Children's Health Scotland

'What is this NHS?'

A survey by Children's Health Scotland[1] to identify local health advocacy, advice, and information services to support all Scotland's children, young people, and their families to exercise their right to the best possible health and access to care and treatment (UNCRC Article 24).[2]

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[1] https://www.childrenshealthscotland.org/

[2] https://www.unicef.org.uk/what-we-do/un-convention-child-rights/

Introduction

Children's Health Scotland (CHS) is the only charity in Scotland dedicated to informing, promoting and campaigning on the healthcare needs and rights of all children and young people.

Our vision is *'for every child and young person in Scotland to realise their right to the best quality healthcare'*. We achieve this in partnership with parents, carers and professionals through delivery of our five key strategic priorities: expertise and information; voice; improving life experiences; training and resources; and health-related play.

Article 24 of the United Nations Convention on the Rights of the Child (UNCRC) states that a child has 'the right to the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health, and that no child is deprived of their right to access such health care services'[3].

As part of our work we learned that some refugee and asylum-seeking families were reluctant to use health services and navigated the complexities of new systems, language, and its unspoken expectations alone, which was impacting their health. In contrast Syrian refugees received significant support as part of the UK Syrian Vulnerable Persons Resettlement Scheme (SVPRS).

In undertaking this survey, we aimed to extend our knowledge of support services able to:

- signpost all families, including Refugees and Asylum seekers, Roma, and Gypsy Travellers, to appropriate local support and advocacy and;
- empower the use of health services.

We knew of NHS Lothian's Minority Ethnic Health Information service, jointly funded with the City of Edinburgh Council and wondered if something similar is available in other health board areas.

Background

Prior to the survey we talked to migrant, refugee, and asylum-seeking parents and children to hear their experiences of using health services. One child asked, 'what is this NHS?', a reminder that our commonest terms can be meaningless. Not all participants had children, but their experiences illustrated where barriers prevented them taking care of their health. Discussion also illustrated where things worked well.

Our 2017 survey to NHS Child Health Commissioners regarding the new European Association for Children in Hospital (EACH) Resolution on the Continuity of Care of Sick Children of Refugee and Asylum-seeking families, confirmed that Syrian families, as part of the SVPRS, received initial health and wellbeing checks, including help to register with a GP, dental checks, and child vaccinations.[4]

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[3] https://www.unicef.org.uk/what-we-do/un-convention-child-rights/

[4] https://www.childrenshealthscotland.org/service/hard-to-reach-families/

For this survey we contacted all local authority SVPRS officers to ask for information regarding the barriers experienced and the availability of local health information, advice, or advocacy services to support families.

Access to healthcare

The Scottish Government has responsibility for healthcare in Scotland. Asylum seekers and refugees have the right to use health services whilst living in Scotland with most services being free. This includes both those receiving asylum support from the Home Office, holding a HC2 certificate, and for those who have been refused asylum for their remaining time in Scotland. Spouses or Civil partners along with children under 16 or under 19 in full time education are also eligible.[5] Everyone is encouraged to register with a GP and to bring along information to help with identity and contact details, this helps ensure medical records are correct and information recorded accurately.

Overseas students and people employed on migrant status pay a variable surcharge to use health services which is paid as part of the Visa Application Process.[6]

Children and young people under the age of 18 who arrive in Scotland without parents or guardians are defined as Unaccompanied Children (UC). UC receive support through the Scottish Guardianship service.[7]

To encourage Asylum seekers and refugees to use health services the Scottish Government website clearly states that personal information is not passed on to the Home Office. This addresses the fear of deportation created by practice in England in which GP services were asked to report on immigration status to the UK Home office. This had a significant impact on the uptake of GP and other health services.[8]

Under the UNCRC refugee children and young people have the same rights as children born in that country.[9] The Scottish Government and NHS Directorate also have a legal duty under the Equality Act 2010 to ensure inclusive practice. It has demonstrated leadership to address health inequalities and established the Health and Wellbeing indicators in the Getting it Right for Every Child approach.

Context

Scottish Government policy sets out the importance of child health and wellbeing with an aim to ensure: ‘children experiencing their rights, as determined by the United Nations Convention on the Rights of the Child (UNCRC), (do so) on a daily basis.’[10]

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[5] https://www.nhsinform.scot/care-support-and-rights/health-rights/access/healthcare-for-refugees-and-asylum-seekers

[6] https://www.nhsinform.scot/care-support-and-rights/health-rights/access/healthcare-for-overseas-visitors#immigration-health-surcharge

[7] https://www.aberlour.org.uk/services/scottish-guardianship service/?gclid=EAIaIQobChMIgeW4oYmY6gIVQYBQBh3P2QNlEAAYASAAEgJsnPD_BwE

[8] file:///C:/Users/Linda%20Alexander/Downloads/DOTW_Access_to_healthcare_final.pdf

[9] https://cypcs.org.uk/rights/uncrc/articles/article-22/

[10] https://www.gov.scot/policies/human-rights/childrens-rights/

As part of this commitment, the Scottish Government, as part of the UK SVPRS, has supported Syrian families displaced by the Syrian civil war to resettle in Scotland. In 2017 the SVPRS expanded to include people with other nationalities displaced by the conflict but do not have Syrian nationality; the Vulnerable Children's Resettlement Scheme also resettles Middle Eastern and North African children who are at risk, together with their families.

This approach is set out in the New Scots: refugee integration strategy now in its second phase 2018 – 2022.[11] The 2017 feedback involving 700 refugees identified the following gaps to existing health services:

- Health Literacy and the understanding of rights and entitlements.
- Understanding of health and wellbeing needs and experience by service providers to enable them to meet the needs of refugees and asylum seekers.
- Communication when accessing health and social care services. Language and access to interpretation services was a recurring theme, as was the need for an empathetic response from staff.

Phase two (2018-2022) objectives aim to enable people to:

- look after and improve their own health and wellbeing.
- use health and social care services and have positive experiences of those services and their rights respected.
- receive services more responsive to their needs; and relevant policy, strategic planning and legislation are informed by the underlying social factors, which impact refugee and asylum seeker health and wellbeing.

Additionally, as the global refugee crisis continues there is increasing research documenting the impact on health and wellbeing and health service access in transit, and in the destination country. The experiences of Gypsy Travellers access to health services are also impacted by the culture of travelling. The following research indicates experiences and impacts:

1. **Vulnerable migrants and wellbeing - A pilot study**[12] (funded by The Nuffield Foundation and involved Doctors of the World UK; University of Birmingham and IRiS (Institute for research into super diversity).

   This research builds 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. The indicators measured wellbeing including health, support, living conditions, and access to healthcare.

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[11] https://www.gov.scot/policies/refugees-and-asylum-seekers/new-scots/

[12] https://www.nuffieldfoundation.org/sites/default/files/files/Final%20report%20-%20February%202019%20-%20Project%2043383(1).pdf

- 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.
- 13% felt their accommodation was detrimental to their health or that of their children.
- There is a differential impact on women and children, especially in regard to understanding their entitlements.
- The UK hostile environment coupled with charging policies and regulations has created a barrier which deters families and children accessing health services for fear of debt, detention and/or deportation.

2. **Access to Health care for those people seeking or refused asylum in the UK 2018**[13] (Equality and Human Rights Commission November 2018). This report identifies where health service delivery and information support or undermine health service take up and the related impact on health. Key findings include:

   - Advocacy and support provided by charities and voluntary organisations can result in improved service access and use.
   - Clinical and non-clinical staff, including those in GP practice and hospital settings, may not understand patient entitlements, and give inconsistent or inaccurate information.
   - A limited knowledge or experience of specific and/or complex health needs results in health needs not being met.
   - Long waiting times and short appointments deter attendance and/or curtail discussion
   - There is evidence staff are unprepared to provide culturally or religiously appropriate health services.
   - Language understanding and communication make it harder to find and use healthcare services, hinder identification of symptoms and delay diagnosis.
   - Miscommunication can lead to a misdiagnosis or patients being unable to follow health care advice, including taking medication.
   - Patient concerns that their medical information could be used in immigration enforcement as well as afear that treatment for certain conditions, such as infectious diseases or poor mental health, might affect the asylum application.

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[13] https://www.doctorsoftheworld.org.uk/wp-content/uploads/2018/11/research-report-121-people-seeking-asylum-access-to-healthcare-evidence-review.pdf

3. **World Health Organisation report on the health of refugees and migrants in the WHO European region: No PUBLIC HEALTH without REFUGEE and MIGRANT HEALTH.**[14] This report highlights where migrant and refugee health deteriorates because of health care gaps and coverage across Europe. It includes:

   - A lack of information to direct refugees and migrants to health services and difficultly accessing it where language and cultural barriers exist.
   - A lack of human and financial resources impacts the availability of screening services and vulnerability assessments for migrant people.
   - Experience of discrimination and difficulty integrating which create barriers to accessing care.
   - A fear of migration authorities, a lack of awareness of rights and poor socio-economic status deter migrants with irregular status from contacting health services.

   It notes that the United Kingdom has attempted to move towards intercultural competence and cultural sensitivity in health care by embedding diversity sensitivity at a policy level. The NHS has attempted to create a “personal, fair and diverse” service by making it a legally enforceable general duty to eliminate unlawful racial discrimination, promote equality of opportunity and ensure racial equality in employment.

4. **Improving the lives of Gypsy/Travellers: 2019-2021,**[15] The EHRC ‘Is Scotland fairer report’[16] and the 2011 census indicate that Gypsy Travellers continue to experience high levels of poverty which is linked to poor health.

   The Scottish Human Rights Commission in its evidence to the Equal Opportunities Committee in 2013 described the discrimination towards Gypsy/Travellers as ‘the last bastion of respectable racism’. Additionally, in 2012 parliamentary evidence states: ‘GP surgeries are able to refuse people as patients without giving a reason; this often happens to Gypsy/Travellers. Sometimes, reasons are given – such as the applicant living on a site that straddles two practice catchment areas or not being able to prove when registering that they will remain in the area for long enough.

   Many Gypsy/Traveller families regularly travel 200-300 miles to see a GP or dentist whom they trust and know will see them.’[17]

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[14] https://apps.who.int/iris/bitstream/handle/10665/311347/9789289053846-eng.pdf?sequence=1&isAllowed=y

[15] https://www.gov.scot/publications/improving-lives-scotlands-gypsy-travellers-2019-2021/pages/3/

[16] https://www.equalityhumanrights.com/sites/default/files/is-britain-fairer-2018-is-scotland-fairer_0.pdf

[17] https://www.parliament.scot/parliamentarybusiness/CurrentCommittees/54885.aspx#accessinghealth

Survey method and questions

Questions

The context, information and framing for responses asked respondents to consider information regarding all migrants, as resettlement for Syrian families is well structured, with other migrant families navigating health services independently. Anecdotally, we were aware of a tiered and unequal system emerging.

1. How do you support migrant children, young people, and their families to access GP, dentist, and NHS services?
2. What, if any, local services/organisations are available to provide ongoing help and information to navigate and access health services independently of SVPRS or for those not part of it? Is it provided by the third sector, NHS, or Local Authority?
3. What else, in your experience would help? What individual or systemic barriers/ difficulties would your suggestions address?
4. What if any changes to service delivery have been implemented to help migrant children and young people claim their health rights? Why was the change made?
5. What has worked well or surprised you in relation to achieving children's health rights locally?

Responses

The 25 local authority responses provided detailed information which created a useful picture of healthcare engagement in Scotland. It can be assumed that where access is problematic for supported families that it will be difficult for those receiving no help at all.

In this section a roundup of information captures a picture of experience.

Q1. How do you support migrant children, young people, and their families to access GP, dentist, and NHS services?

Familiarisation: Families arriving via the Syrian resettlement scheme receive prompt support to register with a GP and Dentist and receive initial health checks, including health visiting, opticians, and mental health services within a general assessment. Welcome packs are provided and contain NHS information. Preparatory information from the UN refugee agency (UNCHR) has helped with this approach enabling NHS arrangements for children and young people with complex medical needs to be put in place prior to arrival. To help families settle, Life Skills training and integration support is given to those newly arrived.

Multi-agency and partnership work have underpinned effective approaches overall.

Families receive direct support to attend appointments including transport where necessary and learn how to make appointments (including double appointments to accommodate Interpretation and translation support (ITS)), understand prescriptions, and how to engage with the pharmacy and minor ailment service.

Once initial settlement and registration has been completed families aim to make appointments with GP services independently. SVPRS staff provide ongoing support especially in the initial period for advice, information, and ITS.

Language support: Interpreters are provided with some SVPRS staff able to speak Arabic. In other areas the availability of an interpreter is not always possible and rather than face to face support, telephone interpreting services are used. This is not the preference of families.

In emergencies Arabic speaking staff attend with families as interpreters are not available quickly and generally translators do not always turn up for appointments. ITS support is also necessary to help complete application forms, this is often provided by SVPRS staff.

The use of existing Arabic and English health literature and NHS videos in 17 languages is cited as being useful.

'Medicines and prescriptions are provided without sufficient information in an understood format'. Survey respondent

Child health: Where children present with complex medical needs, and this is known, specialist services are involved prior to the family arriving in Scotland.

Children under five years old will be given a named Health Visitor and be supported via the universal pathway to have their needs determined, monitored, and supported. In recognition of the child's experience they also receive an additional History of Present illness (HPI). Immunisation information is identified, and appointments put in place to update vaccinations. Eligible 2-year old's applications are completed with families.[18]

Where there is No Recourse to Public Funds (NRPF), or clear immigration status, a Children and Families social worker assists all CYP and their parents to access a GP. All unaccompanied children are offered immediate and ongoing medical support.

Training and Information: SVPRS staff provide refugee training and capacity building to inform Community Health and Getting it Right for Every Child (GIRFEC) Teams around the child (TAC), this helps to set out accessible service requirements and to increase engagement of refugee families with services.

Families also need explanations to understand for example, the reason for the TAC meeting, what is happening and why, or any child protection measures to be clarified etc. Families do not know what and why the meetings are taking place or the implications of them.

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[18] As part of the Scottish Government's Early Learning and Childcare (ELC) policy for families, eligible 2-year olds, long with all three- and four-year olds, can access statutory funded high quality, flexible, affordable, and accessible ELC. From August 2020 this will be 1140 hrs each year.

Ongoing support: Staff work to ensure that in the long-term families can use services independently. This includes knowing about access to ITS and continuing to ask for double appointments for all health contacts. This ensures there is time to accommodate interpretation, discussion, and clarification. In an emergency, families are helped to be confident to call and ask for ITS if not put in place by the emergency team.

CYP and family support outside initial checks and routine appointments is reported as requiring significant introductory work with specific health departments and relationship building with NHS staff.

For some families support to make and attend health appointments is in place up to five years after arrival.

'Some departments response to forthcoming arrivals can be excellent and plans are put in place for families quickly post arrival. Having built a rapport and relationship with (GP) practice managers, they (Practice Managers) are communicative both with negative and positive issues, good to run things through (with them) and to contact GPs on specific issues. As a group they are helpful, communicative, collaborative and want the best for service and clients' Survey respondent

A lack of knowledge regarding how services work and patient responsibilities often result in many families missing appointments, with respondents stating that each step of the process needs support.

Barriers to access: Any service requiring a family to use an automated voice service or message, requires ITS and an explanation of the service. Language proficiency is a barrier for families accessing GP surgeries independently. Despite the NHS Communication and ITS policy, SVPRS staff continue to provide ongoing and long-term support to address this need.

Q2: What, if any local services/organisations are available to provide ongoing help and information to navigate and access health services independently of SVPRS or for those not part of it? Is it provided by third sector, NHS, or Local Authority?

Local services: Services on the ground vary considerably, with most support for the Syrian population co-ordinated and continues via the SVPRS scheme. These teams supplement their knowledge and utilise local services where they exist to support families. These agencies include formal and informal relationships with: local authority equalities teams; Third Sector advice services, including the Scottish Refugee Council, Money Advice and Rights Team, Saheliya, Positive Action in Housing, Women's Aid, Forth Valley Welcome, Citizen's Advice, Book Bug, Integration networks, British Red Cross, Carers Centre, Freedom from Torture, With Kids, and Life skills.

Local authorities with larger diverse populations have embedded equality practice and existing support services, for example, a dedicated Minority Ethnic Health service set up in 1999 continues to be funded by NHS Lothian and Edinburgh City Council. In Glasgow, the integration networks operating across the city, continue to provide significant support on a plethora of issues affecting refugees and asylum seekers.

The Scottish Refugee Council signposts to NHS information services, such as multilingual videos on how to use health services in Scotland.

One respondent reported an Arabic speaking counsellor provided support. Signposting to information regarding childhood cultural circumcision and NHS women's and maternal health screenings have also been necessary.

Initiatives: The establishment of Arabic speaking staff, and dedicated liaison offices employed as part of the SVPRS was cited as a significant approach to help families learn about and navigate health services. As was an Information Card developed to help families to make appointments independently.

Barriers to help and information: Some authority leads were unaware of any relevant local services to support families to navigate and access health services. Others thought that additional support is not required if English is competent as appointments can be made by the family and a translator available for the appointment.

Q3: What else, in your experience would help? What individual or systemic barriers/difficulties would your suggestions address?

Language support: Language was cited as the most significant barrier to healthcare and the right to it. Respondents noted that they needed more time to take account of the speed of speech, accents, noise, and the patients lack of confidence using English. The importance of setting aside sufficient time to explain the new context, and system expectations, alongside a need for health staff to understand how the impact of trauma and stress affects the ability to think and retain information when it is understood. Many responses asserted that the move to automated services cannot accommodate patient need in this instance. Specific points include:

- <u>Hospital appointments:</u> One authority cited that families calling the hospital to make clinic appointments face significant barriers. The necessity to speak results in a reliance on friends or services to make appointments. Interpreters need to have specialist knowledge and understanding of medical terms. Respondents noted that interpreters need support after hearing distressing information.
- <u>Communication method:</u> Face to Face interpretation is preferred to phone use. It was reported that GPs also prefer face to face interpreting or working with the Arabic speaking support worker to the phone service. However, SVPRS staff support many families with appointments and these lead to missed appointments and indicate a barrier to services, and health impact when language support is not available.

- Information and consent: Greater Data Protection Regulations (GDPR) were cited as a barrier to SVPRS staff providing support if an interpreter has not arrived, even when the family has asked for the officer.
- Explanation, information and understanding: Follow up appointments are agreed however families often leave the initial appointment without knowing why they are coming back or the medical condition they have.
- Prescriptions: Instructions are only given in English, with a lack of information given by GPs during the appointment, including the medicines being prescribed and how to take them. One respondent stated that this becomes more acute when someone or several family members are being treated for several conditions and faced with several medications and suppositories; this may lead to someone taking the wrong medicine. It is suggested that prescription information needs to be in both English and the family's language.
- Treatment delay and dangerous practice: it was reported that some major treatments have been completed without an interpreter; a friend, an Arabic speaker without a medical specialism or phone interpreting were used instead. Interpreter availability has resulted in delays to specialist appointments.
- Inconsistency: There is inconsistency of ITS availability in hospitals with some clinics refusing to book interpreters. Some NHS services and GPs book automatically, some do not, or refuse. Each GP and medical centre have different protocols in place, and this creates a difficulty. Automated services assume English proficiency prior to accessing the main reception and cannot be understood. This must be accessed before getting an opportunity to speak to someone to explain that English is not a first language and request ITS. NHS24 options were specifically cited as complicated and not understood.
- Cost and delivery: The cost of providing an interpreter leads to a reliance on phone interpretation, this is particularly true of GP practices. It was also noted that open access systems, operating on a 'first come, first served' are untenable financially and operationally, as interpreters must be booked for open-ended sessions.

'In a lot of cases the diagnosis does not reflect the true nature of a person's medical condition' Survey respondent

'A major treatment took place without face to face ITS and was reliant on telephone support via the SVPRS lead' Survey respondent

What helps: Responding local authorities cited the need for consistent and simplified appointment booking and automated phone systems to improve access and facilitate autonomy, coupled with an interpreter booking system. GP and NHS staff are encouraged to be proactive to increase patient confidence and knowledge accessing services, including staff knowledge re NHS ITS policy. Other responses include:

- Information and training: With SVPRS input patient confidence to use language line has increased; additionally the SVPRS training and information sessions provided to health staff has developed their understanding of patient experience, needs and expectations of other health systems which influence family use of the NHS. This has also encouraged health staff to ask or create opportunities to engage with families about using health services. The availability of telephone interpreting support at a local pharmacy has also helped families with minor health questions and consequently eased GP services.
- Literacy and translated materials: It was noted that despite efforts to provide translated material, many people are not literate in their first language and this needs to be addressed when developing resources or using translated materials. The need for interpreters with specialised medical knowledge was cited as crucial, especially for operations, complex information and to support decision making about their children's health.
- Health information and prevention:
    - Families do not attend screening or health and wellbeing appointments. More work is required to explain the reason and necessity of health prevention rather than cure.
    - In rural areas dental treatment can involve significant travel for families, support workers and interpreters. Oral hygiene information would help address dental care as diets are very sugary.
    - Where health charges are applied, families need information from debt and financial advice agencies.
    - Additionally, local authority staff by necessity become experts in many different areas of health practice to ensure families receive the healthcare they need.
- Cultural requirements and expectations: Information on rights, entitlements, and responsibilities is required to promote knowledge of the healthcare system in the UK and how to access it. For example, Muslim families need to be aware that they can have an alternative to pork gelatine content in immunisations. NHS staff also need to be culturally aware on this and other areas, and to enquire of the families and raise the options with them.
- Mental health: The stigma attached to mental health in some cultures prevents access to the right help. It was suggested that SVPRS staff could receive training and information from mental health professionals to support treatment and access to it. SVPRS staff could then provide some help, particularly where local counselling services do not exist.
- Service availability and key person: Finally, the dedicated SVPRS was raised as the initiative/resource which ensures families and CYP access and receive health services. However, it was noted that a lack of local services impacts on staff time, interpreter, and travel costs. Additionally, there is difficulty identifying who

the key NHS person is, as well as too few NHS staff to register newly arriving families as patients.

Q4: What if any changes to service delivery have been implemented to help migrant children and young people claim their health rights? Why was the change made?

Partnership working arrangements have been put in from the start which has facilitated dialogue between agencies. Additionally, support workers, many with specific language skills have ensured appointments and conversations have taken place when interpreters have not been available.

Local authority SVPRS staff have established closer working relationships with health visitors and community midwives to ensure the needs of young families are met. With processes continually monitored and changed to support families has resulted in more support to the most vulnerable families and face to face assistance in emergencies. Establishing contacts and partnerships has also enabled a quick response to resolve problems, for example a GP surgery refusal to register, which was resolved by social work. Some GP surgeries are changing approaches and initiating appointment reminders with Local Authority staff.

Practical skills and information gaps have been addressed such as IT support to use automated services. Information has been provided to help families know their rights if they are unhappy with their GP for example. The intensive support over several appointments has increased family confidence to attend appointments, travel significantly and continue with NHS appointments if let down by a lack of interpreters. Without SVPRS staff vital NHS treatments would not be accessed.

'(I) meet with Education and highlight issues and reports received (and) taken into consideration (when) allocating housing and schools, asking 'does the school have a child with a similar condition that (will) have knowledge to support the child's condition.' Survey respondent

'Responsibility to use services independently is hindered by automated message machines. Families cannot understand, anticipate, or prepare for the questions as formats are inconsistent posing a barrier to the right service, or asking for an interpreter. NHS inform provides ITS, however the initial automated message is in English.' Survey respondent

Q5: What has worked well or surprised you in relation to achieving children's health rights locally?

Partnership work is reported as being vital to meet the family need, especially when underpinned by good communication and collaboration. Such examples included work with:

- Schools;
- Health and Social Care partnerships;
- Dental teams ensuring oral health, and;
- GP surgeries discussing what works and does not, to support families.

Health visitors have also played a valuable role, assisting parents, and identifying health concerns. This has helped to access the school dental treatments scheme, eyesight tests, and immunisations. Additionally, social workers provided information to health services on the rights of the child.

Despite the many difficulties raised with non-face to face communication some telephone interpreting has worked well, although this was caveated by noting that, important information (reasons why, follow ups) were missed.

Access cards presented to GP services has increased confidence to approach the service and an improvement in children's health was expressed.

Recommendations

The United Nations Convention on the Rights of the Child (UNCRC)[19] is the framework for working with and for children and young people. It has the goal of reporting and securing the full range of children's human rights, and places children and young people at the centre of policy development and the design, delivery, and evaluation of services.

To ensure all children and young people and their parents/carers can claim their right to health we make the following recommendations:

1. A National Vulnerable Persons Resettlement Scheme approach is considered to provide face to face support to help access to healthcare regardless of national origin.
2. Children and young people and their families receive all information in a way it can be understood to ensure involvement in decisions about their health.
3. Children's rights and wellbeing impact assessments (CRWIA) and Equality impact analysis are completed to identify potential barriers to health rights in anticipation of the UNCRC being incorporated into Scottish domestic law.
4. Children's rights are meaningfully embedded into all health sector training, including GP staff roles.

In the short term:

5. Staff understand how to use and access their NHS board's interpretation and translation policy. For example, where possible and for medical treatments, to employ interpreters with specialist knowledge.
6. GP practices and NHS departments check accessibility of the telephone and online appointment systems and where necessary make reasonable adjustments to ensure all children and young people can access health services.

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[19] https://www.unicef.org.uk/what-we-do/un-convention-child-rights/

Conclusion

We conducted this survey to put together a picture of local support and information services which could empower all families, children and young people to exercise their right to the best possible health when problems or barriers are encountered, and for us to be able to signpost appropriately.

We thank those who took the time to respond and help us get closer to this aim. As anticipated, the information captured the specific experiences of the refugees and Asylum seekers displaced as part of the Syrian civil war. It is evident that the SVPRS and the appointment of dedicated support workers (some Arabic speakers) has been significant to support those families to access health services, where this is not the case for others.

The information provided, evidenced the imperative of effective communication in its broadest sense and the importance of dedicated support. It also evidenced a professional willingness to find solutions, whilst usefully describing the pressures, stresses, and gaps both structurally and personally experienced.

It is apparent that there are very committed, resourceful staff endeavouring to help families use health services and understand their rights, responsibilities, and entitlements, including GP practices and other NHS staff. This survey was not conducted to evaluate or comment on the SVPRS but to capture experiences about using health services which have the potential to impact access, discussion, and decisions about a child's health. In particular the right to healthcare, the right to information in a way that can be understood and the right to a voice in decisions that affect them.

For questions or queries please contact:

Linda Alexander, Development Officer
Linda.alexander@childrenshealthscotland.org

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Registered office:
Children's Health Scotland
22 Laurie Street, Edinburgh EH6 7AB
enquiries@childrenshealthscotland.org
www.childrenshealthscotland.org

Find us on:

Scottish Government
Riaghaltas na h-Alba
gov.scot

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