is sent by the Home Office to the applicant together with the decision to grant support under section 95. The certificate will be valid for 6 months and will cover all dependants.

The HC2 certificate entitles the applicant to free NHS prescriptions, dental treatment, wigs and fabric support, sight tests, vouchers towards the cost of glasses or contact lenses and necessary travel costs to and from hospital for NHS treatment under the care of a consultant.

It should be noted that:

- an HC2 certificate does not need to be reissued when the applicant changes address;
- if an HC2 certificate is lost, consideration may be given to producing a replacement on receipt of a written signed report about the loss from the applicant; and
- ASYS will prompt a renewal of the HC2 14 days before the HC2 certificate's expiry.

For more information on when and how to issue/renew/replace HC2 certificates, refer to the ASYS Desk Guidance on HC2 Certificates.

Northern Ireland has its own, slightly different, version of the HC2 certificate but it is valid in Great Britain. A certificate issued in Great Britain is also valid in Northern Ireland.

Although there are no prescription charges in Scotland and Wales, an HC2 certificate must be issued to applicants who live there. This is because an applicant who lives in Scotland or Wales, but is away from home, may need to obtain a prescription whilst in England.

If an asylum seeker is not supported by the Home Office, he is still eligible to register with a GP and is entitled to access all NHS services. However, he will not be issued with an HC2 certificate by the Home Office and will need to apply for one independently using an HC1 form.

## **2.2 HC1 Form**

Failed asylum seekers supported under section 4 of the 1999 Act are not eligible to receive a HC2 Certificate from the Home Office although if they were issued one when they were an asylum seeker they can continue to use it until it expires. To gain assistance with NHS charges that the HC2 covers, these supported persons should apply to the NHS Business Services Authority using an HC1 form.

Guidance on how to obtain a HC1 form can be found on the NHS Business Services Authority website:

<http://www.nhsbsa.nhs.uk/HealthCosts/1128.aspx>

[http://www.nhsbsa.nhs.uk/HealthCosts/Documents/HealthCosts/HC11\\_April\\_2015.pdf](http://www.nhsbsa.nhs.uk/HealthCosts/Documents/HealthCosts/HC11_April_2015.pdf)

[Back to contents](#)

## Chapter 3 – Identifying Healthcare Needs during the Asylum Process

This chapter provides guidance on the process to follow if asylum seekers with healthcare needs are identified during screening and routing. This chapter does not apply to failed asylum seekers in receipt of support under section 4 of the 1999 Act. Initial Accommodation under section 98 of the 1999 Act is limited to asylum seekers and their dependants. Guidance on dispersal of section 4 applicants with healthcare needs starts in the chapter 4 – Dispersal: Consideration of Healthcare Needs.

### 3.1 Registering an asylum claim (Port/Local Enforcement Office/Asylum Intake Unit action)

Screening officers will conduct a screening interview. As part of the screening process the applicant will be asked about any medical conditions (pre-existing and/or recent), medical intervention or drug treatment. Women will be asked if they are pregnant.

If the screening interview cannot take place, the applicant must be asked as soon as practicable about any pre-existing medical conditions he may have, and if the applicant is a woman, whether she is pregnant. This should include the name and contact details of the treating clinician and/or midwife; the details of which must be noted on the Special Conditions screen on CID.

The applicant will be advised by the screening officer that any illnesses he may have or treatment he is in receipt of will not affect his application for asylum in the UK.

If during screening it becomes obvious the applicant has a healthcare need requiring immediate medical attention the following actions must be taken:

- in cases of emergency, call an ambulance; or
- in non-emergencies, instruct the applicant to seek medical help at the local NHS walk-in centre (The location of NHS walk-in centres can be obtained from the NHS Choices website).

If in doubt, the screening officer should call NHS Direct / NHS 24 or local equivalent, describe the symptoms and act on the advice given.

The applicant may request to be screened by someone of a particular gender. If so, he should make the Home Office aware at the earliest possible time, and if possible, a screening officer of the chosen gender will conduct the screening interview.

If any medical issues are identified, the information, including details of the treating clinician and/or midwife, must be entered on to the Notes and, if appropriate, the Special Conditions screen on CID.

**Any medical information must be kept confidential** and records should be kept according to best practice.

[Back to contents](#)



### **3.2 Routing of applicants to Initial Accommodation**

A person who has applied for asylum and who needs accommodation will be offered dispersal accommodation subject to proof of eligibility. If, before the dispersal process can be completed, that person needs emergency accommodation, he will be considered for admission to Initial Accommodation (IA), as provided for under section 98 of the Act. The dispersal property and/or the IA will usually be in the region that has responsibility for considering his asylum application. Initial accommodation centres are provided in each of the regional areas under the COMPASS contracts.

Under the provisions of section 97 of the 1999 Act caseworkers must have regard to the desirability, in general, of providing accommodation in areas in which there is a ready supply of accommodation. There is a limited supply of accommodation within London and South East of England. This means that, as a general rule, unless there are extenuating factors which require the routing of a person to this area, routing of applicants who request support accommodation will usually be away from London and the South East area.

Routing Team caseworkers will normally route an applicant to a regional location within 48 hours of an asylum claim being made. The applicant will normally stay in "Overnight Accommodation" if onward travel to the allocated region is not possible on the day the asylum application is made. The regions and the location of IA are as follows:

**North West** - Liverpool

**Midlands and East of England** – Birmingham

**Scotland** - Glasgow

**Northern Ireland** - Belfast

**North East, Yorkshire and the Humber** – Wakefield

**Wales and South West** - Cardiff

**London and South East** – N.B. limited accommodation within London and surrounding areas

Consideration should be given to finding the most suitably located IA for applicants with healthcare needs. Routing Team caseworkers must check the Notes and Special Conditions screens on CID for any healthcare needs, in particular pregnancy issues, which may impact on appropriate routing arrangements.

If the applicant is receiving treatment in the UK for a severe or complex healthcare need, the Routing Team should, wherever possible, route the applicant to the IA closest to where the applicant is being treated. If the healthcare need is not severe or complex and the treating facility is outside the London and South East region, the Routing Team should, if possible, route the applicant to the IA closest to where the applicant is being treated. Refer to chapter 4.16: Severe or Complex Healthcare Needs for examples of what is considered to be a severe or complex healthcare need.

Consideration of the health needs of the applicant should be given in advance of all journeys to IA, most notably where the transfer to IA will include an overnight stop. The Routing Team in conjunction with the team at point of claim, should ensure that there are no pressing health needs and that the person has sufficient medication. If the applicant has a pressing health need or has insufficient medication which cannot wait until he is able to access treatment in his allocated IA, it may be appropriate to

temporarily accommodate him in the local IA until he is able to travel. The applicant should be referred immediately to the IA Healthcare Team.

When routing families with children, the Routing Team caseworkers should take into account the Secretary of State's obligations under Section 55 of the 2009 Act.

[Back to contents](#)

### **3.3 What to do if a scheduled medical event has been booked prior to routing to Initial Accommodation**

Taking into account the nature of the case, an applicant should be routed to the IA in the most suitable geographical location. This applies particularly where an applicant claims at the Asylum Intake Unit (AIU) in Croydon and provides the screening officer with medical evidence of:

- a hospital/consultant/midwife appointment that is booked within the next week in a specific area; or
- a regular series of ongoing medical appointments with a treating clinician in a specific area.

This may mean that the applicant is accommodated in the London and the South East region. Following attendance at the appointment, it may be appropriate to either route the applicant to another region or to allow them to remain in the London and South East region until effective handover of care can be arranged in another region. Each case will be decided on its individual merits.

[Back to contents](#)

### **3.4 Notifying Initial Accommodation providers**

When making routing arrangements, health information that may impact on appropriate routing arrangements may be obtained from CID from either the 'Notes' or 'Special Conditions' screens. If any health or other issues have been identified which affect the provision of IA, this should be communicated to the IA provider. Sufficient information should be placed in the Special Needs/Additional Information box in the Service Commission Form to enable the IA provider to ensure appropriate arrangements are put in place. For further information on the appropriate communication of information to accommodation providers, refer to chapter 5.1: Informing the dispersal accommodation provider of healthcare needs and sourcing property. The completed Service Commission Form should be faxed to the IA provider to inform them of the name of the applicant and, if applicable, the names of his dependants, the estimated time of arrival, and any specific accommodation requirements, particularly those that relate to any healthcare needs.

If following arrival in the IA to which the applicant has been routed, or upon arrival in the IA being used as temporary/overnight accommodation, the applicant notifies the accommodation provider that he has a healthcare need requiring immediate medical attention; the following action must be taken:

- in cases of emergency, call an ambulance; or
- refer the applicant to the IA Healthcare Team.

[Back to contents](#)

### **3.5 Notifying Initial Accommodation Healthcare Teams by the**

If the applicant is identified as having a pre-existing medical condition or is taking medication, which requires urgent referral to the IA Healthcare Team, Routing Team caseworkers must notify the IA Healthcare Team of the medical need as soon as practicable. If known, the IA Healthcare Team must also be notified of the details of the treating clinician and/or midwife.

[Back to contents](#)

### **3.6 Initial Accommodation Team**

If an applicant is identified as receiving treatment for a severe or complex health need and the details of the treating clinician(s)/midwife are known, the IA Team should send a Treating Clinician Notification of Arrival in Initial Accommodation Letter to the treating clinician(s)/midwife as soon as possible after the applicant has been routed to his allocated IA. The letter must contain the following information:

- the address of the IA;
- a request that the treating clinician/midwife notifies the IA Healthcare Team of any information that will assist in maintaining continuation of care; and
- the contact details for the Initial Accommodation Healthcare Teams (Appendix A).

A copy of the letter should be sent to the IA Healthcare Team and to the applicant. For information on the definition of a severe or complex healthcare need, refer to chapter 4.16: Severe or Complex Health Needs.

[Back to contents](#)

### **3.7 Initial Accommodation Site Health Check**

Applicants resident in IA and those temporarily accommodated in the IA following deferral of routing, are entitled to receive a healthcare service delivered by a healthcare team independent of the Home Office. Though this applies to the vast majority of regions, in some regions an alternative healthcare service is in place.

Applicants are notified of the availability of IA health checks at the briefings provided by the accommodation provider upon arrival in IA.

The IA healthcare team are qualified practitioners in healthcare service delivery. As well as offering general medical assistance, applicants will be offered health screening including the following:

- assessment of current health status and addressing of any immediate concerns;
- screening for tuberculosis (TB), according to local guidelines (tests for other conditions such as Hepatitis A,B or C may be considered if there is cause for concern, and for Human Immunodeficiency Virus (HIV) if the applicant requests a test);
- recording of the patient's history of immunisations and vaccinations. At present and according to local guidelines, TB vaccinations may be offered to those aged 16 and under, and in some regions, but not all, MMR (Measles, mumps and rubella) vaccinations to 16-25 year olds (as a special risk group);
- recording of maternity history. Family planning advice is offered to both men and women;
- a pregnancy test, if there is a medical concern or the applicant requests a test;
- any sexual health issues are discussed on assessment and appropriate action taken;
- identification of special needs and liaison with the Home Office, or whoever is sub-contracted to oversee dispersal, to ensure the provision of appropriate accommodation and support where needed;
- where there is clinical need children under the age of 5 years are seen by a health visitor, and nutritional needs assessed and appropriate advice given;
- consideration of future help can be made for individuals identified with a history of physical or psychological maltreatment, or mental health issues;
- reporting of any concerns about children through the correct internal channels (NHS or otherwise) and liaising with the Local Authority Social Services Department where necessary.

During the IA health check the applicant may be identified as either receiving medical treatment or having healthcare needs, including pregnancy, which might have an impact on dispersal arrangements in the event the applicant is granted support under section 95. If this is the case, the IA Healthcare Team should provide the IA Team with adequate information to enable appropriate dispersal arrangements to be made at the earliest opportunity, including an assessment of the following:

- fitness to travel;
- any travel constraints (including length of journey etc); and
- any arrival issues, including any arrangements that have been or need to be made, and with whom, to ensure effective handover of care.

Where the IA Healthcare Team consider that dispersal out of IA should be delayed on medical grounds, a written request should be made to the IA Team stating the length of delay being requested and the reasons why. When considering such requests, caseworkers should refer to chapter 4.11: Dispersal: Criteria for deferral or selective dispersal on health grounds for guidance.

Whilst applicants are in IA, the IA Healthcare Team will, if required, make appropriate healthcare referrals and assist them in making appointments to see a GP. IA Healthcare Teams will refer applicants with HIV to the local sexual health clinic (Genito-Urinary Medicine clinic) if no continuity of care arrangements are already in place.

[Back to contents](#)

## Chapter 4 – Dispersal: Consideration of Healthcare Needs

This chapter provides guidance on the identification of healthcare needs during the section 95 and section 4 application processes and assessing dispersal requirements based on those needs.

Caseworkers should always check whether an applicant has any special medical needs that will affect dispersal. This may include a need to be accommodated in a particular location or in a certain type of accommodation, or in the case of applicants accommodated in IA, information about ongoing treatment for a medical condition which requires that dispersal from IA should be deferred.

### 4.1 Applying for Asylum Support

Caseworkers must ensure that any healthcare information submitted by the applicant in relation to his application for asylum support, which will potentially impact on dispersal arrangements, is clearly noted on ASYS.

The application process provides a further opportunity for the applicant to disclose information on:

- any medical conditions he may have, or , in the case of a woman, if she is pregnant;
- any treatment he is in receipt of;
- the contact details of his treating clinician/midwife; and
- the location of the treatment centre.

Asylum Support Application UK, a service operated by Migrant Help, is contract by the Home office to assist eligible applicants to complete and submit forms for section 95 and section 4 support. Details of any medical or healthcare needs disclosed by the applicant are included on the form.

The asylum support application form, ASF1, on which applications for support under Section 95 and section 4 can be made, can be accessed from the Asylum Support GOV.UK website or from Asylum Support Application UK

[Back to contents](#)

### 4.2 Prioritising Applications

If an applicant's healthcare need requires the urgent provision of dispersal accommodation, the application for support should be prioritised wherever possible.

Where a heavily pregnant applicant for section 4 support is street homeless, or imminently street homeless (24-48hrs), and is not registered with any maternity services, caseworkers may consider placing the applicant in Initial Accommodation. This would enable access to the IA healthcare team for an assessment of fitness to travel and/or for dispersal, as well as providing assistance on registration with maternity services either locally or at the dispersal destination.

If it becomes evident that an applicant may have a care need which requires some additional help over and above provision of accommodation, caseworkers should liaise with the Local Authority to arrange a Community Care Assessment (CCA) to determine whether support is required under:

- In England: section 21 of the Care Act 2014;
- In Wales: currently under section 21 of the 1948 Act, or from April 2016 under Part 4 of the Social Services and Well-Being (Wales) Act 2014; or
- In Scotland, under section 12 of the 1968 Act.

[Back to contents](#)

### **4.3 Dispersal requirements and healthcare needs**

Information on assessing dispersal requirements based on an applicant's healthcare needs may be obtained from:

- ASF1 (formerly known as NASS1 or Section 4 Application Form);
- CID notes;
- ASYS records;
- Letters submitted on behalf of the applicant by the treating clinician, midwife or social worker;
- The Initial Accommodation Healthcare Team Advice may provide general dispersal advice or specific information on behalf of the applicant (if the applicant is accommodated in IA);
- Home Office Section 4 Medical Declaration (if one is submitted by the applicant to support an application for section 4 support – see Appendix B of the Asylum Support: Section 4 Policy And Process document); or
- Information provided by Asylum Support Application UK if they are assisting the applicant with his application.

This list is not exhaustive.

Each application should be assessed on its individual merits. Careful consideration must be given to the specific circumstances of each case. Decisions must be taken based on the circumstances of the applicant's entire household who have been granted support, and where required, with the guidance of medical experts.

### **4.4 Role of the Asylum Support Medical Adviser**

The Asylum Support Medical Adviser's role in the dispersal process, based upon the written medical evidence/reports submitted, is to:

- Advise Home Office caseworkers about the general availability and capacity of medical treatment in particular regions;
- Advise on fitness to travel to dispersal accommodation;
- Recommend the nature of any accommodation to be provided;
- Advise on requirement to stay in a particular area for medical reasons;
- Advise on medical need to relocate supported persons/applicants from one area to another; and

- Advise on whether failed asylum seekers are unable to leave the United Kingdom by reason of a physical impediment to travel or for some other medical reason.

[Back to contents](#)

#### **4.5 Referring cases to the Asylum Support Medical Adviser**

If the Home Office has granted support to a household which has raised medical issues that could affect the nature and location of accommodation provided, the caseworker needs to consider whether it is necessary to refer the case to the Asylum Support Medical Adviser for advice. Not every case will need to be referred to the Asylum Support Medical Adviser, e.g. if the medical complaint is of an obvious minor nature such as a common cold.

The Asylum Support Medical Adviser's advice will be based on the information provided in the referral. It is, therefore, essential that all relevant medical information is included in the referral and that all relevant medical documents are attached. The Asylum Support Medical Adviser does not have access to ASYS. As a result, where he has previously provided recommendations on the individual concerned, caseworkers should include these in the referral. If known, the caseworker should also provide the proposed address and date of dispersal.

Caseworkers must scan recommendations made by the Asylum Support Medical Adviser on to ASYS.

[Back to contents](#)

#### **4.6 Considering Medical Evidence**

Applicants may submit medical evidence that may have an impact on the dispersal location or the nature of the property allocated. If caseworkers are unsure about what dispersal arrangements would be suitable as a result of the applicant's medical condition/treatment, advice may be requested from the Asylum Support Medical Adviser using the "Asylum Support Medical Adviser Referral Form".

Caseworkers must consider the advice of the Asylum Support Medical Adviser, but should also weigh the circumstances of each case against the relevant legislation and policy instructions. In the majority of cases, the caseworker should be able to make a final decision on the applicant's dispersal requirements which balances the advice from the Asylum Support Medical Adviser on medical needs with access to appropriate housing.

Please note when the Asylum Support Medical Adviser states that treatment is available at any major UK city, this means locations such as: London, Birmingham, Leeds, Manchester, Liverpool, Newcastle, Sheffield, Bristol, Glasgow (populations over 300,000 persons).

In exceptional cases where in-depth direct liaison between the treating clinician/midwife and the Home Office is required to help ensure effective handover  
Healthcare Needs and Pregnancy Dispersal Guidance v3.0

of care, assistance should be sought from the Asylum Support Medical Adviser to make direct contact with the clinician/midwife on behalf of the Home Office.

Where a caseworker is unsure whether medical evidence provided by an applicant is still relevant, the evidence should be referred to the Asylum Support Medical Adviser to assess whether more recent evidence is necessary. If confirmation is received from the Medical Adviser that more recent medical evidence is required, the caseworker should write to the applicant using the “Requesting of Up-to-Date Evidence Letter”.

In the case of information submitted on behalf of the applicant by the IA Healthcare Team (if the applicant is accommodated in IA) or by treating clinicians/midwives, the guidance provided should be carefully considered and weighed against all relevant circumstances, including, where applicable, advice provided by the Asylum Support Medical Adviser.

If caseworkers are unable to make dispersal arrangements which comply with advice received by the applicant’s medical practitioner, caseworkers must ensure they have fully substantiated and recorded reasons for doing so.

Where an applicant asserts in his application that he has a medical need which impacts on dispersal arrangements, but there is insufficient evidence to conclusively prove the claimed medical need, the caseworker should write to the applicant requesting the required supporting medical evidence. If the applicant fails to provide the required evidence by the deadline without a reasonable explanation, dispersal requirements should be assessed based on the information available.

With regards to applicants in IA, if an applicant or his representative requests more time to supply the relevant information, caseworkers should ask for confirmation of the nature of the information sought and when it is likely to be received, before seeking advice from their senior caseworker.

[Back to contents](#)

## **4.7 Representations from NHS Clinicians or NHS Health Professionals**

All representations from NHS clinicians or NHS health professionals who have either written or emailed directly on behalf of an applicant or indirectly through the applicant’s representative **must** be acknowledged. The acknowledgement and subsequent response must include the name of the responder, be dated, contain a contact telephone number, and if the response is by letter, it must be signed.

The speed with which letters from NHS clinicians or NHS health professionals are acknowledged should be determined by the particular scenario. When acknowledging letters from NHS clinicians or NHS health professionals, the “Acknowledgement letter to medical practitioners” should be used.

[Back to contents](#)



## **4.8 Requesting Detailed Medical Information from Treating Clinicians**

Confidentiality rules prevent treating clinicians from disclosing medical records to the Home Office without the applicant's permission. Therefore, if the Home Office requires a treating clinician to disclose medical information about the treatment of an applicant in order to make a decision on appropriate dispersal arrangements, explicit written permission from the applicant must be obtained before the treating clinician is contacted. The "Requesting Consent to Approach Treating Clinician Letter" must be used.

Where the applicant consents to the treating clinician providing medical information directly to the Home Office consent will be valid for the duration of the specified medical condition or for 12 months, whichever is the shorter. Reconfirmation of consent will be required if 12 months has elapsed and the specified medical condition continues.

On receipt of consent for the disclosure of medical information to the Home Office, the case owner/caseworker making dispersal arrangements should send a "Requesting Detailed Medical Information from Treating Clinicians Letter" to the Asylum Support Medical Adviser. It will be for the Asylum Support Medical Adviser to contact the treating clinician on behalf of the Home Office.

[Back to contents](#)

## **4.9 Determining the nature of accommodation required**

Where medical needs are identified, caseworkers should assess if and how these impact on the nature of accommodation required.

As a general rule, where the Home Office is providing support, the following types of accommodation should normally be requested for the following groups:

- Pregnant women: any dispersal property must be suitable not just for a pregnant woman (including mobility issues), but for a mother and baby, post birth;
- Those with mobility problems (but who are not wheelchair users) – ground floor or level access accommodation (via a lift);
- Wheelchair users will require accommodation that allows them access to all the key areas of the accommodation, i.e. kitchen, bathroom and sleeping area;
- Those with diseases such as active infectious diseases – it will not be appropriate for the supported person to share rooms; and
- Those with HIV should be provided with their own room (which can be within a multiple occupancy dwelling).

Households with wheelchair users, or who have a family member who requires special property specifications should be asked to provide the measurements of the wheelchair and details of the special specifications. This information should be passed to the dispersal accommodation providers to help them match suitable accommodation.

If it becomes evident that an applicant may have a care need which requires some additional help over and above provision of accommodation, caseworkers should liaise with the Local Authority to arrange a Community Care Assessment (CCA) to determine whether support is required under:

- In England: section 21 of the Care Act 2014;
- In Wales: currently under section 21 of the 1948 Act, or from April 2016 under Part 4 of the Social Services and Well-Being (Wales) Act 2014; or
- In Scotland, under section 12 of the 1968 Act.

[Back to contents](#)

#### **4.10 Location of accommodation**

When determining locations of dispersal accommodation, decisions must be taken in adherence of the dispersal policy set out in the policy document - Dispersal: accommodation requests.

Caseworkers must have regard to the desirability, in general, of providing accommodation in areas in which there is a ready supply of accommodation. This means that, as a general rule, unless there are circumstances which warrant dispersal to the London and the South East, caseworkers should allocate accommodation in areas outside London and the South East region. Accommodation is provided on a no-choice basis.

There may be cases where particular issues on their own would not require special arrangements, but when taken together the combination of issues may warrant special arrangements regarding the location of the accommodation. For example, a member of the household:

- is receiving ongoing treatment for a pre-existing medical condition, or is pregnant;
- has lived in a location for a considerable period of time; and
- has an existing network of support from family and friends.

Many applicants requesting accommodation in London or the South East region on the basis that they are currently in receipt of medical treatment in the region may only require short term accommodation until arrangements to transfer their medical treatment elsewhere in the UK can be made. Others, due to the nature of their condition, may require London or South East accommodation on medical grounds for as long as they remain eligible for asylum support. The caseworker should consider all the circumstances of the case, including: The caseworker should consider all the circumstances of the case, including:

- the nature of the treatment being provided;
- whether it can be readily transferred elsewhere in the UK;
- whether the effectiveness of the course of treatment would be affected if interrupted; and
- whether an individual's support network would be interrupted.

When considering whether a person requires accommodation in a particular area (London and cities such as Birmingham, Manchester, etc), caseworkers can, if required, request advice from the Asylum Support Medical Adviser.

Where a decision is made to provide accommodation at a location other than that requested by the applicant, the caseworker must fully minute his decisions on ASYS and explain the reasoning behind the decision to the applicant in the dispersal letter.

[Back to contents](#)

#### **4.11 Dispersal: Criteria for deferral or selective dispersal on health grounds**

At the dispersal stage where the Home Office is notified of a medical condition and the condition is confirmed in writing by a qualified medical clinician, consideration must be given to selective/deferred out of region dispersal from IA or selective dispersal from non-IA accommodation. The process of selective/deferred out of region dispersal is dependent upon the availability of appropriate accommodation in the area concerned.

If following selective/deferred out of region dispersal, the applicable medical condition/treatment no longer applies, the applicant's dispersal arrangements should be immediately reviewed. Appropriate review arrangements must be put in place with all selective/deferred dispersals.

The following are some of the circumstances in which selective/deferred out of region dispersal may be considered:

- HIV (Before making dispersal arrangements for applicants with HIV, refer to chapter 7.1 on HIV);
- Active TB (Before making dispersal arrangements for applicants with TB, refer to chapter 7.2 on Tuberculosis);
- Severe mental health problems (Before making dispersal arrangements for applicants with severe mental health problems, refer to chapter 7.3 on Mental Health);
- Pregnancy (Before making dispersal arrangements for pregnant applicants, refer to chapter 7.4 on Pregnancy/New Mothers);
- Where treatment is ongoing and available only in the area where the applicant is living;
- Where replication of treatment is difficult to implement, particularly in cases where the treatment is broad in its nature e.g. where an applicant has more than one ailment that requires more than one specialist to provide treatment, and where the individual has an active support network in that area;
- Where the applicant is in receipt of specialist treatment that may be hard to replicate at advanced stages of treatment, especially where invasive surgery or intensive treatment is required;
- Where invasive surgery has been booked to take place within a month or a person is recovering from an operation, e.g. caesarean section. If the applicant is recovering from an operation, dispersal which requires long distance travel

- should not take place until the individual has been medically assessed as fit to undertake the journey;
- Where invasive surgery has been booked to take place in excess of a month's time but where evidence has been supplied that there will be a delay in rebooking the surgery at an alternative hospital and the delay would have an adverse impact on the health of the applicant, and travel from out of area dispersal accommodation to the treating hospital is not appropriate.
  - Where it is necessary to arrange continuity of care, e.g. where a person is undergoing kidney dialysis;
  - Where there is a presence, or suspicion, of infectious and notifiable diseases – see <http://www.patient.co.uk/showdoc/40000306/> for further information; and
  - Where referral or admission to secondary care services is necessary due to acute need.

This list is not exhaustive.

Where treatment is ongoing and available only at a particular hospital/clinic and the applicant needs to attend appointments at least on a fortnightly basis, serious consideration should be given to accommodating the household as close as possible to where the regular medical treatment occurs. All other cases where treatment is ongoing and available only at a particular hospital/clinic, the applicant should be accommodated within reasonable travelling distance from where the regular medical treatment occurs. A reasonable travelling distance depends on the nature of the medical condition. If an applicant's medical condition appears to affect the length of journey that is suitable for him to travel to attend medical appointments, advice should be sought from the Asylum Support Medical Adviser.

Where, on advice from the Asylum Support Medical Adviser, out of area dispersal is assessed as being suitable, but treating clinicians/midwives need to make appropriate handover arrangements to enable continuity of care, it may be appropriate to temporarily accommodate the applicant within the area he can access his current treating medical facility. This will give the treating clinicians/midwives suitable opportunity to make appropriate arrangements, before dispersal commences. The applicant's dispersal arrangements should be reviewed at regular intervals.

Where appropriate, e.g. in the case of infectious disease, either the Initial Accommodation Health Team or the caseworker must undertake a joint risk assessment with the local Health Protection Unit, the consulting clinician and the Asylum Support Medical Adviser. The risk assessment should inform the Home Office decision. For some diseases and acute medical conditions, the priority would be hospitalisation rather than consideration of dispersal. As a result, it is unlikely that Home Office caseworkers would be presented with such a case for consideration.

If the applicant has a severe or complex healthcare need, caseworkers must refer to chapter 4.16: Severe or Complex Healthcare Needs before arranging dispersal accommodation.

[Back to contents](#)

## 4.12 Deferred dispersal from IA

If a one-off hospital or GP appointment has already been booked within 7 days of the dispersal date, it is often appropriate to delay dispersal until the appointment has taken place.

However, following attendance at the appointment the applicant will be expected to show that:

- treating clinicians have been made aware of the application for support and that their patient may be transferred to another region;
- discussion has taken place regarding how a transfer of any ongoing treatment may be effected; or,
- if transfer is said not to be possible, they have provided full details setting out why transfer is not possible.

If caseworkers are unsure about what dispersal arrangements would be suitable as a result of the applicant's medical condition/treatment, advice may be requested from the Asylum Support Medical Adviser using the Asylum Support Medical Adviser referral form.

Please note in the event the supported person has been assessed as being eligible for section 95 support but dispersal from IA is delayed, even though the supported person is accommodated in IA he should be supported under the power of section 95. This applies to all references to delayed dispersal out of IA within this asylum instruction. The supported person should be issued with a section 95 grant letter and a HC2 certificate.

[Back to contents](#)

## 4.13 Requests from applicants to delay dispersal on grounds of ill health

From time to time, once arrangements for dispersal to asylum support accommodation have been made, representations are received from an applicant to either delay travel or amend dispersal arrangements on healthcare grounds. In such cases, caseworkers should take into consideration the written medical evidence supplied when determining whether to change the original dispersal date or location. In the majority of cases, if the information is received via a telephone call, the decision to change the original dispersal date or location should not be made until written medical evidence has been received.

The Home Office retains the discretion to re-book or to take "failure to travel" action where the illness is minor, e.g. failing to travel due to having a cold or a skin rash. Caseworkers should bear in mind that some applicants may have difficulty in gauging the severity of a medical condition.

If an out of area dispersal or dispersal from IA has been delayed, the review date should be determined by nature and frequency of the medical treatment. Unless guidance is received from the IA Healthcare Team on when the applicant is fit to

travel, caseworkers should write to the applicant or their representative for an update.

Late representations should not be automatically interpreted as an attempt to avoid dispersal. Some asylum seekers may well be fearful of initially disclosing their healthcare needs in the mistaken belief that it will have a negative outcome on their asylum claim. Each case should be considered on its individual merits.

[Back to contents](#)

#### **4.14 Notifying Initial Accommodation Healthcare Teams**

During the assessment and dispersal process for an applicant who has a severe and complex healthcare need, the Home Office is often notified of the contact details of the treating clinician/midwife. Unless it is known that the IA Healthcare Team already has this information, the IA Healthcare Team should be provided with those details. This will assist the IA Healthcare Team to take action to ensure an effective handover of care in the event the applicant does not provide this information during the IA health check.

IA healthcare teams should be notified by the Home Office IA teams on a daily basis of any planned dispersals, including details of destinations and proposed dates of dispersal, to enable sufficient time for any travel assessments and continuity of care arrangements to be made.

[Back to contents](#)

#### **4.15 Effective Handover of Health Care**

The Home Office aims to assist in ensuring that applicants, who at point of claim present with health issues, are able to access appropriate medical care and any special facilities they may need. Together with the relevant health practitioners (doctors, midwives etc), the Home Office aims to assist in ensuring that effective handover arrangements are made to enable continuity of treatment when a supported person is moved within the UK.

Whilst the Home Office aims to assist in ensuring the effective handover of care, the applicant also has a critical role in helping to ensure continuity of their care during dispersal. The applicant can do this by divulging healthcare needs information to the Home Office and, if applicable, to the IA Healthcare Team, as well as by providing the dispersal information to treating clinicians/midwives.

Following notification of section 4 or section 95 dispersal arrangements, an applicant in receipt of healthcare treatment in the UK should notify his treating clinician/midwife of the dispersal location. This would enable the treating clinician to assist, if required, in transferring treatment to the dispersal area. If the applicant requires assistance in contacting his treating clinician/midwife, he should seek assistance from the IA Healthcare Team (if in IA) or the Home Office. If the applicant requests assistance from the Home Office, caseworkers can, if required, seek the assistance of the Asylum Support Medical Adviser.

If there are issues of continuity of care for an applicant in IA who has been granted section 95 support, the IA Healthcare Team will liaise with the caseworker, and if required, the relevant clinician(s) regarding appropriate handover of care arrangements. If the applicant has taken up the offer of a health assessment whilst in IA, he should take the hand-held record (usually in the form of a printout of computer records) recording the results of the assessment to show to the GP when he registers in the dispersal area. The aim will be to minimise the upheaval of the move to dispersal accommodation.

[Back to contents](#)

#### **4.16 Severe or Complex Healthcare Needs**

(Action to be taken to assist in effective handover of care following allocation of a dispersal address)

In order to assist in the effective handover of care during dispersal, where contact details have been provided or are known, caseworkers will be required to notify both the current treating clinician/midwife and the Healthcare team (or other health contact) at the dispersal destination, if the applicant:

- is not receiving medical assistance from an IA Healthcare Team;
- has a severe or complex healthcare need; or
- is pregnant; and
- dispersal is to an area where he cannot continue to receive treatment from his current medical facility.

In these circumstances, the caseworker should issue a “Treating Clinicians Notification Letter” and a “Healthcare Team Notification Pro Forma” as follows:

- **Notify treating clinicians/midwives following allocation of a dispersal address:** If the applicant’s treating clinician(s)/midwife is known, the Home Office has an address for the treating clinician(s)/midwife, and the applicant has not had IA health screening, a “Treating Clinicians Notification Letter” should be sent to the treating clinician(s)/midwife, informing him that accommodation has been offered, the area of the accommodation, and the dispersal date. A copy of the letter should be sent to the applicant.
- **Notify Asylum Seeker Primary Care General Practice/Healthcare Team:** Where these teams exist, or where there is a known health contact in the dispersal area, a “Healthcare Team Notification Pro Forma” should be sent to the Asylum Seeker Primary Care General Practice/Healthcare Team which has jurisdiction for the area to which the applicant is being dispersed,. The pro forma informs them that the applicant will be dispersed to their area and dispersal date. A copy of the notification should be sent to the applicant.

The following is a list of examples of severe or complex health needs which requires caseworkers to undertake the above actions:

- Pregnancy (refer to chapter 7.4: Pregnancy / New Mothers- Dispersal Guidelines);
- Active tuberculosis and Infectious / active communicable diseases (when making dispersal arrangements for applicants with Tuberculosis also refer chapter 7.2: Tuberculosis –Dispersal Guidelines);
- Serious mental health issues where there is a high risk of suicide, serious self-harm or risk to others (when making dispersal arrangements for applicants with mental health issues, also refer to chapter 7.3: Mental Health –Dispersal Guidelines);
- Chronic disease, e.g. kidney disease – the patient requires regular dialysis, etc;
- A serious child illness, or specific safeguarding/child welfare concerns (where the case is being managed/investigated by social services or other government departments);
- HIV (when making dispersal arrangements for applicants with HIV, also refer to chapter 7.1: HIV – Dispersal Guidelines).

If an applicant is in IA and has received an IA health check, action to ensure effective handover of care will be undertaken by the IA Healthcare Team.

[Back to contents](#)

#### **4.17 Relocation to Alternative Asylum Support Accommodation**

When consideration is being given to moving an accommodated supported person to alternative accommodation, the appropriate dispersal considerations and actions as specified in chapter 4.15: Effective handover of health care and in chapter 5: Arranging Dispersal Accommodation should be undertaken.



# Chapter 5 - Arranging Dispersal Accommodation

This chapter provides guidance on arranging accommodation following a grant of asylum support.

## 5.1 Informing the dispersal accommodation provider of healthcare needs and sourcing property

The Home Office may hold information relating to the supported person that directly impacts on the allocation of accommodation, transport, or reception arrangements. When arranging accommodation, it is absolutely essential that sufficient information is communicated to the accommodation provider to enable them to ensure that any necessary arrangements are put in place.

The level of information provided should be justified and proportionate. The information should be enough to enable the accommodation provider to arrange appropriate accommodation, but not so much as to make the disclosure disproportionate.

If the applicant needs access to health services because of a pre-existing condition, the dispersal accommodation provider should be informed that on dispersal the applicant needs to register with a GP. For further information on communicating dispersal requirements to dispersal accommodation providers, refer to chapter 6: Role of Dispersal Accommodation Provider.

[Back to contents](#)

## 5.2 Notifying Initial Accommodation Healthcare Teams

Following allocation of a dispersal address from IA for an applicant identified as having a healthcare need, the IA Team should promptly notify the IA Healthcare Team of the dispersal location.

IA healthcare teams should be notified by the Home Office IA teams on a daily basis of any planned dispersals, including details of destinations and proposed dates of dispersal, to enable sufficient time for any travel assessments and continuity of care arrangements to be made.

[Back to contents](#)

## 5.3 Notifying Clinical Commissioning Groups / Health Boards / Health Care Trusts

The Home Office aims to support planning by healthcare providers. Following allocation of a dispersal address or a change of dispersal address, a notification should be sent by the caseworker to the Clinical Commissioning Group (CCG) (if dispersed in England) or Local Health Board (if dispersed in Scotland or Wales) or Health Care Trust (if dispersed in Northern Ireland) which has responsibility for the

area the applicant is due to be dispersed to. The notification provides name and address information of the applicant being dispersed to the area. Unless alternative arrangements have been established to notify the relevant CCG (or local equivalent), the notification should be in the form of a letter:

- In section 95 cases, the notification letter can be found on ASYS (NASS 17); and
- In section 4 cases, the “Section 4 notification letter” can be used.

Notifications should also be sent following grants of subsistence only support under section 95.

[Back to contents](#)

## 5.4 Failure to Travel

Where the applicant subsequently fails to travel to the dispersal accommodation offered, a letter stating that dispersal has been cancelled should be sent immediately to those people previously notified of the applicant’s dispersal arrangements. This will include cases in which notification letters have been sent to the applicant’s:

- treating clinician(s) /midwife;
- Asylum Seeker Primary Care General Practice/Healthcare Team (where such teams exist); and/or
- CCG (or equivalent).

This action should be completed by the team responsible for issuing the original dispersal notification i.e. the regional IA team.

In addition, caseworkers also should refer to Chapter 19 on “Failure to Travel” in the Asylum Support - Policy Bulletins Instruction for guidance on failure to travel action in both section 95 and section 4 cases.

[Back to contents](#)

## 5.5 Unsuitable Accommodation

Where an applicant believes the dispersal accommodation allocated does not meet his accommodation requirements arising from his healthcare needs:

- If the applicant has not yet moved in to his allocated accommodation, the applicant or their representative should immediately either contact the asylum support caseworker responsible for arranging the accommodation or his asylum caseworker.
- If the applicant has moved in to his allocated accommodation, he should immediately contact the accommodation provider who will liaise with the Home Office. If a response is not promptly received, the applicant or their representative should contact the asylum caseworker, who will investigate and ensure appropriate action is taken.

[Back to contents](#)

## **5.6 Requesting the provision of section 4 accommodation**

When requesting the provision of accommodation from providers for applicants with healthcare needs who have been granted support under section 4(2) or 4(3) of the 1999 Act, the priority of the accommodation request is predominantly determined by whether the applicant is street homeless or imminently street homeless.

However, in circumstances where an applicant needs to be urgently dispersed to a particular area due to an urgent need to receive healthcare treatment, careful consideration should be given to designating the applicant as a high dispersal priority when requesting accommodation from the accommodation provider.

An accommodation booking form should be submitted via the Collaborative Business Portal to an appropriate accommodation provider. This will inform them that accommodation needs to be arranged for the successful applicant, as well as specifying any additional accommodation requirements that may be necessary. A copy of the accommodation booking form should be faxed to the applicant's representative, to keep him informed that a request for the arrangement of section 4 accommodation has been made and the dispersal requirements specified. If the applicant is not represented, the form is sent to the applicant.

[Back to contents](#)

## Chapter 6 - Role of Dispersal Accommodation Provider

The COMPASS contracts contain a Statement of Requirements which sets out the duties placed on both the Home Office and the Accommodation Providers. The contracts, including the Statement of Requirements, can be accessed at:

<https://data.gov.uk/data/contracts-finder-archive/contract/503103>

[Back to contents](#)

### 6.1 Registering with a GP

Registering with a General Practitioner (GP) on dispersal is essential to providing access to health services to the supported person. The accommodation contracts allow for the provider to be advised in advance of dispersal that an applicant has a pre-existing condition requiring registration with a local GP.

It is the responsibility of each applicant who has been given a copy of their records as part of the IA health assessment to take them to each medical appointment.

[Back to contents](#)

### 6.2 Timescales for registering with a GP

The provider is contractually obliged to take a supported person to a GP within 5 working days of his arrival at the dispersal address if:

- a supported person has a pre-existing condition; or
- is in need of an urgent GP appointment.

Pre-existing medical conditions that require a Provider to register a supported person with a GP include:

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

If a supported person has a pre-existing condition or is in need of an urgent GP appointment, **and** states that he is in urgent need of a new supply of prescribed medication, the provider is contractually obliged to take the supported person to a GP within 1 working day of his arrival at the dispersal address.

[Back to contents](#)

## 6.3 Briefing of applicants by the Dispersal Accommodation Providers

Dispersal Accommodation Providers are required to ensure that all supported persons are briefed within one day of arrival at dispersal accommodation. This service includes assisting dispersed supported persons to register with a local GP and a dentist through the provision of oral and written instructions. The briefing must be delivered in a language that the supported person understands. Accommodation providers must also assist supported persons in their accommodation by providing them, where necessary, with information on how to make contact with, and the appointment systems associated with, the local National Health Service.

[Back to contents](#)

## 6.4 Urgent health need

If emergency assistance is required (also referred to as an urgent health need) when the supported person arrives at the dispersal address, the provider shall take the appropriate action to respond to the need, such as taking the supported person to the nearest GP, hospital Accident and Emergency Department, or calling the emergency services. If in doubt, the Provider will call NHS 111, NHS 24 (Scotland), or the local equivalent, describe the symptoms and act on the advice given.

The provider is required to notify the Home Office of the incident, or its outcome, at the earliest convenient time but not exceeding 4 working hours.

In the event of immediate emergency assistance, as a follow up, the dispersal accommodation provider will arrange for the supported person to be registered with a GP as a matter of urgency when he subsequently moves into the dispersal accommodation.

Incidents considered an urgent health need include:

- loss of consciousness, fits or fainting during the journey
- heavy blood loss
- suspected broken bones
- severe chest pain
- difficulty breathing
- overdose, ingestion or poisoning
- pregnancy complications including labour pains or excessive vomiting
- acute mental health issue
- inflamed eye or a foreign body in the eye
- attempted suicide
- acute toothache and /or facial swelling (the provider should contact NHS Direct (0845 4647), NHS 24 if in Scotland (08454 242424) or local equivalent for advice on how to get dental treatment).

This list is not exhaustive.

[Back to contents](#)

## **6.5 Providing assistance to attend medical appointments where the supported person has a visual impairment**

In the event that the Home Office notifies the dispersal accommodation provider that a supported person is visually impaired, to the extent that he cannot make the journey alone to receive treatment, the dispersal accommodation provider will make arrangements for him to be accompanied.

If it becomes evident that an applicant may have a care need which requires some additional help over and above provision of accommodation, caseworkers should liaise with the Local Authority to arrange a Community Care Assessment (CCA) to determine whether support is required under:

- In England: section 21 of the Care Act 2014;
- In Wales: currently under section 21 of the 1948 Act, or from April 2016 under Part 4 of the Social Services and Well-Being (Wales) Act 2014; or
- In Scotland, under section 12 of the 1968 Act.

[Back to contents](#)

## **6.6 Dispersal Accommodation Provider – When to contact the Clinical Commissioning Group (or local equivalent)**

If, in any one week period, 10 or more supported persons are placed in the same area by the Accommodation provider, the provider shall:

- notify the relevant Clinical Commissioning group (CCG) asylum healthcare worker of their arrival; and
- arrange, within two working days of the last supported person arriving, for the CCG asylum health care worker, or equivalent in Scotland and Wales to meet all the individuals (together), so that they can, if they wish, be registered with GPs at the same time.

Where there is no CCG asylum healthcare worker (or local equivalent), contact should be set up, and maintained, with a local health contact that will undertake these duties.

[Back to contents](#)

## **6.7 Dispersal Accommodation Provider – Contract Compliance**

In the event it is identified that an accommodation provider is not complying with the duties set out in the Statement of Requirements, caseworkers/stakeholders should notify the applicable regional contract compliance team.

[Back to contents](#)

## Chapter 7 - Further guidance on specific healthcare needs

In addition to the general guidance set out in chapter 4 –Dispersal: consideration of Healthcare Needs, and in order to assist dispersal decisions in the case of applicants with HIV, tuberculosis, mental health issues, or who are pregnant/new mothers, further information on appropriate dispersal requirements can be obtained from the following sections:

- 7.1 - HIV
- 7.2 - Tuberculosis
- 7.3 - Mental Health
- 7.4 - Pregnancy/New Mothers

Though further guidance is limited to the above listed medical conditions, all dispersal decisions will be made on a case by case basis, taking in to account medical information provided on behalf of the applicant, and if required, medical advice from the Asylum Support Medical Adviser.

[Back to contents](#)

### 7.1 HIV – Dispersal Guidelines

Following a grant of section 95 support newly arrived applicants with HIV who are not currently receiving ongoing treatment in the UK, should be dispersed from IA to dispersal accommodation at the earliest opportunity to enable them to start treatment without delay.

Following a grant of support under section 95 or section 4, and where accommodation is available, applicants with HIV who are currently receiving treatment in the UK should be dispersed to an area where they can reasonably be expected to access their current treating facility. If dispersal is to a location outside the area where they can reasonably be expected to access their current treating facility, dispersal should **only** take place:

- following and in accordance with any written expert clinical advice from the treating clinician. This should include advice about potential dispersal locations and confirmation that the applicant is medically stable and does not have any other active complication (Refer to chapter 4.8: Requesting Detailed Medical Information from Treating Clinicians for information on requesting detailed medical information from Treating Clinicians); or
- when this will not cause any harm to the individual or pose any risk to wider public health; or
- when applicant and clinicians have had time to adequately prepare for dispersal.

The expectation is that these arrangements would be completed within 4 weeks. However, if a person's condition is complicated by co-infection, this may take a little longer. It may be appropriate to temporarily accommodate the applicant within the area he can access his current treating facility, to give the treating clinicians suitable

opportunity to make appropriate arrangements before out of area dispersal commences.

When dispersal out of the area where the person can access their current treating facility is required, caseworkers should aim to ensure that the treating clinician is:

- notified of the applicant's new address;
- satisfied that there are appropriate facilities (including suitable accommodation facilities) to ensure continuity of care;
- ready to discharge and transfer the applicant's treatment to the receiving Clinical Commissioning Group (or local equivalent); and
- able to provide the applicant with sufficient medication to allow time for the receiving clinician to assess the treatment. This is to ensure that there is no interruption in the treatment and that there will be sufficient time for the receiving clinician to properly review the current treatment regime.

If an HIV positive applicant is pregnant, additional care is required and the prevention of mother to baby transmission should be of utmost importance.

Extra care should be taken when finding accommodation for families with children infected with HIV. Caseworkers will need to satisfy themselves that any accommodation is located where there are appropriate facilities specifically for treating children with HIV. The Asylum Support Medical Adviser should be asked to provide advice about specific locations. When dispersing families with children the Secretary of State's obligations under Section 55 of the 2009 Act should be taken in to account.

### **7.1.1 Confidentiality**

Those working with asylum seekers within or on behalf of the Home Office should ensure that applicants understand that disclosure of an HIV diagnosis will not have negative effect on their asylum application, but that it is essential in order for treatment to begin or continue. This is a major concern for many asylum seekers and leads to late disclosure of significant medical information, causing difficulties for the Home Office, and for both the treating and the receiving clinical teams.

Home Office caseworkers should take account of the information contained in chapter 7.1.2: HIV – Further Information when considering dispersing applicants who are HIV positive, and are reminded that **confidentiality** is paramount.

Caseworkers working with families will need to be aware that, for many important reasons, children are often not informed about their own or family members' HIV status. Inappropriate disclosure of HIV to children and young people can be traumatic and have long-term consequences. It should never be assumed that a diagnosis of HIV is common knowledge within a family.

[Back to contents](#)



### **7.1.2 HIV – Further Information**

Although HIV remains incurable, treatment advances have now made it a medically manageable condition and life expectancy has dramatically improved in the UK. Rates of HIV transmission from pregnant women to their children have also fallen with appropriate intervention. Key factors underpinning these substantial gains are the long-term engagement by people who are HIV positive with specialist, confidential medical care, very high levels of adherence to drug therapy, and an early HIV diagnosis.

The long-term relationship that is built up between doctor and patient is important in HIV medicine and a crucial aspect of successful management. There is substantial evidence that clinical outcome is directly related to HIV expertise. Patients cared for in hospitals with substantial HIV knowledge consistently fare better than those cared for in units with less experience. The Recommended standards for NHS HIV services sets out consistent standards for all as part of HIV service networks (<http://www.medfash.org.uk/uploads/files/p17abl6hvc4p71ovpkr81ugsh60v.pdf>).

Interruption of antiretroviral drugs is a key determinant in both treatment failure and the development of long term drug resistant HIV. Adherence – the ability of patients to take their medication exactly as prescribed – is highly emphasised in HIV care to maximise treatment benefits and reduce the risks of resistance. Disruption of daily routine has the potential to upset this crucial aspect of care.

The drugs have their own limitations – for maximum effectiveness some must be taken with meals, which requires a daily routine. Side effects are common and may include, for example, diarrhoea and nausea, which make access to a bathroom particularly important.

People with HIV face a range of associated medical problems and co-infections including hepatitis. HIV infection leads to progressive weakening of the individual's ability to counteract an array of complex life threatening infectious and malignant conditions. Although treatment for many of these complications is available, it is often protracted and requires input from a variety of specialists, which may not be widely available.

It may not just be HIV care that is required. Appropriate medical care for HIV increasingly requires the input of other specialist skills outside but associated with HIV, for example, liver experts to manage co-existing hepatitis B and C. The care of HIV infected children is a particularly specialised branch of medicine, with limited facilities for family care outside the larger clinical centres.

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

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

[Back to contents](#)

## **7.2 Tuberculosis – Dispersal Guidelines**

Although applicants who receive an IA health check are offered TB tests as part of their Health Assessment, caseworkers should not assume TB testing has been carried out.

If chest x-rays have been taken following suspicion of active TB but the results of a chest x-ray are not yet known, consideration should be given to delaying dispersal out of IA or dispersal to an area outside of the area the applicant can access the testing facility until the results of the chest x-ray are known.

In cases of active TB which remain infectious, dispersal out of the area the applicant can reasonably access their current hospital/clinic should be delayed and treatment commenced locally under the supervision of a TB specialist. Local accommodation is to be provided until the patient is no longer contagious and is able to travel. If dispersal within the area the applicant can access treatment at his current hospital is not possible, there will need to be direct communication between the Home Office and the treating clinician to ensure the effective handover of care. This should include providing the treating clinician with sufficient warning and information about the dispersal arrangements.

If an applicant in IA is diagnosed with active TB which is still infectious, unless hospitalisation is required, dispersal out of IA should be delayed while the active TB remains infectious. Where possible, while accommodated in IA, single person accommodation should be provided.

Except in cases of active TB which remain infectious, dispersal out of the area the applicant can reasonably access their current hospital/clinic may occur if the treating clinician advises that onward dispersal can take place, so that treatment can continue in the new dispersal area. If onward dispersal is appropriate, the treating clinician should be provided with information about the dispersal arrangements and adequate time in which to make the required continuity of care arrangements.

When making dispersal arrangements for an applicant with Active or Latent TB or awaiting the results of chest x-rays to identify whether the applicant has TB, advice should be sought from the Asylum Support Medical Adviser. If required, he will also liaise with the treating clinician on the Home Office's behalf. If the applicant is receiving assistance from an IA Healthcare Team, they must also be informed of any dispersal arrangements.

Applicants with active respiratory TB should not share a bedroom.

[Back to contents](#)

### 7.2.1 TB – Further Information

- TB is an airborne infectious disease that spreads through prolonged close contact.
- Rates of TB in the UK have increased from 6,724 in 2000 to 9,040 in 2009<sup>1</sup>.
- Rates of TB cases with first-line drug resistance in the UK have increased from 3,205 in 2000 to 4,991 in 2009<sup>2</sup>.
- Persons diagnosed with active TB will be placed on drug treatment lasting at least 6 months.
- Persons diagnosed with latent TB will be placed on drug treatment lasting three months.
- TB can almost always be cured provided that the medication is taken regularly and for the entire course. If complete treatment is not taken, then there is a risk of developing drug-resistant TB, which is more difficult to treat. People with drug-resistant TB are also likely to be infectious for longer periods. Treatment takes much longer and involves drugs with more side effects than standard treatments.
- Although infectivity ceases after two weeks antibiotics, risks restart if medication is not continuous and correct.

Further information on TB can be obtained from the Public Health England web pages on TB:

<https://www.gov.uk/government/collections/tuberculosis-and-other-mycobacterial-diseases-diagnosis-screening-management-and-data>

[Back to contents](#)

### 7.3 Mental Health –Dispersal Guidelines

Where an applicant is engaged in psychological and psychiatric services, the dispersal process, wherever possible, must not adversely affect the mental health of an individual and the care he receives.

Mental health issues may be identified during an IA health assessment, but it is likely that for the majority of cases treatment will begin on dispersal. Applicants who contact their primary healthcare team with mental health issues or who are identified as having mental health issues should:

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

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<sup>1</sup> Tuberculosis in the UK Health Protection Agency (HPA): Annual report on tuberculosis surveillance in UK 2010 ([http://www.hpa.org.uk/web/HPAwebFile/HPAweb\\_C/1287143594275](http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1287143594275)).

Caseworkers should not assume that because an applicant is not currently engaged in psychological and psychiatric services that he is not experiencing mental health problems.

Caseworkers should also be aware that some applicants may be used to a more holistic approach to mental health issues, which may rely more heavily on the support of family and other networks rather than counselling and medication. For this reason consideration should be given to requests for applicants not to be separated from existing support networks on a case-by-case basis, taking advice from the Asylum Support Medical Adviser.

Asylum seekers/failed asylum seekers may have the same range of psychiatric and psychological disorders as the general population. Mental health issues may arise out of the treatment of the applicants in their country of origin. Asylum seekers and refugees experience a higher incidence of mental distress than the wider population and the most common diagnoses are trauma-related psychological distress, depression and anxiety. Those who have been diagnosed with a terminal illness or who are HIV positive may experience mental health issues.

Abrupt cessation of psychiatric medication can result in a serious deterioration in the mental health of an individual, which goes beyond that which the individual would normally have without medication, placing themselves and others at risk. People at risk of suicide are often prescribed medication sufficient for just a few days, to reduce the risk of an overdose. Therefore it is imperative that in the cases where dispersal is out of the area they can access treatment from their current GP, sufficient medication for the dispersal period is obtained and that registration with a new GP is facilitated as soon as possible.

The disruption of therapy with a trusted clinician may be detrimental to an individual's mental health and compromise his capacity for recovery in the long term. Where an applicant is engaged in psychological and psychiatric services, consideration should be given to dispersing within that area or deferring dispersal out of the area that the applicant is receiving treatment in, in order to allow treatment to continue and be completed.

Where an applicant is receiving ongoing treatment from a psychiatrist, clinician, doctor, or nurse, and the medical practitioner states that an individual is at high risk of suicide, serious self-harm or risk to others, the caseworker, with the assistance of the Asylum Support Medical Adviser, must liaise with the relevant treating clinician if dispersal is the only option.

[Back to contents](#)

### **7.3.1 Applicants not yet in receipt of treatment**

Applicants may not immediately disclose that they are engaged in psychological and psychiatric services in the UK or in the country of origin. Mental health is understood very differently by all communities, and there are often cultural and religious taboos, stigma or family dynamics related to mental ill-health that makes it hard for applicants to talk openly about mental health issues. At screening, the applicant may still be very traumatised by recent events, and it can take months for the applicant to

feel confident and secure enough to articulate an experience of trauma and the impact it has had on his mental health. Some mental health problems may not even develop until after the applicant arrived in the UK.

If an individual is suspected of having mental health problems and appears in need of medical treatment, but is not currently in receipt of medical treatment, caseworkers should advise the person to contact his GP or relevant NHS contact (if one is known).

If, at the pre-dispersal stage, an applicant has been identified as being at high risk of suicide or serious self-harm, or as a risk to others, consideration should be given to delaying dispersal out of the area the applicant can access the local mental healthcare services to which they have been referred until assessment is completed (and where required, referred for appropriate treatment). Unless the assessment results in the provision of support from another government authority, the dispersal arrangements should take in to account the findings of the assessment, requesting advice from the Asylum Support Medical Adviser when required.

[Back to contents](#)

### **7.3.2 Behaviour that suggests drug abuse**

If an applicant in Initial Accommodation exhibits behaviour that suggests misuse of drugs for which he is not currently receiving treatment, IA Caseworkers should liaise with the IA Healthcare Team, seeking assistance from the Asylum Support Medical Adviser when required

[Back to contents](#)

## **7.4 Pregnancy / New Mothers - Dispersal Guidelines**

Pregnancy, birth and new motherhood have a significant impact on a woman's physical and psychological health, but the nature of that impact varies considerably between individuals. No single solution is likely to be in the interests of all pregnant women and each case should be sympathetically considered on its own merits and solutions sought in consultation with the woman

Every effort should be made to protect the health of pregnant women, new mothers and their babies. Caseworkers who are responsible for dispersing pregnant applicants should seek to minimise stress to the woman during her pregnancy.

[Back to contents](#)

### **7.4.1 Risks during pregnancy**

In September 2010, the National Institute for Health and Clinical Excellence (NICE) published a guideline<sup>2</sup> that identified particular groups of pregnant women who are affected by complex social factors. One of the groups identified included women who are “recent migrants, asylum seekers, refugees or who have difficulty speaking or reading English”.

The guideline makes clear that pregnant asylum seeking women may be affected not only by complex social factors within the UK (lack of knowledge of the health system; problems with interpretation), but also by poor health and other medical concerns arising as a result of pre-arrival issues, such as:

- A poor overall health status;
- Underlying and possibly unrecognised medical conditions;
- Possible FGM issues;
- psychological and medical effects of flight from war torn countries;
- Fears about immigration; and
- Languages difficulties.

It is also recognised that maternal stress in pregnancy has a detrimental effect on subsequent childhood development

Maternity care covers the entire period of pregnancy, labour, and the postnatal period. NICE has identified several key issues throughout this to improve pregnancy outcomes and safeguard the health of mothers and babies. These are:

- Early booking into maternity services, ideally by 10 weeks gestation;
- Continuity of care;
- Family and social support;
- Planning labour;
- Post natal care for 6-8 weeks.

Given the potential for increased risks to the health of some women in these circumstances, caseworkers should try to avoid dispersing women away from the area in which they are living and receiving maternity care, and in which they can access social and family support. If dispersal is unavoidable, caseworker should take particular care when arranging accommodation for pregnant women and their children.

[Back to contents](#)

### **7.4.2 General background information on pregnancy**

Asylum seekers/failed asylum seekers have an increased risk of mortality during pregnancy or soon afterwards compared with the indigenous population, and two of the key risk factors are late enrolment in maternity care or missed appointments.

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<sup>2</sup> “Pregnancy and complex social factors” National Institute for Health and Clinical Excellence (NICE) guideline published September 2010.

Various tests are required at the first ante-natal visit and at specific intervals during pregnancy, including blood tests, an optional HIV test and ultrasound scans. Regular visits to a clinic ensure that blood pressure and other factors are within normal limits. Certain tests are relevant to the various stages of pregnancy and cannot be delayed. Caseworkers should therefore take care that dispersal does not disrupt this programme and particular care should be taken not to disrupt any anomaly screening which has been scheduled.

Following a birth, mother and baby are visited frequently by a midwife until day 14 (sometimes up to day 28) and then by a health visitor. This is followed by a post natal examination at 6 weeks.

Consideration may need to be given in both dispersal and IA to the number of flights of stairs women who have recently given birth need to negotiate in the short-term. More than one flight of stairs can be exhausting and painful.

Within the constraints of a no choice dispersal policy, it is likely that women will have individual preferences regarding the timing of their dispersal from IA. However, the aim, wherever possible, will be to settle them into accommodation where they will be able to access services throughout their pregnancy and into new motherhood, by:

- a. if possible, accommodating pregnant women as close to the maternity unit where they are currently accessing care, as well as existing sources of family and social support; or,
- b. where there is no previous link to maternity services, disperse them from IA as soon as possible so that they can establish health and community links in the dispersal area and avoid disruption around delivery.

No single solution is likely to be in the interests of all pregnant women and each case should be sympathetically considered on its own merits.

[Back to contents](#)

### **7.4.3 Confirmation of Pregnancy**

The Home Office requires **original**, written confirmation of pregnancy from a health official, e.g. a MATB1 form or a letter from a treating clinician.

The original document should be scanned onto to ASYS tab 9 for a permanent record. If the original document has already been seen in a Regional Office and entered on ASYS, this will be acceptable evidence.

[Back to contents](#)

### **7.4.4 The Late Stages of Pregnancy**

Caseworkers should be aware that many asylum seeking women have shorter pregnancies than the indigenous population and may well give birth earlier than the estimated date of delivery (EDD). Although the whole of pregnancy, labour and the

postnatal period must be taken into account when considering dispersal, there are additional risks to women whose pregnancies have reached the late stages.

**For the purposes of this policy, the late stages of pregnancy will be defined as normally running from six weeks before the Estimated Date of Delivery (EDD) until a clinician has signed off on the postnatal checks. The latter will usually be around six weeks after birth, unless there have been complications.**

[Back to contents](#)

#### **7.4.5 Dispersing asylum seeking women who are pregnant on arrival in the UK**

Pregnant asylum seeking women who have recently arrived in the UK are unlikely to be registered with maternity services. As a result, it should be possible to disperse the women from Initial Accommodation (IA) to suitable accommodation as soon as possible.

If an applicant is in the late stages of pregnancy, as defined above, priority should be given to finding appropriate dispersal accommodation nearby so that she can continue to access the local maternity unit. If accommodation is not available within the area where the woman has booked into maternity services, then the options of either dispersal to another location or the deferral of dispersal should be considered in consultation with the applicant.

Dispersal in the late stages of pregnancy should only be undertaken either at the request of applicant or her treating medical practitioners. If such a request is made, it must be made in writing. Caseworkers should liaise with the IA Healthcare Team when making dispersal arrangements, taking advice from the independent Asylum Support Medical Adviser where appropriate.

Wherever possible, pregnant women should only be dispersed once whilst they are pregnant, unless they specifically request relocation. This means that any dispersal accommodation must be suitable to the woman's needs both before and after birth and available throughout that period.

There should be a dispersal notice period of at least ten calendar days between a pregnant woman in the late stages of pregnancy (as defined above) being advised of the area of her dispersal accommodation and her actual dispersal. The IA healthcare team should be notified of the intended dispersal, including the destination and the intended dispersal date, at the same time as the pregnant woman.

When making dispersal arrangements for such cases, caseworkers should liaise closely with the IA Healthcare Team to ensure that all issues relating to the set up and/or effective handover of care, including any referrals to maternity services etc at the dispersal destination are completed before the dispersal takes place.

Full use should be made of the dispersal notice period to ensure that where dispersal requires any travel, it should not take place before the views of a midwife or treating clinician on the following issues have been obtained:

Healthcare Needs and Pregnancy Dispersal Guidance v3.0

40



- the woman's fitness to travel;
- any travel constraints (length of journey etc); and
- any arrival issues, including any arrangements that have been made, or need to be made, and with whom, to ensure effective handover of care.

[Back to contents](#)

#### **7.4.6 Dispersing pregnant asylum seeking women who have been residing in the UK for some time**

When dispersing a pregnant woman who is already registered with maternity services, caseworkers should try to ensure that she is able to continue to live in her usual residential area. This would enable her to maintain access to her current maternity service and any other health and support services she may need access to, as well as maintaining any social support networks she has.

Wherever possible, pregnant women should only be dispersed once whilst they are pregnant, unless they specifically request relocation. This means that any dispersal accommodation must be suitable to the woman's needs both before and after birth and available throughout that period.

However, for those applying for support under section 95, it may prove necessary for them to spend some time in the nearest IA if they are unable to remain in their current private accommodation until appropriate dispersal accommodation is found. Every effort should be made to find appropriate accommodation in the area where the local maternity unit with which they are registered is located.

Whilst access to IA is generally not available to persons applying for support under section 4, if a woman is in the late stages of pregnancy (as defined above) and is either street homeless or imminently street homeless, consideration may be given to placing her in IA. This would enable access to the IA healthcare team for an assessment of fitness to travel and/or for dispersal, as well as providing assistance on either continuity of maternity and other care, or registration with maternity services, locally or at the dispersal destination.

If accommodation is not available within the area where the woman is registered with maternity services, as a last resort the options of either dispersal to another location or the deferral of dispersal should be considered in consultation with the applicant.

Dispersal in the late stages of pregnancy should only be undertaken either at the request of applicant or her treating medical practitioners. If such a request is made, it must be made in writing.

When making dispersal arrangements for such cases, caseworkers should liaise closely with the IA Healthcare Team to ensure that all issues relating to the set up and/or effective handover of care, including any referrals to maternity services etc at the dispersal destination are completed before the dispersal takes place.

Full use should be made of the dispersal notice period to ensure that where dispersal requires any travel, it should not take place before the views of either the IA health team or midwife/treating clinician on the following issues have been obtained:

- The woman's fitness to travel;
- any travel constraints (length of journey etc); and
- any arrival issues, including any arrangements that have been made, or need to be made, and with whom, to ensure effective handover of care.

[Back to contents](#)

#### **7.4.7 Pregnant women with HIV**

Pregnant women with HIV infection should be subject to very careful consideration, so that the risk of transmission before, during and after delivery can be kept to the absolute minimum. Such cases should be referred to the independent Asylum Support Medical Adviser. If accommodation is available, dispersal should occur to an area where they can reasonably be expected to access their current treating facility. In the event a baby is born to a HIV positive mother who is due to be dispersed out of the area she can access treatment at her current medical facility, the continuity of care action specified in chapter 71: HIV – Dispersal Guidelines must be adhered to. It is essential that good handover of care is arranged so that the results of specialist tests carried out to establish the HIV status of the baby can be passed to the receiving clinician.

[Back to contents](#)

#### **7.4.8 Other high risk pregnancies**

Other high risk pregnancies include cases where a woman has a chronic disease or pregnancy related disorder such as pre-eclampsia. If accommodation is available, dispersal should occur to an area where they can reasonably be expected to access their current treating facility.

Dispersal to an area requiring transfer of care to a different maternity unit should take place only under endorsement and supervision of the treating clinician, with treatment arrangements in place in the receiving area so to ensure that vital medication is not discontinued at any point. In some cases of asylum seekers accommodated in IA, it may be appropriate to further delay dispersal out of IA pending appropriate treatment and supervision. All such cases must be referred to the independent Asylum Support Medical Adviser. For further information on deferred dispersal, refer to chapter 4.11: Dispersal: Criteria for deferral or selective dispersal on health grounds.

[Back to contents](#)

### 7.4.9 Miscarriage or still birth

In cases where there has been a miscarriage or still birth and the applicant is accommodated in IA, dispersal out of IA should not take place until all related procedures, including recovery have been completed. In cases where the applicant is not accommodated in IA, dispersal out of the area the applicant can access treatment at her current maternity unit should not take place until all related procedures, including recovery have been completed. In the case of still births, for most parents this constitutes a funeral. Information about funeral costs can be found in Chapter 18 of the Asylum Support Policy Bulletins Instruction on 'Help with the Cost of Funerals'.

[Back to contents](#)

### 7.4.10 Termination of pregnancy

Where a woman is awaiting an appointment to discuss a termination of pregnancy or who has a date for termination, she should not be dispersed out of IA until:

- after the termination has taken place and initial recovery completed; or
- until the woman has made a clear decision to continue with the pregnancy and has completed initial booking, information sharing and screening.

In the case of women not accommodated in IA, they should not be dispersed out of the area they can access treatment at their current medical facility until after this has occurred. The aim should be to avoid disruption to this time-sensitive process. For further information on deferred dispersal, refer to chapter 4.11: Dispersal: Criteria for deferral or selective dispersal on health grounds.

Information on NHS Choices suggests that the process should take no more than 3 weeks from initial appointment. Please see:

<http://www.nhs.uk/Livewell/Sexualhealth/Pages/Abortionyouroptions.aspx>

**Caseworkers are reminded that information about a woman's termination of pregnancy is confidential and should not be disclosed to anyone, including her husband/partner.**

[Back to contents](#)

### 7.4.11 Additional Financial Support

Pregnant women and children under the age of three who are supported by the Home Office may be eligible to receive additional support.

- For further information on the provision of additional support under section 95 for expectant/new mothers and for young children, refer to chapter 24 of the Asylum, Support Policy Bulletins Instruction on Maternity Payments and Additional Payments to Pregnant Women and Children Aged Under 3.

- For further information on the provision of additional support under section 4 for expectant/new mothers and for young children, refer chapter 11 of the Asylum Support, Section 4 Policy and Process document on “Additional Services or Facilities under the 2007 Regulations”.

[Back to contents](#)

## Appendix A - Initial Accommodation Healthcare Team Contact

Health assessment and TB screening services dedicated to regional IA sites are outlined below. These sites are at varying stages of transition and development but the contacts identified below are the most up to date.

These contacts are all front-line practitioners either working in, or closely aligned to IA. To ensure good continuity of healthcare and service provision, it is important that Home Office regional routing teams and other operational colleagues are able to develop useful working relationships with these IA contacts.

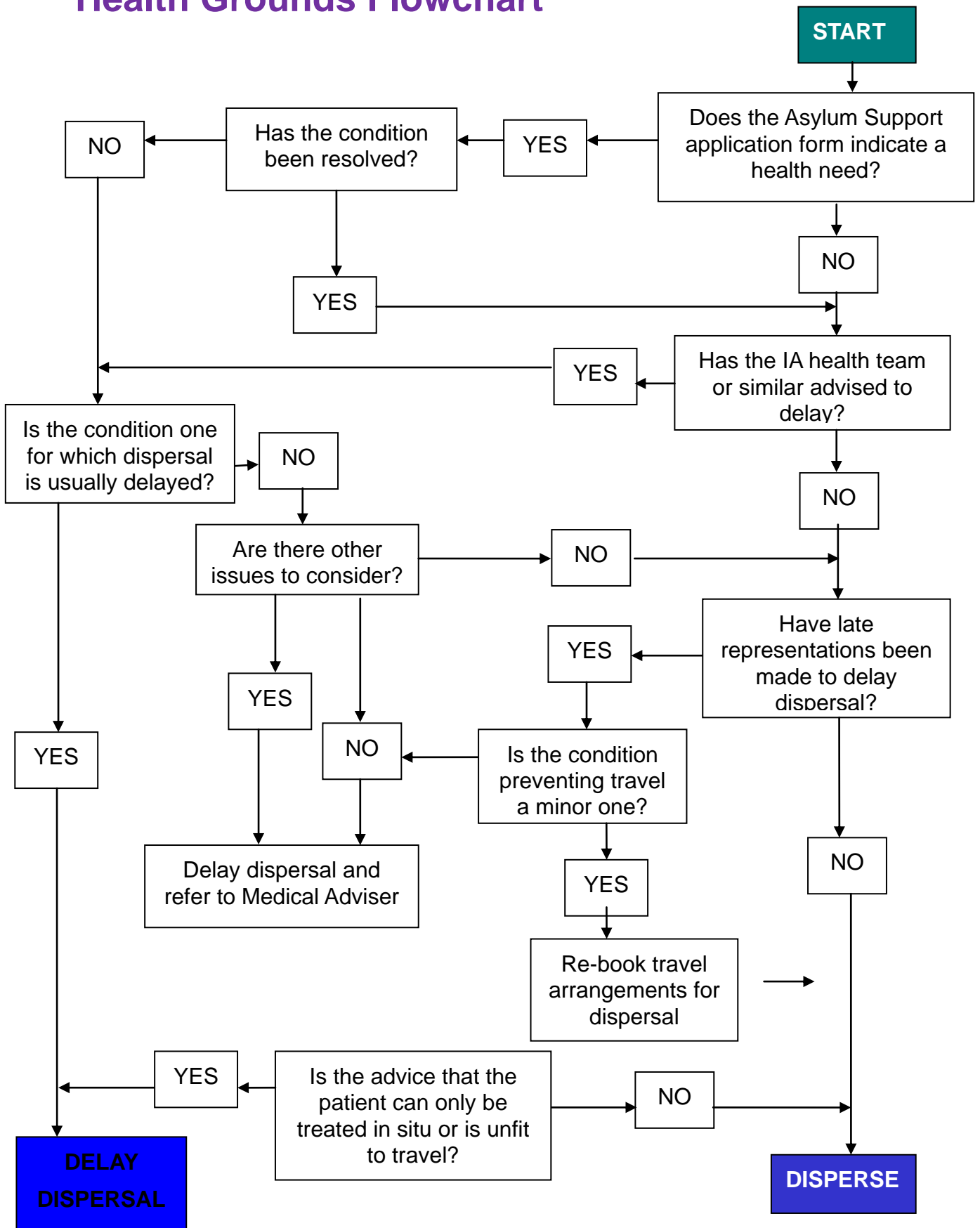
Subject to normal medical confidentiality, these contacts may be able to advise on how health issues for individual asylum seekers might affect dispersal arrangements.

Area	Contact Names	Organisation	Job Title	Contact Details
Birmingham	Jan Hardinge	Virgin Care	Service Manager	<p>Summerfield GP and Urgent Care Centre                      Finch Road Surgery                      Kingstanding Community Practise                      Birmingham</p> <p>Tel: 0121 255 0430                      Tel: 07817 908055</p> <p>Email: <a href="mailto:jan.hardinge@nhs.net">jan.hardinge@nhs.net</a>;  <a href="mailto:jan.hardinge@virgincare.co.uk">jan.hardinge@virgincare.co.uk</a></p>
Croydon	Paul Coleman	Croydon University Hospital	Clinical Team Lead / Nurse Practitioner	<p>The Rainbow Health Centre                      141 Brigstock Road                      Thornton Heath                      CR7 7JN</p> <p><a href="mailto:Paul.coleman@croydonhealth.nhs.uk">Paul.coleman@croydonhealth.nhs.uk</a></p> <p>Tel: 0208 251 9280                      Mob: 07786 518622                      Fax: 0208 251 9286</p>
Liverpool	Tracey Harrington	UC24 Asylum	Practise Manager	<p>Urgent care 24 Asylum                      28 Argyle Street                      1<sup>st</sup> floor Rope Walks                      L1 5DL</p> <p><a href="mailto:Tracey.harrington@uc24-nwest@nhs.uk">Tracey.harrington@uc24-nwest@nhs.uk</a></p> <p>Tel: 0151 230 5550                      Mob: 07809 442613</p>

Area	Contact Names	Organisation	Job Title	Contact Details
South East London	Viv Monaghan	Guys & St Thomas's Foundation Trust	Nurse Practitioner, Clinical Lead Refugee health	Three Boroughs Health Inclusion Team Gracefield Gardens health and Social Care Centre 2-8 Gracefield Gardens Streatham London SW16 2 ST  <a href="mailto:vivienne.monaghan@nhs.net">vivienne.monaghan@nhs.net</a>  Tel: 020 30494700 Mob: 08831 284754
Wakefield	Ellie Armitage	South West Yorkshire	Team Leader	Nurses office Angel Lodge 5 Love lane Wakefield WF2 9AF <a href="mailto:Eleanor.Armitage@swyt.nhs.uk">Eleanor.Armitage@swyt.nhs.uk</a>  Tel: 01924 362965 Fax: 01924 37010

[Back to contents](#)

# Appendix B - Criteria for Deferred Dispersal on Health Grounds Flowchart



## Appendix C - Glossary

Amniocentesis	Removal of amniotic fluid from the womb of a pregnant woman in order to detect possible abnormalities in the foetus.
Antiretroviral drugs	Drugs that act against diseases caused by infection by retroviruses, primarily HIV viruses.
Asylum Routing Team	This is the team that allocates new asylum cases to the regional asylum teams and if the applicant is destitute, arranges for the applicant to be accommodated in temporary accommodation under section 98.
Asylum Seekers Support System (ASYS)	ASYS is the IT database that delivers asylum support.
Co-infection	Simultaneous infection by two or more infectious agents (e.g. viruses or bacteria).
Co-Morbid	Simultaneous illnesses within the same person.
Deferred Routing	If applicants are required to return to the Asylum Intake Unit to complete the asylum screening process, they may, if required, be temporarily accommodated in the IA nearest to the Asylum Intake Unit until the screening process has been completed and routing of the applicants takes place.
Dispersal accommodation	If applicants are considered as being eligible for support, they will be dispersed to longer term accommodation provided under section 95 or section 4.
Human Immunodeficiency Virus (HIV)	HIV attacks the body's immune system. A healthy immune system provides a natural defence against disease and infection. If the immune system is damaged by HIV, it increases the risk of developing a serious infection or disease.
Initial Accommodation	Temporary accommodation provided under section 98 until an application for section 95 support can be considered.
Overnight Initial Accommodation	This accommodation is provided under section 98 where the applicant cannot be taken to Initial Accommodation in their case-owning region on the same day, owing to the distance involved.
Point of claim	Point at which a claim for asylum is registered. This may be at a port, an Asylum Intake Unit, or Local Enforcement Office.
Post Traumatic Stress Disorder	A mental illness occurring following a traumatic event or sequence of events, which may involve a variety of symptoms including flashbacks and hyper vigilance, and continue for an extended period.



Pre-eclampsia	Pre-eclampsia is a condition, which occurs only during pregnancy, or immediately after delivery of the baby. Women develop high blood pressure together with protein in the urine and fluid retention (oedema). Although most cases are mild and cause no trouble, it can get worse and be serious for both mother and baby. It can cause fits in the mother (eclampsia) and affect the baby's growth, and be life-threatening if left untreated. If it does get worse, the treatment ranges from rest at home or hospital to drugs to lower the high blood pressure, or, occasionally early delivery of the baby.
Regional asylum support team	In each region, asylum support caseworkers are responsible for considering applications for support. These caseworkers are either embedded in the asylum teams or within separate support teams.
Thalassaemia	Name given to a group of inherited blood disorders that affect the body's ability to create red blood cells.
Tuberculosis	Tuberculosis (TB) is a bacterial infection. It is spread by inhaling tiny droplets of saliva from the coughs or sneezes of an infected person. Mycobacterium tuberculosis is the bacteria responsible for TB. Mycobacterium tuberculosis are very slow moving, so a person may not experience any symptoms for many months, or even years, after becoming infected. TB primarily affects the lungs (pulmonary TB). However, the infection is capable of spreading to many different parts of the body, such as the bones or nervous system. Typical symptoms of TB include a persistent cough, weight loss and night sweats.
Venous thrombo-embolism	Blood clots in the veins, such as deep vein thrombosis, which can be fatal if they travel from the legs to the lungs (called emboli). Pregnant women and women who have recently had a baby are amongst those more at risk.

[Back to contents](#)

# Document Control

## Change Record

Version	Author	Date	Change made
1.0	SM&G JB	02/08/2012	First Version
2.0	GJB	02/12/2013	HC2 chapter updated and HO branding
3.0	GJB	01/02/2016	Update to pregnancy chapter and reformatting

[Back to contents](#)

