Vulnerable migrants and wellbeing
A pilot study

Final Research Report for the Nuffield Foundation

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Executive Summary

- The aim of this project was to build an evidence base to study the wellbeing status of individuals living in the UK, focussing on undocumented migrants and asylum seekers, and others who can experience vulnerability, and to explore factors that may contribute to shaping this.
- This was done by pooling, harmonising, and exploring a unique and relatively unutilised dataset of service users from the clinic-based advocacy programme run by Doctors of the World UK (DOTW), a registered charity that that is part of the international Médecins du Monde network. This data, covering the period from 2011 to 2016, allows us to focus on the wellbeing of groups about whom there is very little quantitative data.
- The pooled dataset comprised a total of 8,489 unique consultations across the years, with most service users visiting the clinic once and the most often mentioned reason for the visit being an administrative, legal, or social issue.
- In the dataset, 48.3% of service users were female, and 51.7% male, with an average age of 35.6 years, with most users living in the vicinity of the DOTW UK clinics. With regard to immigration status, a large proportion of service users are undocumented, have been in the UK for various periods of time (average of 5.6 years since last arrival, but with a large range), and have claimed (or planned to claim) asylum.
- The indicators used to measure wellbeing include measure of health, support, living conditions, and access to healthcare.
- With regard to health, the analysis indicated that service users' self-reported general health is much lower to that recorded in the general population. Women have better self-reported general and physical health, whereas older service users reported poorer general and physical health. Service users classified as asylum seekers have more negative reported health, especially with regard to mental health.
- These patterns are similar when looking at service users' reported presence of support networks, with male service users, as well as undocumented users and asylum seekers, reporting higher levels of isolation.
- In terms of living conditions, a very large majority of service users live in a flat or house, with just over a third of service users reporting that their accommodation is not stable.
- Just over 70% of service users report some limitation to their daily movements for fears of being arrested, which has increased in recent years.
- A small proportion of service users report having an activity allowing them to earn a living, and a very large percentage were living below the poverty line.
- Access to healthcare is an issue for service users, with large numbers reporting not even trying to access healthcare. When service users who are not registered with a GP seek to access care, they tended to use Accident & Emergency and Walk-in Centres.

- Most often mentioned barriers to healthcare access include administrative issues, lack of understanding, language barriers, fears of being arrested, and denial of entitlements.
- The results presented in this report highlight the richness of the data collected by DOTW UK, which warrants further analysis, especially with regard to unpacking some of the results shown here for various groups, demographics and wellbeing indicators.
- There is extensive research, practice, and policy relevance to the findings with further analyses offering much potential, including a more in-depth examination of identifying and breaking down the barriers to legal healthcare access; evaluating the impact of the hostile environment; and developing relevant indicators of wellbeing for individuals at risk of vulnerability.
- Further analysis of this data would be beneficial, especially with regard to delving deeper into some of the relationships examined, disaggregating groups at risk of vulnerability, evaluating the impact approaches to data collection, and examining in some detail the experiences which underpin many of the findings. Such an analysis would lend itself to a mixed methods approach.

Introduction

Vulnerable individuals are those who "face[s] a significant probability of incurring an identifiable harm while substantially lacking ability and/or means to protect oneself" (Schroeder and Gefenas, 2009: 177). Vulnerabilities can occur because of individual and structural factors or often a combination of both. One such structural factor being uncertain immigration status, which can cause increased vulnerability (Craig et al., 2015; Medecins du Monde, 2015; MigrationWork and Migrants' Rights Network, 2009) as access to services and resources have been limited by recent governments (Home Office, 2016) in a bid to create a "hostile" environment denying undocumented migrants access to welfare, housing, employment and banking. Uncertain immigration status increases the risk of harm (e.g., limited access to services, greater exposure to exploitation, limited recourse to justice and protection, etc.) while simultaneously decreasing people's means of protecting themselves. There is, however, a dearth of quantitative data on the experiences of individuals most at risk of vulnerability, which include asylum seekers, refugees and undocumented migrants. This is especially with regard to their wellbeing, here defined as the fulfilment of physical, material, psychological, social/relational, and spiritual needs at various levels (La Placa et al., 2013).

This pilot study starts to fill this gap in knowledge about the relationship between vulnerability[1] and wellbeing by exploring a unique and relatively unutilised dataset of service users from Doctors of the World UK (DOTW UK), a registered charity that that is part of the international Médecins du Monde (MdM) network, and provides medical care and support to populations, most of whom face vulnerability, who have difficulties accessing the National Health Service and other statutory services. Service users include undocumented migrants, asylum seekers, sex workers, and homeless people. In this pilot project, service user data from 6 years (2011 to 2016) are merged together to produce an analytical dataset and investigated through descriptive analyses. Our preliminary analyses enable us to explore the potential that the data can provide to study the wellbeing of some of the groups with higher levels of vulnerability, with the aim to further explore these links in a larger, possibly mixed methods, project.

This report is divided as follows. It starts by describing the project, outlining the aims, objectives and relevance of the project, and presents the research team. It then discusses the data in more detail, before presenting descriptive results from the project. Finally, the last section discusses conclusions, implications, and recommendations that can be drawn from the work.

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[1] Also a contested concept in policy and academic circles.

The project

Aims, objectives, and relevance of the project

The principal aim of this pilot study is to build an evidence base to study the wellbeing status of individuals living in the UK that can experience vulnerability, and explore factors that may contribute to shaping this.

The objectives of the pilot project are as follows:

1. To prepare a dataset allowing for the in-depth examination of the data;
2. To examine, via descriptive analyses, the available variables in the data and their suitability for measuring wellbeing;
3. To document the results, with the aim to inform the larger project, as well as practitioners, and policy makers; and
4. With the project partners and advisory board, consider the need for, and develop, a proposal for a larger project, with an analytical, engagement, and dissemination strategy.

The evidence base generated by this project has important implications for research and practice. The pooling, analysis and dissemination of this rich source of data allows researchers and practitioners to better understand the situation of populations with potentially high levels of vulnerability; engage in discussion about service provisions for those populations; and frame research priorities, especially with regard to further utilising this dataset to explore in more detail the wellbeing of services users and the factors that shape it.

The team

The team is comprised of members of the core team and the advisory board. The team members met on three occasions during the course of the project: at the advisory board meetings in November 2017 and March 2018, and at the project roundtable in June 2018. Team members were also consulted throughout the course of the project on various issues. The individuals involved are as follows:

- Core team at the University of Birmingham
  - Laurence Lessard-Phillips
  - Antje Lindenmeyer
  - Jenny Phillimore
- Core team at/affiliated to DOTW UK
  - Lucy Jones
  - Fozia Hamid
- Advisory board
  - Hannah Boylan (Greater London Authority)
  - Sin Yi Cheung (Cardiff University)

    - Lisa Doyle (Refugee Council)
    - Hiranthi Jayaweera (University of Oxford)
    - Alyna Smith (PICUM)

In addition to the research team, the following individuals have contributed to the research. Kyounghee Chong provided administrative assistance. Additional feedback was also provided by participants at the project roundtable, held on 26th June 2018.

Methodology

The main objectives of the project are to prepare and provide a descriptive analysis of the quantitative data from DOTW UK, focussing on selected wellbeing and demographic indicators. In what follows, a description of the data and the outputs generated is provided.

Data

Background

The data used in this project come from the clinic-based advocacy programme run by DOTW UK. Basic primary care was delivered by volunteer doctors and nurses in clinics based in London and Brighton (the Brighton clinic is no longer running). A family clinic service dedicated to pregnant women and children was added in 2014 in response to increasing numbers of pregnant women attending the main clinic who had not received any antenatal care. Additionally, outreach clinics serving specific groups such as domestic workers and sex workers have been provided away from the main clinics in locations more easily accessible to these groups.

On attending any clinic, service users are interviewed by a clinic support worker, who completes a social form during or after the consultation, including their own notes and observations (see Appendix Table A1 for the items covered by the social form across years). Questions relate to social situation, immigration status, living conditions, self-reported health status and barriers to health care (Chauvin et al., 2009). Support workers actively assist service users to register with a General Practitioner (GP), the entry point to the National Health Service, and provide information on how to access other services such as legal advice or women's refuges.

A proportion of service users then see a volunteer doctor or nurse for a medical assessment during which a medical form is completed by the volunteer (see Appendix Table A2 for the items covered by the medical form). This includes questions about health and experience of violence, as well as the volunteer's notes and observations. Specific diagnoses are recorded using the ICPC-2 (International Classification of Primary Care – second edition) pathology classification system (World Health Organisation, 2003).

Written consent is gained beforehand that permits the collection and use of anonymised data for DOTW UK reports and research for advocacy purposes. It is important to note that the data collection is not administered like a typical survey, but more on the basis of a conversation/interview where relevant information is gathered based on direct responses to the items in the forms, assumed responses, or impressions of the support workers and volunteers.

The questionnaires were devised and validated by MdM in collaboration with researchers based at INSERM (French National Institute of Health and Medical Research) and CNRS (The National Centre for Scientific Research) (Chauvin et al., 2009). They were designed for routine data collection from countries participating in the first MdM international Observatory Report in 2006, and evolved from the system of data collection used by MdM in its free clinics since 1994 (Chauvin and Simonnot, 2012). Data was initially collected only for undocumented migrants attending MdM clinics and from 2011 was expanded to include all service uses (Chauvin and Simonnot, 2012). This data is summarised in yearly Observatory Reports, which can be found on the MdM website.[2]

The social and medical forms are reviewed each year by the Médecins du Monde Observatory team to improve the quality of data and analysis that is produced (Chauvin et al., 2014). Over the years some questions have been updated or removed and new questions added to reflect recommendations made by INSERM researchers and feedback from teams in the field (Chauvin et al., 2015). The collection of data has the triple aim of improving service quality, production of good quality public health data for healthcare providers and policy makers and supporting field teams in programme monitoring (Simonnot et al., 2016).

Missing data

In each year a significant amount of missing data has been noted that can be related to one of the following three situations: the forms were adapted by some countries and questions from the social or medical form were removed; the issue was not raised by certain programmes or volunteers, particularly for issues considered sensitive such as exposure to violence; or (more rarely) the service user preferred not to answer the question (Chauvin et al., 2014). It is not always possible to disentangle the reason for missing values in the dataset.

Data processing

The original data files were provided in comma separated and Microsoft Excel formats for processing; all data manipulations were performed using the statistical software Stata. Data from 2011 to 2014 were obtained from the Observatory data store, which had been already processed and harmonised for the Observatory Reports (one datasheet per year). Data from 2015 and 2016 were provided by DOTW UK in an unprocessed format (one datasheet per questionnaire). The steps involved in data processing were as follows:

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[2] https://mdmeuroblog.wordpress.com/resources/publications/

1) Importing, formatting, and merging the data files into one pooled data set;
2) Harmonising data into consistent variables over time for the various sections of the questionnaires, including consistency checks; and
3) Generating descriptive statistics (see below).

Data analysis

Once pooled and harmonised, the data were analysed. Given the exploratory nature of the project, only descriptive statistics were generated (frequency distributions and measures of central tendency for relevant variables, and tabulations between key variables and demographic indicators such as gender and immigration status).

Key findings

Overview of the sample

The merged dataset included 10,692 observations (1 observation = 1 recorded consultation) across the available years. For ease of analysis, we only included unique visits in our sample for the whole period, for a raw total of 8,489 observations (1 observation = 1 unique consultation by service users in the period; this implies that the number of observations in this dataset differs from those from the MdM Observatory Reports, which include one consultation per individual but may include repeated consultations across various years). The breakdown of observations per year can be found in Table 1. Out of the 8,489 observations in the sample, 82.9% visited a DOTW UK clinic once, 12.2% visited twice, 3.1% visited three times, and the remainder visited the clinic over four times during the time period covered by the data. This pattern of visits is consistent with the DOTW UK programme's model.

Table 1 Number of observations per year

Year	Pooled data	Observatory data
2011	1,462	1,449
2012	1,497	1,561
2013	1,046	1,047
2014	1,284	1,395
2015	1,479	1,601
2016	1,721	1,758
Total	8,489	8,811

The reason(s) for consultation is recorded for each service user. If we look at Table 2, which states mentions of the main reasons for consultation, we see that most consultations are linked to administrative, legal, and social issues, broadly defined (one of the most common reasons for consultations appears to be GP registration – see Doctors of the World UK, 2016). Across all years covered by the sample, 87.3% of all service users report having no health cover, with a similar percentage (2011-2014 data only) not registered with a GP.

Table 2 Reasons for consultation

(N=7,752)	% Mentions
Administrative, legal, social issue	91.2%
Medical issue	47.4%
Psychological/Psychiatry issue	1.2%
Other	6.5%

Demographic information and immigration situation

We now delve into details about the demographic characteristics and immigration situation of the clinic's service users (see Table 3), which we will use to examine wellbeing profiles. Looking at the demographic characteristics, we see that service users are more or less evenly split with regard to sex, which is a finding of interest given the fact that larger shares of asylum seekers, for example, are men (Blinder, 2013). The mean age of service users is 35.6 years, with just under 50% of service users being between 25 and 44 years of age. Approximately 35% of services users have used interpreters during their consultation. Looking at their geographical distribution across London (Figure 1 – where darker colours indicated boroughs with the highest number of service users, which are divided in quintiles[3]), we see that most service users come from areas close to the main clinic in Bethnal Green, but that the geographical spread within London is quite broad as well. Note that just over 10% of the service users reside outside of London.

Looking at the immigration status of service users, a large majority (58.1%) are undocumented and 15.1% are asylum seekers. Among undocumented entrants, most are either visa overstayers or irregular entrants to the UK. Within the 'other' category of service users, of which only a small proportion (4.4%) do not require a residency permit, quite often because they are a UK national, about half are non-EEA nationals with other types of visit or residency rights (tourist, student, or work visa for example). 'Undocumented', 'asylum seekers', and 'other' are the main groups that we are focussing on in this report, but there is scope to disentangle the 'other' category further in future work. For those not born in the UK, the mean number of years since last entry into the country is 5.2 years, going from people with very recent entry to the UK, to over 10 years since last entry to the UK. Among those eligible, 44.5% of respondents have either claimed asylum or are planning to claim asylum. These are mostly current asylum seekers but also a large share (40.7%) of the undocumented service users.

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[3] Quintiles divide data into 5 equal groups.

Table 3 Demographic and immigration characteristics of service users

Variable	Categories	%/mean	N
Sex	Female Male	48.3% 51.7%	8,226
Age		35.6 years	8,148
Age groups	0-17 18-24 25-34 34-44 45-54 55-64 65+	4.1% 10.9% 32.0% 27.9% 16.1% 6.4% 2.6%	8,148
Use of interpreter	No need No Interpreter present Interpreter over phone No information	48.1% 7.2% 24.8% 10.1% 9.8%	8,498
Immigration status	Undocumented Asylum seeker Other	58.1% 15.1% 26.9%	7,603
Years since last entry		5.2 years	7,008
Years since last entry (grouped)	< 1 year 1-<3 years 3-<6 years 6-<10 years Over 10 years	23.8% 18.3% 21.1% 21.2% 15.6%	7,008
Ever claimed for asylum (or planning to)	Yes	44.5%	7,129

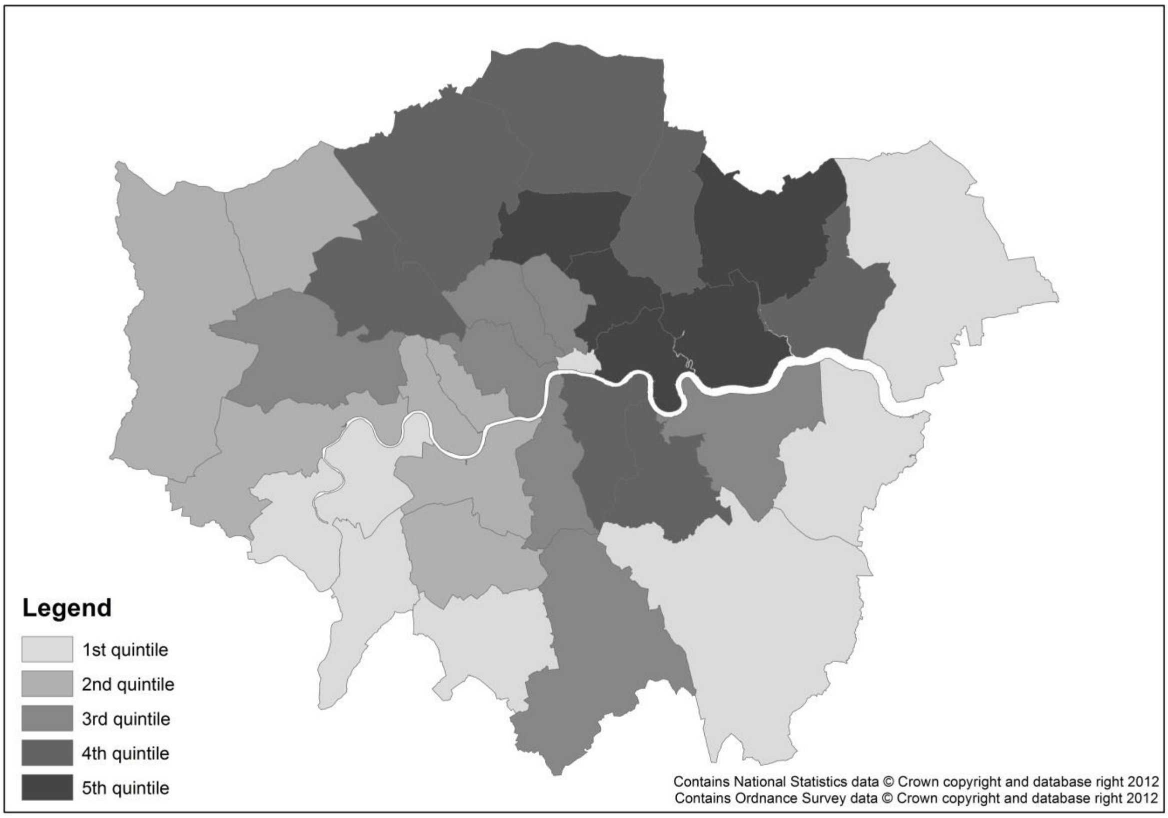

Figure 1 Borough of residence of service users

Wellbeing: health, support network, living conditions, and income situation

We now move to the wellbeing profiles of service users, using information available in the social form that can be linked to wellbeing. Given our multidimensional approach to wellbeing, we look at health-related indicators, as well as measures linked to service users' support networks, living conditions, and income situation.

Health

In our dataset, we have three different conceptualisations of self-reported health:[4] general (asked in all years); physical (asked from 2013); and psychological (asked from 2013). Figures 2 to 4 show the distribution of self-reported health for all service users, and for service users according to sex, age group, and immigration status. In order to provide a comparative benchmark, at least for general health, we use the 2011 Census question on self-reported health for England, which show that 47.2% of the population rated their health as very good; 34.2% as good; 13.1% as fair; 4.2% as bad; and 1.2% as very bad (Office for National Statistics, 2013). Despite the crude comparison, it is possible to see that this distribution of self-reported general health is quite different to that of the service users in the data. This

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[4] Despite health status being reported by the support worker based on their conversation with the service user, which may bias the evaluation in a different way than if done directly by the service user, we still label it as self-reported.

contrast with population figures is quite stark: among all service users, 4.9% of service users rated their general health as very good; 31.2% as good; 36.3% as fair; 22.5% as bad; and 5.2% as very bad. Men tend to rate their health as worse than women, older service users have poorer health ratings, whereas asylum seekers appear to be the group with the most negative rating of their general health.

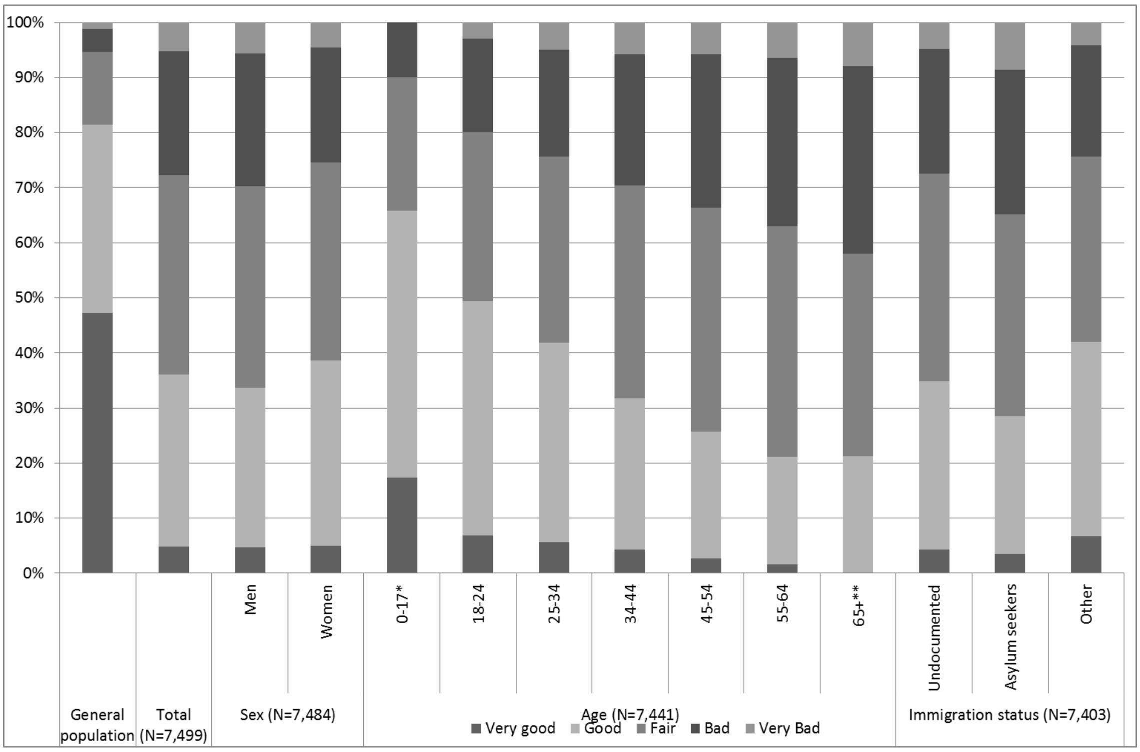

Figure 2 Self-reported general health
Note that certain categories have been merged because of small cells (very bad health for 0-17 and very good health for 65+).

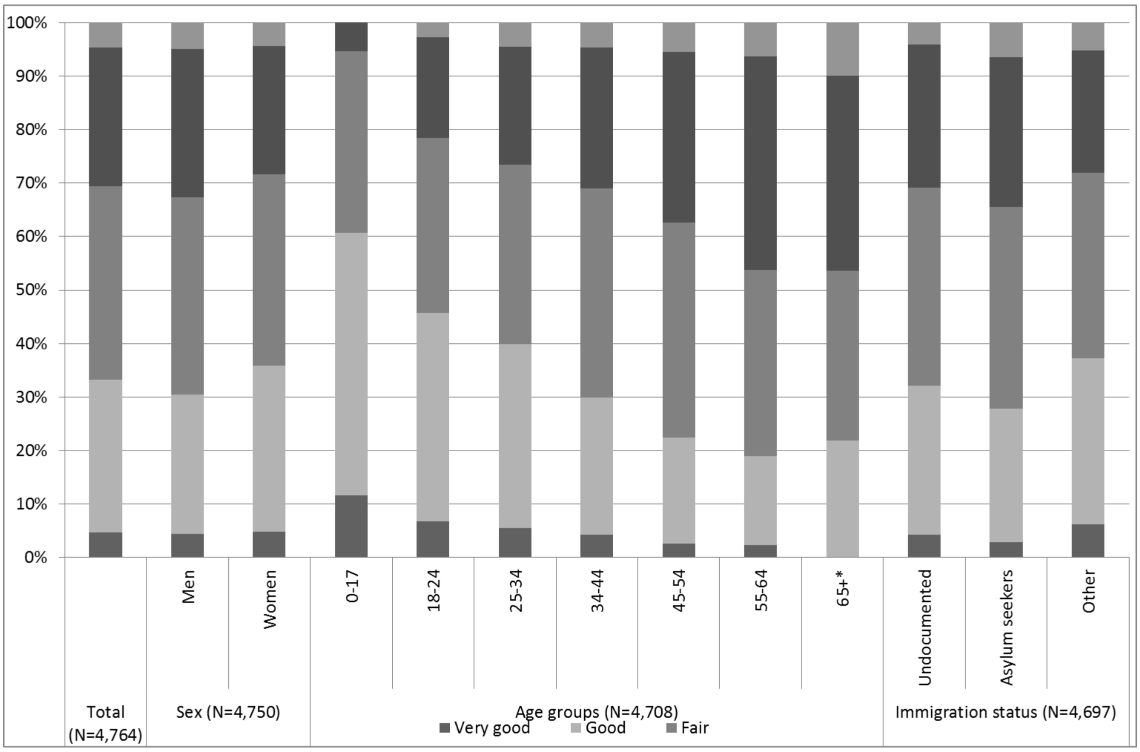

Figure 3 Self-reported physical health

Note that certain categories have been merged because of small cells (very good health for 65+).

Moving on to physical health in Figure 3, similar patterns of self-reported health arise for the overall sample and between men and women. There is also a step decline in self-reported physical health as service users grow older. Whereas asylum seekers tend to have a poorer evaluation of their physical health, the difference with undocumented service users is, however, not as large. Looking at psychological health (Figure 4) is where there are larger differences in evaluations for asylum seekers: theirs are much poorer than the other groups when it comes to their mental health. There does not appear to be any sex- or age-related differences in reported psychological health.

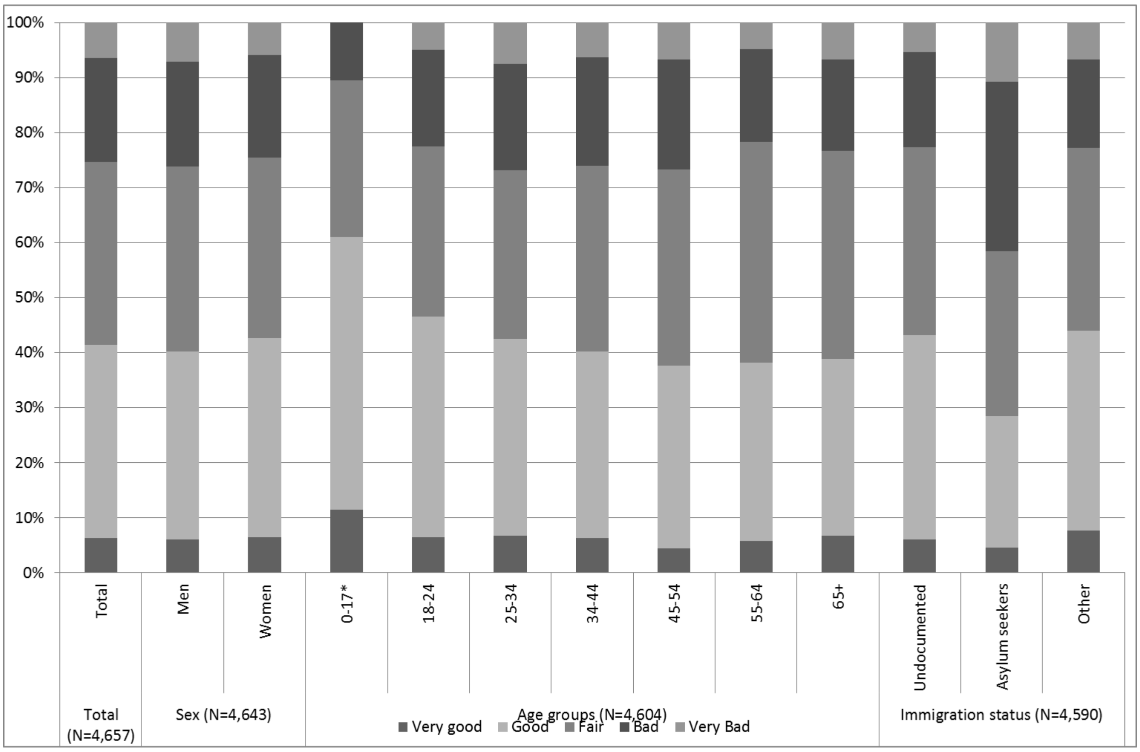

Figure 4 Self-reported psychological health

Presence of support network

Research has shown that the presence of support networks is important for many aspects of everyday life, including integration (see, e.g., Ager and Strang, 2008; Cheung and Phillimore, 2014). Figure 5 highlights service users' perception of the presence of support in the place where they live. Just over 10% of service users feel like they do not have anyone to rely on; this is higher for men, younger service users, undocumented users and asylum seekers. At the other end of the scale, 26.8% of service users feel that they have very frequent access to support, which is especially strong for female service users and those with 'other' migration statuses. Thus, there seem to be some specific groups who may be more at risk of isolation, which may affect other aspects of wellbeing.

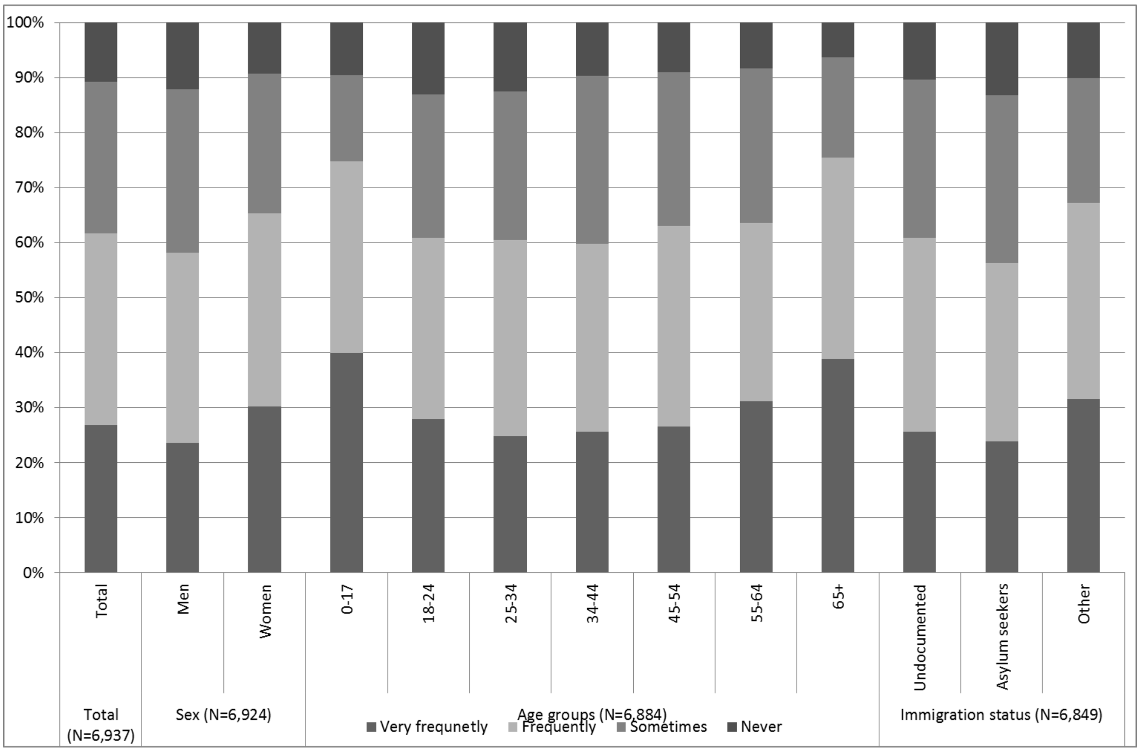

Figure 5 Presence of support network

Living conditions

We now turn to service users' living conditions (Table 4). With regard to housing, we see that just under 88% of service users live in a flat or house (although it is not clear whether this is shared accommodation or not, or whether this was with family and/or friends prior to 2014), but that a lower share of service users evaluates their accommodation as stable (64%). Just over 13% of service users, however, felt that their accommodation was detrimental to their health or that of their children.

Table 4 Living conditions of service users

Indicator	Categories	%
Type of accommodation (N=7,565)	Rough sleepers	4.4%
	Charity/Camp/Squat/Work	4.7%
	With friends/family^	3.5%
	Flat or house	87.5%
Stable accommodation (N=7,323)	Yes	64.0%
Accommodation affecting health (N=6,709)	Yes	13.4%
Limitation of movement for fear of being arrested (for undocumented – N=4,533)	Very frequently	25.6%
	Frequently	17.5%
	Sometimes	27.5%
	Never	29.5%

Note: ^Living with friends and/or family has only been asked since 2014.

We also investigate whether undocumented service users tend to limit their movements for fear of being arrested. Among this sub-group, just over 70% of service users tend to limit their movement, with various levels of frequency. We see from Figure 6, however, that the number of service users never limiting their movements for fear of being arrested has decreased in recent years which may relate to the implementation of so-called "hostile environment" policies by the UK Government.

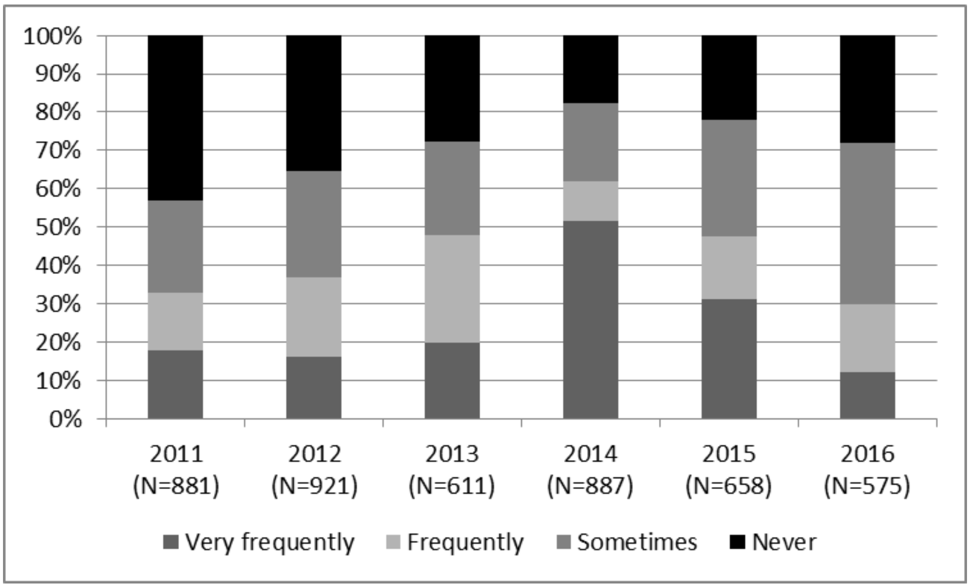

Figure 6 Limitation of movements by year

Income situation

The income situation of service users is highlighted in Table 5. Among them, less than a third have a job or other activity that earns them a living (information about the source of income is not available); this rate is higher for women, which is rather unusual given rates of economic activity within the general population (Office for National Statistics, 2017). Of those working, a very large proportion of service users earn an income that is below poverty thresholds (from 2013 onwards, a set poverty threshold was used to determine this, whereas earlier years enquired as to whether service users felt that their funds were sufficient to live). Economic hardship appears to be a reality for the overwhelming majority of service users, something that has been well-documented for asylum seekers (Allsopp et al., 2014).

Table 5 Income situation of service users

	Total	Women	Men
% with job/activity to earn a living for service users over 15 years of age (N=7,086)	29.5%	35.1%	24.4%
% with income below poverty threshold (2013-2016, N=4,234)	82.3%	77.6%	87.0%

Healthcare access

We now turn to issues of healthcare access, as shown in Table 6, which are important factors in influencing wellbeing, especially with regard to health, and one of the main areas of focus of the DOTW UK social questionnaire.

Table 6 Healthcare access issues for service users

		Asylum seekers	Undocumented
% Access denied by healthcare provider (N=6,630)	18.6%	26.0%	16.5%
% Given up seeking treatment (N=6,526)	10.6%	13.0%	11.6%
% Victim of racism by healthcare provider (N=6,415)	1.6%		
% Mentions of healthcare services accessed by unregistered service users (N=2,918/2,878 by immigration status, 2011-2014)			
None	59.2%	54.4%	60.6%
Walk-in centres	13.6%	13.6%	12.5%
A&E	29.7%	33.9%	29.6%
Private clinic/GP	1.7%	3.1%	1.6%
Pharmacy	1.3%	1.4%	1.3%
% Mentions of problems in accessing healthcare (N=7,245/7,159 by immigration status)			
Did not try	44.9%	38.0%	48.1%
None	4.7%	6.7%	3.6%
Administrative issues	32.1%	34.7%%	32.7%
Lack of understanding	32.6%	33.2%	34.6%
Denied coverage	10.5%	14.0%	9.5%
Treatment too expensive	2.2%	1.6%	2.3%
Language	16.3%	16.6%	17.6%
Fear of being reported/arrested	11.8%	6.8%	16.9%
Previous bad experience	1.8%	2.7%	1.6%
Healthcare coverage too expensive	2.3%	1.8%	2.4%

With regard to difficulties in accessing healthcare, during the consultations, 18.6% of service users indicated that they were denied access to healthcare by their provider (with a much higher share of asylum seekers reporting this); 10.6% reported they had given up seeking treatment and 1.6% reported being a victim of racism by their healthcare provider. Among service users not registered with a GP (as mentioned, a large proportion of service users are not registered), most did not mention using any healthcare services for health issues. Among those who did, A&E and Walk-in centres were the services most frequently mentioned. When discussing the type of problems faced when trying to access healthcare, although around 45% of service users mentioned not having tried to access healthcare (which may have various explanations), most mentioned problems were linked to administrative issues, lack of understanding, language barriers, fears of being reported and denial of coverage. For these two aspects, there were some differences between asylum seekers and undocumented service users.

Conclusions, implications and recommendations

This pilot project has allowed us to produce, and briefly describe, a large pooled dataset (8,489 unique observations) that has the potential to provide us with extremely useful insights on the wellbeing of individuals facing vulnerability. It has the potential to inform research, practice, and policy in important ways. This is based on 6 years of data provided by Doctors of the World UK about the service users of their advocacy clinics, collected by clinic volunteers. These data have been imported, formatted, merged, harmonised, and analysed in an exploratory manner. Descriptive analyses of the data have shown us that the large majority of service users, who tend to visit the clinics once, usually for information about GP registration (a very large percentage of service users were not registered with a GP at the time of their consultation), are undocumented. A smaller share of service users comprises current asylum seekers. The reported general health profile of the service users is a lot worse than what is reported in the general population, with asylum seekers having lower reported general and psychological health. Economic hardship is a reality for an overwhelming majority of the service users, as are issues in trying to access healthcare services.

This pooled dataset comprises valuable information to further our understanding on the topics of vulnerability and wellbeing, especially with regard to exploring the multidimensionality of wellbeing for groups facing vulnerability, and beyond.

Yet, there is scope to analyse this dataset further. This would allow us to explore various issues of relevance, going beyond what has been presented above, including, but not limited to:

- The relationship between different aspects of wellbeing;
- The relationship between wellbeing and vulnerability;
- The validity of the wellbeing measures, including cross-validation with established scales and more objective measures, especially given the mode of data collection;
- Wellbeing and detailed immigration status;
- Wellbeing and language ability, as they relate to or affect access to services;
- Wellbeing and isolation, including availability and provision of support;
- The gender dimensions of wellbeing, including intersectional understandings of wellbeing;
- Wellbeing and access to services, including issues of chargeable costs and reasons for not accessing services;
- Changes over time;

- Impact on women and children, especially with regard to understandings of entitlements;
- Local commonalities and differences, especially across devolved authorities; and
- The impact of questionnaire implementation on response bias, which includes an exploration of the context in which data is being collected.

The data and the results shown, as well as ideas for future analyses, are especially relevant in identifying issues of concerns and practical steps to be taken in many areas of policy and practice. These include:

- The link between vulnerability and immigration status, and the extent to which resolving precarious immigration status could address vulnerability, as well as other measures that may be needed;
- The public health implications of people falling outside statutory health services with regard, for example, preventing, diagnosing and treating infectious diseases;
- The GP registration process and issues of GP surgeries turning down people with legal entitlements to healthcare access – which could involve training provision to align healthcare access policy and practice;
- The conditions, quality, and stability of housing;
- The provision of interpreting/information in other languages, as well as English language training, and its link to service access;
- The impact of the hostile environment and charging policies and regulations on wellbeing and, generally speaking, human rights, especially for pregnant women and children;
- Differences and commonalities between boroughs in order to advise Clinical Commissioning Groups (CCGs) about good practice in terms of service and language provision;
- Identifying barriers in access to care and services understanding the rationale behind it, and comparing this with data for the general population, to ensure that individuals healthcare is accessible – this could also be delivered via information campaigns for surgeries and individual GPs; and
- The need to develop relevant indicators to monitor wellbeing of people at risk of vulnerability – the priority of which could be determined via interviews and scoping workshops with relevant stakeholders.

In order to fully address the above, more work is needed. Given this, a main recommendation for future work is that 1) the data be further explored to unpack the results presented here, along the lines suggested above; and 2) some of this unpacking may require a different methodology, which could include further qualitative analysis of the social forms (which have free-text elements) and/or interviews with support workers and/or service users. This will allow an in-depth understanding of the wellbeing of individuals most at risk of vulnerability.

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Appendix

Table 1 Social questionnaire items

	Year					
	2016	2015	2014	2013	2012	2011
Demographic characteristics						
User id	***x***	x	x	x	x	x
Date of consultation (+ year of first consultation)	***x***	x	x	x	x	x
Sex	x	x	x	x	x	x
Date of birth	x	x	x	x	x	x
Age				x	x	x
Person unaccompanied minor	x	x				
Use of interpreter	x	x	x	x	x	x
Language of interpreter	x	x	x	x	x	x
Name/id of interpreter (confidential?)		x	x	x	x	x
Borough of residence/1st part of postcode (2011-2013)	x	x	x	***x***	***x***	***x***
Have children in need of care					x	x
Reason for coming to clinic	***x***	x	x	x	x	x
How heard about service				x	x	x
Living conditions						
Type of accommodation	x	x	x	***x***	***x***	***x***
Stability of accommodation	***x***	x	x	x	x	x
Accommodation: impact on health (+ reason as write in)	x	x	x	x	x	x
Children: have any	x	x	x	***x***		
Children: live with person	x	x	x	***x***		
Children: how many	x	x	x	***x***		
Children: where live if not with person			x	***x***		
General health	x	x	x	x	x	x
Physical health	x	x	x	x		
Psychological health	***x***	x	x	x		
Rely on support	x	x	x	x	x	x
Activities and resources						
Job/activity status	x	x	x	x	x	x
Support others with income			x	x	x	x
Current income sufficient for daily life					x	x
Average amount of money to live in past 3 months above poverty	x	x	x	x		
Administrative/Immigration situation						
Nationality (+ country)	***x***	x	x	x	x	x
Ethnic group	***x***	x	x	x	x	x
Date began living in UK	x					
Date of last entry	x	x	x	x	x	x
Length of residence (days & years)	x	x	x	x	x	x
Immigration status	***x***	x	x	x	x	x
Permit/visa end date (if applicable)	***x***	x	x	x	x	x
Asylum: ever claimed		x	x			
Asylum: plan to claim		x	x			

Asylum: have (or plan to) claim	x	x	x	x	x	x
Potential asylum claimants: current situation	***x***	***x***	***x***	***x***	***x***	***x***
Travel documents when entered UK			x	x	x	x
Agent brought R into UK				x	x	x
Undocumented: limit movement for fear of being arrested	***x***	x	x	x	x	x
Reason for leaving country	***x***	x	x	x	x	x
Health cover and obstacles to accessing healthcare						
Chargeable healthcare costs	***x***	x	***x***	***x***	***x***	***x***
GP: registered?			x	x	x	x
GP: have ever tried register			x	x	x	x
GP: ever been registered	x	x	x	x	x	x
GP: how long without		x	x			
GP: ever tried registered with friends/family GP (+ info)		x	x	x	x	x
GP registration: have proof of ID	x	x	x	x	x	x
GP registration: have proof of address	x	x	x	x	x	x
Not registered: accessed other services?			x	x	x	x
Problems in accessing healthcare and healthcare services: last 12 months	x	x	x	x	x	x
Denied access to healthcare in past 12 months	x	***x***	***x***	x	x	x
Given up seeking treatment in past 12 months	x	***x***	***x***	x	x	x
Victim of racism by healthcare provider	x	x	x	x	x	x
Need HC2/HC3 certificate		x	x			
Have HC2/HC3 certificate (+ details)				x	x	x
Support provided (type + further details)		x	***x***	***x***	***x***	***x***
Details of help for non-medical issue				x	x	x
Type of referral made		x	x	x		

Notes: Items in bold and italicised indicate a change across years in terms of response categories, question wording, or question placement

Table 2 Medical questionnaire items

	Year					
	2016	2015	2014	2013	2012	2011
Demographic characteristics						
Patient id	x	x	x	x	x	x
Date of consultation	x	x	x	x	x	x
Sex	x	x	x	x	x	x
Date of birth	x	x	x	x	x	x
Nationality	x					
Ethnicity	x					
Use of interpreter	x	x	x	x	x	x
Language of interpreter	x	x	x	x	x	x
Name/id of interpreter		x	x	x	x	x
Medical history						
Have access to contraception				x		
Want information on contraception (+ details)				x	***x***	***x***
Previous pregnancies (+ number)		x	x	x	x	x
Age at first pregnancy		x	x	x	x	x
Where children were born (if in UK, was charged?)				x	x	x
Currently uses contraception	***x***	x	x			
Would like contraception (+ details)	x	x	x			
Pregnancy status (+ termination info from 2012-2015)	x	x	x	***x***	***x***	***x***
Pregnancy: weeks	x	x	x	***x***		***x***
Wants pregnancy	x					
Tested for HIV after becoming pregnant	x					
Pregnancy: access to antenatal care (+ reasons if not <2016)	x	x	x	***x***	***x***	***x***
Pregnancy: antenatal care provided late		x	x	***x***	***x***	***x***
Week of first antenatal visit	x					
Reason for non-access	x					
Women: current pregnancy: want termination	***x***	x	x			
Experience of FGM (+ when/where)	***x***	***x***	***x***	x	x	***x***
Allergies (+ details)		x	x	x	x	x
Relevant medical history (2016: includes allergies)		x	x			
Children: vaccination history (2016: whether vaccinated today)	x	x	x	x	***x***	***x***
Children: parent informed about vaccination requirements					x	x
Children: know how to access vaccinations		x	x	x		
Children: know where to access vaccinations	x					
Medical examination						
Details of treatment (usual or ongoing)		*x*	*x*	*x*	x	x
Blood pressure	x	x	x	x	x	x
Pulse	x	x	x	x	x	x
Weight	x	x	x	x	x	x
Height	x	x	x	x	***x***	***x***
BMI	x	x	x	x	x	x

Preventative questions						
Tests: Hep C (including results + date)	x	x	x	x	x	x
Tests: Hep b (including results + date)	x	x	x	x	x	x
Tests: HIV(including results + date)	x	x	x	x	x	x
Tests: Tuberculosis (including results + date)		x	x	x	x	x
Serology and tuberculosis: wants tests	x	x	x	x		
Serology and tuberculosis: knows where to get tested	x	x	x	x		
Wants to be tested for tuberculosis	x					
Prescribed treatment (details)	***x***	***x***	***x***	x	***x***	***x***
Exam: Blood glucose level		x				
Exam: Respiratory rate						
Exam: Body temperature		x				
Health problem flag		x				
Work puts health at risk				x	x	x
Experiences of violence (detail + when occurred + further details)	***x***	***x***	***x***	***x***	***x***	***x***
Health problem/result of consultation: diagnosis required	x	x	x	x	x	***x***
Diagnoses: in words		x	x	x	x	***x***
Diagnoses: ICPC code		x	x	x	x	x
Diagnoses: waiting for diagnosis	x					
Diagnoses: acute or chronic	***x***	x	x	x	x	x
Chronic diagnosis: treatment/follow-up needed	***x***	x	x	x	x	x
Treatment necessary: was there follow-up or under treatment?	x	x	***x***	***x***	x	x
Medicines accessed before	x					
Health problem: prior knowledge	x	x	x	x	x	x
Health problem should have been treated earlier	x	x	x	x		
Urgency of case	x	x	x	x	x	x
Need for close follow-up	x	x	x	x	x	x
Referral details	***x***	***x***	***x***	***x***	***x***	***x***

Notes: Items in bold and italicised indicate a change across years in terms of response categories, question wording, or question placement.