

**HANDBOOK FOR
CLINICIANS
UNDERTAKING UASC
FITNESS TO TRAVEL
SCREENING**

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PURPOSE:

This handbook has been written to provide clinicians with

- An overview of the Fitness to Travel Screening process
- Guidance on conditions of importance for FTT
- A standardised process to obtain appropriate and accurate information
- Guidance on deciding fitness to travel status

INTRODUCTION:

Since June 2016, Kent has seen an unprecedented rise in the number of young people arriving through the Port of Dover and The Channel Tunnel. The Home Office and Kent County Council have been driving forward plans for compulsory dispersal enshrined within the Immigration Act 2016.

Over the past 12 months some Local Authorities have offered to voluntarily accommodate young people but the statutory responsibility has remained with Kent County Council and so by default the health responsibilities have remained the duty of the seven Kent CCGs.

However, from 1st July 2016 Unaccompanied Asylum Seeking Children and Young People (UASCs) arriving in Kent will be dispersed to the on-going care of other Local Authorities, as advised by the UK Government so that no individual local authority bears a disproportionate share of the burden. Currently, UASCs arriving in Kent will reside in the county for less than 5 days before being collected by the Receiving Local Authority (RLA).

The National Transfer process brings a new challenge to health, both in Kent and in the Receiving Local Authority area. Kent CCGs need to ensure UASCs are well enough to travel and the receiving CCGs will have to be ready to meet the ongoing health needs of UASCs placed with them.



THE NATIONAL UASC TRANSFER PROTOCOL

All asylum seeking individuals who are accepted or temporarily treated as being below 18 years of age during an initial Home Office welfare interview are eligible to be included in the transfer scheme.

Article 3 of the United Nations Convention on the Rights of the Child provides that in all actions taken concerning children, the best interests of the child shall be a primary consideration.

The long-term objective of the transfer scheme is to achieve a fairer distribution of unaccompanied children through a scheme which is equitable and transparent, across all local authorities and all regions. The scheme is intended to build on existing regional structures and enable regional pooling of knowledge and resource.

The protocol can be found at the following address:

<https://www.gov.uk/government/publications/unaccompanied-asylum-seeking-children-interim-national-transfer-scheme>

Essentially when a young person arrives in the UK and is seeking asylum a form – the National UASC Transfer Scheme Unique Unaccompanied Child Record is completed and part A and B are sent to the Home Office to request transfer to a receiving local authority (RLA) in a new region. Meanwhile if they are male, 16 or over, they are placed in a reception centre (either Millbank or Appledore) and if 15 or younger or female they are placed in foster care, pending collection by the RLA.

It has been proposed that YP would be collected by their RLA within 5 days of arrival but to date not all have been accepted by a RLA and if they have it has typically taken 10 days before they move. Once they are accepted by a RLA they become the responsibility of that local authority and it will be the RLA who arranges the Statutory Initial Health Assessment and ongoing medical support.

RISKS

As we know, UASCs are vulnerable young people who arrive with a range of health conditions and risks. Dispersal, whilst ultimately aiming to give young people better options in terms of access to appropriate accommodation and education does pose some additional risks to “health” as follows:



Immediate Health Risks:

In some, albeit a very small minority of cases there could be an immediate risk to life on moving of a newly arrived UASC. E.g. If a young person is suffering an acute exacerbation of asthma, that may have been triggered by the later part of their journey to UK, they could develop a life threatening attack during subsequent, a serious head injury that may have caused a bleed on the brain or a sickle cell crisis.

In other cases there could be worsening of a condition if treatment is delayed as a result of dispersal e.g. acute infections, physical injuries and chronic health conditions such as diabetes and epilepsy, mental health concerns such as self-harm.

In other cases there could be unnecessary suffering as a result of delay in accessing treatment e.g. gastro intestinal symptoms, skin infections

Intermediate Health Risks:

There may be situations where moving a Young Person could affect continuity of care e.g. YP with broken bones or injuries who have received treatment but require follow up and possibly further intervention e.g. removal of sutures, dressing changes etc.

Longer Term Health Risks:

We know that there are longer term health issues that need to be addressed and that these would usually be identified by the IHA when a comprehensive assessment of health and need is made. With dispersal it becomes the RLA responsibility to arrange the IHA locally. Many LAC health teams around the country are already struggling to meet the timescales required for their own UK LAC. Drift and then the risk of unidentified and unmet health needs for UASCs is a risk. In addition, the assessment of health needs for UASCs and the implementation of health plans and the provision of screening (e.g. for TB and hepatitis B) is complex. Many health teams will be ill prepared and will not have services in place to meet the needs of a population of young people who do not speak English (e.g. dental and vision services). LAC CAMHS services around the UK are particularly stretched and may not be skilled in meeting the complex needs of this population.

- i. There are infection risks in this population such as malaria, TB and hepatitis B. Plans would usually be made at the IHA stage to screen for these infections. UASCs are also missing immunisations and again programs for immunisation will need to be put in place as soon as possible to protect the UASC but also to address public health concerns.
- ii. Receiving health teams will need to be able to arrange immunisations, screening and health assessments for UASCs.

Public Health Risks:

UASCs are also missing immunisations and should have the first course of the agreed UK immunisations as soon as possible. If these are not started prior to dispersal there is a health risk to the UASC but also to the community in which they are placed.

RISK MITIGATION

1. The Designated professionals for Looked after Children in Kent have written an introduction letter to fellow designated professionals nationally, explaining the 5 day dispersal model, responsibilities for health, and the FTT health screening process and the links to the Kent resources.
2. Kent CCGs have developed a number of resources that will support RLAs and their allied health teams in their preparation of receiving UASC. These include bespoke UASC initial health assessment guidance and templates, podcasts in different languages to explain the IHA consent and process and blood borne virus testing and a DVD to explain health needs of UASCs to front line staff. A number of training resources have been developed as well and these will soon be available on a Kent UASC health needs website, details of which will be shared with RLAs.
3. UASCs should be registered with a GP and allocated an NHS number as soon as possible after arrival and prior to transfer. This allows any health actions to be safely recorded. When the young person moves there should be an agreed action that the RLA will arrange registration with a new local GP. The young person will need to have provided their previous GP details and their NHS number when registering with the new GP in order that the previous GP record can be transferred.



UASCs can be registered with a GP as follows:

The Young Person's Social Worker needs to fill in a GMSI (Family Dr Service's registration) form with the YP and take this to the GP practice who then register them on the system and apply for an NHS number.

4. A Fitness to Travel screening process will be introduced with an agreed traffic light approach to health risks whereby red relates to a health need to delay dispersal for an agreed period of time, amber requires further action and consideration such as a consideration to the RLA's ability to meet the specific health needs of the UASC, some immediate treatment prior to dispersal and then medical handover or just specific handover to the new area's health teams and new GP. If the UASC has no apparent health concerns they will be deemed fit to travel and given a "green light" with some standard UASC health recommendations to hand over to their new RLA and health team.
5. The first set of UK recommended immunisations will be given prior to dispersal to protect the UASC but also to address public health concerns.

HEALTH RESPONSIBILITIES

UASCs become Looked after Children under Section 20 of the Children Act 1989. As such they are entitled to the full range of services available to LAC. The following must be addressed:

1. **Access to universal health service:** UASCs need to register with a GP. They must register with a GP as soon as possible after arrival in the UK. Those that are being placed in Millbank should be registered with the South Ashford Medics practice and those placed in Appledore should be registered with the Old School Practice. A decision is required about GP registration for those in foster care (it may be appropriate to decide that those nearest to Millbank register with South Ashford Medics practice and those placed in Appledore are registered with the Old School Practice).

As part of the registration process an NHS number will be applied for. Details of their NHS number and GP registration will be placed in the UASC health passport. There will then be a need for the UASC to register with a new GP in their RLA and this information will need to be passed on to their new GP in the RLA.

- 2. Statutory Initial and Review Health Assessment:** The Statutory Guidance “Promoting the health and well-being of looked after children” March 2015 states that all looked after children and young must have a holistic health assessment and creation of a health care plan within 20 working days of coming into care. Regulation 7 of the Care Planning, Placement and Case Review (England) Regulations 2010 requires the local authority that looks after the child/young person to arrange for a registered medical practitioner to carry out an initial assessment of the child’s health and provide a written report of the assessment. So, a thorough health assessment of a UASC is a statutory requirement for the RLA and the CCG, who have a shared responsibility to ensure that this happens.

Within the 5 day window prior to dispersal to the RLA, a health will be undertaken and any immediate health needs will be identified and addressed where possible. It is proposed that in order to ensure that the UASC is well enough to travel; Kent CCGs will provide *Fitness to Travel* (FTT) screening appointment for those UASCs whose plan is dispersal. This **does not** replace the need for the young person to have a statutory IHA once moved to the RLA.

3. Fitness to travel (FTT)

Many of the UASCs seen to date have had concerns about their health and many have had physical findings. The vast majority of these are considered to be easily managed and would not prevent onward travel. It is important that the FTT screen does not delay their onward travel as the aim is that the YP will be given the opportunity to settle in their new area as soon as possible. Many will be anxious about their circumstances and many will have experienced traumatic events and/or loss. Mental health problems are unlikely to present acutely in this group but their longer term needs must be addressed.

THE FITNESS TO TRAVEL ASSESSMENT

- i. The FTT health screening will cover the following:
 - Any concerns about health
 - Whether the reception staff/foster carer or other have concerns about the YP’s health
 - Any known illnesses
 - Any pain



- Any medication
 - Height
 - Weight
 - Blood pressure and heart rate
 - Urine dipstick
 - Any obvious physical findings
 - Any concerns about emotional well-being (using the DT – distress thermometer)
-
- A form will be completed for each UASC which contains the above information and the young person's will be allocated a traffic light health status – red, amber or green.

HOW TO COMPLETE THE ASSESSMENT:

VENUE:

The FTT assessments will be undertaken in either the medical rooms at Millbank and Appledore or at the Old School Surgery in Cranbrook or at St. Stephen's Primary Care Health Centre, Ashford.

Girls in foster care will have their FTT screening at either The Old School Practice or at South Ashford Medical Practice, whichever is closest. We have recommended that any male UASC who are placed in foster care are transported to a reception centre for their FTT.

EQUIPMENT REQUIRED:

The following equipment will be required:

FTT assessment forms

Access to PC, printer and email

Supply of health passports

Centile chart for height and weight



Height meter, scales, blood pressure machine, watch or stop watch (for respiratory rate), thermometer and urine analysis sticks. Urine bottle/jug, disposable gloves.

Immunisation consent form and supply of first set of immunisations.

FILLING OUT THE FORM

DEMOGRAPHIC DETAILS:

For each young person that is seen, a completed Part A of the National UASC Transfer Scheme Unique Unaccompanied Child Record will have been provided (Appendix A). This will provide background information as well as demographics. Please check Name, DOB, date of arrival, Country of Origin with the YP (via interpreter) and complete Page 1 of the FTT screen.

CONSENT:

Please explain to the Young person that the fitness to travel screen is a basic health check up to make sure that they are healthy before they move to their new home. Explain that you will be weighing and measuring them and testing their urine. Ask them to let you know if they need to pass urine. Ask them to sign the Consent box on page 1. Please also explain that in order for the doctors and nurses to ensure that they remain as healthy as possible that we want to send a copy of this form to their new Dr and nurse and that we would also want their social worker to have a copy so that they can help to make sure that they have any treatment or tests that are recommended. Please tick the PERMISSION box on page 1 if they agree.

MEDICAL HISTORY:

At the beginning, ask whoever has accompanied the child/young person if they know of any concerns about the young person. You want to know whether the foster care (if applicable) has noticed anything of concern and the reception centre staff. E.g. Excessive sleeping, distress, not eating.

Enquire about any current medications and known allergies. Does the young person have any current health concerns? Any symptoms? Ask about cough, fever, pain, itching etc. Do they have any pre-existing health conditions?

PHYSICAL SCREENING:

Weigh and measure the young person and document their centiles. Measure heart rate, blood pressure and respiratory rate. Check temperature and urine. Does the YPO look unwell? Pale? Clinically anaemic? Are they jaundiced? Do they appear malnourished? Look at their teeth and document dental status. Do they have any obvious injuries? If you feel that they need to be physically examined or there is any concern about acute illness, this should be discussed with the GP.

EMOTIONAL HEALTH:

There is a need to ensure that each UASC is screened in respect of the level of distress that they are experiencing. There is evidence that shows that there are triangulated processes that compromise the resilience of these children. Firstly the events that have led them to be exiled from their country of origin, secondly the journey itself and lastly, the asylum process once they arrive in the UK.

It is important therefore to be able to identify the level of distress being experienced by the UASC which links them into appropriate support services once they have been transferred. Yet it also needs to be recognised that the distress experienced is a natural by product to the experiences had and that they will need support and a time to settle before a clear clinical understanding can be formulated. Please see the UASC trauma protocol for more information.

We have therefore devised a short distress screening tool that links to the competencies and early intervention support required by all UASC. The distress screening tool uses a thermometer from which the child can identify their level of distress. They can also name the things that are escalating their distress and the findings will support the clinician to formulate the supports required by the young person according to the UASC competency framework. This will then help the receiving authority to devise a care plan that meets the emotional health and well-being requirements of the UASC.

Please see the distress screening tool and the new ASC competency framework.
New paragraph

The reception centre staff have been undertaking emotional health and well-being work with each child using the UASC early intervention framework. Therefore each young person will have had a sleep assessment and formulation, nutritional assessment and formulation and hope aspirations assessment and formulation which will be placed in the health passport.

Please see the new ASC early intervention framework.

A UASC will be deemed fit to travel from an emotional health and well-being point of view and this they are presenting with a psychotic episode that requires immediate assessment and intervention.

IMMUNISATIONS:

Please ask about immunisation status. We know for the health needs assessment that most will have incomplete information/will not be fully immunised and therefore the recommendation is that they start the UK catch up immunisation program (Appendix B).

Please explain that you want to give them a vaccination and ask them to sign an immunisation consent form. In order for the UASC to be able to give informed consent to immunisations they will need to have seen a copy of the patient information leaflet and to sign a consent form. A copy of the consent and record form should then be completed (document immunisations given) and given to the young person.

OUTCOMES:

You will now need to decide on the Young Person's Fitness for onwards travel according to the traffic light system.

THE TRAFFIC LIGHT SYSTEM FOR FITNESS TO TRAVEL

	DISPERSAL SHOULD BE DELAYED
	CHILD/YOUNG PERSON CAN MOVE BUT THERE ARE "SPECIAL CIRCUMSTANCES"
	CHILD/YOUNG PERSON CAN MOVE

	DISPERSAL SHOULD BE DELAYED
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	<p>This is because there is an immediate and serious risk to health and the young person either needs emergency treatment or their health status could be made worse by travel.</p> <p>Examples: Acute physical injury that requires immediate treatment, rest or poses a risk to travel e.g. broken bones, head injury</p> <p>Medical conditions that could be life threatening and need to be treated and stabilised prior to travel e.g. acute asthma, unstable diabetes, sickle cell disease, seizures, serious infections such as acute malaria, possible cerebral malaria, acute TB, Suspected septicaemia/sepsis, acute Hepatitis B.</p> <p>Medical signs that could indicate serious illness e.g. pyrexia of unknown origin, tachycardia, severe dehydration, highly elevated blood pressure</p> <p>Significant mental health concerns - requiring emergency mental health assessments for mental illness including section 12 for section in under MHA</p> <p><i>The status red section of the FTT Assessment form should be completed and reasons why clearly stated along with actions required and a clear plan. The Designated Dr and Sarah Hammond ADCS West Kent must be informed by email. If there are any queries about status red, first discuss with your GP colleagues. You can also discuss with the Designated Doctor.</i></p> <p><i>The timescale for when a child/young person can be reassessed in terms of subsequent fitness to travel must be clearly stated on the form.</i></p>
	<p>CHILD/YOUNG PERSON CAN MOVE BUT THERE ARE “SPECIAL CIRCUMSTANCES”</p> <p>This is because there is a health action or health risk that needs to be considered by UASC central admin or the RLA or a health action or risk that needs to be handed over to the receiving health team.</p> <p>Examples: Conditions that will require treatment, are not considered life threatening but do require a health handover:</p> <p>Physical injury e.g. burns, cuts, wounds, strains and sprains (need</p>

to be clearly documented prior to travel)

Stable chronic medical conditions such as asthma, diabetes, epilepsy

Skin infections e.g. scabies, fungal infections etc.

Chest infection or upper respiratory tract infections

Suspected sexually transmitted infections

Gastro-intestinal e.g. possible parasitic infection, gastro-oesophageal reflux

Identified dental decay

Identified visual problems

Pregnancy

FGM

Young person has a condition that has been partly treated and further treatment is required

An injury that has been sutured and will require removal of sutures, a fracture that requires review

Investigations that have been initiated but that require follow up and possibly further treatment e.g. Asthmas, diabetes, epilepsy, fever

Conditions that require access to specialist medical provision

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Sickle cell anaemia

Other rare and unusual medical conditions that would require access to a tertiary hospital

***If there is a medical condition that requires access to specialist health provision the Young Person's Social Worker must be informed immediately so that they can inform the Home Office Central Admin team so that this information can be considered when allocating the young person to a region.**

For children and young people who have an amber status the following action is recommended: The status amber section of the

	<p><i>FTT Assessment form should be completed and reasons why clearly stated along with actions required and a clear plan. If there are any queries about status amber, first discuss with your GP colleagues. You can also discuss with the Designated Doctor.</i></p>
	<p>CHILD/YOUNG PERSON CAN MOVE</p> <p>There are no apparent or reported health conditions or concerns and the young person appears fit for onward travel</p> <p><i>For children and young people who have a green status the following action is recommended: The status green section of the FTT Assessment form should be completed with a statement that the child/young person has no known health conditions, is currently physically well and is fit for travel.</i></p>

RECOMMENDATIONS:

	<p>A clinical decision will need to be made in terms of actions required prior to ensuring the young person can be considered fit to travel and the duration for which travel should be delayed. Clinical judgment should be used and if in doubt discuss with GP colleagues and Designated Doctor.</p> <p>Examples are as follows:</p> <ol style="list-style-type: none"> 1. Acute Injury: If a fracture is suspected then the recommendation would be for the YP to be taken to A&E for assessment, X-ray etc. It is likely that the Orthopaedic team would want to see the person within the first week in fracture clinic. A recommendation could be made that the young person is seen in fracture clinic and status red decision delayed until the outcome of the fracture clinic is known. It may be that the YP does not require further follow up for say 6 weeks, in which case their status would become amber as they can now travel but there will be a handover requirement to ensure that the young person has fracture clinic follow up in their new region. 2. Acute illness: If the young person has presented with signs indicative of an acute illness e.g. asthma or epilepsy, their travel may need to be delayed until they are considered stable. They may require hospital assessment in which case, advice can be taken from hospital colleagues re when they would be considered fit to travel or they may need
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	<p>immediate outpatient treatment and regular reviews. For example a young person may present with an acute exacerbation of asthma having not had any asthma treatment during their journey. They may need to be stabilised by commencing regular inhalers and to be reviewed prior to onward travel. When they then travel they will be considered as having status amber as they will need a clear emergency management plan and ongoing health plan to be handed over.</p> <p>3. Possible infectious illness: If the young person presents with fever they may have an infectious disease. They are likely to require investigations and treatment, possibly as an inpatient depending on symptoms. Again, there would need to be discussion with the hospital team, if involved about timing of onward travel. When considered fit to travel, status would move to amber.</p> <p>If a young person's travel is going to be delayed by more than 3 weeks then arrangements should be made for the young person to have a Statutory Initial Health Assessment arranged.</p>
	<p>CHILD/YOUNG PERSON CAN MOVE BUT THERE ARE “SPECIAL CIRCUMSTANCES”</p> <p>In this situation a recommendation has to be made regarding the level of medical handover required e.g. directly with the LAC medical team that will be seeing the young person for their Initial Health Assessment, the new GP (once known) or indirectly only via the Designated LAC Professionals in the new area.</p> <p>If there is a treatment or intervention required shortly after the young person is due to move e.g. sutures to be removed, dressing to be changed, review of asthma or diabetes medication, blood test to be arranged then there should be direct medical handover.</p> <p>If there is medical information to be passed on e.g. details of a treatment given or a recommendation made then this could be passed on via Designated professional.</p>
	<p>CHILD/YOUNG PERSON CAN MOVE</p> <p>General recommendation will be made, as indicated on the Fitness to Travel assessment form such as the young person needing an Initial Health Assessment, TB screening, further</p>

ADMIN PROCESSES:

After the FTT screening the FTT assessment form will need to be typed up and a copy given to the YP's current GP (this can be emailed so it is stored electronically), a copy placed in the YPs Health Passport (see below) and a copy emailed to the CCGLAC admin (TCCG.CCGLACEnquiries@nhs.net) which will then be sent on to the designated professionals for LAC in the new area.

If there is medical information to be handed over please clearly document this in the status amber section and indicate if you think this information needs to be handed over clinician to clinician. If this is the case, once the SW has been informed of where the YP is moving to. CCG LAC Admin will send you details of the new local health team so that you can contact them directly. IN some case it will be appropriate for the handover of medical information to be sent on behalf of the clinicians by CCG LAC Admin but this will have to be indicated on the form.

For young people considered to be status green the following will apply:

Sharing of health information

Local authorities, CCGs and providers of services have to ensure that there are effective arrangements in place to share information about the UASCs health. These arrangements have to balance the need to know with the sensitive and confidential nature of some of the information. It is important that the FTT information is shared with the child but it is also made available to the new GP and to the clinician who undertakes the IHA.

With the child or young person: Kent Designated professionals are developing a 'health passport' for the UASC to take with them to the RLA. At present it is proposed that this will contain the following information:

- A copy of part A of the National UASC Transfer Scheme Unique Unaccompanied Child Record
- A copy of the completed Fitness to Travel Assessment form

- And the following leaflets:

NHS info leaflet for refugees
IHA info leaflet
Blood Borne Infection leaflet
TB
Sleep
Nutrition
Customs, views and values
Sexual health/STIs, keeping safe etc.

With social care staff: Provided that the Young Person has given consent, a copy of the FTT health screening to a nominated representative in KCC (as Corporate Parent) to then distribute to the RLA UASC social worker.

With health colleagues: A copy of the FTT medical will be emailed to the Designated Nurse for the receiving CCG with a cover letter. Further consideration will be made with regard to how this will then be passed to the GP.

USEFUL INFORMATION

USEFUL DEFINITIONS:

Asylum seeker: applies to be given refugee status under terms of 1951 UNHCR (United Nations Refugee Agency) Convention or someone who says he or she is



refugee and has lodged an application for protection on the basis of the Refugee Convention or Article 3 of the European Convention of Human Rights, but their application has not yet been definitively evaluated ([UNHCR](#)).

Unaccompanied minor: separated from both parents and no person can be found who by law or custom has primary responsibility (1951 UNHCR Convention)

Refugee: leaves or does not return to country of their nationality because of well-founded fear of being persecuted for reasons of race, religion, nationality, membership of particular social group, or particular opinion (1951 UNHCR Convention). This term is widely used to describe displaced people all over the world but legally in the UK a person is a refugee only when the Home Office has accepted their asylum claim

UASC: (Unaccompanied Asylum Seeking Children) A person who, at the time of making their asylum application is under 18 years of age or who, in the absence of documentary evidence, appears to be under that age and who is applying for asylum in his/her own right and is without a family member (s) or guardian (s) to turn to in this country. The definition for immigration purposes of an unaccompanied asylum seeking child is given by the Home Office as 'a person under 18 years of age or who, in the absence of documentary evidence establishing age, appears to be under that age' who 'is applying for asylum in their own right; and is separated from both parents and not being cared for by an adult who by law or custom has responsibility to do so'. Children in this situation are also known as separated children or unaccompanied minors (UAM) ([Kamena Dorling and the Migrant Children's Project team, May 2013](#))

What is "seeking asylum"? Asking for protection and permission to stay in the UK

Some UASCs will later become refugees if their claims for asylum are successful

An age-disputed child or young person: An age-disputed child or young person is child or young person whose age has been disputed and has not had their claimed date of birth accepted by the Home Office and/or by the local authority that he or she has approached to provide support or protection. This term is usually used to refer to people who claim to be children, but who are treated as adults by the Home Office and/or the local authority ([Kamena Dorling and the Migrant Children's Project team, May 2013](#))

A separated child: A separated child- is a child who has been separated from both parents, or from their previous legal or customary primary caregiver, but not necessarily from other relatives. These may, therefore, include children accompanied by other adult family members. The Home Office definition of unaccompanied children does not include children who arrived in the United Kingdom in the care of a parent or other adult (for example, a relative or family



friend) who by law or custom has responsibility for the child, even if the child is no longer living with such an adult due to the subsequent breakdown of such an arrangement ([Kamena Dorling and the Migrant Children's Project team, May 2013](#)).

Trafficking: The recruitment, transportation, transfer, harbouring or receipt of a child for the purpose of exploitation shall be considered “trafficking in human beings” – Council of Europe Convention on Action Against Trafficking in Human Beings, ratified by the UK Government in 2008.

LEGAL ASPECTS

Current UK Asylum Process

A refugee wishing to stay in the UK must apply for asylum. To be eligible they must have left their country and be unable to go back because of fear of persecution. Refugees should apply for asylum when they arrive in the UK or as soon as they think it would be unsafe to return to their own country. After applying, refugees will have a meeting with an immigration officer (known as a ‘screening’) and then an asylum interview with a caseworker.

Decisions about application are usually made within 6 months. Further information can be found on the [Home Office website](#).

Unaccompanied Asylum Seeking Children and Young People

Following an initial [age assessment](#) by the Home Office and social services, a young person judged to be under 18 years of age, without an adult to care for them, is entitled to the same rights as other looked-after children and young people, including accommodation, some finance, education, statutory health assessments, support and reviews.

This group of young people will most likely be given discretionary leave to remain until 17 ½ years old leaving detailed processing of an asylum application for when they are older. They are entitled to legal aid. Therefore as much information as possible should be gathered using an appropriate interpreter at an early stage as this will be relevant to their application.

After full consideration by UK Visas and Immigration there is one of three outcomes:

- **Full Refugee Status**

The Young Person meets the definition of a refugee under the 1951 United Nations Convention Relating to Refugees. Granted Indefinite Leave to Remain after being in UK for 5 years. Not sent back.



- **Humanitarian Protection or Discretionary Leave** - this replaced Exceptional Leave to Remain (ELR) in 2003. This is time limited and actively reviewed.
Humanitarian Protection: removal places serious risk to life or person

Discretionary Leave: the UASC is allowed to stay until aged 18
- **Refusal:** May appeal, if unsuccessful are removed from UK. If UASC, not until 18. It is imperative that that UASC has legal advice during the process.

AGE ASSESSMENT

Most refugee children and young people will not have a passport, although some may have been given a passport to help them to leave a situation where they are at risk. Sometimes the child's stated age may be disputed; with serious implications for the outcome of their asylum claim and for their ability to access health services, education and welfare support ([Crawley, 2007](#)). Adults indicating that they are children present a risk to younger cohorts if placed into accommodation together. However the converse is true and vulnerable young people should not be placed with adults.

The Home Office and the Association of Directors of Children's Services have produced [joint working guidance](#) about how UK Visas and Immigration decide applications.

The Association of Directors of Children's Services have also produced age assessment [guidance](#) for assisting English social workers in conducting age assessments of unaccompanied children seeking asylum. This states that the process for age determination by the local authority should take place in the presence of an appropriate adult, by two qualified and one senior social worker, taking into account a number of social and other factors. If in doubt the local authority should give the young person the benefit of the doubt as to their age.

Age assessment guidance has also been developed in [Scotland](#) and [Wales](#).

In these situations, remember that there is no single reliable method for making precise age estimates and the most appropriate approach is to use a holistic evaluation, incorporating narrative accounts, physical assessment of teeth, puberty and growth, and cognitive behavioural and emotional assessment ([RCPCH, 2013](#)). The use of radiological assessment is extremely imprecise and can only give an estimate of within two years in either direction and the use of ionising radiation for this purpose is inappropriate ([RCPCH, 2007](#)). The British Society for Paediatric Endocrinology and Diabetes are clear that it is not possible to accurately assess a child's age based on physical examination or bone age assessment ([Dr Tabitha Randell](#)).



A paediatrician has to be honest with the social worker when contacted regarding age assessment, explaining that dental x-rays, bone age and genital examination will not add any further information to the assessment process based on the current evidence available.

Some age assessments carried out by the Home Office have been subject to dispute with some young people subsequently assessed to be minors (Crawley 2007). Further information about age disputes is available from the [Coram Children's Legal Centre, 2013](#).

- >50% of births in the developing world are not registered therefore a UASC's age cannot be validated with written proof.
- Age Assessments should be carried out only if:
 - there is no proof of age
 - Physical appearance/demeanour suggest that they may be younger or older than claimed
 - The Home office has disputed their age
- Carried out by two social workers
- Not a health responsibility but we should comment if appropriate
- 5 year margin of error (15-18)
- If in doubt, assume is a child
- Must follow Merton guidelines

http://mertoncs.proceduresonline.com/pdfs/app_1_age_assess.pdf

EXPERIENCES:

Why unaccompanied?

- Danger of being murdered or imprisoned
- Parents/guardians have “disappeared”
- Danger of being forced to join army/other fighting unit
- Prevented from practicing their religion
- Forced to practice religion
- Intimidated or tortured
- Banned from political activity
- Forced to take part in political activity
- Member of persecuted social, religious, ethnic or political group

Experiences of UASC:

- War and terrorism
- Civil unrest
- Ethnic persecution
- Political persecution
- Religious persecution
- The journey to the UK
- The asylum-seeking process
- Media reporting

Possible effects of traumatic experiences

- Brutalised
- Start hating
- Want revenge
- Feel abandoned
- Stop trusting adults
- Wary about making new bonds
- Psychological symptoms

Key Risk Factors

- Loss of parent or primary caregiver
- Experiences of neglect and poor parenting before exile
- Exposure to violence
- Isolation
- Difficulties in the mourning process
- Difficulties in managing change and other difficult events
- Difficult experiences after arriving in the UK
- Identification with oppressive or aggressive political, religious and ethnic groups

Key Protective Factors

- Having an appropriate adult to provide care
- Having access to community and social networks and appropriate services
- Being able to encourage a natural healing process
- Being able to integrate into a normal life
- Finding meaning in what has happened and being able to process events
- Finding culturally sensitive ways to express loss and move on

HEALTH NEEDS OVERVIEW

While many people seeking asylum arrive in the United Kingdom in relatively good health, it is also recognised that others will have physical and mental health needs at greater prevalence than the general population. Reasons for this include, the experience of imprisonment, torture or physical and sexual violation and the physical and psychological consequences of this; time spent in refugee camps which may be overcrowded and lack access to adequate food and sanitation, the journey to the host country, which is often long and arduous and limited or no access to basic healthcare prior to migration, particularly in people from countries which have or are experiencing prolonged periods of conflict, and the associated instability and destruction of local health infrastructure. Young people may have experienced particular health issues in relation to their age and reason for leaving their home country. For example some young people may be forced into or escaped from becoming child soldiers, or have been exposed to sexual exploitation, rape or trafficking.

The key areas of physical health which should be considered are:

- Communicable Diseases
- Nutrition and metabolic concerns
- Women's health, including family planning and maternity care
- Oral health
- Sexual health

Access to Healthcare

Refugee and unaccompanied asylum seeking children and young people have rights to primary and secondary healthcare. The Refugee Council provide a [fact sheet](#) in a variety of languages which contains information on healthcare eligibility and access for people seeking asylum in the UK. The Refugee Council have also developed an [information pack for refugees](#) which provides information about accessing health services.



For babies, children and young people born outside the UK, the usual route for obtaining an [NHS number](#) is to have one allocated through GP registration. In England, there is no set length of time that a patient must reside in the country in order to become eligible to receive NHS primary medical care services. Therefore all asylum seekers and refugees are eligible to register with a GP practice. For further information, see NHS England's [Standard Operating Principles for Patient Registration](#).

Specific guidance on accessing NHS services is available for [Scotland](#) and [Wales](#). In 2015 new regulations were introduced in [Northern Ireland](#) meaning that all refugees and asylum seekers (including refused asylum seekers) are not required to pay for their healthcare treatment, including primary care and secondary care.

Children aged under 16, and children 16-19 in full time education are entitled to exemption from charges for prescription items, free dental services and free eyesight tests following completion of a HC2 certificate. In order for unaccompanied children aged over 16 years and not in full time education to access these entitlements, the local authority must complete a certificate of exemption, HC1, confirming that the young person is on low income. Additionally, the UK Border Agency provides HC2 certificates to asylum seekers on behalf of the Department of Health (6).

Specific guidance for unaccompanied asylum seeking children and young people:

- **England:** [Care of unaccompanied and trafficked children](#)
- **Scotland:** [The Scottish Guardianship Service](#)
- **Wales:** [Safeguarding and Promoting the Welfare of Unaccompanied Asylum Seeking Children and Young People](#)

Specialist referral should be made in the usual way; however the referrer should be aware of factors which may impact on a child or family being able to make appointments such as language barriers and transport.

Where appropriate, a [personal child health record \(red book\)](#) should be issued. These are available from the health visitor and local health clinics and for some local authorities, online.

LOCAL AUTHORITY RESPONSIBILITIES FOR UASC

Corporate Guardianship – where a child comes to the United Kingdom to seek asylum and is not in the care of an appropriate adult, the local authority is obliged to assume the role of the child's 'corporate parent'. This role involves a number of responsibilities outlined below.

Named social worker/case manager - who will coordinate the assessment, planning, protection and placement of the child.



Accommodation – the majority of unaccompanied children require the level of support outlined in Section 20 of the Children’s Act, 1989. While this does not define the nature of accommodation, the local authority should, so far as practical, provide accommodation that is suitable to the level of need of the child and in line with his/her wishes. In practice it is common for children under 16 years to be placed in foster care, and for children aged over 16 years to be placed in semi-independent living accommodation with variable additional support. In Kent all unaccompanied girls under 18 years and boys aged under 16 years are placed in foster care, and boys aged 16-18 years are placed in a reception centre for 4 weeks and then moved into semi-independent accommodation. Foster carers and staff working in residential facilities should have an understanding of the particular needs of unaccompanied children. Where there is a concern that the child has been trafficked there should be an escalation plan in so that carers can raise concerns about ongoing risk of trafficking and have an action plan should the child go missing.

Immigration legal advice - Unaccompanied children require support in dealing with immigration questions or proceedings. Immigration legal advice must be provided only by a regulated solicitor or registered with the Office of the Immigration Services Commissioner (OISC) to provide immigration advice to the relevant level.

Role in supporting asylum application – it is critical that the local authority works alongside the child’s case manager at the UK Border Agency to support the resolution of the child’s asylum application.

Statutory health assessment, which includes an including assessment of physical, emotional and mental health. This assessment will result in a health plan to address any health issues identified during the Health Assessment including a timescale and responsibility for actions.

A personal education plan should be produced as part of the overall care plan. Where English is not the first language of the child, this should include access to English language skills training, as well as opportunities to develop literacy in skills in the child’s mother tongue. Schools in which unaccompanied children are placed may require additional support to understand and meet the needs of unaccompanied children.

Rights of care leavers – immigration status does not affect the obligation on Local Authority to provide support to young people who are leaving care. If the unaccompanied young person has been in the care of the local authority for 13 weeks prior to their 18th birthday they are entitled to the same care leaver’s support as any indigenous looked after child, as outlined in the Children’s Act and including



having a named personal advisor to support their needs. Leaving care may be associated with increased risk of becoming isolated or vulnerable. Transition planning by the local authority should take into account factors which may decrease this risk, such as language and cultural factors.

What do we know about the Kent UASCs and their health?

Please refer to the health needs assessment

INSERT HEALTH NEEDS LINK

Guidance on using interpreters in health care settings and appointments

- When using interpreters to assist with assessments or meetings involving UASCs the following advice/information may be helpful: Make sure that your interpreter speaks the same language as the UASC including the same dialect if relevant and is also able to read and write in this language.
- Be aware that if the UASC is from an area of conflict then the possible political affiliation/ethnicity of the interpreter may be an issue for the UASC. If concerned about this check with the interpretation agency when booking or speak with the UASC's social worker about suitable interpreters.
- An interpreter of the same sex as the UASC may be more appropriate especially for those UASC's coming from cultural backgrounds where the sexes are more segregated than in the UK. The UASC will already be familiar with meetings involving the use of interpreters and will already have experienced at least one, probably with UK Visas and Immigration. It may be possible to arrange to book the same interpreter that was previously used – the UASC will probably find the process easier with a known interpreter. The UASC's social worker will be able to advise on previously used interpreters and whether they would be suitable to use in a health care setting/appointment.
- Make sure that the interpreter is clear about the purpose of the session and has been adequately briefed before starting.
- Encourage the interpreter to interrupt and intervene during the interview when necessary, for example if the member of staff is speaking too fast or for too long without pausing or the UASC or interpreter has not understood and needs clarification. But also explain to the interpreter that you want them to translate what the UASC is saying, and they are not to give their own opinion or add extra information unless directly asked by you. You will need to watch the UASC's body language to try to ensure that your questions and their



answers are being translated appropriately. They will, however, indicate if they feel the UASC has not understood the question or needs clarification. They will also indicate if there is a cultural reason for a possible misunderstanding and will provide clarification and explanation about the cultural issue.

- Be aware of cultural issues depending on the background of the interpreter. It may not be appropriate to shake the hand of an interpreter from certain backgrounds, for example, especially if they are of the opposite sex. Similarly, it may not be appropriate to maintain prolonged eye contact with them, especially if they are of the opposite sex.
- Make sure that the interpreter is introduced to the UASC and that their purpose at the meeting is explained.
- Make sure that it is made explicit to the UASC that the interpreter will not pass on anything that he/she hears at the meeting – everything is confidential. A UASC may feel particularly worried about someone from his/her own cultural background hearing certain information in case anything is passed back to their country of origin.
- The interpreter should sit next to the UASC to facilitate communication.
- The doctor undertaking the assessment should speak and look directly to the UASC, not the interpreter. Questions should be phrased 'Do you ...' for example, not 'Does he/she...'
- The doctor needs to speak at a reasonable pace and must remember to pause to allow the interpreter to interpret. Do not speak for too long without pausing as this will make it difficult for the interpreter to remember exactly what has been said. The doctor/nurse should use straightforward language and avoid jargon.
- At the end of the assessment check whether the UASC has understood everything and wants to know or ask anything else.

CONSENT

The clinician should refer to [GMC guidance](http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_index.as) http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_index.as information about obtaining consent and what to do if consent is refused. Information is also provided in the RCPCH [Child Protection Companion](#)



You must have consent or other authority before examining, investigating or treating a child or young person. Unaccompanied minors may be able to consent to their own treatment however it is always good practice to attempt to contact their parents/guardians for a history and to communicate follow-up management.

In the UK, children and young people, including unaccompanied minors, can consent to treatment if they are deemed [Gillick Competent](#), meaning they can:

- understand the nature, purpose, benefits, risks and consequences of not proceeding;
- retain the information discussed;
- use and weigh this information, and
- Communicate their decision to others.

A child or young person with capacity to consent, who refuses, should have their decision respected unless there are exceptional circumstances.

Young people over 16 years should be assumed to have capacity unless there is reason to believe that they have an impairment of mind or brain that affects their capacity for the specific decision at the specific time. If there is doubt about capacity, an assessment of capacity should be undertaken.

Young people aged 16 years or over who are assessed to lack mental capacity for a specific decision at a specific time should have an Independent Mental Capacity Advocate appointed, with the [best interests decision-making process](#) of the [Mental Capacity Act 2005](#) followed.

More information on Mental Capacity and Best Interests can be found in the [Disability Matters](#) eLearning Package. Or from your local safeguarding team

Kent has produced an Initial Health Assessment information leaflet for UASCs, a podcast and a consent form to be used.

CONFIDENTIALITY

As for all children and young people, it should be explained that in the UK health information is recorded on a computer health system and shared with other health professionals, such as the GP and health visitor, and that health information may be shared with other agencies such as school and social services.

It should also be explained that details will not be shared with outside agencies such as legal or immigration officials unless the young person/family consent to this. A copy of the care plan and any information shared with other professionals should be sent to the young person/family in the usual way.

More detailed information about confidentiality is provided in the [Child Protection Companion](#) and the [GMC](#) also provide guidance on this. [Caldecott principles](#) on record keeping and information sharing should be followed.

The Kent IHA information leaflet for UASCs includes a section on confidentiality.

FURTHER INFORMATION INCLUDING COUNTRY SPECIFIC INFORMATION AND CLINICAL INFORMATION CAN BE FOUND ON THE UASC HEALTH WEBISTE. **Insert LINK**

APPENDICES

1. National UASC Transfer Scheme Unique Unaccompanied Child Record

NEED TO ADD

2. UK Immunisation Program

