Needs Assessment

Bradford District's
Central and Eastern European Communities

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A2	Accession countries joining the EU in 2007
A8	Accession countries joining the EU in 2004
BNES	Bradford Needle Exchange Service
CBMDC	City of Bradford Metropolitan District Council
CCG	Clinical Commissioning Group
CEELS	Central and Eastern European Liaison Service
CMT	Council Management Team
CVD	Cardio Vascular Disease
DWP	Department of Work and Pensions
ESOL	English for Speakers of Other Languages
EU	European Union
GP	General Practitioner
GUM	Genitourinary Medicine
HNA	Health Needs Assessment
IPEDS	Image Performance Enhancing Drugs
JSA	Jobseekers Allowance
JSNA	Joint Strategic Needs Assessment
LSOA	Lower Super Output Area
MDR TB	Multi Drug Resistant Tuberculosis
NINo	National Insurance Number Registration
NOIDs	Notification of Infectious Diseases
NDTMS	National Drug Treatment Management System
ONS	Office for National Statistics
PHE	Public Health England
SOMS	Specialist Offender Mentoring Service
STIs	Sexually Transmitted Infections
TB	Tuberculosis
VCS	Voluntary and Community Sector
WHO	World Health Organisation

Foreword

Bradford District has a rich history of immigration. Our population, like others in the UK, is changing as migration across Europe becomes more common. During 2011, 1.3 million people previously resident in an EU member state migrated to another member state. We know from individual services that Bradford District Council (CBMDC) alongside our health and voluntary sector partners are experiencing increased need for services from our new communities. This needs assessment describes and quantifies Central and Eastern European migration to Bradford District and highlights some of the challenges and opportunities this change makes. This clear assessment of need is intended to support CBMDC's response and future planning; working together with other public and voluntary sector partners and with the CEE communities themselves.

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Executive Summary

1. Background

City of Bradford Metropolitan District Council (CBMDC) is experiencing increased need for services from Central and Eastern European (CEE) communities. This needs assessment draws together intelligence and knowledge to inform future planning of health and social care services. The focus is on eleven Accession countries: Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia, Slovenia, Bulgaria, Romania and Croatia. Patterns of migration are different from each country of origin, for example Polish migrants in Bradford are generally employed. The majority of migrants from Slovakia and the Czech Republic are Roma many of whom have experienced extreme discrimination in their country of origin.

2. CEE migrants' entitlements

CEE migrants are currently entitled to NHS health care, primary and secondary education and social services. Rights to claim welfare benefits are changing in line with a national policy to reduce welfare support available to CEE migrants. This is leading to many families with no recourse to public funds; approximately 500 families in Bradford District between April and October.

3. Methodology

The needs assessment comprises of a literature review, epidemiological needs assessment including data and information about services and a corporate needs assessment, including views of staff and CEE communities.

4. Literature review findings

The literature review combines findings from eight published needs assessments and two dissertations undertaken in Bradford. Many issues are identified. In general terms people from CEE experience poorer health compared to people in the UK and life expectancy for Roma people is lower

- Age, sex, hereditary factors: Consanguinity is an issue in Roma communities.
- Lifestyle factors: Smoking rates are higher in CEE communities with many people accessing illicit tobacco. Levels of poverty are high which can result in a poor diet.
- Social and community networks: There is a stigma around homosexuality. There are concerns around some families' experiences of child neglect, domestic violence, being targets of hate crime and bullying. There are reports of antisocial behaviour. There are concerns about the effects of stress and mental health problems linked to social isolation.
- Health care services: Dental health is comparatively poor and many people find it a challenge accessing a dentist. Issues are reported around accessing health care services, fears of social services and issues with language and communication.
- Housing: Housing for some CEE migrants is extremely poor with reports of overcrowding and unscrupulous landlords or tenancies linked to employment.
- Education: There are some concerns around education in terms of accessing school places and transient communities.
- Employment: Employment is an issue with many people employed in low paid and low skilled jobs. The grey market is an issue, accessible to people without papers but with the potential for exploitation. Forced labour and trafficking is an issue.

- Poverty: Poverty is a problem which leads to many more problems including malnutrition, exploitation and poor housing.
- Assets: There is net economic benefit to the UK from EU migration. Roma communities in particular are resilient and place importance on the extended family and support these units can provide each other.

Not all problems apply to all CEE communities. The most vulnerable are identified as the Roma communities.

5. Demography

There is no single source of data to describe the CEE community in Bradford. Some organisations collect data by country of birth, however most collect data by ethnicity. Self-reporting as Roma / Gypsy Roma is low. Most CEE migrants will be recorded as White Other. It is estimated that there are at least 12,000 CEE individuals, and 6,000 Roma living in Bradford District. This is based on official figures so is likely to be an under estimate.

- 2011 Census data show 2.5% of respondents speak a European Accession country language.
- Of these, 53% speak Polish, 21% speak Slovakian, 9% speak Latvian and 6% speak Czech.
- Census data show the proportion of White Other in Bradford District has increased from 1.5% in 2001 to 3.0% in 2011.
- In the 2011 Census, 12,096 people were born in EU Accession countries.
- Between January 2002 and December 2013 there were 22,729 NINo registrations of migrants from Accession countries, of these 44% were Polish migrants, 26% Slovakian, 12% Latvian and 8% Czech.
- Electoral roll data record 2% (7,063) of the electorate as having a CEE nationality. The wards with the highest CEE populations are City, Little Horton, Manningham and Bowling and Barkerend. 69% of CEE electorate are Polish or Slovakian.
- There are 3,050 CEE children on roll in Bradford District schools, representing 3.16% of the school population. In 2003 there were only 70 CEE children on roll. 81% of the children speak Polish, Slovakian or Czech at home.
- 409 births (4.9%) were to mothers from the new EU in Bradford District.
- 6% of JSA claimants are White Other. 6% of claimants who are sanctioned are also White Other. Between 2010 and 2013 adverse sanction decisions increased by 50% of all claimants but by 84% for White Other claimants.
- Data are not available for health status of CEE communities in Bradford, however WHO data is published for key health indicators in the country of origin. In general terms CEE countries have higher rates of smoking, alcohol consumption, TB incidence, infant mortality, death due to circulatory disease and lower life expectancy.
- A children and young people's lifestyle survey undertaken in Bradford found that there are a higher proportion of CEE children living in temporary accommodation, with special educational needs, have parents or carers who smoke, who smoke and want to give it up, who have never been to the dentist and who plan to start a family. There is a lower proportion of CEE pupils worrying about all issues apart from health and lower proportions planning to continue in education, find a job or become an apprentice.

6. Services

The most recent data show:

- The most commonly requested language requiring translation from Enable2 is Slovakian, followed by Urdu, Polish, Punjabi and Bengali.
- 2.9% of the population registered with a GP is CEE.
- 5.5% of people admitted to secondary care were White Other.
- 1.7% of people on primary care mental health registers are White Other or CEE.
- 32% of mothers on the Specialist Midwife for Teenage Pregnancy caseload were CEE, all of whom were Slovakian.
- 9% of people in alcohol treatment are White Other.
- 5% of people in drug treatment are White Other.
- 9% of people who accessed Bradford Needle Exchange Services were CEE.
- 3.16% of school pupils are CEE.
- 3.9% of people assessed for housing by CBMDC were CEE.
- 50% of people sleeping rough were CEE (all single males).
- 43% of children missing from education were CEE.
- 32.2% of children believed to be resident in Bradford but not on school roll were CEE.
- 7% of referrals to children's social care are recorded as White Other or Gypsy Roma as are 3.9% of Looked After Children and 15.9% of children subject to a child protection plan.
- Between April and June 2014, 820 (5.2%) of contacts with CBMDC commissioned welfare advice services were from people speaking CEE languages, with the highest proportion (65%) of these being from Slovakian speakers.

7. Stakeholder views

Views were gathered from health care staff through two pieces of field research undertaken as part of dissertations in 2013. Views were gathered from voluntary sector workers and community members at a CEE engagement event run by the CBMDC CEE Working Group. Common themes emerged including:

- Differences in culture between CEE communities
- Transience of Slovakian and Czech people
- Traditional gender roles
- Poor health
- Poor educational attainment
- Low skilled jobs, exploitation, grey economy, forced labour
- Examples of children who are neglected
- Barriers to accessing services (language, trust, fear)
- Poor knowledge of health care staff
- Experience of prejudice against Roma people

8. Discussion

This needs assessment aims to present a rounded view of needs and assets of CEE communities in Bradford District to enable CBMDC and partners to plan a strategic response. The needs assessment has been shared with key staff from the CEE working group throughout its development. Priority areas identified by the working group and confirmed by the needs assessment include the need to:

- Agree a CBMDC wide response to CEE communities needs

- Provide support into employment; this includes education, training, volunteering opportunities, trusted childcare, apprenticeships
- Focus on strengths, skills and community self help
- Commission awareness training
- Tackle trafficking, slave labour and child sexual exploitation
- Increase aspiration and opportunities
- Provide an immediate culturally sensitive multi-agency response to children's social care concerns
- Address housing and homelessness
- Support integration between CEE and host communities
- Make options for voluntary repatriation clear
- Identify and tackle domestic abuse
- Ensure effective sex education
- Improve access to health care
- Target public health action and health improvement support

9. Recommendations

1 CBMDC CMT to note the findings of this report and agree a response to the needs of CEE communities.

2 CBMDC CMT to agree how ongoing CEE needs are responded to at a strategic level, including monitoring change using an agreed set of indicators.

3 CBMDC to build strategic alliances with other organisations form a response to the priority areas identified on pages 98/99.

4 Training to be delivered to raise awareness amongst CBMDC elected members, directors, managers and front line staff.

5 Public Health and Adult Services to ensure the community development role of commissioned welfare advice posts is strengthened.

6 CEE communities are made aware of their responsibilities and entitlements and are supported to access all benefits available.

1. Introduction

1.1 Bradford District's Central and Eastern European Community

Bradford District Council (CBMDC) is experiencing increased need for local authority services from Central and Eastern European (CEE) communities. Local authorities are required to take a leading role in coordinating local responses to their changing communities. This needs assessment aims to describe Bradford's CEE communities in order to support future planning and commissioning.

Anecdotal evidence is available about Bradford District's CEE communities from a range of services; but not collated, quality assured and quantified. Routinely collected data are available from national sources, however none fully describe the CEE population in Bradford District. This needs assessment aims to bring together qualitative and quantitative data from a broad range of sources about the needs of CEE communities in Bradford District and make sense of the current and developing situation.

1.2 Local Strategic context

This needs assessment has been written by the CBMDC Public Health Department. It builds on a long history of partnership working in Bradford, organised by the CBMDC CEE Working Group which has been leading this agenda since 2005. More recently, a data pack was prepared by the Neighbourhoods Team within the Environment and Sport Department and was presented at a CBMDC Joint Leadership Event in 2013. This needs assessment was presented to the Race and Equality Strategy group, a subgroup of the Environment and Sport Department, in October 2014 and disseminated across all council departments and to health and voluntary and community sector (VCS) partners. The needs assessment will also be used to inform the CBMDC Joint Strategic Needs Assessment.

1.3 Describing needs assessment

Health needs assessment (HNA) has been described by Bindra (2008) as an essential tool to inform commissioning and service planning. HNA can be defined as a systematic method of identifying the unmet health and healthcare needs of a population, and making changes to address those unmet needs. Stevens and Raftery (1997) define need in the context of health care as "the ability to benefit from health care". HNA allows for appropriate targeting of resources. HNA involves gathering information to inform service planning with the aim of improving health. Services may need to change for a number of reasons, including: inequalities in outcomes; local sensitivities; changing demographic patterns or disease trends; availability of new treatments and changing expectations.

Stevens et al (2007) describe three approaches to HNA:

- Epidemiological: considers the epidemiology of the condition and current service provision.
- Comparative: compares service provision between different populations.

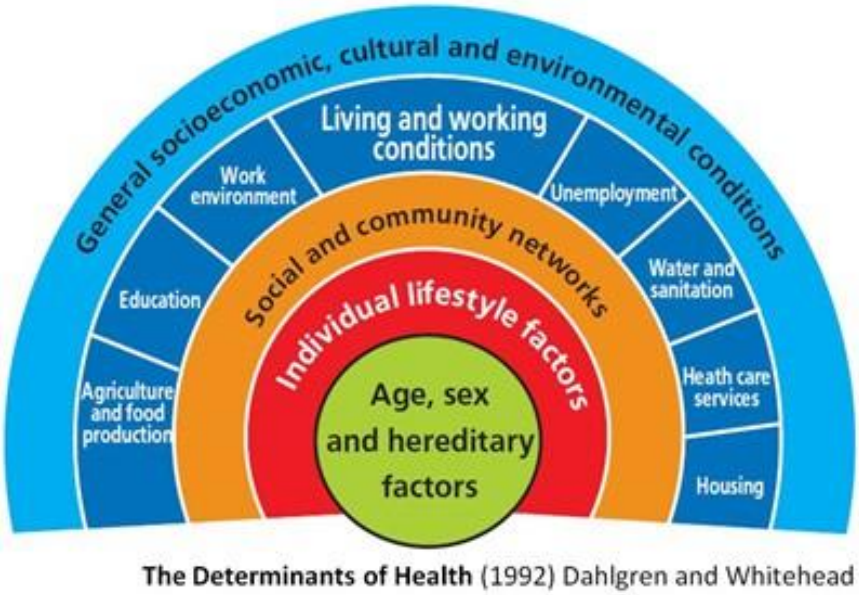
- Corporate: is based on eliciting the views of stakeholders; these may include professionals, patients and service-users, the public and politicians; on what services are needed.

Bradshaw (1972) described four types of need:

- Normative: Need that is defined by experts. Normative needs are not absolute and there may be different standards laid down by different experts.
- Felt: Need perceived by an individual. Felt needs are limited by individual perceptions and knowledge of services.
- Expressed: Felt needs turned into action. Help seeking – also known as "demand".
- Comparative: Individuals with similar characteristics to those receiving help.

This needs assessment aims to use a range of data sources and methods to ensure needs are assessed from a range of perspectives. It is broader than a traditional HNA. The focus is on the *needs* of the CEE community in Bradford District in addition to their health care needs. Therefore this needs assessment will include knowledge and information relating to broader determinants of health as illustrated in figure 1 below.

Figure 1: Determinants of health



The Determinants of Health (1992) Dahlgren and Whitehead

Dahlgren and Whitehead created this model to explain the influences which have an impact on the health status of an individual. These include boarder determinants e.g. housing, education and unemployment as well as individual lifestyle factors e.g. diet and smoking.

A *needs* assessment suggests a deficit model, with passive recipients of services waiting for their needs to be met. This needs assessment aims to

also capture the assets of Bradford's CEE communities which support self help and recognise the social, cultural and economic benefits new communities bring.

1.4 What this report includes

This report describes the national and local context of European Accession and migration of people from Central and Eastern Europe to Bradford. The methodology used to undertake the needs assessment is described. Results are presented under the headings of

- literature review
- epidemiological needs assessment, which includes a description of demographics, health status and services
- corporate needs assessment which includes views of service providers and CEE community members.

A conclusion is included and recommendations are presented.

2. Context

2.1 National context of Accession

This needs assessment focuses on migrants from eleven Accession countries. In May 2004, ten countries joined the European Union (EU): Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia. All but two (Cyprus and Malta) had restrictions placed upon them. For example in the UK, the government regulated access to work through the Worker Registration Scheme and restricted access to the welfare system. The eight countries with restrictions placed on them are known as the A8 countries. In 2007, Bulgaria and Romania also joined the EU and are known as the A2 countries. Nationals from these countries were allowed gradual access to employment. Those with recognised trades, experience and qualifications were allowed access as highly skilled workers, while for lower skilled workers, quotas were set and restricted to specific schemes e.g. the Seasonal Agricultural Workers scheme or the Sector Based Scheme which covers the food and manufacturing industries (Brown et al, 2013). Since July 2013 Croatian nationals have been free to come to the UK but are subject to the same rules as the A2 nationals. In summary, this needs assessment focuses on migrants from the following countries listed in table 1 below.

Table 1. Countries includes in this needs assessment	
A8 (2004)	Czech Republic Estonia Hungary Latvia Lithuania Poland Slovakia Slovenia
A2 (2007)	Bulgaria Romania
2013	Croatia

2.3 Patterns of Polish migration

There are large differences between the CEE communities in Bradford District. The largest group of migrants from a single country are Polish. The main reason for Polish migration to the UK is the opportunity to earn money. In 2004, wages in Poland were often as little as £200 a month. Polish migrant workers have a reputation for being hard working and are often prepared to do jobs that many UK nationals will not do. Many Polish migrants are Catholic and church attendance has increased in most areas Polish migrants have settled in, with some churches needing to provide extra services to meet demand. The recession has seen many Polish people returning home from the UK, wages in Poland having doubled over a five year period, whilst there has been little movement in UK wages. The Polish Zloty has strengthened against the Pound so the exchange rate is only around two thirds of what it was in 2004 (Source: http://www.polish-migrants.co.uk/). The pattern of Polish migration has changed since Accession. Solo parent migration was the

norm 1989-2004, and remains common. This type of migration implies very little integration into the receiving society with the idea of earn abroad, spend at home. However, since 2004, an increasing number of families have begun to break this norm. It is perceived that migration with children increasingly seems both feasible and better for the whole family (White, 2012).

2.3 The European Roma Community

Roma people live in all CEE countries. The CBMDC Education Service estimates that 95% of migrants from Slovakia and the Czech Republic resident in Bradford are Roma. In general terms, the Roma population has a different pattern of migration to the Polish community.

The precise number of Roma living in each country of origin is unknown. The Council of Europe Roma and Travellers Division estimated the Roma population in Europe in 2010 to be 11 million, 1.36% of the population. Table 2 below shows the percentage of the population estimated to be Roma by CEE country. The countries with the highest estimated Roma populations are Bulgaria, Slovakia, Romania and Hungary.

Table 2. Percentage of population estimated to be Roma

Country	% of population estimated to be Roma
UK	0.37
Czech Republic	1.96
Estonia	0.10
Hungary	7.05
Latvia	0.65
Lithuania	0.08
Poland	0.10
Slovakia	9.17
Slovenia	0.42
Bulgaria	10.33
Romania	8.32
Croatia	0.78

Source: Council of Europe Roma and Travellers Division, September 2010

The term Roma covers a wide range of communities within Europe. The Council of Europe uses the term Roma to include “Roma, Sinti, Kale and related groups in Europe including Travellers and the Eastern groups (Dom and Lom) and covers the wide diversity of the groups concerned including persons who identify themselves as Gypsies” (in Brown et al, 2013).

The social exclusion faced by members of Roma communities living in Europe and beyond is widely recognised (Amnesty International 2011, Bartlett et al, 2011, Brown et al, 2013). EU member States have on repeated occasions expelled Roma from other EU member States. Highly publicized expulsions of Roma have been recently carried out by France, Italy, Germany, Denmark and Sweden (Cahn and Guild, 2008).

In Slovakia, the Roma population suffers disproportionately from higher rates of poverty, unemployment, illiteracy, crime and disease. Roma often live

outside villages in camps or settlements with limited facilities. Some camps were built on dumping grounds or contaminated land. There are examples where walls have been built in cities to separate Roma families from the majority Slovaks. Roma children are widely discriminated against in the education system. Huge numbers are segregated into Roma only schools and others are placed in "special" schools despite not having any disabilities. In parts of Slovakia all schools are segregated, Roma children receive a second rate education and only a minority (3%) finish secondary school education. Turning to the Czech Republic, 90% of Roma who lived in the Czech Republic were exterminated by Nazi Germany. In 1989 some Roma women started to accuse the state of forced sterilisations. Currently Czech Roma are the target of far right protest groups.

Many Roma move to settle in new countries because they experience relatively low levels of discrimination compared to their countries of origin (European Dialogue, 2009). The National Inclusion Health Board has described Roma communities in the UK. They explain, Roma often migrate to the UK to find work, to enjoy equal opportunities and a good education for their children and to escape racism and discrimination. They have established significant communities in the north of England, East Midlands, Kent and north and east London, however, not all local authorities are aware of Roma living in their area as ethnic monitoring is poor. Roma share many of the factors and barriers experienced by other migrants. Poor health outcomes are common; causes are numerous and include high levels of illiteracy; lack of good quality health supporting accommodation; lack of knowledge of mainstream services; and a mistrust of authority. Procedures for registering and accessing primary care services are a significant barrier, as well as a lack of cultural awareness and cultural competency amongst health staff which can cause misunderstanding and tension, and can deter some from seeking health care until there is an emergency. These factors can also be compounded by a sense of fatalism and low expectations about their own health and health services. Ill health is seen as normal, an inevitable consequence of adverse social circumstances (Inclusion Health 2011).

These living conditions have a huge impact on health. Roma have a life expectancy ten years lower than other European citizens. Roma child mortality rates are between two and six times higher than the general population of Europe. Less than half of Roma children complete primary school and a very low number attend secondary school. Employment rates are lower for Roma than the general population and housing is often poor, with inadequate access to services (Roma Matrix, 2014).

2.4 History of CEE migration into Bradford

Census data (2011) shows that around 10% (1,564) of migrants from Accession states came to Bradford before 2003 and 90% (10,532) since 2004. Significant numbers of people from CEE countries, notably Polish, came to Bradford following World War Two (WW2). Second and third generations of WW2 migrants are well integrated into life with in Bradford District, whilst continuing to maintain some aspects of their culture. Many of the more recent migrants from CEE have few connections with the settled

CEE communities (Charlton, 2013). Some Roma came to Bradford as part of the Home Office asylum and refugee dispersal in the 1990s. Others came for work opportunities, low accommodation costs and following families and friends to the District. Some Roma have commented that they are not immediately recognised as Roma in Bradford and this means they face less discrimination (Charlton, 2013). Roma are likely to have lower expectations and have lower skills although most can read and write in their first language. Many Roma have tended to come to the District as larger extended families (Charlton, 2013).

3. Rights and responsibilities of CEE migrants

The rights and responsibilities of CEE migrants are fully described in appendix 2. In summary, CEE nationals are currently entitled to NHS health care, primary and secondary education and social services. Rights to claim welfare benefits are complicated and changing as a result of a national policy drive to reduce welfare support available to CEE migrants. Changes are to access to free NHS care are also planned.

- In December 2013 a more robust habitual residency test was introduced, that people struggle to evidence.
- Since January 2014, CEE migrants are only able to claim Jobseekers Allowance once they have been in the UK for three months.
- Since 1st April 2014, new CEE jobseekers are not eligible for housing benefit.
- A new "genuine prospect of work" check was introduced in July 2014 which means that unless candidates provide compelling evidence they can find work, their JSA will end after 6 months.
- From July 2014 new JSA claimants are no longer entitled to claim child tax credit or child benefit.
- In addition, from July 2014 most new CEE job seekers are only allowed JSA for a maximum of six months. From November 2014 this will be reduced to three months.

It has been reported nationally that people claiming JSA are being sanctioned more frequently. If a JSA claimant is sanctioned, they also lose related benefits including housing benefit, council tax benefit and free school meals. If a pupil is no longer entitled to free school meals, their school can no longer claim their pupil premium payment.

4. Methodology

The development of the needs assessment was guided by a Task and Finish Group which included members from the CBMDC Neighbourhoods Team and Public Health Department as well as a senior VCS colleague. The project began on 14th May 2014 and results were presented to the CBMDC Race and Ethnicity Strategy Group on 15th October 2014. The project was divided into four phases: information gathering, data analysis and knowledge synthesis, sense checking and writing up. Three main approaches were taken: a literature review, an epidemiological needs assessment and corporate needs assessment.

4.1 Literature review

It was not possible to conduct a comprehensive and scientifically rigorous literature review within the timescales. In addition this type of literature review would not be appropriate as the needs assessment takes a very broad perspective on new communities and therefore is concerned with a new and emerging body of evidence. Instead a review of previous needs assessments of CEE communities was conducted. Eight published needs assessments were found covering populations in Hertfordshire, Barking & Dagenham, Calderdale, Newcastle, Nottingham and Leeds. (Patel, 2011 Coakley, 2011, Tobi et al 2010, Leaman, 2011, Bunting, 2010, Sankar et al, date unknown, McNulty, 2014 and Thompson, 2013). From these needs assessments a list of data sources was collated to use as a template to add to as a guide for the Bradford District needs assessment. Mini literature reviews were included from two BSc dissertations (Richards, 2013 and Wilson, 2013) conducted in Bradford. These data are triangulated with two reports produced locally. Firstly the CBMDC CEE Communities of Interest Action Plan, which incorporates local knowledge from the CBMDC CEE working group, district advice workers, community members and frontline staff (Natarajan, 2014) and the report “Roma in Bradford”, a VCS Perspective (Speight, 2014).

4.2 Epidemiological needs assessment

An epidemiological needs assessment was carried out. Available data were sourced to describe the demographics of CEE communities in Bradford District over time.

Service mapping was conducted, using local knowledge and sharing first drafts of results with knowledgeable partners. Where possible service usage was ascertained however this was not always possible within the timescale or by using the data collection systems of all services.

4.3 Corporate needs assessment

A corporate needs assessment was undertaken. Views of workers were gathered through the two Bradford dissertations. These captured workers perspectives through interviewing three GPs, two practice nurses, two receptionists, one nurse practitioner, one patient services manager, one health promotion manager, three staff from community / social services and eleven staff made up of midwives, health visitors and voluntary sector workers.

Views of CEE community members were sought. The findings of the dissertations were presented to individuals from CEE communities during the CBMDC Ten Years On CEE consultation event (see appendix 3). The findings were discussed in turn. The event also considered areas broader than health.

5. Results

5.1 Literature review

This literature review summarises findings from the Bradford dissertations (Taylor, 2013 and Richards 2013) and the eight published needs assessments (Patel, 2011, Coakley, 2011, Tobi et al 2010, Leaman, 2011, Thompson, 2013, Sankar et al 2013 McNulty, 2014 and Bunting, 2010) as well as other literature identified, significantly the Bradford CEE Working Group reports and Speight's reports based on local knowledge. Findings are presented under headings selected from the Dahlgren and Whitehead model of factors influencing health (shown in figure 1) with an additional headings of Poverty and Assets added.

The health of migrants commonly exceeds that of their country of origin and the UK population, often referred to as the "healthy migrant effect" (Rechel, 2011). Despite this, migrant health often deteriorates after arrival in the UK. It is uncertain if the healthy migrant effect applies to migration from the EU countries this needs assessment applies to, as the Roma population in particular experience poorer health that the majority population in their country of origin.

The needs assessment undertaken in Calderdale focuses on the Czech and Slovak communities and includes findings from broader studies along with views of workers in Calderdale (Leaman, 2011). The Leeds needs assessment focuses on the Gypsy and Traveller community; which included English Gypsy, Romany, Irish Travellers and Scottish Travellers; and aimed to understand the needs of these communities from their own perspective (Thompson, 2013). The Roma HNA undertaken in Leeds aimed to identify the health status and needs of Roma communities and to reduce health inequalities and improve access to services (Sankar et al, 2013). The needs assessment was led by Advocacy Support and data was gathered via training Roma community members to carry out the HNA.

Two HNAs were undertaken in Hertfordshire, one looking at health needs of CEE migrants (Patel, 2011) and the other looking at health needs of the Polish community (Coakley, 2011). Patel undertook a literature review and interviewed community development workers who worked with CEE communities across Hertfordshire. Coakley interviewed Polish community leaders, surveyed Polish people and undertook a literature search.

A large health and social care needs assessment of Eastern European individuals living in Barking and Dagenham was carried out in 2010 (Tobi et al). This needs assessment undertook surveys, focus groups, and interviews with the local community. Four groups were focused upon: Polish, Lithuanian, Albanian and Roma. The first three were chosen as they are the largest CEE communities living in Barking and Dagenham and Roma were selected because they are known to disproportionally suffer worse health and social inequalities. The Newcastle needs assessment gathered views from 45 CEE community members and 28 practitioners working with the CEE community.

5.1.1 Age, sex, hereditary factors

The Calderdale needs assessment (Leaman, 2011) states that "Since the mid 60s, the health of people of central and eastern Europe has lagged behind those living in the west and both the Czech Republic and Slovakia have a substantial Roma population, the exact size of which is uncertain and that Roma are one of the most vulnerable groups facing health inequalities. Life expectancy amongst Roma is ten years less that that of the majority of the population" (Boback and Marmot, 1996; Hajiof and McKee, 2000 and Commission of the European Communities, 2009)

The Leeds Roma HNA (Sankar et al 2013) states that approximately 25% of the community have a long term illness of disability.

There is a suggestion that because Roma populations are generally small, consanguous (cousin) marriages are more common, increasing the risk of inherited genetic disorders resulting in higher risk of congenital deafness and cataracts.

5.1.2 Individual lifestyle factors

Leanman (2011) found that there was an increase in heroin use amongst young Slovak, Polish and Czech migrants. Teenage pregnancies were more common amongst Czech and Slovak young women although it was perceived by staff that the young women were married and well supported. Calderdale reported probable use of illicit tobacco and that some Roma parents have low uptake of vaccination programmes (Hajioff and McKee 2000). Diet was seen as poor with many families reporting eating pasta with ketchup for a meal. Calderdale also report that consanguinity (cousin marriage) is more common in Roma communities, leading to a higher incidence of genetic abnormalities (Hajioff and McKee, 2000).

The Nottingham needs assessment discusses crime and states "Those living in destitution with no recourse to public funds and unable to find work could turn to crime or begging in order to gain money to meet their needs. Concern was also raised at a local level of individuals moving from alcohol dependency to drug use" (Bunting, 2010). The Nottingham needs assessment found that the number of arrests amongst those of Polish origin doubled between 2009 and 2010 and that arrests of people of Polish origin accounted for 7% of all arrests in the city, suggesting this group is overrepresented compared to Census data. The needs assessment does not list what offences the arrests are made for.

Turning to drug treatment, the Nottingham needs assessment found that between 1 and 1.5% of those in drug treatment were of European origin (excluding the UK) and that less than 1% was of Polish origin. This suggests that there are either lower levels of drug use compared to the UK population or that less people are using the drug treatment services (Bunting, 2010).

Sankar et al (2013) found that approximately 40% of Roma in Leeds smoke and 36% are ex smokers. Most Roma found fruit and vegetables were hard to find. Approximately 30% of respondents had eaten no fruit or vegetables in

the previous day and 52% had eaten one or two portions. Turning to mental health, the HNA found that 89% of respondents reported high levels of stress in the last year with causes including money problems, family life, lack of work, caring for others and problems with the neighbourhood.

The Barking and Dagenham needs assessment found that 48% of survey respondents smoke, with the highest rates amongst the Roma (74%) and lowest in Albanians and Kosovans (20%). 51% of respondents said their alcohol consumption was mild to moderate with the highest rates amongst the Polish (69%) and Lithuanians (68%) (Tobi et al, 2010).

In terms of sexual health, Speight (2014) reported that there is evidence that Roma, especially young men, are coming to England so that they can acknowledge their sexual identity. Homosexuality is not recognised in Roma communities and where someone identifies as being gay or lesbian they may be ostracised. A study in London (Del Amo, 2011) found that men who have sex with men from CEE countries accessing genitourinary medicine clinics report high frequencies of unprotected anal sex with casual partners of unknown HIV status. The study also found women from CEE communities were overrepresented amongst female sex workers.

Speight (2014) reported that the majority of CEE nationals in Bradford smoke tobacco. Many buy tobacco through the grey economy or at local CEE stores. The risks associated with smoking, especially passive smoking, are not understood. Smoking rates are high across both genders. Levels of stress and anxiety are given as a reason to smoke even when there is very limited income.

The LACO project has referred clients to smoking cessation initiatives provided by the NHS but with very limited success rates. LACO are currently targeting pregnant women or women considering pregnancy and this is proving to be more successful in terms of quitting.

Speight (2014) reports that alcohol forms part of many Roma celebrations. Knowledge of the health implications and basic knowledge of unit measures are not widely understood. Alcohol is also often accessed through the grey economy. The Bradford CEE Working Group (2014) reports alcohol misuse by single Polish males and increasingly Roma. Reports are being received by community members, council wardens and elected members of anti-social behaviour, drinking in public spaces and noise nuisance.

Speight (2014) reports there have been growing concerns of Roma youth being drawn into gangs and into drug use. Significant numbers of Roma youth still find it difficult to gain school placements and this makes them susceptible to being targeted and drawn into this area. Local information indicates that some of the alcohol and cigarettes contain ‘fillers’ that could be health hazards.

5.1.3 Social and community networks

A study aiming to quantify the Roma population in the UK (Brown et al 2013) described push and pull factors for Roma migrants. Push factors from countries of origin include systematic discrimination, poverty and poor living conditions. Pull factors in the UK include an absence of overt discrimination, basic health care and the potential of paid work. A front line local authority worker described how immigrants share their experiences with broader family networks:

"When people first arrived there was concern that they wouldn't want to access specialist education for children with complex special needs, in fact it's been the opposite. What we know anecdotally is that there are families who have been told, well, our children have got speech therapy here and their hearing has been sorted and they have got glasses. They've got teaching assistants who speak Czech or who speak Slovak or Romanian and are therefore helping them and then it tends to be an extended family then will come. We are experiencing that actually our numbers will increase year on year."

The Barking and Dagenham needs assessment found that two thirds of community members responding to their survey said they intended to reside permanently in the UK, 80% were not planning to bring any family members to the UK to live with them (Tobi et al, 2010).

The Calderdale needs assessment stated that concerns included children being home alone, domestic violence and neglect (Leaman, 2011).

The Leeds Roma HNA (Sankar et al, 2013) raised concerns about community safety. These included hate crime, incidents of bullying, antisocial behaviour and drug dealing in some areas of the community. Concerns were also raised about safeguarding, especially the rising number of Roma children involved in sexual exploitation and trafficked families, the fact that there is no citywide intelligence on this matter and that Leeds City Council ethnicity forms do not include Roma so data are not collected for this community.

The Hertfordshire CEE HNA (Patel, 2011) found that concern has been raised about the frequency of mental health problems amongst migrant groups, in relation to multiple stressors such as trauma or persecution in their countries of origin, bereavement and separation from families and friends, poverty, poor housing conditions and social isolation in the UK. Members of the Lithuanian community described issues such as culture shock, isolation, financial, employment and accommodation worries as major factors contributing to stress. There is also poor understanding of mental health support available and high levels of stigma.

The Barking and Dagenham needs assessment quotes a Roma community member who explained how taboo mental health is amongst their community:

"Roma adults need education about mental health and disabilities. It cannot be done overnight and authorities must realise that health and

especially mental health, learning and other disabilities are taboo subjects amongst Roma. Authorities should be aware that those subjects are very sensitive and that if they want to change things they should provide culturally appropriate support for Roma with mental health problems, learning difficulties and other disabilities and for their families."

The Hertfordshire Polish HNA (Coakely 2011) found that young single Polish people living in urban areas often felt isolated and vulnerable, living in unregulated accommodation and moving often. Feelings of social isolation can lead to depression.

The Barking and Dagenham HNA found that for the Roma community, health issues identified were diabetes, depression, asthma, cancer, TB and heart problems. The HNA states

"In fact, in their own opinion, the Roma have so many problems that every other person is depressed. Illnesses amongst the Roma in Barking and Dagenham are often related to poor working and living conditions and poor diet. Anecdotal evidence from fieldworkers spoke of some respondents living in appalling conditions, in rat infected squats in the middle of industrial estates and fieldworkers also observed several untreated injuries and conditions" (Tobi et al, 2010).

Attitudes towards homosexuality in Eastern and Western Europe differ. The national Pew Global Attitudes Survey (2007) highlighted the difference and stated that in Eastern Europe homosexuality is seen as a taboo subject, hidden from the public realm. Attitudes are mixed. Generally Czechs and Slovaks believe homosexuality is a lifestyle choice and acceptable; Poles and Bulgarians are divided on this issue and Russians and Ukrainians strongly oppose it. Younger people are more likely to think homosexuality should be accepted. The Barking and Dagenham needs assessment found these attitudes reflected in interviews with CEE community organisations.

The Barking and Dagenham needs assessment asked how people found out about services available. The main sources of information reported was from family and friends (41%), dedicated websites (21%) and translated leaflets (20%). Another key source was community venues (11%).

Speight (2014) explains the background and culture of Roma which underpins their lives in Bradford. Most Roma now live a settled lifestyle, unlike the Romany Gypsy community who share the same cultural heritage. Roma in Europe are the largest minority with over seven million people. Roma are a disadvantaged and marginalised group and experience exclusion. Many live in ghettos and suffer forced eviction from their homes. A basic necessity for any organisation is to develop trusting relationships using community members as intermediaries or employing community members. In their counties of origin Roma tend to live in their own communities, often secluded villages away from the mainstream. Roma are not used to being included in statutory provision, it may appear to Roma that they are being 'targeted' in what is a normal process e.g. accessing school placements and local

community policing. In many of the countries of origin, bureaucracy and the need to pay for every service makes life particularly difficult for Roma people. Roma communities are distinctive in nature and differences go beyond language. There is a difference between Roma and white CEE nationals. Prejudice and discrimination in their home countries affect Roma's perceptions of statutory services and their willingness to self-identify. There are high levels of discrimination experienced between white CEE nationals and Roma, this is relevant especially where white CEE nationals are being used to lead initiatives with Roma or provide interpreting support. Many Roma come to Bradford to join family members or as a family. They may move into areas where Roma are already based, this leads to families having small support networks. It also can create enclaves of Roma with limited opportunity to build links with local or other Roma and CEE communities. High levels of poverty, lack of understanding of legal systems, poor literacy both in Bradford and in their countries of origin make Roma susceptible to low level criminality, fraud, human rights abuses, slavery, human trafficking and forced prostitution. Roma community members indicate that despite all the challenges they face, their life is much better here than in their country of origin. Levels of poverty are leading Roma community members to scavenge, children have been found in the BD3 area searching bins for food items. There are some reports of Roma beginning to collect metal to sell.

The Bradford CEE Working Group also notes issues of family breakdown, domestic violence, mistrust of the Police and authorities, as well as a desire to maintain culture, traditions and languages.

Social isolation has also been identified by Speight (2014) as a factor in the mental wellbeing of local community members, people often live within extended families with limited contact to wider social networks. The Bradford CEE Working Group (2014) notes isolation, depression and mental distress as an issue. Speight (2014) reports that Roma find limited opportunities to celebrate their cultural identity and heritage through music, art and dance. This leads to community members expressing that they have no sense of belonging to their new community. Community tensions have been identified, levels of noise and alcohol fuelled events have also been reported due to the cultural and lifestyle differences. This again is leading to increased isolation and anxiety. The Bradford CEE Working Group has noted poor relations with other communities, some CEE members are unaware of social norms of their neighbours and vice versa. In extreme cases, some Roma and white Europeans have been victims of hate crime, as they have been perceived as taking jobs from local people.

The Bradford CEE Working Group's report (2014) also provides information on the strengths of the CEE communities in Bradford. These include support from established community and family members, resourcefulness, community associations, including Romano Drom, Kameleon, Zielono Nam, Wesole Minutlki, Blatic Family Association, Romano Ilo, and the Keighley Polish Group. Faith communities also provide support.

5.1.4 Health care services

Leaman (2011) states that people from Czech Republic and Slovakia seem aware of available services, but expectations are sometimes unrealistic, particularly in terms of having to book appointments. Health care workers stated that it is really hard to engage with the communities in terms of screening and management of long term conditions. The communities are seen to be transient and communication is perceived as a problem. It is felt that the interpreting service is great but needs to be planned and longer appointments are required. Immunisation and vaccinations are found to be challenging, workers find it hard to get a prior history and repeat visits.

A theme that was found many times in the Leeds Gypsy and Traveller needs assessment was the experience of being treated less well than others by many professionals because they were Gypsy and Traveller people (Thompson, 2013). However, positively 92% of survey respondents were registered with a GP and 68% of people who had been invited to a health check had attended. Only 69% were registered with a dentist. In Barking and Dagenham 80% of people were registered with a GP but this differed between communities, with 97% of Albanian and Kosovans being registered compared to 57% of Roma (Tobi et al, 2010).

The Leeds Roma HNA also found that registration with a GP was high, and registration with a dentist was low. They found there was inconsistent availability of interpreters and a strong feeling that GP assessments were not thorough enough. The community want it to be easier to get appointments (Sankar et al 2013). The HNA found that 50% of Roma rate hospitals as good or excellent. Language barriers were an issue for 18% of respondents.

However the Barking and Dagenham needs assessment found that respondents from all communities spoke about difficulties registering with GPs and other services. The main reason was inability to show proof of address often compounded by uncooperative landlords (Tobi et al,2010).

Patel (2011) found that migrants had difficulty in accessing health care services due to a poor understanding of the UK health care system, confusion regarding their entitlement to health care and lack of awareness about services and support available. Language barriers were perceived to be the main cause of these problems. Interviews held with members of the Lithuanian community found that there was often no or inadequate provision of translation and interpreting services. Informal interpreters such as family members (including children) are often used during consultations which compromise both patients' confidentiality and understanding of their health problems. The Barking and Dagenham needs assessment links the issue of interpreting with cultural sensitivity and explain that culturally specific norms and taboos about subjects such as sexual health, homosexuality, domestic violence, drug and alcohol abuse, disability and metal health means that it is often difficult to discuss these issues in front of community or family members (Tobi et al, 2010).

Coakely (2011) found that many Polish do not understand the UK health care system and role of GPs, as Poland does not have primary care and people can access specialists directly. Many Polish go home for medical tests and to see their doctors. Some Polish people in Hertfordshire expressed frustration around the lack of autonomy in the UK as investigations aren't available on demand.

These problems were echoed by the Barking and Dagenham needs assessment (Tobi et al, 2010) which stated:

"Problems with language skills have cumulative effects. They reinforce and are reinforced by a lack of cultural understanding between BME community members and those working with in the NHS and its services. BME community members may often have limited knowledge of the culture of the British system, its history, its processes, its mechanisms and at the same time many of those working to plan or provide services may often have a limited understanding of the cultures, manners, customs and sensitivities of the BME communities who they deal with in the course of their work. This can engender a lack of trust."

Tobi et al also stated that any information needs to be honest, it needs to "tell it straight" and not to raise expectations, there is a need to explain when a service is limited, and why, explain waiting lists, and times people might wait for housing or health for instance, and how decisions are made.

Speight (2014) reported issues with Roma women accessing antenatal care; and provides examples of women who were six months pregnant but not yet in touch with the midwifery service. There are low levels of knowledge amongst some Roma about the health care system and how to access services. Speight also reports low levels of understanding and uptake of contraception services. Other issues include high levels of smoking during pregnancy and lack of knowledge and money to eat healthily.

Speight (2014) reports that sexual health is a taboo subject in the Roma community, families do not often discuss sexual health and there is a lack of understanding about sexually transmitted infections. Speight reports that 48% of CEE men in touch with MESMAC (a support service for men who have sex with men) in Leeds Bradford are HIV positive. Speight reports that generally Roma communities have low awareness of HIV or treatment available.

The Bradford CEE Working Group (2014) reported problems accessing dentists especially for the Roma children and a higher incidence of poor oral health. There are also some problems accessing health services as ID cards are sometimes not accepted, there is a lack of clarity on the rules from some NHS staff.

Deborah Manger, a dentist working in Northamptonshire, noticed that some CEE children she treated had a large number of caries requiring extraction under general anaesthetic, but parents did not bring their children back for treatment. She discussed this pattern with a Polish colleague who is also a

dentist who explained that in Poland, children are held down whilst self draining cavities were made and that parents were frightened of this treatment. It was agreed that dentists would visit children's centres to discuss with CEE parents what treatment is offered in the UK. Deborah Manger has shared the case notes of 300 children requiring extraction under general anaesthetic (3 months worth of cases) with a dental Public Health Consultant in PHE who is analysing the data for nationality, using language of translator, to asses what proportion were CEE children (September 2014, personal correspondence).

McNulty (2014) found that in Newcastle one of the biggest needs was to build trust in the health care system with CEE communities.

5.1.5 Housing

Nationally, migrant workers are recognised to most commonly live within the private rented sector. Some employers provide tied accommodation, limiting security of tenure and creating difficulties if complaints arise around either employment or housing. Overcrowding and houses of multiple occupation are also a recognised issue (Audit Commission, 2007). In Nottingham, 73% of EU migrant workers sampled were living in privately rented accommodation. Of the respondents, 11% indicated that three people were currently sharing a bedroom, while 1% indicated that four people were sharing a bedroom. 9% of respondents indicated that they or people within the household were sharing bedrooms with non-family members (Bunting, 2010).

The Leeds Roma HNA (Shankar et al 2013) found concerns over poor living conditions and overcrowding, tenancy agreements and high rents and waiting times for homes for large families. In Newcastle one of the main needs identified was finding good quality accommodation (McNulty, 2014)

Rough sleeping CEE migrants are found in significant numbers in London and other cities, some may have no recourse to public funds and some may be seasonal migrant workers homeless during the winter season. Alcohol use is particularly high in this group (Aspinal, 2014). A Nottingham based study identified reasons amongst migrant workers for rough sleeping as loss of employment, difficulties finding work, problems with landlords or breakdown of relationships (Scullion et al, 2009).

The Bradford CEE Working Group (2014) noted that some CEE communities being exploited by private sector landlords, many people are paying to live in rented accommodation that doesn't meet the required standards. For example there are issues with landlords not clearing unwanted furniture left by previous tenants, gardens are not maintained by landlords and there are increasing cases of cockroaches and bedbugs, which are spreading as people move and take the pests with them. There are also reports of rough sleeping, usually single males, some of whom have problems with drugs, alcohol or lack of employment.

5.1.6 Education

The Leeds Roma HNA (Sankar et al 2013) identified concerns about education. These include lack of school places especially for reception, key stage one and high school. Concerns were also raised about poor levels of attendance and attainment and engaging parents in their children's education.

The Bradford CEE Working Group (2014) notes that Roma children sometimes have irregular attendance at school and there is a shortage of school places for children aged 15 and above.

There are issues faced by CEE families and early education. Usual practice in CEE communities to send children to school at an older age. Some CEE communities are apprehensive about childcare as they have less authoritarian approaches to childcare in their countries of origin. There is a mistrust and resistance to statutory services and authority due to past experiences of persecution (Charlton, 2013).

5.1.7 Employment

Nationally EU migrants are recognised to more commonly work in low paid jobs within administration, hospitality and catering, agriculture, manufacturing and good processing (Pollard et al 2008). A needs assessment in Nottingham quoted a local survey of 235 migrant workers (2008) which found that 81% were in paid employment with the most common occupations being elementary jobs or process plant and machine operatives. The study found that mode than 50% of respondents had experienced a reduction in their occupational level since coming to the UK (Bunting, 2010).

The Leeds Roma HNA (Shankar et al 2013) raised concerns about the informal labour market, young Roma with low job prospects, low aspirations and low levels of English.

The Barking and Dagenham needs assessment surveyed 130 community members and found the proportion of people in current employment was highest for Lithuanians and Poles and lowest for Albanians, Kosovans and Roma. The most common sectors that CEE migrants are employed in are construction (30%) and hospitality or catering (14%). Despite relatively high levels of education, CEE workers received relatively low levels of pay (Tobi et al, 2010). The Newcastle research found that one of the biggest causes of stress was the challenge of securing employment that provided a living wage (McNulty, 2014).

Charlton (2013) reports that there are cases of economic exploitation for example where people are being brought to Bradford under false pretences and their papers are withheld, people being paid below the minimum wage, people being dependent on gang masters, subject to threats and intimidation, and people working in unsafe and unhealthy workplaces. Undocumented migrants, mainly people who have entered the UK illegally, are largely invisible in official records and have few, if any, entitlements to services including heath care. Some work in low paid occupations with minimal regard for health, sanitation and safety, under the authority of gang members.

Migrants who have been trafficked are also vulnerable. Some may have been sexually abused, physically abused or forced into the sex industry (Aspinal, 2014).

The CEE Working Group have identified a lack of childminders as a cause of problems for CEE migrants who are required to attend training as part of their JSA conditions. There are no registered Roma childminders in Bradford District. The majority of Roma parents do not feel comfortable leaving their children so they can attend appointments or commit to employment.

5.1.8 Poverty

The Leeds Roma HNA (Sankar et al 2013) raised concerns about poverty. These include high rents, low incomes, fuel and food poverty, poor access to advice and credit and benefit fraud.

Speight (2014) notes that in Bradford; poverty is leading to malnutrition, specifically underweight and overweight people members. Between 15 and 20% of the CEE population are reliant on food parcels either from food banks or family and community members. Levels of poverty impact on food provided to children and infants. Families have reported watering down formula milk so that it went further. Poverty can lead children to miss school, if families can't afford to provide packed lunches. Many families are not entitled to free school meals. Some families are unable to cook as they are not able to pay for utilities. Most CEE families in touch with the Bradford VCS live in fuel poverty. People chose cheap alternatives which limits intake of fruit, cheaper cuts of meat, high fat meats and lots of sweet dishes that are cheap and filling. Levels of anxiety and depression are also linked to weight gain. Limited access to leisure activities and erratic work patterns are also leading to poor diets and children again being fed on cheap fast food.

The Bradford CEE Working Group (2014) notes exploitation by gang masters, employment agencies and some employers, especially of unskilled or undocumented migrants of those with low levels of English. There are also issues of sexual exploitation of young women and girls including trafficking, grooming and prostitution.

The Bradford CEE Working Group (2014) also noted trafficking of children to work and send money home, and that Roma communities are not always aware they are doing anything wrong. There are reports of safeguarding issues, where families are facing multiple problems and examples of ID fraud, where job seekers have shared documentation.

The Bradford CEE Working Group (2014) noted problems around income and benefits. Some CEE people have experienced very slow decisions on entitlement and a lack of clarity and consistency in decisions. Some Roma families face destitution, insufficient income to pay for food and shelter; for example Roma families unable to find work and awaiting slow decisions on benefit claims, or single workers paid below the minimum wage e.g. £5 a day. Some people's qualifications are not recognised. Some people have lost their identification papers which impacts on accessing employment of benefits.

The Bradford CEE Working Group noted a shortage of advice services, with interpreters available. Levels of English can be low. Lack of access to computers and IT skills makes it difficult for the communities to fulfil the job seeking requirements necessary to be eligible for Jobseekers Allowance, resulting in sanctions which in turn results in other benefits being stopped including housing benefit and free school meals. The changes in welfare reform are not understood by all. People are often in low paid, unskilled work, there are limited employment opportunities and heath and safety at work is compromised by some employers.

Organised crime and sexual exploitation have been raised as an issue. However it is difficult to access accurate information due to low reporting and fear of reprisals. Women and girls from Slovakia, Romania, Poland and the Czech Republic have been observed working as sex workers. It is suspected many have been trafficked and forced into prostitution. Women and girls who have learning disabilities are targeted. Further information on trafficking is included in section 6.3.28.

5.1.9 Assets

A traditional needs assessment focuses on need. A practical assessment focuses on needs and assets in order to ensure future planning builds on both. This needs assessment highlights many needs, however these needs mainly relate to a minority of the CEE community. There are significant CEE communities who have low levels of need and have integrated well to the UK.

In terms of finances, there is evidence that overall the impact of migration from the EU has had a positive financial effect. In the four fiscal years following EU enlargement in 2004, migrants from the A8 countries made a positive contribution to public finance in the UK. While A8 migrants work mostly in lower wage occupations, they tend to have high labour force participation rates and employment rates (The Migration Observatory, 2013). In addition new communities bring benefits of culture and tradition that increase diversity and cultural assets within Bradford.

Turning to Roma communities. Yaron Matras (2014) is an academic and expert in Romani culture. Matrass describes the role and importance of the extended family in Roma culture and how the extended family will often migrate together. Families search for accommodation near to each other, which may cause problems with neighbours as families congregate outside in summer. Matras describes how in Manchester some families have relocated to other areas and built their own houses to be able to preserve this aspect of their culture without drawing negative attention from neighbours. Matras describes how extended families share responsibility for caring for children, income and other resources. This network of mutual support helps families to remain resilient and cope with difficulties faced when establishing themselves in a new country. This network of support helps to explain why many Roma do not become street homeless when they have housing problems as many will be able to rely on their family network for support.

Matras describes how the collective responsibility for young children is not always fully understood or appreciated by professionals in the UK. Matras identifies a challenge Roma communities face is to find a way of integrating into new communities whilst also retaining their strong sense of identity and tradition.

In the experience of the CEE Working Group, Roma are generally a very resilient and resourceful people and upon arriving in an area will discover the options they have for work and the opportunities to sell their labour and skills. Many Roma in Bradford provide for themselves and their families working in the grey economy when they have been denied the opportunity to get a national insurance number and therefore access to legitimate work.

The CEE working group state that currently in Bradford Roma leadership and representation is lacking, but some Roma professionals are discussing and exploring the possibility of setting up a Roma community organisation to help support Roma communities in Bradford and to represent their needs. In the last ten years some have been formed by different family groups often with a cultural focus, but most have struggled to find venues they could afford.

6. Results from the epidemiological and comparative needs assessment

This section presents results in three main categories: demographics, health status and services. The services section covers health, local authority and the voluntary and community sector.

6.1 Demographics

As previously stated, there is no single reliable source of data to describe the CEE population in Bradford. It is not mandatory to record nationality. It is mandatory to record ethnicity. CEE migrants would be categorised as "White Other" or "Roma/Gypsy Roma", however as discussed, often Roma people do not ascribe to that ethnicity due to previous experiences of persecution and discrimination.

There are a range of data sources that enable us to build a picture and make an informed estimate of the demography of the CEE population in Bradford.

This section includes data from:

- The 2012 Bradford Joint Strategic Needs Assessment to understand the population within which we are comparing the CEE communities.
- A profile of general migration in Bradford using Census data from 2011 to set the context of migration from the EU.
- Census data for Bradford describing main language spoken, ethnicity, and country of birth.
- National Insurance Registration (NINo) data which describes workers from the A2, A8 countries and Croatia who have registered to work between 2003 and 2013.
- CBMDC electoral registration data, which is collected by nationality and available for July 2014 by ward.
- CBMDC schools data which provides number of CEE children which has been analysed per ward and per school year and compared with the number of all children on roll in July 2014.
- Office for National Statistics data (from 2001 - 2011) describing births to mothers from "the New EU" (which contains Malta and Cyprus but leaves out Croatia).
- Department for Work and Pensions Data on Jobseekers Allowance claimants and sanctions.

6.1.1 The Bradford District Population

In 2010 it was estimated that the population of Bradford District was 512,600. This is 5,800 more than in 2009 and represents an increase of 1.1% and the highest annual growth rate since 2005. The 2009-10 growth rate for England and Wales was 0.8% (Bradford JSNA, 2012). During the 1990s the population in Bradford remained fairly static and at the time of the 2001 Census 467,000 people lived in the Bradford District. However, since 2001 the population has been steadily growing. Since 2001, the population of the Bradford District has increased by 45,600, a rise of nearly 10%. The main driver of the District's population growth is natural change (the difference between births and deaths). The difference between the number of births and deaths in the District accounted for three quarters of the population growth for

the 12 months to July 2010. This is slightly lower than the figure for 2008-09 of 78%. The remaining population growth is attributable to net migration gains.

6.1.2 Migration to Bradford

Migration Yorkshire have analysed the 2011 Census data and found that there are five times as many residents in Bradford who were born in a country outside the EU than were born in the EU; 82,100 compared to 16,400 respectively. This difference is common across the Yorkshire and Humber region, but very pronounced in Bradford. Asia is dominant among ten world regions of birth, followed by the EU, and is also the most common passport type. However the difference between Asian and EU passports is less extreme and may reflect the fact that many Asian-born residents have British citizenship. Pakistan is by far the most common country of birth for non-UK born residents, accounting for 7.7% of the whole population, far higher than the Yorkshire and Humber average of 1.6%.

Migration Yorkshire also produced a Local Migration Profile (2014) for Bradford. There is a continuing decline in overall immigration to Bradford and net migration to Bradford in 2012 was just under 1,500 in 2012. New migrant workers arriving in Bradford in 2013 rose to 4,500, this rise was due to the increase in CEE Accession migrants with the greatest increase of arrivals from Poland and Slovakia. The level of workers from non-Accession counties remained the same with approximately 1,900 workers arriving in 2013. The number of new migrant workers from EU Accession countries rose to around 2,800 in 2013; 1,100 people were from Poland and 670 were from Slovakia.

6.1.3 Census data for CEE migrants

Various data are available from the 2001 and 2011 Censuses. These are presented below. Table 3 below shows main language spoken at home from the 2011 Census for all Bradford District residents aged over three. These data show that 2.5% of Bradford District residents aged three and over have a main language that is from an EU Accession country.

Table 3. Main language spoken at home Bradford

Main language spoken:	Bradford Residents (no)	Bradford residents (%)
UK Language	424,615	85
South Asian Language	47,290	10
Other European Language; Accession Countries	10,439	2.5
West/Central Asian Language	8,005	2
Other European Language; Non Accession Countries	3,195	0.6
East Asian Language	2,391	0.5
African Language	1,170	0.2
Sign Language	264	0
All Other Languages	272	0
All usual residents ages 3 yrs and over	497,641	100

Source: Census 2011

Table 4 below breaks down the languages spoken by Accession countries. This shows that the two main languages spoken are Polish and Slovakian.

Table 4. Main language spoken by Accession country		
Main language spoken by Accession country	Bradford Residents (no)	Bradford residents (%)
Polish	5,526	53
Slovakian	2,162	21
Latvian	985	9
Czech	642	6
Lithuanian	436	4
Romanian	253	2
Hungarian	160	2
Bulgarian	72	1
Estonian	50	0
Slovenian	20	0
Other (Serbian, Croatian, Bosnian)	132	1
Total Accession country language	10,438	100

Source: Census 2011

Ethnicity was recorded in both 2001 and 2011. White Gypsy or Irish traveller was added as a new category 2011. Table 5 below shows people who state their ethnicity as White Other or in 2011, White Gypsy or Irish Traveller. It is unlikely that a large proportion of White Gypsy or Irish Traveller is CEE as 66% of this group identified as English. The percentage of people who are White Other doubled between 2001 and 2011.

Table 5: Ethnicity in Bradford 2001 and 2011				
Ethnicity	2001		2011	
	No.	%	No.	%
All people	467,665	100	522,452	100
White Gypsy or Irish Traveller	Not asked	N/A	433	0.1
White Other White	6,878	1.5	15,715	3.0

Source: Census 2001 and 2011

Country of birth was also recorded in 2001 and 2011, and is shown in table 6 below. These data show in 2011, 2.3% of respondents were born in EU Accession countries.

Table 6. Country of Birth Bradford 2001 and 2011		
	2001 (No.)	2011 (No.)
All residents	467,665	522,452
UK born	414,992	434,966
Other EU countries	4,049	4,288
EU Accession countries (all except Croatia)	Not recorded	12,096

Source: Census 2011

6.1.4 National Insurance Registration Data

Overseas nationals who are looking for work in the UK are required to register for a National Insurance Registration Number (NINo). Table 7 below shows the number of NINo registrations in Bradford between 2002 and 13. They provide an indication of comparable population size between CEE communities, however they only count people registered to work, do not include children and do not measure people who have returned home or moved from Bradford. In addition local voluntary sector partners working with CEE communities report that it has become les easy to get a NINo, people are being turned away if they are considered not to have a prospect of getting a job, this is happening at different rates in different areas. These VCS organisations report that as a result, the grey economy of work has expanded.

Table 7. NINO registrations Bradford 2002 - 13		
NINO registrations to overseas nationals Jan 02- Dec 13	No.	%
Poland	10,051	44
Slovakia	5,983	26
Latvia	2,726	12
Czech Republic	1,832	8
Lithuania	1,087	5
Romania	417	2
Hungary	318	1
Estonia	172	1
Bulgaria	104	0
Slovenia	16	0
Croatia	6	0
Total	22,729	100

Source: DWP

Strategic Services within CBMDC provided analysis for the Neighbourhoods Team which compared NINo registrations in Bradford District between 2012 and 13. Table 8 below shows the largest percentage increase in NINo allocations between 2012 and 13 were from Romanian, Estonian, Bulgarian and Slovakian nationals. The largest numbers of new NINo registrations were from Polish and Slovakian nationals, accounting for 68% of all NINo

registrations followed by Czech, Latvian and Lithuanian NINos which accounted for a further 20%.

Table 8. Comparing NINo registrations Bradford 2012 - 13				
NINo allocations	2012	2013	Difference (No.)	Difference (% change)
Poland	770	1,112	342	44.9
Slovakia	365	670	305	83.6
Latvia	175	246	71	40.6
Czech Republic	212	215	3	1.4
Lithuania	147	134	-13	-8.8
Romania	46	125	79	171.7
Hungary	66	76	10	15.2
Estonia	12	23	11	91.7
Bulgaria	9	17	8	88.9
Slovenia	6	10	4	66.7
Croatia	0	5	5	
Total	1,808	2,633	825	45.6

Source: DWP

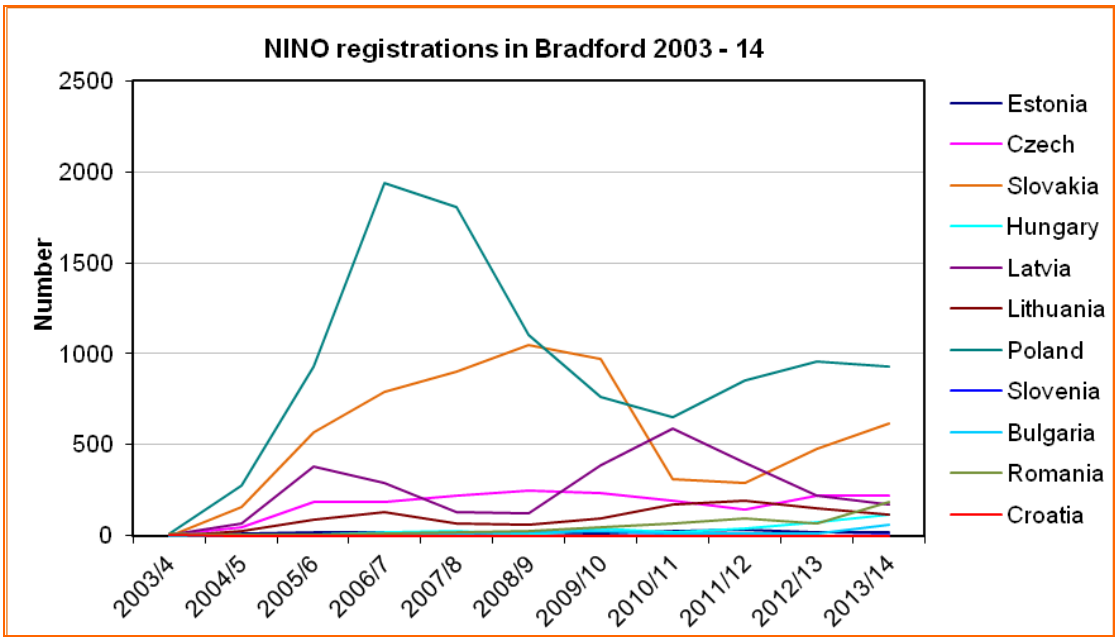
Table 9 below shows NINo registration in Bradford by country of origin over the last ten years.

Table 9. NINo registrations Bradford, by CEE country 2004 - 13											
Nationality	2003/4	2004/5	2005/6	2006/7	2007/8	2008/9	2009/10	2010/11	2011/12	2012/13	2013/14
Estonia	0	10	21	16	9	16	14	25	29	15	20
Czech	7	45	184	186	217	245	234	190	141	219	221
Slovakia	0	161	571	789	901	1046	971	310	291	480	620
Hungary	0	6	7	18	25	6	41	21	38	71	114
Latvia	5	66	378	289	133	120	390	586	398	223	173
Lithuania	0	26	91	129	70	61	96	169	194	154	114
Poland	11	273	929	1937	1807	1106	763	650	854	957	928
Slovenia	0	0	5	0	0	0	0	6	0	0	6
Bulgaria	0	6	0	0	9	20	22	12	11	13	58
Romania	13	7	5	11	17	27	46	68	98	70	182
Croatia	6	0	0	0	0	0	0	0	0	0	0
TOTAL	42	600	2191	3375	3188	2647	2577	2037	2054	2202	2436

Source: DWP

These data are plotted in figure 2 below. We can see that the group with the highest number of NINo registrations are Polish and that these peaked in 2007/8 which is when the global recession impacted on the English economy. The second highest numbers of NINo registrations were from Slovakia, these have dropped sharply in 2009/10. The nationality with the third highest number of NINo registrations are Latvians.

Figure 2. NINo registrations in Bradford by country 2003 – 14



Source: DWP

Table 10 below shows age at NINo registration. We can see the majority of registrations (n= 16,414) are from people aged 18 – 34 years. The NINo registration data also tell us that between January 2002 and December 2013, 55.6% of registrations were from males and 44.4% from females.

Table 10. Age at NINo registration 2002 - 13

Age at NINo Registration Jan 02- Dec 13	No.	%
Less than 18	244	1.1
18-24	8,758	38.5
25-34	7,656	33.6
35-44	3,361	14.8
45-54	2,200	9.7
55-59	421	1.8
60 and over	134	0.6

Source: DWP

6.1.5 Electoral roll data

The Electoral Services Unit within CBMDC provided information on the nationality of people registered to vote in Bradford District. Annually an electoral registration form is sent to all households. It is a mandatory duty to complete the form which also requires people to state their nationality. It is a legal document. People are included if they are aged 16 and above. Nationally it is thought that 10 – 15% of people who should be registered to vote aren't. It is reasonable to expect this proportion will be higher for recent

immigrants due to living in houses of multiple occupation and being more transient.

The table of data is included in appendix 5. These data are from 10th July 2014 and show that 69% of the population of Bradford (n=354,234) are registered to vote. 2% of the electorate (n= 7,063) have their nationality recorded as CEE. Four wards are home to 42% (2,948) of registered CEEs. The wards with the highest percentages of CEEs registered are City, 8.6% (n= 1,067), Little Horton, 6.9% (n=810), Manningham 5.1% (n=590) and Bowling and Barkerend, 3.8% (n=481).

69% of the CEE population registered to vote are Polish (3,145) or Slovakian (1,699). The next largest groups are Latvian (818) and Czech (561). There are different patterns to the wards Polish and Slovakian electorate live in. Table 11 below shows wards where more than 100 Polish or Slovakians are registered to vote.

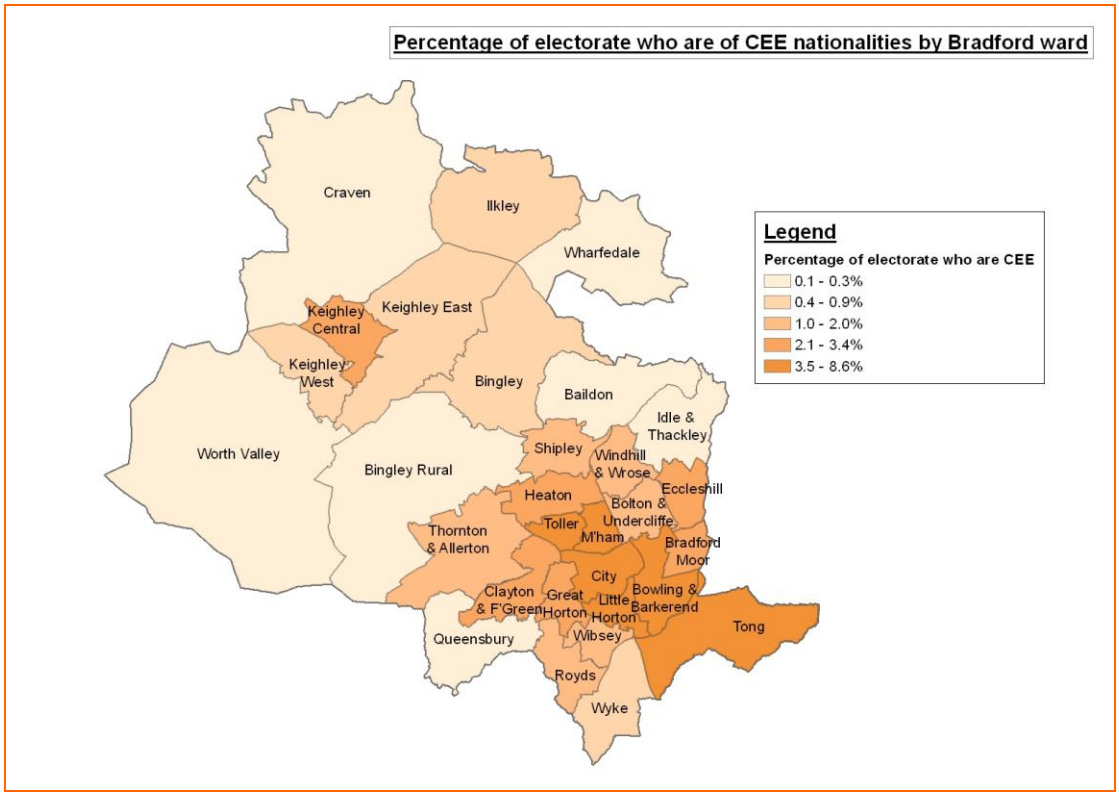
Table 11. Wards where more than 100 Polish or Slovakians are registered to vote

Ward	Polish	Slovakian
City	378	164
Little Horton	351	233
Manningham	217	217
Bowling and Barkerend	211	108
Heaton	87	233
Toller	133	222
Tong	275	33
Windhill and Wrose	110	0
Royds	133	7
Keighly Central	86	123
Great Horton	38	137
Eccleshill	209	26
Clayton and Fairweather Green	103	66

Source: CBMDC Electoral Department

Figure 3 below, shows the % of electorate who are CEE in Bradford by Ward.

Figure 3. Percentage of Electorate who are CEE by Ward



6.1.6 Schools registration data

Data from the Education Service for Travellers and New Communities are categorised slightly differently to the definition used in this needs assessment. The Education Service includes the CEE countries this needs assessment focuses on and also includes Russian as some Latvian and Lithuanian children speak Russian at home.

The schools admissions data shows that on 5th June 2014 there were 3,050 children and young people aged between 3 and 18 years, whose families are originally from Central and Eastern Europe, on roll in Bradford District schools. This equates to 3.16% of the total school population which currently stands at 96,322.

When school application forms or entry paperwork is completed, “Gypsy Roma” is one of the ethnic category parents or young people can ascribe to. 1,154 (37.8%) of these children and young people self-ascribed to being of Gypsy Roma ethnicity. The Education Service believes this is an underestimate due to racism experienced in countries of origin. The professional judgement of the Education Service is that this does not accurately reflect the size of the Roma community. Using their experience of day to day contact with families; which includes informal disclosure of ethnicity, the Education Service’s estimate is that approximately 90 - 95% of

Slovak, Czech, Romanian and Hungarian speaking families are of Roma origin. There are also Roma families included amongst Polish speaking migrants, estimated as between 5 and 10%.

Figures for children from CEE countries in Bradford schools are available from 2003; however these are not available by language spoken, ethnicity or nationality of parents. The data for 2013/14 is available by language spoken. Table 12 below shows how many CEE children were on roll each year from 2003.

Table 12. CEE children on roll in Bradford schools 2003 - 14	
Academic year	Number of CEE children on roll
2003 – 4	70
2004 – 5	190
2005 - 6	491
2006 – 7	534
2007 – 8	810
2008 – 9	1,200
2009 – 10	1,459
2010 - 11	1,808
2011 - 12	2,249
2012 - 13	2,687
2013 – 14 (on 5th June)	3,050

Source: Education Service for New Communities and Travellers, Children's Services, CBMDC

There has been an increase in CEE children on roll, in the last 10 years numbers have increased by over 4,257% from 70 to 3,050.

Table 13 below shows numbers of children by language spoken at home on roll in Bradford District schools in the current year. The majority of children (81%, n=2,835) children speak Polish, Slovakian or Czech at home.

Table 13. School children's CEE language spoken at home 2014	
First language of CEE Children on roll in Bradford District schools, Jan 2014	%
Bulgarian	0.0
Croatian	0.0
Czech	11.2
Estonian	0.0
Hungarian	6.4
Latvian	4.8
Lithuanian	1.9
Polish	30.0
Romanian	1.2
Russian	3.5
Slovak	40.4
Slovenian	0.6

Source: Education Service for New Communities and Travellers, Children's Services, CBMDC

Table 14 below shows the total number of children in Bradford in school by school year, the number of CEE and what percentage this represents. These data are from July 2014.

Table 14. Percentage and number of CEE children per school year 2014

School year	Total no on roll	Number CEE children on roll	% CEE children on roll
-2	1208	16	1.0
-1	5928	60	1.0
Reception	7911	165	2.0
1	7982	234	2.9
2	7739	289	3.7
3	7706	300	3.9
4	7421	298	4.0
5	7139	179	2.5
6	7014	239	3.2
7	6200	189	3.0
8	6012	213	3.5
9	6029	237	3.9
10	6036	242	4.0
11	5854	198	3.4
12	3581	69	1.9
13	2499	39	1.6
Total	96,259	3067	3.2

Source: Education Service for New Communities and Travellers, Children's Services, CBMDC

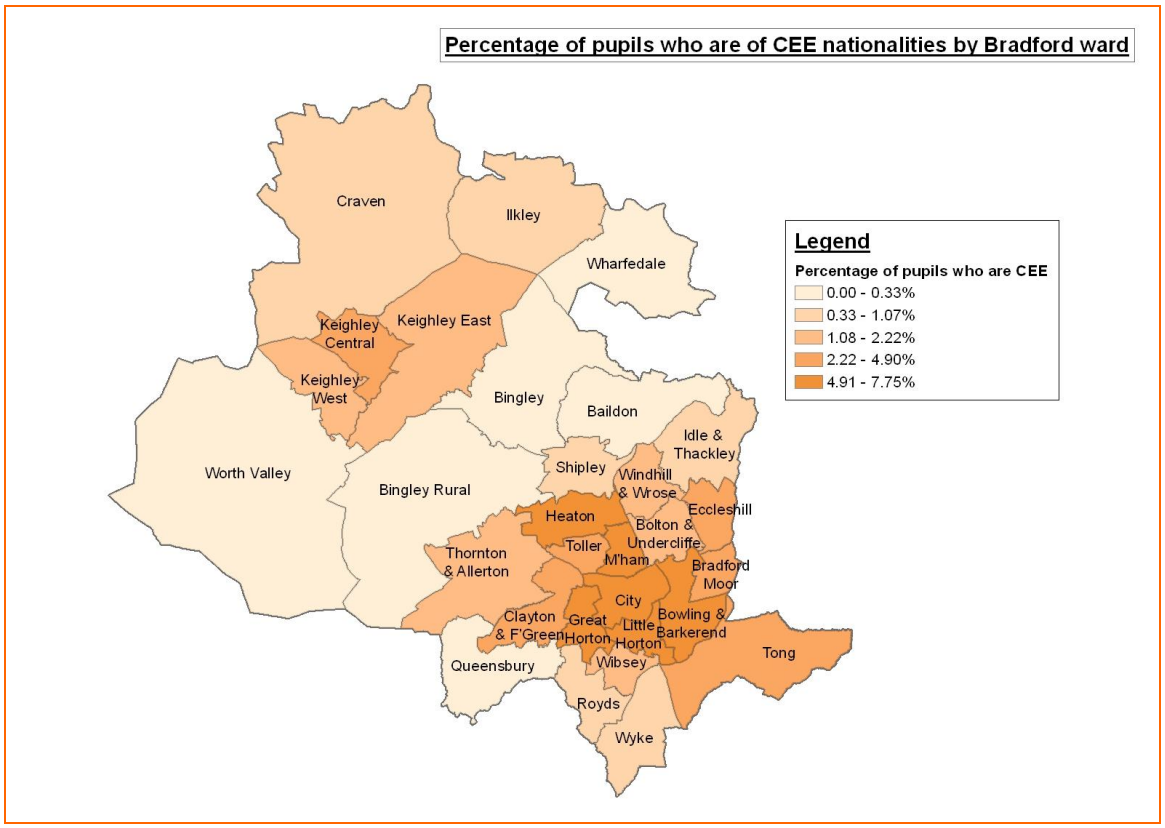
Data are available to describe the number and percentage of CEE school pupils by ward. These are listed in table 15 below. Additional columns have been added, to include the number of CEE over 16s in the electoral register for that ward, which are added with the pupil numbers to provide an estimate of CEE population size per ward. This will be an undercount due to issues with the electoral ward data described in section 6.1.5.

Table 15: Schools data combined with electoral register data showing numbers and percentage of CEE population by ward					
Ward	No of CEE	% CEE pupils	No CEE on electoral register	% of CEE Electorate	Total CEE population by ward
Baildon	Less than 5	-	36	0.3	36
Bingley	5	0.20	79	0.6	84
Bingley Rural	8	0.33	32	0.2	40
Bolton and Undercliffe	36	1.10	114	1.0	150
Bowling and Barkerend	283	5.57	481	3.8	764
Bradford Moor	182	3.49	255	2.1	437
City	309	7.75	1067	8.6	1376
Clayton and Fairweather Green	104	3.08	287	2.5	391
Craven	6	0.52	42	0.3	48
Eccleshill	90	2.54	289	2.4	379
Great Horton	280	6.58	315	2.8	595
Heaton	235	5.72	373	3.4	608
Idle and Thackley	10	0.53	43	0.3	53
Ilkley	7	0.37	54	0.5	61
Keighley Central	127	3.05	274	2.3	444
Keighley East	31	1.09	76	0.6	107
Keighley West	36	1.26	95	0.8	131
Little Horton	391	6.83	810	6.9	1201
Manningham	261	4.94	590	5.1	851
Queensbury	7	0.29	35	0.3	42
Royds	33	1.07	198	1.6	231
Shipley	21	0.94	121	1.1	142
Thornton and Allerton	63	1.95	130	1.1	193
Toller	256	4.90	487	4.0	743
Tong	147	3.64	410	3.5	587
Wharfedale	Less than 5	-	29	0.3	29
Wibsey	58	2.22	129	1.2	187
Windhill and Wrose	33	1.23	142	1.3	175
Worth Valley	Less than 5	-	12	0.1	12
Wyke	19	1.04	58	0.6	77

Source: CBMCD Children's Services and Electoral Department

Figure 4 below shows % CEE school children by ward In Bradford District

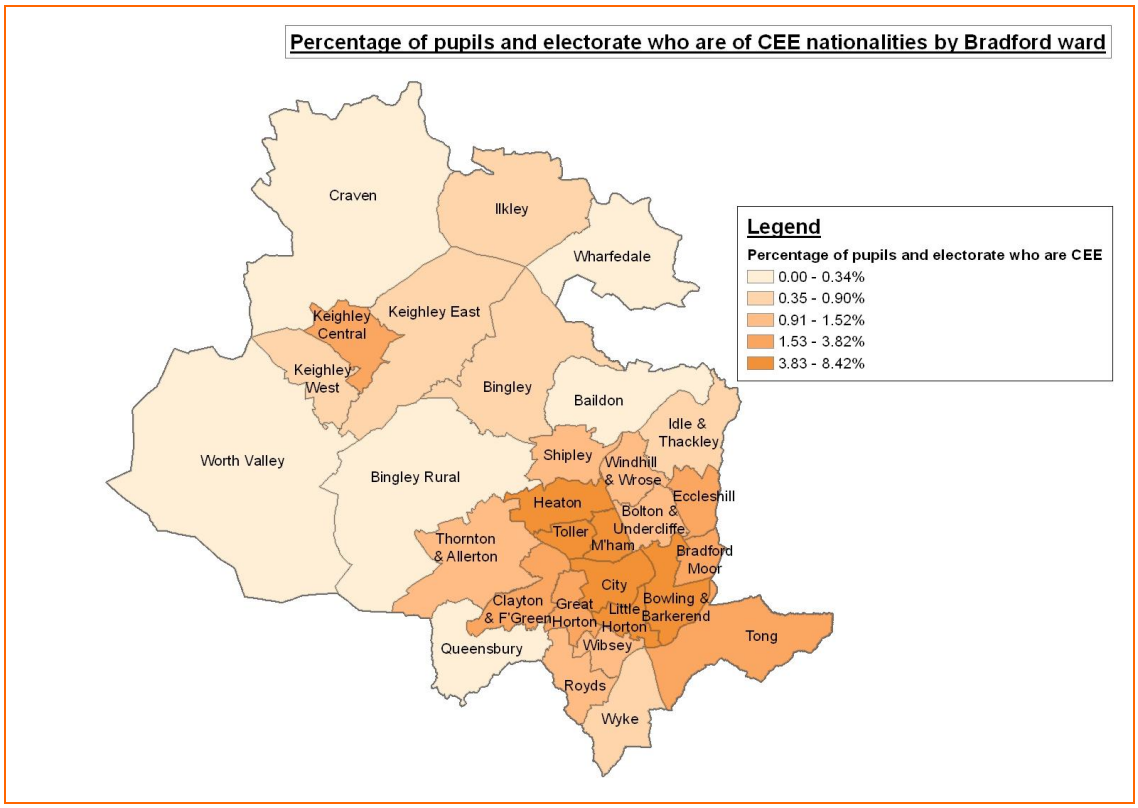
Figure 4. Percentage of CEE school children in Bradford by Ward 2014



Source: Source: Education Service for New Communities and Travellers, Children's Services, CBMDC

Figure 5 below combines the electoral and schools data and shows % of school children and registered electorate together

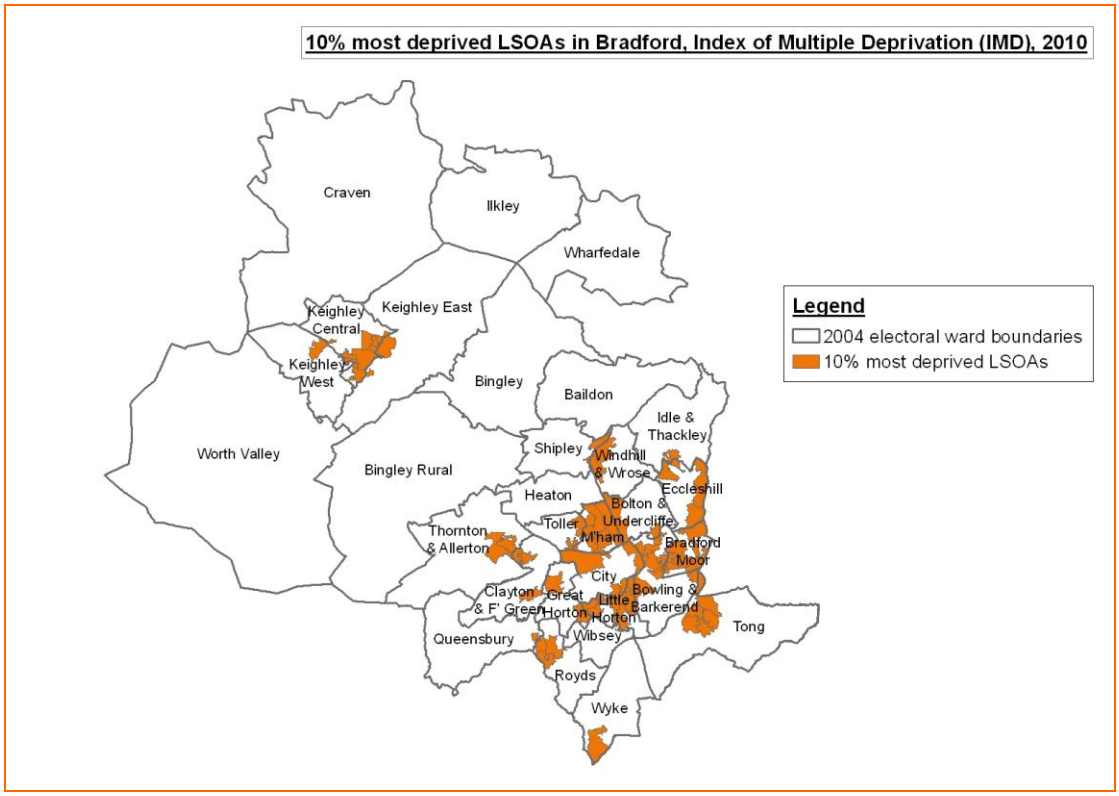
Figure 5. Percentage of electorate and school children who are CEE by Ward in Bradford, 2014.



Source: CBMCD Children's Services and Electoral Department

Figure 6 below shows the areas (LSOA) in Bradford where the poorest communities live, the 10% most deprived communities in Bradford.

Figure 6. The 10% most deprived Lower Super Output Areas in Bradford



Source: IMD, 2010

6.1.7 Births to CEE mothers

The Office for National Statistics collates data on births in England by the country of birth of mothers. These data are collated using the category "New EU" which includes the countries this needs assessment is focusing on as well as Malta and Cyprus. Table 16 below shows numbers of live births in Bradford to mothers born in the New EU from 2001 – 11.

Table 16. Numbers of births in Bradford District born to mothers born in the New EU 201 - 11

Year	Total births (No.)	Births (No.) to new EU mothers	% births to new EU mothers
2001	7,205	13	Less than 1
2002	7,302	15	Less than 1
2003	7,495	24	Less than 1
2004	7,686	34	Less than 1
2005	8,104	123	1.5
2006	8,153	174	2.1
2007	8,288	317	3.8
2008	8,580	300	3.5
2009	8,603	327	3.8
2010	8,627	380	4.4
2011	8,301	409	4.9

Source: ONS

These data show that until 2005, the numbers of births in Bradford to New EU mothers were very small. This increased significantly in 2004 (1.5% of all Bradford births) and has increased year on year, representing 4.9% of Bradford births in 2011.

6.1.8 Jobseekers Allowance Claimants

Table 17 below shows the total number of JSA claimants in Bradford, and the number of White Other JSA claimants over the last ten years as a number and percentage. The number is a count of people receiving JSA in November each year. These data show that the total number of people claiming JSA started to rise in 2007 and has been decreasing since 2012; however the number and proportion of White Other claimants was low until 2010 and has risen significantly since 2010 – 2013.

Table 17. Total and White Other JSA Claimants in Bradford 2003 - 13

Year	All JSA recipients (no.)	White Other recipients (no.)	White Other recipients (%)
2003	8,630	60	1
2004	7,380	50	1
2005	8,640	70	1
2006	9,380	80	1
2007	8,350	80	1
2008	10,930	100	1
2009	14,980	160	1
2010	14,950	150	1

2011	18,280	480	3
2012	19,470	740	4
2013	16,810	970	6

Source: DWP

Table 18 below shows the total number of people and number and percentage of White Other people Bradford District who were claiming JSA and have been sanctioned, i.e. no longer able to claim JSA. These data are for original adverse decisions. The DWP list the main reasons for sanctioning as failure to actively look for work, failure to attend employment training opportunities and failure to attend meetings at a job centre.

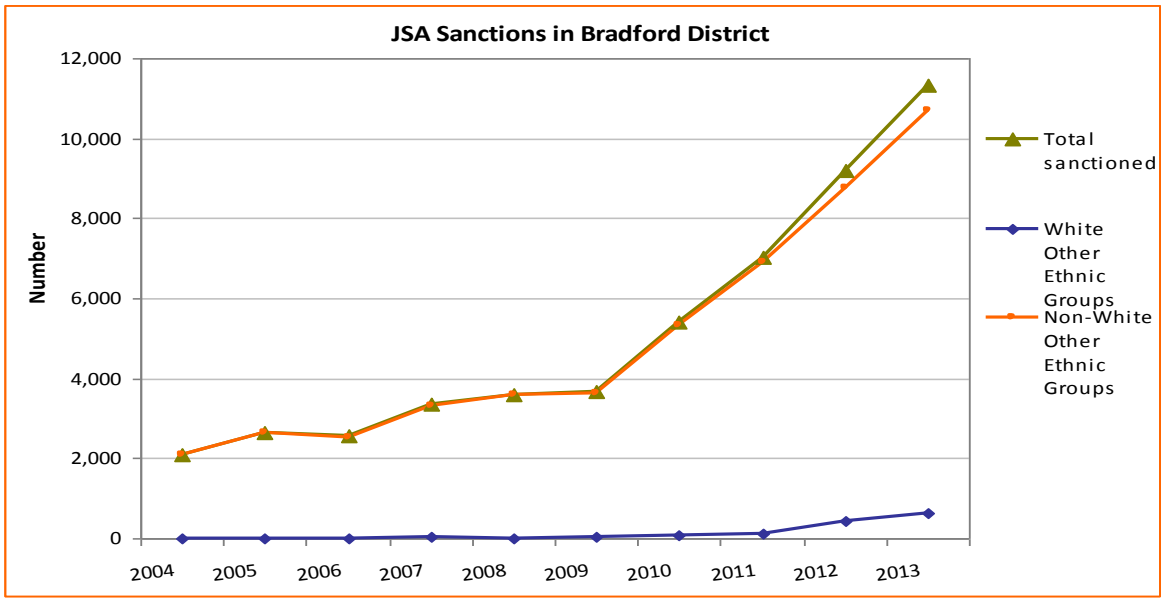
Table 18. Total and White Other JSA sanctions Bradford 2004 - 13

Year	No of all claimants sanctioned	White other claimants sanctioned (no.)	White other claimants sanctioned %
2004	2,076	0	0
2005	2,649	6	0
2006	2,548	6	0
2007	3,349	35	1
2008	3,604	12	0
2009	3,676	36	1
2010	5,398	77	1
2011	7,029	108	2
2012	9,202	443	5
2013	11,315	629	6

Source: DWP

These data are presented in figure 7 below. The data show that between 2010 and 2013, adverse sanction decisions have increased by 84% for White Other claimants and 50% for non White Other claimants. This supports local anecdotal evidence that claimants from CEE countries have been disproportionately sanctioned. Between 14th April and 8th October 2014, 483 CEE families have become no longer eligible to claim Housing Benefit, this is due to being sanctioned for JSA and therefore are no longer receiving any welfare payments (Source: Revenues and Benefits Department, CBMDC).

Figure 7. Total and White Other JSA Sanctions in Bradford 2004 - 13



Source: DWP

Based on these figures, it is estimated the CEE population in Bradford District is at least 12,000. This is made up of 3,050 school children, 409 live births (2011), 7,063 people in the electoral roll, plus 15% (1,059) as we know the electoral roll does not include 10 – 15% of the population. This is an underestimate as it does not count CEE migrants who are undocumented, have been trafficked, are not in school, were born since 2011, or are not on the electoral register (likely to be more than 15% in the CEE community). It is estimated that over half of this number are Roma. It is useful to have population estimates, more important however is the data measuring changes which require responses to for example the hundreds of CEE people who since April 2014 no longer have recourse to public funds.

6.2 Health status

The health status of the CEE community in Bradford is unknown. However data are available from the World Health Organisation (WHO) which compare core health indicators between EU countries (2013). These data should be interpreted with caution, taking into account the impact of the healthy migrant effect coupled with the deterioration of health migrants generally face when they are in the UK.

Table 19 below shows indicators (2011) for countries of origin and the UK as a comparator for:

- Percentage of men and women aged 15 and over who smoke
- Litres of pure alcohol equivalent per year consumed by people aged 15 and over
- TB incidence per 100,000 population
- Newly diagnosed HIV cases per 100,000 population
- Estimated life expectancy at birth (years)
- Estimated infant mortality rate per 1,000 births and
- Age standardised death rates for circulatory system

Table 19. Health indicators for CEE countries								
Country	Smoke ♂ %	Smoke ♀ %	Alcohol	TB	HIV	Life expectancy	Infant mortality	Death rates circulatory disease
UK	22	22	10.7	12.6	10	80	4	164
Czech	40	32	15	5	2	78	3	325
Estonia	43	21	13	22	27	76	3	369
Hungary	35	27	12	13	2	75	5	401
Latvia	46	20	13	42	2	74	8	471
Lithuania	43	25	13	54	15	74	4	495
Poland	38	27	10	21	5	76	4	318
Slovakia	39	19	11	6	3	76	6	440
Slovenia	28	21	12	9	1	80	3	218
Bulgaria	48	31	10	30	3	74	11	592
Romania	38	18	13	79	2	74	11	540
Croatia	36	30	10	14	2	74	4	342

Source: WHO 2013

6.2.1 Smoking

These data show that the percentage of men who smoke is higher in all Accession countries than in the UK. The percentage of women smoking is higher than in the UK in all but 4 of the Accession countries. Bulgaria has the highest percentage of male smokers (48%) and the Czech Republic has the highest proportion of female smokers (32%).

6.2.2 Alcohol consumption

Alcohol consumption is higher than the UK in 8 of the 11 Accession countries. Poland, Bulgaria and Croatia show lower drinking levels and the Czech Republic shows the highest at 15 litres of pure alcohol equivalent per year consumed by people aged 15 and over.

6.2.3 Tuberculosis Incidence

Tuberculosis (TB) Incidence is lower than in the UK in 3 of the 11 Accession countries (Slovakia, Slovenia and the Czech Republic). TB incidence is highest in Romania (79.2 per 100,000) Lithuania (54.2 per 100,000) and Bulgaria (29.6 per 100,000). It is important to note these figures are for incidence (new cases) not prevalence (all cases with TB) and may not be an accurate marker of TB incidence as a high incidence rate may reflect high diagnosis rates rather than high prevalence rates.

The TB Europe Coalition published a paper in 2013 describing multi-drug resistant tuberculosis (MDR TB). MDR TB is a form of TB that does not respond to the standard treatment of first-line drugs. It emerges as a result of poor adherence to accepted TB control practices, including inadequate treatment of tuberculosis, patients interrupting their treatment and lack of drugs. MDR TB is much more costly and difficult to treat than TB. Currently, the treatment of MDR TB takes up to 24 months with the use of second-line drugs, which cause major side effects, from vomiting and headaches to

blindness, deafness, and depression. The cost of these drugs is on average 50 to 200 times higher than the cost of first line drugs.

Although TB rates have been steadily decreasing in the European region, MDR TB remains a major public health concern in several countries within the European Union. WHO reported an estimated 74,000 cases of multi-drug resistant TB in the European Region in 2012, which accounts for almost a quarter of the global burden. Fifteen of the 27 MDR TB high-burden countries worldwide are located in Europe and include Romania, Bulgaria, Estonia, Lithuania and Latvia. Eastern Europe and Central Asia (EECA) have the world's highest rates of new TB patients with MDR TB, with 20% of new cases having MDR TB.

Accessing healthcare can be a special challenge for migrants. A recent study identified several issues that limit cross-border TB control and care, varying from the limited access to early TB diagnosis to the lack of continuity of care and information during migration and the availability of, and access to, health services in the new country.

Moreover, the fear of discrimination and of deportation because of TB may result in hiding symptoms and delay in diagnosis, commencement of self-treatment or even the interruption or discontinuation of treatment, which can eventually lead to development of MDR TB.

At the same time, across Europe, individuals affected with TB are increasingly moving from one country to another to access healthcare. There are a variety of reasons to explain this phenomenon, including the need to access treatments that are not available in the country of origin, better quality of treatment in a foreign country, lower cost of healthcare and/or long waiting times to access certain services in the country of origin. Medical tourism is also an important factor when it comes to MDR TB. Romania, for instance, has one of the lowest rates of MDR TB treatment success in the world: 20%. This is due to a number of different reasons, including that certain second-line drugs are not available in the country. A growing number of MDR TB patients from the region, who cannot access MDR TB treatment in their countries of origin, therefore search for treatment in other countries of the EU (TB Europe Coalition, 2013).

6.2.4 Newly diagnosed HIV cases per 100,000

Nine of the Accession countries have a lower rate of newly diagnosed HIV cases than the UK. The UK has 10 newly diagnosed HIV cases per 100,000, the 9 countries with a lower rate range from 0.9 – 5.2, with an average of 2.29 newly diagnosed cases per 100,000. The two countries with higher rates are Estonia (27.3) and Lithuania (14.5). Again these figures are for incidence rather than prevalence.

6.2.5 Estimated life expectancy

Estimated life expectancy is lower than in the UK for all CEE countries apart from Slovenia which has the same life expectancy as the UK of 80 years.

However, the range of life expectancy, 74 – 80 years, is smaller than the difference between the most and least deprived communities within the UK.

6.2.6 Infant Mortality

Estimated infant mortality is lower than the UK in 4 of the 11 Accession countries (Czech Republic, Estonia, Hungary and Slovenia), the same in 2 (Lithuania and Poland) and higher in 5 countries. The highest estimated infant mortality rates are in Bulgaria and Romania where it is estimated 11 children per 1,000 live births will die before their first birthday.

6.2.7 Deaths rates for circulatory disease

The age standardised death rate is the number of deaths, usually expressed per 100,000, that would occur in that area if it had the same age structure as the standard population and the local age-specific rates of the area applied. Age standardised death rates per 100,000 population for circulatory disease are higher than the UK for all 11 Accession countries. In the UK the rate is 164 CVD deaths each year per 100,000 population. The highest rates in Accession countries are Bulgaria (495), Romania (540), Lithuania (495) and Latvia (471).

6.2.8 Local data on communicable diseases

There is a legal duty for all health professionals to notify specific communicable diseases to Public Health England (PHE). PHE is responsible for public health management and surveillance of these infections. The surveillance system comprises of a national Notification of Infections Diseases (NOIDs) database and a local case management system called HPZone. A query was run to search for cases in Bradford for people whose country of birth was one of the 11 Accession countries the needs assessment covers.

Between 2010 to date, only 190 cases of notifiable diseases were recorded for Bradford District among this population. This is likely to be an underestimate because it only captures diseases where medical attention has been sought and then where the medical professional has notified PHE. This population group may not always be registered with a GP.

The diseases recorded for each county are not unusual when compared to diseases recorded for the broader Bradford District population. For each disease less than 10 cases were recorded for any single country. The only exception were 22 chronic Hepatitis B cases recorded for people from Poland and 43 chronic Hepatitis B cases recorded for people from Slovakia.

Hepatitis B is a virus affecting the liver, which can cause scarring of the liver, liver failure and liver cancer. It is spread by infected blood and other bodily fluids such as semen, vaginal secretions, saliva, open sores and breast milk. In most cases, Hepatitis B causes limited infection. It is possible for infected patients to fight off the infection successfully within a few months, developing an immunity that lasts a lifetime. However, some patients don't clear the infection and the disease becomes chronic.

The data were examined again to see what proportion of cases from other countries were due to chronic Hepatitis B infections. These are shown in the table 20 below.

Table 20. Chronic Hepatitis B cases in Bradford District notified to PHE 2010 – July 2014

Country	Total notifications no.	Chronic Hep B cases no.	% notifications which are Hep B
Czech	7	<5	28.6
Estonia	0	0	0
Hungary	0	0	0
Latvia	17	8	47.1
Lithuania	12	5	41.7
Poland	69	22	31.9
Slovakia	61	43	70.5
Slovenia	0	0	0
Bulgaria	5	<5	20.0
Romania	15	7	46.7
Croatia	0	0	0
Total	186	160	

Source: Public Health England, West Yorkshire Health Protection Team

The data above show between 2010 and July 2014 there were 160 cases of chronic Hepatitis B infection notified to PHE from Bradford residents who had migrated from CEE countries, with the highest proportion from Slovakia. There is no denominator available which matches these data precisely. The closest information has been published in the West Yorkshire Annual Hepatitis Report (PHE, 2014) which shows in Bradford District, between 2010 and 2012 there were 299 notifications of acute and chronic Hepatitis B. It is likely that CEE communities are overrepresented in terms of Hepatitis B prevalence but we do not have the data to definitively conclude this. The PHE report states that where ethnicity is recorded, 13% of chronic Hepatitis B cases were coded as White Other (PHE, 2014).

In Sheffield, a GP practice with a high number of Slovak-Roma patients set up a targeted nurse led clinic. Screening for Hepatitis B was made routine. The practice found that 9.4% of Slovak-Roma patients had a current Hepatitis B infection and 28% had previously been infected but had cleared the infection. They also found that the mean average number of household contacts was 7 (range 1 – 21). In response they have set up a targeted Hepatitis B vaccination programme (Gregory et al, 2014).

In terms of demographics. PHE report more men that women have Hepatitis. HPZone data shows that 17% of acute cases were women but 43% of chronic cases were women. This may reflect increased opportunity for diagnosing women with no symptoms who have been tested in pregnancy. The peak age for positive Hepatitis B tests was in the 25 to 34 year age group (PHE, 2014).

In terms of communicable diseases other than Hepatitis, there is no accurate data source which describes the prevalence of communicable disease

amongst CEE migrants. Recently the CBMDC Public Health Team undertook a project to ascertain the need of CEE migrants living in Bradford with both HIV and TB who were also injecting drug users. The group found that:

- MESMAC are supporting 6 HIV positive men who live in Bradford from CEE countries, none with TB.
- The VCS in Bradford are aware of 3 CEE migrants who have TB and live in Bradford. They report that there is a fear of TB amongst CEE migrants of both the disease and stigma of having the disease. In some countries of origin TB patients were taken to sanatoriums.
- In the last 7 years there have been 15 TB cases amongst CEE migrants, none of whom were known to be HIV positive, cared for by the Bradford District Care Trust.
- There are 13 known HIV positive CEE IV drug users in contact with GUM services in Bradford District.

The group concluded that there may be undiagnosed cases of TB in Bradford District, but this snapshot does not highlight an immediate need which requires a response. It was noted that WHO data (2013) show that Latvia, Lithuania and Romania have a TB prevalence higher than 40 cases per 100,000 population and therefore in the UK children from these families would be eligible for BCG vaccination. It was also noted that Romania, Bulgaria, Estonia, Lithuania and Latvia are considered MDR-TB high burden countries, meaning approximately 20% of new TB cases have MDR TB (2013, TB Europe Coalition).

6.2.9 Lifestyles and perspectives of CEE children and young people

A survey was commissioned by the three Bradford District CCGs to understand the lifestyles and perceptions of children from primary and secondary schools in Bradford District. It was conducted during 2012 – 13. All schools were invited to take part in the survey, each participating school was asked to sample all children in year four and at least one hundred young people from years seven and ten (ages 8-9, 11-12 and 14-15 years respectively). 111 primary schools and 21 secondary schools took part and 9,372 valid completed questionnaires were returned. In terms of ethnicity / nationality, 2.43% of respondents (n= 228) self identified as being Gypsy Roma, Czech, Latvian, Lithuanian, Polish, Slovak or Other White Eastern European. 1.7% of respondents didn't want to say what ethnicity they were, 10% didn't respond to the ethnicity question.

Key findings have been analysed by the CBMDC Public Health Analysts Team and are listed in table 21 below:

Table 21. Key findings from the Bradford Young Peoples Lifestyle Survey 2013

	All pupils (%)	CEE pupils (%)	CEE
Have a disability or long standing illness	10.7	8.8	↓
Have a special educational need	8.7	14.6	↑
Live with both mother and father	70.2	59.9	↓
Have three meals a day	81.7	80.2	↓
Have never been to the dentist	4.6	21.6	↑

Problems finding an NHS dentist (year 7)	3.2	5.0	↑
Problems finding an NHS dentist (year 10	6.7	15.2	↑
Have never smoked cigarettes	88.1	85.4	↓
I smoke and would like to give it up	1.5	2.0	↑
I smoke and do not want to give it up	1.44	2.02	↑
My parents / carers smoke	44.7	68.9	↑
I have ever drunk alcohol	22.8	16.9	↓
I worry a lot about:			
School work (year 7)	4.9	4.0	↓
School work (year 10)	11.2	8.1	↓
Exams and tests (year 7)	14.4	12.2	↓
Exams and tests (year 10)	28.2	8.1	↓
Money problems (year 7)	3.5	2.0	↓
Money problems (year 10)	6.5	2.7	↓
Bullying (year 7)	7.7	6.1	↓
Bullying (year 10)	6.1	2.7	↓
Health (year 7)	9.5	10.2	↑
Health (year 10)	12.3	13.5	↑
Problems with friends (years 7 and10)	0	0	↔
Family problems (year 7)	11.0	8.0	↓
Family problems (year 10)	13.0	8.0	↓
The way you look (year 7)	8.6	2.0	↓
They way you look (year 10)	14.1	16.2	↑
Relationships (year 7)	4.0	2.0	↓
Relationships (year 10)	8.4	10.8	↑
Sexually transmitted infections (year 7 and 10)	0	0	↔
Drugs (year 7)	4.0	2.0	↓
Drugs (year 10)	3.3	0	↓
The environment (year 7)	4.1	4.0	↔
The environment (year 10)	3.3	0	↓
War and terrorists (year 7)	6.7	2.0	↓
War and terrorists (year 10)	87.6	2.7	↓
Crime (year 7)	7.0	2.0	↓
Crime (year 10)	6.7	5.4	↓
Gambling (year 7)	3.3	2.0	↓
Gambling (year 10)	3.0	0	↓
I have been bullied in the last 12 months (year 7)	22.6	14.6	↓
I have been bullied in the last 12 months (year 10)	17.2	9.2	↓
I am living in temporary or emergency accommodation	1.6	11.1	↑
Plans for year 10 pupils:			
Continue in full time education	61.4	54.1	↓
Find a job as soon as you can	37.7	21.6	↓
Take up an apprenticeship	18.9	13.5	↓
Stay in the neighbourhood where you live	24.1	18.9	↓
Start a family	13.0	21.6	↑

Source; CBMDC Public Health Department

Table 21 provides data to build a picture of the lifestyles and perceptions of CEE young people in Bradford District schools compared to the whole school population. Conclusions are made with the caveat that these are responses from 228 children who identify as CEE or Gypsy/Roma, compared to the whole CEE school population of 3,050 pupils, i.e. these responses represent 7.5% of the CEE school population.

When compared to all pupils, there are a higher proportion of CEE pupils:

- Living in temporary accommodation
- With Special Educational Needs
- Have parents or carers who smoke
- Who want to give up smoking
- Who have never been to a dentist
- Have had problems finding a dentist
- Who plan to start a family

When compared to al pupils, there is a lower proportion of CEE pupils:

- In all categories of worrying apart from about health
- Who plan to continue education, find a job or become and apprentice.

6.3 Services

This section describes services available to Bradford District's CEE communities and where possible. information about service usage, lack of usage or emerging issues.

Data provided from Enable2, the interpreting and translation agency used by health and social care services in Bradford illustrate the changing patterns of translation needs over the last four years. Enable2 are or have been commissioned to provide interpreting services by a broad range of health and social care organisations including Bradford District Care Trust (TCS services), the NHS Commissioning Board, the CCG Collaborative, Bradford City CCG, Bradford District CCG, Airedale Wharfedale and Craven CCG, Airedale NHS Foundation Trust Transferring Community Services, Bradford Teaching Hospitals Foundation Trust (TCS services), NHS Bradford and Airedale and Bradford Council.

Requests by language have changed over recent years. Table 22 below shows the number of requests by language made to Enable2 for the top five most frequently requested languages.

Table 22. Number of translation requests to Enable2 2011 - 14

Year	Language	Number of requests
2014 to June	Slovakian	3305
	Urdu	2923
	Polish	1715
	Punjabi	1099
	Bengali	889
2013	Slovakian	4702
	Urdu	4345

	Polish	2899
	Punjabi	2567
	Bengali	1194
2012	Slovakian	3315
	Urdu	3151
	Punjabi	2710
	Polish	2081
	Bengali	1039
2011 Oct - Dec	Urdu	824
	Punjabi	751
	Slovakian	664
	Polish	441
	Bengali	268

Source: Enable2

These data show that since 2012 Slovakian has been the most commonly requested language and since 2013 Polish has been the third most commonly requested language. Requests are made to support people with other CEE languages. Between January and end of June 2014 there have been requests made for language support in Czech (514), Hungarian (357), Latvian (144), Lithuanian (101) and Romanian (71).

As previously stated, All EEA nationals are eligible for health services. Data are available for some of these services described below.

6.3.1 Primary care

It is possible to ascertain the number of individuals that register with a GP in England whose previous address was outside of the UK and who have spent more than three months aboard. These are known as Flag 4 Records. In theory because all migrants are allowed to register with the local GP this Flag 4 data should be accurate. However there is no indication of the delay between arrival and registration, there is no information on patients who have left the UK, some migrants may not register with a GP, the flag 4 code is not retained once a patient moves GP and information on nationality and country of birth is not systematically recorded. In Bradford data are available from 2001 – 2010 and shown in table 23 below.

Table 23: New Flag 4 GP registrations in Bradford 2001 - 10

Year	New flag 4 registrations (No.)	Rate per 1,000 resident population
2001	4,728	10
2002	4,839	10
2003	4,376	9
2004	4,848	10
2005	5,955	12
2006	5,918	12
2007	7,435	15
2008	7,899	16
2009	6,918	14
2010	6,595	13

2011	6,598	13
2012	6,135	12

Source: Patient Register Data Service, held by NHS Connecting for Health

These data show that in 2005 (the year following Accession of the A8 countries) the number and rate of Flag 4 Records increased. This is however simply an observed association as the data are not detailed enough to draw any firm conclusions and include GP registrations of all migrant groups.

Ethnicity is recorded by individual GP practices. Only 0.9% of patients registered with GPs in Bradford District do not have their ethnicity recorded. Table 24 below shows that 16,014 patients (2.9% of all patients) registered are CEE or White Other. A table listing percentage CEE registered at each practice is included in appendix vii.

Table 24. CEE patients registered with a GP 2012

Ethnicity	Total	%
Other White background	10,381	1.9%
Gypsy/Romany	113	0.0%
Polish	2,895	0.5%
Baltic Estonian/Latvian/Lithuanian	875	0.2%
Croatian	8	0.0%
Other mixed White	55	0.0%
Other White European/European unspecified /Mixed European 2001 Census	1,397	0.3%
Other White or White unspecified ethnic category	290	0.1%
Total	16,014	2.9%

Source: SystmOne, April 2012

6.3.2 Emergency Care

A report was published in January 2014, which investigated how people in Bradford District access urgent care (Ipsos Mori, 2014). The report was commissioned by the CCGs because of a concern that patients were accessing care to meet urgent care needs from services that may not be best suited to their needs and the resulting pressure this places on the health care system. The researchers wanted to understand how Bradford District residents made decisions about where to access urgent care services. As part of the research, focus groups were undertaken in a walk in centre, GP out of hours clinic and Emergency Department. There was a specific focus on marginalised groups and communities of interest, of which CEE and in particular Roma were one. The researchers accessed Roma people to interview through LACO, Thornbury House and The Eastern European Workers Group. In total 35 Roma people were involved in focus groups. The researchers concluded that the desire for quick reassurance and treatment resulted in services not being accessed as intended. The authors recommend greater flexibility of GP appointments, more community based services, education on how to use the 111 service and tailoring services to the needs of minority groups. There were three recommendations for tailoring urgent care

to minority groups (which include Roma but also other groups including people with mental health problems, homeless people, and drug users). These are:

- Urgent care works best when delivered in a setting people are comfortable and familiar with.
- Groups need more information to understand what services are available.
- There is a need to make links with community groups or organisations close to minority groups in order for this to happen.

The School Nursing Service has a project which aims to identify children who are not attending school. They monitor attendances at Emergency Departments for all children. Between September 2012 and June 2014, the School Nursing Service reported there were 72 children identified as Eastern European attending who were not attending school in Bradford. Of these:

- 45 children (62.5%) were allocated schools.
- 3 (4%) were attending school outside of the area.
- 3 (4%) have since left the country.
- 13 (18%) are still on the case load of the Educational Social Worker, awaiting allocation of a school place.
- For 8 (11%) the case has been closed, for one as they are no longer school age, and for 7 (10%) as the school nurses have exhausted all lines of enquiry and are unable to locate the child.

It was not possible to access data for all children in Bradford District identified as not attending school in order to determine wether CEE children were over-represented.

6.3.3 Vaccinations and immunisations

It was not possible for the NHS England or the Bradford Child Health Information System to provide data on vaccination coverage to children of CEE migrants within the needs assessment timescale and capacity of their team. These data are not routinely recorded and many children of migrants may have been vaccinated in their country of origin. It is thought that vaccination coverage may be lower if access to primary care is worse in comparison to more established communities however the data are not available to test this hypothesis.

The CEELS project in Bradford report that that GP practices raise concerns about low uptake of vaccination amongst CEE communities. They confirm that newly arrived migrants often have patchy or incomplete information about the immunisation status of their children. Problems arise as health service staff are then required to start the immunisation process from scratch. Due to communication difficulties parents to not understand the reason for re-starting the process, leading to mistrust and confusion (CEELS, 2014)

6.3.4 Secondary care

Ethnicity monitoring for admissions to secondary care is very well completed with only 4 admissions out of 164,183 having no ethnic code recorded. However the categories are broad and CEE communities are most likely to come under the category of White Other. In 2012 /13, 5.5% (n = 8,476) admissions were for people with an ethnicity of White Other. This includes all admissions so may count the same person twice. Without a further breakdown on ethnicity it is impossible to draw any conclusions from this figure. Source: Secondary Uses Service data.

6.3.5 Mental health services

Each GP has a register of people who have been diagnosed with mental disorders. These can be analysed by ethnicity. Ethnicity was not recorded for 1.5% of patients on mental health registers in Bradford District. Table 25 below shows numbers and percentages of CEE and White Other patients who are on the mental health register. Only 1.7% of patients on the register are CEE or White Other which suggests mental disorders are under diagnosed in the CEE community and / or mental health services are underused.

Table 25. Numbers of patients on primary care mental health registers 2014

Ethnicity	Total	% of MH register
Other white ethnic group	8	0.2%
Other White background	48	1.0%
Polish - ethnic category	13	0.3%
Baltic Estonian/Latvian/Lithuanian	<5	-
Other mixed White - ethnic category 2001 Census	<5	-
Other White European/European unsp/Mixed European	5	0.1%
Other White or White unspecified ethnic category	<5	-
Czech	<5	-
Slovak	<5	-
Total	84	1.7%

Source SystmOne, April 2014

6.3.6 Community based nursing

It was not possible to access any local data on community nursing and CEE communities.

6.3.7 Dental care

It was not possible to access any local data on dental services and CEE communities within the publication deadline for the needs assessment. However links have been made with Dr Julia Csikar, Senior Dental Public Health Manager at Public Health England and this work could be taken forward in the future.

The CEELS liaison group shared anecdotal data. They are told by school staff in Bradford District that newly arrived CEE pupils and their families have difficulty accessing NHS dentistry, resulting in poor dental health. (CEELS,

2014). In addition the young people's lifestyle survey reports a higher proportion of CEE pupils have never accessed a dentist when compared to all pupils and more CEE year 7 and 10 pupils have experienced problems finding an NHS dentist than all pupils.

6.3.8 Maternity services including teenage pregnancy services

The latest data on births to mothers born overseas is collated by the ONS and available up until 2011. These data are included in section 6.1.7.

Data were also shared by the specialist midwife for teenage pregnancy. The teenage pregnancy service supports young women aged 16 or under at the time of conception or aged 17 to 19 with complex needs.

In July 2014 the specialist midwife had 28 young women on her case load, 32% (n=9) CEE, all of whom are Slovakian. Six of the Slovakian young women were aged 16 or under with one girl who is 14 years old. Three were aged 17 – 18 years, all of whom were pregnant with their second child. 67% (n=6) of the Slovakian young women smoke. Given that 3.2% of the school population is CEE and using the number of children who have Slovakian as their first language we can estimate that 1.3% of the school population are Slovakian; Slovakian young women have a disproportionate need for the teenage pregnancy service. Given that approximately 12.7% of women smoke during pregnancy, the smoking rate in this cohort of young women is also disproportionately high.

6.3.9 Drug and alcohol services

Changes in patterns of alcohol and drug use have been reported anecdotally by public health commissioners of drug and alcohol services, specifically day-time street drinking by Polish men and a new cohort of young injecting heroin users. There are a range of drug and alcohol treatment services in Bradford. The most robust data came from the National Drug Treatment Monitoring System (NDTMS) which collates data about drug and alcohol treatment service activity nationally.

All Tier 3 and 4 drug treatment agencies must provide a basic level of information to the NDTMS on their activities each month known as the Core Data Set. Tier 3 services include a structured rehabilitation plan; prescribing and psychosocial interventions and Tier 4 services provide in-patient care. In Bradford District there is a range of drug and alcohol treatment services listed in table 26 below.

Table 26. Alcohol and Drug Treatment Services report to NDTMS

	Drug	Alcohol
Airedale - Fresh Start	No	Yes
Airedale Community Drug and Alcohol Team	Yes	Yes
Arch Initiatives	Yes	No
Bradford Community Drug and Alcohol Team	Yes	Yes
Bradford One Stop Maternity Service	Yes	No
Bradford Single Point of Contact	Yes	No

Bradford Substance Misuse Service	Yes	No
Bridge Project	Yes	No
Bridge South & West	Yes	No
Bridge Unity	Yes	No
Bridge Women's	Yes	No
Fairfield Medical Practice	Yes	No
Holycroft	Yes	No
Kensington Street	Yes	No
Kilmeny Surgery	Yes	No
Lifeline - Piccadilly Project	No	Yes
Ling House	Yes	No
North Bradford Drug Service	Yes	No
Project 6	Yes	Yes

Source: CBMDC Public Health Department

As with GP registration data, ethnicity coding is complete however the categories are too broad to allow analysis. The CEE communities would be counted in the category White Other. Data are available for the past four years and are shown in the tables 27 and 28 below for alcohol and drug treatment.

Table 27. People who are Other White in alcohol treatment 2010-14

Year	White Other (No.)	Other White %	Total
2010 / 11	39	4	1,118
2011 / 12	86	8	1,081
2012 / 13	76	7	1,051
2013 / 14	113	9	1,281

Source: CBMDC Public Health Department

Table 28. People who are Other White in drug treatment

Year	White Other (No.)	Other White %	Total
2010 / 11	67	2	3,306
2011 / 12	123	4	3,194
2012 / 13	139	4	3,198
2013 / 14	161	5	3,157

Source: CBMDC Public Health Department

The tables above show that numbers of White Other people in drug treatment services are increasing however percentages of White Other people in alcohol treatment services are higher and also increasing. In 2013/14 5% and 9% of people in alcohol and drug treatment respectively were White Other. It is not possible to draw specific conclusions in relation to CEE communities as the ethnic category is not specific enough, however when compared to 2% of the electorate, it is possible that people from CEE communities have a higher need for drug and alcohol treatment services.

The Bradford Needle Exchange Service (BNES) record nationality (listed in their annual report as ethnicity). The vast majority of people using BNES are male (88%) and 96% of users request needles to inject heroin (54%) or Image and Performance Enhancing Drugs (42%). The data relevant to CEE communities for 2013 are presented in table 29 below.

Table 29. CEE patients accessing Bradford Needle Exchange Service 2013

Nationality	No. Male	No. Female	Heroin	IPEDS	% of all users	Change in no. from 2012/13
Czech	67	7	57	8	2.3	+13
Latvian	31	<5	28	<5	1.1	-5
Lithuanian	5	<5	<5	<5	0.2	-2
Polish	61	<5	30	30	1.9	+10
Slovak	52	<5	35	10	1.8	-3
White Other	42	<%	24	17	1.6	+10

Source: CBMDC Public Health Department

These data show that 282 CEE nationals are using BNES, which represented 8.9% of all users. Interestingly the nationality with the highest percentage using the service is Czech. This is of note because we know the Czech community is smaller than the Polish and Slovak communities. It is also of note that this need has had the biggest increase since last year. There are a significant number of Latvian, Polish and White Other individuals accessing the service. The majority of all CEE nationalities request needles to inject heroin, the exception are Polish nationals where the split is equal between heroin use and IPEDS.

In spring 2012, a series of interviews were undertaken by Andrew O'Shaughnessy with key stakeholders (see list in appendix xi) in relation to alcohol and CEE communities. The interviews were analysed by Public Heath Intern James Harris in July 2014. Four key themes emerged: language barriers, lack of trust, trafficking and conflict.

Language barriers. Interviewees stated that many CEE community members are not aware of the dangers of excessive drinking. Language barriers make it more complex to share information about risks of alcohol and services and support networks available. Some services have run drop in sessions targeted at CEE members, but no one turned up to use the service as they were not aware. Translation services are perceived to be inadequate.

Trust: Lack of trust in alcohol services was raised as a significant issue and barrier for people from CEE communities. Some individuals did not expect services to be free. Some are undocumented migrants and cautious about accessing services where they fear they may be deported. Some CEE individuals struggling with alcohol dependence were concerned about losing custody of their children. Some interviews reported difficulty in encouraging people to commit to detox plans as alcohol use was so ingrained culturally that people did not want to abstain.

Trafficking: Interviewees shared their knowledge of the experience of trafficking amongst some members of the CEE community. People who had been trafficked were likely to have been very poor in their country of origin, some were alcohol dependent and some were ex-prisoners. Trafficked CEE men were often working in the grey economy and paid in alcohol (spirits) rather than money. These men were threatened with exposure if they disobeyed their employer.

Conflict: Alcohol is fuelling conflict in communities. It contributes to disorderly behaviour and violence on the streets. Interviewees described cases of domestic violence where alcohol was a catalyst. Women working in the sex industry drank alcohol in the day as an escape. When individuals from CEE communities have been drinking on the streets and in parks and playgrounds, conflicts occurred. Examples were given where South Asian communities have expressed anger. Interviewees described gradually building tensions between ethnic groups charged by the stark differences in lifestyles.

6.3.10 CBMDC Engagement with CEE Communities

A Central and Eastern European Working Group has met since 2005. This group has helped coordinate work across departments and organisations with different CEE communities in the District. The group has developed an assessment plan for the community which has informed the literature review of this needs assessment. The group has strong links through ward officers and council wardens to the wards with high numbers of CEE residents. The working group has brought partners together to explore issues around housing, employment, community safety and education and develop multi-agency action plans in response. Most recently the working group led the Ten Years On consultation event which has informed this needs assessment.

6.3.11 Education

A full description of numbers of CEE in Bradford schools is provided in section 6.1.6, describing the demography of the CEE population in Bradford. In summary, the schools admissions data shows that on 5th June 2014 there were 3,050 children and young people aged between 3 and 18 years, whose families are originally from Central and Eastern Europe on roll in Bradford District schools. This equated to 3.16% of the total school population which stood at 96,322 in June 2014. CMBDC provides an Education Service for New Communities and Travellers. The service aims to ensure that all Traveller, Asylum Seeker / Refugee and EU Migrant Worker children have access to a full curriculum within mainstream schools and that education is a positive experience. It is funded through the Single Children's Services Grant. The Service provides advice regarding educational social work issues, interpreting and translation, culturally relevant resources, home-school liaison and training sessions.

Data are available for attainment, the "long listing" for ethnicity includes categories of White Other and Gypsy/Gypsy Roma.

There are no relevant data to compare for Early Years Foundation Stage Profile achievement as ethnicity is not broken down to White Other and Roma / Roma Gypsy Categories.

Key Stage One covers years one and two of primary school where pupils are aged between 5 and 7. Their attainment is assessed through SATs exams. Table 30 below shows results by ethnicity, comparing White Other, Roma/Roma Gypsy with all Bradford and National results.

Table 30. 2013 Key Stage 1 SATS % achieving level 2 and above

	Reading	Writing	Maths	Science
White other	50.9	46.9	59.2	53.5
Roma / Roma Gypsy	16.5	15.3	20.0	12.9
Bradford all	83.0	80.0	87.0	84.0
National	89.0	85.0	91.0	90.0

Source: CBMDC Education Services

These data show a lower percentage of Roma/Gypsy Roma and White Other children achieve level 2 and above when compared with all children in Bradford.

Key Stage Two SATs are taken in the last year of primary school. Table 31 below shows results by ethnicity, comparing White Other, Roma/Roma Gypsy with all Bradford and National results.

Table 31. 2013 Key Stage 2 SATS % achieving level 4 and above

	Reading	Writing	Maths
White other	57.1	57.9	64.7
Roma / Roma Gypsy	17.2	8.6	20.7
Bradford all	80.0	81.0	80.0
National	Higher than all the above %s		

Source: CBMDC Education Services

Again the data show a lower percentage of Roma/Gypsy Roma and White Other children achieve level 4 and above when compared with all children in Bradford, with scores significantly lower for writing.

Key Stage Four results relate to GCSEs. Table 32 below shows results by ethnicity.

Table 32. 2013 Key Stage 4 % achieving 5 A-C GCSE grades

	% A - C	Maths % A-C	English % A - C
White other	77.9	52.9	36.5
Roma / Roma Gypsy	31.0	6.9	6.9
Bradford all	83.4	63.9	61.9
National	81.4	71.5	66.4

Source: CBMDC Education Services

Again these data show a lower percentage of Roma/Gypsy Roma and White Other children gaining 5 GCSEs grades A-C when compared with all children in Bradford, with scores significantly lower for Maths and English.

6.3.12 Housing

CBMDC Housing Service provided data on housing and CEE communities in Bradford. Data are available for 2011-13. The data show the number of housing assessments undertaken and overcrowding cases assessed in Bradford District. The purpose of the assessment is to determine if CBMDC have a legal duty to provide housing to these applicants. The data in table 33 below above show that between 2011 and 2013 there was a decrease in requests for housing assessments from the Czech community, a gentle overall rise from all CEE nationalities and a large rise from the Polish community. In 2013, 3.9% of housing assessments in Bradford District were for CEE communities. This is higher than the 2% on the electoral roll or 3.2% of school population. This may point to CEE migrants having a slightly higher need for housing assessment when compared to all Bradford District residents.

Table 33. Number of Housing Assessments undertaken by CBMDC 2011 - 13

	2011	2012	2013
Czech	51	27	34
Estonia	0	0	<5
Hungary	<5	<5	7
Latvia	11	18	21
Lithuania	7	17	13
Other EEA	26	27	33
Poland	43	55	100
Romania	<5	<5	6
Slovenia	<5	0	<5
Slovakia	72	46	74
Grand Total	218	194	292
All CBMDC applicants	8,572	7,852	7,469
% CEE	2.5	2.5	3.9

Source: Housing Department, CBMDC

The data in table 34 below show that overcrowding cases have remained stable overall between 2011 and 2013, with the largest number of requests from the Polish community.

Table 34. Overcrowding cases referred to CBMDC 2011 - 13

	2011	2012	2013
Czech	<5	<5	<5
Estonia			
Hungary			<5
Latvia	<5	<5	<5
Lithuania	<5	<5	<5

Other EEA	6		<5
Poland	<5	<5	8
Romania			<5
Slovenia			
Slovakia		7	<5
Grand Total	18	17	18

Source: Housing Department, CBMDC

Data are also available describing CEE individuals who have applied for housing as a homeless person and the outcomes of assessments. These are listed in separate tables 35, 36 and 37 for 2011, 12 and 13.

Table 35. Number of homeless applications to CBMDC for housing 2011

2011	Total applications	Priority Need	Ineligible	Intentional	Non Priority	Not Homeless
Czech	9	<5			<5	5
Hungary						
Latvia	<5					<5
Lithuania						
Other EEA	<5	<5				<5
Poland	6	<5	<5		<5	<5
Romania						
Slovenia	<5					<5
Slovakia	16	8	<5		<5	<5
Total	36	14	<5		<5	14

Source: Housing Department, CBMDC

Table 36. Number of homeless applications to CBMDC for housing 2012

2012	Total applications	Priority Need	Ineligible	Intentional	Non Priority	Not Homeless
Czech	6	<5	<5	<5		<5
Hungary						
Latvia	<5					<5
Lithuania	<5	<5				<5
Other EEA	<5	<5				<5
Poland	11	<5			<5	5
Romania						
Slovenia						
Slovakia	11	<5	<5	<5	<5	<5
Total	36	12	<5	<5	<5	14

Source: Housing Department, CBMDC

Table 37. Number of homeless applications to CBMDC for housing 2013						
2013	Total applications	Priority Need	Ineligible	Intentional	Non Priority	Not Homeless
Czech	<5	<5	<5			<5
Hungary						
Latvia	<5				<5	<5
Lithuania	<5	<5	<5			
Other EEA	<5				<5	
Poland	<5		<5		<5	<5
Romania	19	<5	<5		<5	<5
Slovenia						
Slovakia	<5					<5
Total	13	<5			<5	8
	46	11	7		8	20

Source: Housing department, CBMDC

The data above show that between 2011 and 2012 the number of homeless applications was steady. There was an increase from 36 to 46 in 2013, 19 requests were from Romanian nationals. The number of people assessed as being Priority Need has remained stable. The number of people assessed as being Not Homeless increased in 2013.

Homelessness is an issue for people from CEE communities. At the last rough sleeping count in Bradford, held on 27th November 2013, over a 24 hour period, providers collect information on who is sleeping rough or in emergency shelter. Approximately 50% of rough sleepers (n=6) were male CEE migrants. Hope Housing and Horton Housing also report high demand for services from CEE single homeless men.

Charlton (2013) reported that housing inspections have found properties containing fourteen people living in two bedroom properties sleeping in shift patterns and in the cellar. Some families rent properties and sub-let to other migrant workers. There have been cases of highly inflated rents and illegal evictions. There have been cases of vigilante behaviour from neighbours to force Roma tenants from an area and cases of single males living in outhouses, sheds, garages and derelict properties. If landlords are served with suspended prohibition orders to reduce occupancy levels, this moves the problem to another property.

6.3.13 Social care

The Education Social Work Service has provided data on children who are school age but not at school. These data are collated into four main categories listed below:

- Missing Child. Missing with their families and their current whereabouts are unknown. These cases are currently open and enquiries are on going to establish their whereabouts.

- Not on Roll Bradford Resident. These pupils have been identified as living in Bradford but not on the roll of a school. These cases are currently open while the family is engaged with to assist them to access the appropriate education provision.
- Removed from Roll Extended Leave. These are pupils who have lost their places in school having failed to return at the correct date, within twenty school days, following a period of leave of absence. These cases are currently open in order that families can be assisted to find alternative school places upon their return.
- Other Local Authority Referral. These are cases referred by other Local Authorities who believe children may have moved into Bradford. These cases remain open while checks are made with partner agencies and school admissions to establish if the family are in Bradford

Nationality is not recorded by the Education Social Work Service, however ethnicity is. The data in tables 38 - 41 below cover the last five academic years and ethnicity data for Roma / Roma Gypsy and Any Other White Background. These data are presented alongside the total number of children in each category.

Table 38. Missing child CBMDC 2009 - 14

Year	Roma / Gypsy Roma and Any Other White background	All	% CEE
2009/10	145	409	35.5
2010/11	197	528	37.3
2011/12	154	609	25.2
2012/13	307	719	42.7
2013/14	329	766	43.0

Source: Education Social Work Service, CBMDC

Table 39. Not on roll Bradford resident CBMDC 2009 - 14

Year	Roma / Gypsy Roma and Any Other White background	All	% CEE
2009/10	163	572	23.8
2010/11	230	1143	20.1
2011/12	296	964	30.7
2012/13	293	686	42.7
2013/14	203	630	32.2

Source: Education Social Work Service, CBMDC

Table 40. Removed from roll / extended leave CBMDC 2009 - 14

Year	Roma / Gypsy Roma and Any Other White background	All	% CEE
2009/10	9	94	9.6
2010/11	20	143	14.0
2011/12	15	142	10.6

2012/13	37	142	26.1
2013/14	14	103	14.0

Source: Education Social Work Service, CBMDC

Table 41. Other local authority referral to CBMDC 2009 - 14			
Year	Roma / Gypsy Roma and Any Other White background	All	% CEE
2009/10	11	84	13.1
2010/11	7	81	8.6
2011/12	8	62	12.9
2012/13	<5	45	6.7
2013/14	5	39	12.8

Source: Education Social Work Service CBMDC

These data show in 2013/14 of all children missing with their families, Roma / Roma Gypsy and Any Other White background children account for 43% (n=329) of all missing children in Bradford. This has increased by 21% from 35% since 2009/10. In 2013/14 children classified as Roma / Roma Gypsy and any white other, account for 32% (n=203) of all children resident but not on roll in Bradford. This is an increase of 35% from 24% in 2009/10. When we look at children removed from roll / on extended leave, in 2013/14 14% (n=14) Roma, Roma / Gypsy and any white other children were removed from roll / on extended leave which represents a 42% increase from 10% in 2009/10. Finally, when we look at other LA referral numbers, 13% (n=5) Roma, Roma/Gypsy and any white other children were referred by other authorities, which is unchanged from 2009/10.

Roma / Roma Gypsy and White Other background children are overrepresented in all of these groups, when we consider only 3.16% of children on roll in Bradford schools have a CEE language spoken at home.

The CBMDC Children's Social Care Department also provided data. Table 42 below shows the number of referrals to children's social care in the last five financial years.

Table 42. Numbers of Referrals to Children's Social Care, CBMDC 2009 - 14					
	2009-10	2010-11	2011-12	2012-13	2013-14
Referrals recorded as White Other or Gypsy Roma	217	240	392	319	385
All referrals to CSC	7,547	5,777	4,712	4,609	5,486
Referrals recorded as White Other or Gypsy Roma (%)	2.9	4.2	8.9	6.9	7.0

Source: Bradford Safeguarding Children Board, CBMDC

Table 43 below shows a snap shot of numbers of Looked After Children on 31st March in 2010 - 14.

Table 43. Numbers of Looked After Children on 31st March 2010 - 2014					
	2010	2011	2012	2013	2014
Referrals recorded as White Other or Gypsy Roma	10	12	28	34	35
All Looked After Children	885	888	896	877	905
Referrals recorded as White Other or Gypsy Roma (%)	1.1	1.4	3.1	4.2	3.9

Source: Bradford Safeguarding Children Board, CBMDC

Table 44 below shows children subject to a Child Protection Plan.

Children subject of a Child Protection Plan (No. at 31 March)					
	2010	2011	2012	2013	2014
Referrals recorded as White Other or Gypsy Roma	6	31	26	43	85
All children subject of CPP	404	364	392	375	574
Referrals recorded as White Other or Gypsy Roma (%)	1.5	8.5	6.6	11.5	15.6

Tables 42 to 44 show that the proportion of CEE referrals to children's social care has increased over the last four years. If we use 3.2% of children on roll in Bradford District schools to compare, the data above suggest CEE children have a dispropritionally high need for children's social care. Seven percent of all referrals in 2014 were for CEE children and 3.9% of Looked After Children were CEE. The largest increase has been in CEE children subject to a Child Protection Plan. Between 2010 and 2014 the percentage of CEE children with a Child Protection Plan has increased 940%, from 1.5% to 15.6%.

6.3.14 Welfare advice services

CBMDC commissions welfare advice services across Bradford District. The Public Health Department have commissioned three advice workers and engagement and development posts focusing specifically on CEE communities. These posts work for the Girlington Advice and Training Centre, West Bowling Advice Centre and Keighley Citizens Advice Bureau. The Girlington Advice and Training Centre also supports CEE migrants by providing volunteering opportunities and in some cases this has led to paid employment. The contract manager analysed use of services by language spoken between April and June 2014. Of 15,636 contacts in this time, 830 (5.2%) were from people who spoke CEE languages. These are listed in

table 45 below. Advice was most commonly sought from Slovakian speakers who made up 65% of CEE welfare advice requests.

Table 45. Contacts with welfare advice services by language April – June 2014		
Language	Number	Percentage
Czech	93	1
Hungarian	13	0
Latvian	18	0
Lithuanian	<5	0
Polish	154	1
Slovakian	538	3

Source: Strategic Services, CBMDC

The CEE Working Group has received reports from advice services stating that CEE communities face prejudice when dealing with the DWP including receiving inaccurate advice, loss of documents and slow decision making. This results in people having no income or food. Advice sought by CEE communities includes school places, debt, food, housing and heating. Advice services are under pressure in terms of demand and language and translation issues (Charlton, 2013).

6.3.15 Youth work

The Joshua Project delivers outreach to CEE young people, targeting CEE young people who are not engaging with mainstream services.

The Hand in Hand Project is a partnership between The Children's Society and Bradford District Care Trust, operating in the Keighley area of Bradford District. The team is made up of social workers, youth workers and nurses. The team supports young people involved with or vulnerable to sexual exploitation including CEE young people.

Scholemoor Youth and Community Centre delivers outreach work to young people in and around the Scholemoor community with a focus on building supportive relationships between South Asian, White and CEE young people.

MAPA in Little Horton provides youth work services to CEE young people who access generic open access youth work provision one evening a week. MAPA's largest challenge is language and interpretation. Young people interpret for each other with staff.

Youth workers have raised concerns about the social norms of dress in different cultures and misperceptions different cultures may have of each other.

6.3.16 Children's Centres and the Families Information Service

Children's Centres offer integrated education, care, family and health support to support families with a child under five years of age. There are currently forty-one centres in Bradford District; six are Children's Centre Plus which offer extra support to families with children who have additional needs.

However due to current pressures resulting from changing needs and reduced budgets, the configuration of Bradford's Children's Centres is changing.

The Children's Centres have developed a leaflet designed for CEE communities in partnership with The Families Information Service. Their Early Childhood Service team developed the leaflet explaining the Children's Centre services in Polish, Slovak and Czech. The leaflet has been distributed through Children's Centres and schools, with the aim of signposting families to support for a range of services such as the benefits of childcare, local services, help with childcare costs and free early education entitlement. Some CEE families have low literacy levels and may not understand what is written in the leaflet. The Families Information Service also runs an Eastern European Helpline between Wednesday and Friday from 9am to 3pm, and provides information in Polish, Slovakian, Czech and Russian.

6.3.17 Community Associations

There are a number of CEE community associations and places of worship in Bradford, formed following post World War Two immigration. There are five Slovak and Latvian groups, one Polish Roma group and some more recently formed groups, for example the Baltic Family Association. The Baltic Family Association has volunteers but no venue to meet in. Lack of venues to meet in has been identified as a barrier for community associations to form.

6.3.18 LACO Eastern European Migrants Project

LACO works with CEE community members and aims to support service users to obtain the necessities of life, improve health and wellbeing outcomes, understand their rights and responsibilities, feel valued and empowered to contribute to society and make choices that help them achieve their potential. LACO is funded through a range of sources including the CCGs and CBMDC Public Health Department. LACO works with partners to empower clients by supporting benefits drop-ins, providing outreach case worker support, social evenings, health and community cohesion initiatives, specialist support into early years provision, health workshops and liaison with food banks. LACO also provide bespoke training to organisations beginning to work with CEE communities, with specialist support around working with Roma communities.

In 2013 LACO worked with 2,138 people and provided in-depth case management to 144 individuals and families. LACO also support partners work e.g. the Better Start Bradford programme, input to strategic work and advocate for CEE communities. LACO provide a link between the community and operational services e.g. providing support to CEE people to register with a GP or find a school place or dentist.

6.3.19 CEELS

The Central and Eastern European Liaison Service (CEELS) aims to improve communication between CEE communities and health service providers. It is a partnership between Manningham Healthy Living Network and Bradford Sharing Voices. It is funded by Bradford City and Bradford Districts CCGs. CEELS collects information about the main health issues effecting CEE communities and aims to improve access to and uptake of health services.

The organisation has established a CEELS liaison group to improve communication and offer a forum for members of CEE communities and health staff to discuss issues that have been highlighted e.g. lack of understanding of the UK health system and uptake of childhood immunisations. The CEELS service is currently working with Bradford City CCG and Bradford District Care Trust across a range of services.

6.3.20 The Bridge

The Bridge is a Bradford based drug treatment charity. The project aims to help people achieve healthy, positive and fulfilling lifestyles, promote healthy families and reduce crime and all forms of harm associated with additions. They have produced a leaflet in Slovakian, English, Polish and Czech.

6.3.21 Gateway project

The Gateway Project was originally established to support Romany Gypsy and Irish Travellers; however they have expanded their remit to support CEE and Roma communities due to their level of need particularly in relation to benefits and housing related support. Gateway's overarching aim is to support Gypsies and Travellers who wish to live independently in the community and maintain their cultural identify. The Gateway project also aims to provide a responsive service to Gypsies and Travellers in any tenure who may have difficulties accessing accommodation or services to prevent homeless and support Gypsies and Travellers in maintaining their choice of accommodation and lifestyle and to support Gypsies and Travellers in developing skills and confidence to live independently in their chosen setting as well as access other services that can help with health, wellbeing, education and accommodation. The project is funded through Supporting People and had has recently had to reduce their staff due to funding cuts.

6.3.22 Hope housing

Hope Housing is a Christian charity working with homeless people in Bradford. Many of the people Hope Housing supports are CEE migrant men, some of who have been trafficked. Hope Housing link closely with Hope for Justice. They have a hosting project to house homeless people in volunteers homes in Bradford on a night by night basis. This provides emergency accommodation to those aged twenty six and older, for whom there is often a lack of provision. Hope Housing have an assessment centre for people who are sleeping rough. This service provides ten emergency beds for people sleeping rough and has workers who assist homeless people to move into longer term accommodation. Hope Housing works in partnership with several churches to offer supported tenancies to people who have been homeless. Housing Associations and charities including Green Pastures and In-communities work with Hope Housing to provide properties to house homeless people in. Support for the tenants is given by volunteers from local churches who are trained and supported by Hope Housing.

6.3.23 WomenZone

WomenZone is a women's only charity funded by a broad range of organisations including Bradford District CCG and CBMDC Public Health. WomenZone runs programmes of work around physical wellbeing, mental

wellbeing and training and employment including ESOL courses. WomenZone has a centre, which provides a gym and sauna facilities. WomenZone works with all communities and has recently employed a CEE worker.

6.3.24 Girlington Advice and Training Centre

The Girlington Advice and Training Centre provide information, advice and advocacy on welfare benefits, housing, immigration, debt, employment and consumer issues. The centre offers drop-in sessions and telephone support. They also provide outreach sessions at local GP surgeries, schools and other community venues. The Girlington Centre has an inclusive approach to working with CEE migrants that are part of the local communities. Community members are encouraged and supported to volunteer at the centre and progress to secure paid work.

6.3.25 Horton Housing

Horton Housing is a voluntary sector organisation, which aims to meet the housing and support needs of excluded and vulnerable people in Bradford. Some staff speak CEE languages and the centre is accessed by mainly single CEE homeless people. They run a day shelter which supports people who are homeless, in need of housing or living in poor accommodation. The shelter offers a safe sociable place to spend the day and a point of contact for help with housing and other problems. Advice and practical help is available. The day shelter also provides services aimed at preventing homelessness, poor housing, social exclusion, poor mental and physical health, poverty, isolation and involvement in the criminal justice system. The day shelter provides hot drinks, a free laundry service, clothing store, toilets, baths, toiletries, health care and an outreach service. Horton Housing also provides sheltered housing and this service is also accessed by single CEE men.

6.3.26 Specialist Offender Mentoring Service

The Specialist Offender Mentoring Service (SOMS) is a peer support project targeted at people from CEE communities who have had recent contact with the Police, probation, court or prison. SOMS began in April 2014, is funded by the Crime Reduction Initiative and covers West Yorkshire. SOMS aims to match CEE migrants who have become involved in the UK criminal justice system with a community mentor who can offer support to change. This includes setting and working towards goals such as finding a job, entering education, improving their English, accessing drug or alcohol treatment or getting more involved in the local community. Currently the service has ten volunteers who are being trained; five are Polish, three are English one is Hungarian and one is Czech. Eight client referrals have been received. The project is being externally evaluated.

6.3.27 The Reconnections Service

The Reconnections Service no longer exists. It ran for three years, ceasing in March 2014. It was funded by all local authorities across West Yorkshire. The aim of the service was to support CEE nationals who wished to return home but faced barriers. Over three years the service supported approximately 400 CEE nationals to return home. The service uncovered

issues with people who had been trafficked. This made up 15% of the teams workload. The service used to solve issues such as having no identification or paperwork and provided temporary accommodation for individuals who had escaped from slavery.

6.3.28 Hope for Justice

Hope for Justice is a national organisation which aims to rescue people from slavery in the UK. Hope for Justice is a charity working across the UK. They take referrals from front line workers and investigate suspected cases of trafficking with the Police. Sometimes the victims do not want the Police to be involved. The government provide access to a safe house for 45 days. In this time Hope for Justice keep in contact with the victim, provide interpreting and translation services and support the victim to move from rescue to recovery. Both men and women are trafficked. Data are not available for Bradford, but in 2013 there were 1,746 victims of trafficking known to Hope for Justice nationally. It is estimated that there are between three and four thousand people in forced labour in the UK. Nationally 64% of cases were female and the majority of people were trafficked for sex followed by labour exploitation. This represents a 47% increase from the year before. There are 112 countries of origin; the top five are Albania, Nigeria, Vietnam, Romania and the UK. The UK is the second most common country of origin for trafficking children. In West Yorkshire the vast majority of trafficked people have been trafficked for labour exploitation. (Source: Abbie Williams, Survivor Support Worker, Hope for Justice, West Yorkshire Hub.)

When a referral is made, a victim is taken to a safe house, then moved to accommodation funded by housing benefit. Hope for Justice try to connect the individual with an organisation to support them improve their English and apply for Jobseekers Allowance. English as a Second Language courses are available, paid for by donors. It is likely that the changes to the benefit system will make this a very difficult process, indeed Hope for Justice report that the changes in the habitual residency test mean when trafficked victims can't prove they have been in the country working for three months their applications for benefits are overturned and they have to rely on food banks.

6.3.29 The Gangmasters Licensing Authority

The Gangmasters Licensing Authority (GLA) was set up to protect workers from exploitation. They are a non departmental public body with a board made up of members from industry and government. Their licensing scheme regulates businesses that provide workers to a range of industries to make sure they meet the employment standards required by law. Employment agencies, labour providers or gangmasters who provide workers to agriculture, horticulture, shellfish gathering and any associated processing or packaging need a GLA licence. Labour providers are assessed to check they meet the licensing standards which cover health and safety, accommodation, pay, transport and training. It is a criminal offence to supply workers without a licence or use an unlicensed labour provider. To date there have never been any convictions or prosecutions in Bradford, indeed there has only ever been one prosecution in Northern Ireland. There have been over two hundred cases where licences were revoked although not in Bradford District. The

GLA report that the exploitation of workers is linked very closely to the provision of accommodation, which is very much part of the controlling mechanisms put in place for exploitation. It also provides an opportunity for exploitation through fraudulent benefits claims (Heath, personal correspondence, 8th September 2014).

7. Results of the corporate needs assessment

7.1 Views of staff

It was not possible to undertake large scale inclusive research with staff working with CEE communities across Bradford District.

The views of staff included in this needs assessment are from two undergraduate dissertations undertaken in 2013 by medics on placement with CMBDC Public Health. The first dissertation aimed to ascertain professionals views on influences on maternal and infant health of Eastern Europeans in Bradford District. The second dissertation aimed to understand issues facing A8 migrants living in Bradford from the perspective of providers and involved interviewing thirteen people from primary care, community care and social support sectors.

7.1.2 Dissertation on maternal and infant health

The first researcher (Richards) interviewed eleven health care professionals. Themes are summarised below.

Culture

Differences in culture were perceived. Slovakian and Polish migrants were often mentioned as larger populations but most participants agreed they had clients from a range of A8 countries. Most agreed there were many differences between CEE populations. Polish people were perceived to have smaller family size, better English, employment and attended clinic. Roma were viewed as having the greatest health needs. A specialist midwife commented: *"With the Roma clients, their base health before they come to us, so their, their profile at booking, they're poorly before they start you know, they tend to be under-nourished, as I say they're already smoking, they've very rarely had their full vaccination because of you know, lack of access to health care."*

A lack of integration was perceived, interviewees commented that CEE groups seemed unwilling to integrate with the rest of Bradford, health visitors had experienced people reluctant to be referred to Children's Centres but willing to go to social evenings at LACO.

Interviewees commented on cultural norms. Health visitors were often concerned about prolonged use of dummies. Certain sensitive discussions were perceived to be culturally unacceptable in front of men e.g. sexual health. Some respondents perceived parenting culture as unacceptable. One midwife described how she frequently saw pregnant girls whose own mothers were also pregnant. Comments were made about young Roma girls getting married at a very young age, and concerns this raised as they were under 16. One midwife mentioned that in her experience women from CEE communities cope better in labour. The religion of most CEE women was perceived as Catholic or Christian.

Transience

All health care professionals interviewed discussed the transience of CEE communities as a concern, in terms of locating their clients. Czech and Slovakian communities were highlighted as moving most, often two or three times during a pregnancy. Many staff discussed concerns about families who go missing. Workers were not sure if families had moved on or were in danger of exploitation. One midwife said: *"As soon as I start asking the sensitive questions, that's when people are disappeared and that's really really scary you know, really scary."*

Young mothers

The age at which CEE women became mothers was a concern for nearly all participants. Examples were given of 19 year old women pregnant with her fourth baby. Concerns were raised for these young women's education

Gender roles

Staff reported that women generally were housewives. Some women were not allowed to leave home without their partners and others had experience of patients not being admitted without a partner present. Women were perceived to be able to speak less English than men. One health visitor shared: *"There's a family that I see that are Slovakian and each time I go, 'cause that can be opportunistically because they're not on the telephone, the females wont let me in the house to see the baby, they have to wait until their husband comes home."*

Family and support networks

Most health care professionals had visited large families but this wasn't always the case. Polish families were perceived to have two children or fewer with Slovakian families perceived as being larger. No interviewees had experience of safeguarding issues relating to neglect in the smaller families. One midwife commented: *"The women will chose to have a baby every year because that's what their mum did and that's what grandma did and that's what their best friend did and that's what their sister did! So it's normal. You know they don't see necessarily that they've got a choice".*

Some health visitors found families to be very loving towards their children but thought some children were not provided for in a way that they found acceptable. One health visitor said: *"They don't meet the threshold for social services involvement because actually the children are well cared for despite not possibly being cared for in the way that we want them to be."*

Health

Some interviewees perceived CEE women struggling to access contraceptive services, it was felt this may be for a range of reasons including lack of education about contraception, lack of knowledge about the NHS and lack of empowerment due to dominant families or partners. Language barriers were seen as particularly problematic when using termination services due to privacy and stigma.

It was perceived unhealthy foods were eaten, due to lower costs. Other perceived influences were limited time and different cultural ideas about food. Concerns were raised due to the effect of unhealthy food on teeth and general health. The use of alcohol and illicit drugs was not perceived as a problem.

Breastfeeding was perceived to be more common amongst CEE women. One health visitor commented: *"Quite a lot of them'll breastfeed and will breastfeed really well for really long, you know, extended times so up to kind of toddler and beyond… this is definitely cultural".* Others found CEE women unwilling to consider breastfeeding.

Some participants had noticed problems they perceived more common to infants born to CEE mothers, including low birth weight and rickets. Health visitors felt that generally CEE women brought their children for immunisation.

Dental health was perceived to be poor. Accessing dentists was considered difficult, dental decay was observed in all generations. A health visitor commented; *"A few of them, because the dental decay's so bad, and some of the children have been in quite a lot of pain, we've accessed emergency dentists"*

All staff agreed there were serious issues with smoking generally and smoking during pregnancy in the CEE population. There was perceived variation between nationalities. One midwife said *"The Slovakian families tend to smoke but the Polish don't really smoke that much, they don't seem to smoke as much anyway".* People from CEE communities did not appear to view smoking as having detrimental effects on their health. Interviewees were concerned about the impact of passive smoking on children in households where a large number of people smoke. One midwife commented: *"There was about fifteen in that room all smoking, and they must have been chain smoking. And it literally was a fog and the baby was in a Moses basket in the middle of the room".*

Some interviewees discussed a reluctance to seek help from mental health services. They were not sure if this was because there was no need for mental health services or because CEE migrants were concerned about prejudice they may face. One health visitors said: *"In Slovakia they don't see it as an issue or maybe you're made to feel mad if you're depressed so I think they just get on with it and I don't think they'd maybe tell me if they did."* Another said *"I wouldn't say they get a lot of post-natal depression. They tend to get up and get on with it more do the Eastern Europeans".*

Housing

All interviewees agreed housing was a serious problem. Staff discussed landlords not fulfilling basic responsibilities and charging extortionate rents. It was suggested that CEE families move quickly due to rent arrears. Rat and lice infestations, damp houses and poor amenities were experienced. Overcrowding was common with extended family often occupying one house. Some CEE children shared beds. Roma and Slovakian groups were viewed as living in worse housing than Polish groups. One midwife said: *"It tends to*

be rented accommodation that they're living … quite often in grotty areas, grotty grotty places", another said *"A lot of it's damp, poor ventilation, bad windows, no heat and because they're very deprived anyway in financial terms they're occupying these really low rent houses and they're over populated so they're hugely overcrowded."*

Poverty

Financial issues included living off one income or benefits. Lack of money impacted on housing and providing necessities for children. Interviewees commented that some CEE women are unable to volunteer or train because they need to earn money. All participants had experience of clients living in deprived circumstances whilst waiting for benefits. Interviewees also explained problems some CEE people faced trying to prove habitual residency in order to claim benefits. There was consensus that Slovakians were more likely to claim benefits than the Polish.

Most staff stressed CEE communities accepted their conditions and living in poverty. Their first need is getting somewhere to live. Interviewees described cases of fuel poverty, lack of cleanliness and other basic unmet needs. The group perceived as living in abject poverty were Roma. A midwife commented: *"they are uneducated, repressed, they just don't know what is available for them and they're living from hand to mouth really and their address changes every time you see them, if you see them at all."*

Education

All interviewees commented on education Starting school age was problematic as CEE communities were used to their children starting school aged six or seven, truancy was suspected. Attitudes towards school seemed casual with little concern about children missing long periods of time. Concern about Social Services removing children was one reason offered for avoiding schools. The importance of stable schooling was not appreciated, due to the frequency at which children move schools. There were issues with teenage mothers who should have been in school. Most staff raised questions of educational attainment of CEE women, mainly illiteracy. The association between deprived education and deprived heath was expressed. Roma were seen as the least educated group. Education was seen as an empowering force. One midwife commented: *"I definitely think education is just the big thing. So much education is about giving the woman education to read and write, to speak and write English. Therefore if they can read and write English that will give them confidence. Empower them to go out and get the pill, go out and get on a bus, you know go out and do the shopping."*

Employment

Most work appeared to be manual, such as factory work or farming. Often people have lower skilled jobs than in their country of origin. Men and women from Poland and Latvia were perceived to work more than those from Slovakia. There was a suggestion some CEE people might be involved in illegal work. Across all nationalities, young women were seen who were not involved in education, employment or training. Language was viewed as a

barrier to employment. Examples were shared describing women who had been sacked when their employer learned they were pregnant.

Crime

Criminal behaviour was considered a means of survival. Staff had experience of clients being used for criminal activity.

Abuse

Many participants discussed cases where they had observed neglect, including leaving babies and young children at home alone, poor hygiene, head lice and dental caries. Lack of stability and cycles of poor parenting were raised as concerns. Interviewees said more CEE women were seeking assistance for domestic violence, and this was perceived to be a new pattern. Many participants believed CEE woman had been exploited in some form; examples were given about employers who paid low wages for long hours, landlords who ignore regulations, and young women who had been used to shoplift.

Prejudice

Some staff mentioned issues of prejudice between different CEE nationalities and groups. Roma were considered most discriminated against. One midwife said: *"I have heard other cultures being quite rude to them, saying they are scruffy and dirty and things like that."* Another midwife said: *"Racism is one of the main, I think that the prejudice from their own communities, their own, like Latvian and Ukrainian clubs and things like that, they wont have the Roma, the Roma are filth to them, then will not integrate with them at all."* This has caused problems when delivering health care. One midwife reported an interpreter who only partly interpreted health messages due to personal prejudice.

Communication

Language was perceived to be a barrier. It was reported that some women were perceived as uninterested in learning to speak English. Several health materials are only available in English. Staff gave examples of how it is hard to do their job without an interpreter. All staff valued interpreters. Continuity of interpreters was desired but this was not always possible. A need was cited for a variety of interpreters including Roma dialects. The importance of rapport and good communication were discussed by some participants, a collaborative approach and sustained contact were found to be most effective in promoting health messages.

Relationships with services

Smoking was the main public health issue raised as a concern by health staff who perceived that despite advice and encouragement, little progress was made. Other messages that health staff felt are ignored include accessing services in a way which was considered inappropriate, contraception and vitamin supplements. One midwife gave examples of lack of trust in health services and lack of understanding of their illness and medical advice. Some staff shared examples of CEE communities attending A&E for primary care purposes; this was not an exclusive issue to CEE communities. Some staff

perceived some women as demanding where others seemed surprised to receive care. Polish women expected more from services. Staff spoke of misunderstandings exacerbated by stories about CEE communities in the press. One health visitor commented: *"on the Slovakian news, there was a thing about In England, that social care was going in and removing children. We've had real trouble as health professionals actually getting in the doors since that came out. They think we are going to take their children away from them! And they can't understand why. They are really quite worried about that."*

The voluntary sector built trust more easily than health care professionals and this led to increased engagement. It was perceived that fear of judgement may have prevented CEE communities from initiating contact with health care services. Knowledge about service provision seemed sporadic. All midwives agreed accessing antenatal care late was common with CEE women, causing problems with antenatal screening. This was found in women new to the country as well as those who were well established. Most staff found there were problems with CEE women attending clinic, it was generally agreed that Polish women attended more than Slovakian women. Reasons suggested were language barriers and expectations about care. Often CEE women didn't understand the role of heath visitors or midwives. Some staff had experiences of clients expecting help with benefits forms and finances rather than traditional health care.

7.1.3 Dissertation exploring professionals' perspectives on issues facing A8 migrants

The second researcher (Wilson) interviewed thirteen health and social care professionals including three GPs, two practice nurses, two receptionists, one nurse practitioner, one patient services manager, one health promotion manager and three professionals from the community / social support sector. Wilson summarised his findings under the headings of accessing health services, lifestyle and health, mental wellbeing, support services, housing and employment. The themes reflect almost exactly the same findings as Richards' study. The only differences were that Wilson found alcohol use high and his study included questions around primary care staff's understanding of third sector support which was poor.

Accessing health services

The perceptions of Wilson's interviewee's was that A8 migrants in Bradford understood the need to register with GP practices and reportedly do so, though not always prior to seeking their first appointment. Primary care is often approached for issues that could be dealt with at home or through a visit to a chemist. Migrants are used to being prescribed medicine, particularly antibiotics and are often unsatisfied when only advice is given. There is a lack of faith in the UK health system, with some Roma migrants being suspicious of receiving sub-standard service due to the discrimination they have been subject to in the past. Polish migrants reportedly get themselves checked out on trips home due to lack of faith in the UK healthcare system. Roma in particular move house frequently making it difficult for GP surgeries to stay in contact. Roma migrants are often not identified by health professionals and

awareness of how persistent discrimination has affected the way some Roma engage with services in Bradford is poor.

Lifestyle and health

Alcohol is perceived as being part of A8 migrant culture and intake is perceived by the health care workers as high but more sensible in terms of drinking patterns when compared to the white British population. There is a subset of migrants where alcohol consumption is dangerously high and intervention is required. Drug use is reportedly increasing but not an issue that is routinely identified in primary care. Respondents from the community said most drug misuse is amongst adult males but increasing amongst the teenage population. Smoking rates are high in all CEE communities. Diet is generally poor.

Mental health

Mental heath issues are not frequently seen in primary care, there was consensus between interviewees that CEE communities are unwilling to discuss mental health issues for a variety of reasons and therefore it is likely to be an issue that is underreported.

Support services

People working in primary care tended to have a poor knowledge of third sector support services. Migrants typically learn of these services though word of mouth. Family, friends and wider social contacts are a significant source of support for A8 migrants. A8 migrants tend not to integrate with other A8 countries in terms of social interaction and attending community support services.

Housing

The vast majority of A8 migrants live in private rented accommodation, which is of poor quality and often dangerous. There are cases where landlords do not respond to complains of migrant tenants and circumvent legislation relating to tenancy agreements and deposits. Common areas where migrants live are reported to be BD3, 4, 5, 7, 8 and 9.

Employment

Migrants often work in low-skilled jobs where the hours are long and the pay is poor. Work can be sporadic and often though agencies, this makes it hard for migrants to maintain a dependable income in the absence of benefits. The Polish population are reportedly averse to seeking benefits and have high rates of employment. The Slovakian and Czech population, particular Roma are more likely to claim benefits and have higher rates of unemployment.

7.2 Views of CEE communities

The CBMDC Central and Eastern Working Group ran a consultation event in June 2014, with 17 members of CEE communities and 54 representatives from voluntary and statutory sector organisations who work with CEE communities. The event called Ten Years On was made up of a series of discussions to identify issues and solutions for Bradford's CEE communities ten years on from Accession. These are described below.

Housing

Issues were discussed including: illegal evictions, landlords not following correct procedures, overcrowding, living in flats above shops, houses being vacated before Housing Standards become involved, the bond scheme not being used, lack of knowledge on housing and rights by tenants, landlords from all sectors not accepting people on housing benefit, made worse following the recent welfare reforms, people working cash in hand not being eligible for housing benefit as it is more difficult to prove income and domestic abuse.

Solutions were also discussed, suggestions included: more funding for training and information sharing, building up trust with the community, educate children about these issues, raise expectations and ambitions in terms of housing quality, expose rogue landlords and education to maintain tenancies, avoid bad landlords and poor quality housing.

Promoting tolerance and respect in communities.

Issues identified included language, access to services, trust, racism and lack of understanding of cultures, the need to develop a welcoming environment and reduce fear, myth and media images, Roma are not aligned to countries and the impact of welfare reform.

Solutions suggested included: identify and invest in community advocates as conduits in to the communities based on some existing good examples, better co-ordinate information about what is already available, raise awareness about cultural differences and design solutions that enable people to grow within their role e.g. in the workplace offer traineeships, not NVQ3, take a community development approach to bring communities together, build trust, need to develop opportunities to share experiences, sharing food always works well and understand the role and responsibility of schools in supporting children.

Health

Issues around health care were discussed. These focused on language barriers, interpreting services and expectations of the health care system. Language was identified as a barrier to accessing health care services, interpreters can be requested. It was felt that it is better to have an interpreter present rather than Language Line as patients are often uncomfortable with Language Line. The quality of interpreters is important. There are issues associated with elderly populations. There are issues in terms of prejudice and gender that impact interpreting. The qualifications and quality of interpreters need checking. There is a distrust of the health care system e.g. in countries of origin antibiotics are generally easier to access. Primary care was perceived as poor in some areas of Bradford. It was felt that reception staff needed cultural awareness training for example some CEE families are close knit and entire families may accompany a family member to a doctor's appointment. Issues were raised about the need for education around contraception and a need to raise the awareness of choice amongst young women. Broader issues around the determinants of health were discussed.

These included imbalanced power relationships between genders. Poverty was seen as a major problem. It was felt there was a need to help Roma communities especially to realise a way out of poverty and a need to raise aspirations and provide opportunities. There is a lack of knowledge amongst communities of the impact of smoking and alcohol on health and a need to make people aware of health risks. In terms of mental health, depression is an issue amongst CEE communities.

Possible solutions were discussed including: cultural awareness training for reception staff, contraception education for young people and women, education around about antibiotics and self care, raise the quality of care and access to appointments, educating GPs about voluntary sector support available and education about the harms of smoking and alcohol and black market products.

Employment

Issues discussed included fears about using unknown child care providers, fears of children being removed coupled with wanting to stay home with children when they are young. Some families have unsettled lives (accommodation problems etc) and have fears on various levels preventing them from being able to focus on finding work.

Possible solutions were discussed. For example we need to raise aspirations and show how to recognise transferable skills for unemployed people and people in work. Practical welcome packs are needed explaining about public transport to get to work, how to access health and other services. Access and training for web based job searches would be useful, some agencies can help. There is a need to understand barriers to work better and to develop parent champions with the aim of getting other parents involved in early education, ESOL, Families First etc. It would be useful to survey job seekers to understand barriers to finding work, aspirations. Awareness raising and training on different communities is needed for staff including Job Centre Plus work coaches.

Community leadership and empowerment

Community leaders need to be inclusive and provide volunteering and training opportunities. There is a need to promote services. The work of all organisations e.g. the job centre, Bradford council etc., should be available through a single point of access. Facebook was suggested as an idea to improve communication. Some groups of staff could benefit from CEE awareness training. Partnership working is key.

Young people and drugs

Issues discussed included the need to raise awareness of issues in the school setting. There are problems when young people move into adult services. There is a high turnover of social workers in children's services. It is seen as easier to engage with young people than adults as their English is generally better. In terms of drugs, there is often a family history of drug use, so children have little support from family. Services are not always aware that parents have a drug problem. The Bridge Project has an approach that

involves the whole family. Young people are being groomed and being given free drugs to deal or are being sexually exploited. Families are aware of the drug use as parents will have to support young people to get medication. Children that are involved in drug use are not allowed to be children, young people are sexually exploited.

It was suggested that it could be useful to run education programmes for families that are suitable for the communities in terms of language and culture; provide outreach sessions delivered by the youth service for young people around drug and alcohol awareness, employ staff that speak EU languages. Include CEE young people in general youth work services. Provide specialist services for housing, health and networking, language, drug and alcohol services. There is a need to support and identify role models who aspire to be more than cleaners and builders and share stories about drug use and how they changed and became drug free. We need to foster self reliance rather than dependence on services.

Youth work

The Joshua Project have a CEE youth group of mainly Slovak Roma, aged between 13 and 19 years old. It was set up because CEE young people were feeling isolated and afraid of authorities. Young people shape the activities themselves. The group is now open to all young people. There was a view that groups are not hard to reach, instead services need to reach out. It is important to systems and social norms and develop an intercultural understanding of alcohol. Communities need to communicate with each other. There is a need to identify and build up leaders and the capacity within CEE communities. There is a growing cohort of staff from the communities. Started work with a dedicated group and have widened things out. Language speakers are important, especially young children.

Actions discussed include the need to invest in community leaders and develop a pathway for community leaders training. There is a need to work in schools and look at emotional wellbeing in Citizenship. There needs to be a greater understanding of changing demographics and the strategic level e.g. elected members. People who are hard to reach need to be reached by all, not palmed off to voluntary sector organisations, we need to support for the local authority to do this. There needs to be better use of community hubs that are well used and trusted by CEE communities.

Trafficking

The perception is that trafficking is a massive problem on the basis of figures coming through the multi-agency hub. The UK Human Trafficking Centre oversees this area of work. Figures from the Serious and Organised Crime Agency record West Yorkshire Police as second behind the Metropolitan Police in terms of referrals to the National Referral Mechanism. Referrals can be made by the Police, but often the Salvation Army will refer. When incidents are reported to the Police, there is a feeling that they are ignored because of lack of knowledge around human trafficking. Hope for Justice have reported 142 cases of trafficking in West Yorkshire; this can involve enforced labour and sexual exploitation. The UN has recognised Bradford as

a trafficking hub. It was expressed that the police and the community may have different priorities. It was felt that the police may prioritise burglary, robbery or theft, but communities are more concerned about forced marriage and human trafficking. It was felt that victim support may be lacking.

In terms of solutions, there needs to be better understanding of what trafficking is including a definition. Key stakeholders in particular need to be fully aware. Also best practice is required, particularly in relation to working with Roma communities, who may be closely involved as victims or perpetrators of trafficking.

It was suggested that a public campaign to raise awareness could be useful, in the county of origin as well as the destination. There is a low level understanding of the Modern Slavery Bill. Hope for Justice has taken the lead on this, but there is a clear need for multi-agency working. Penalties for traffickers need to be levied and enforced.

Comparing these views with 2005

In 2005 the CEE Working Group pioneered running consultation events with members of CEE communities. The concerns highlighted in the 2014 consultation echo those raised in 2005. The main issues raised in 2005 were employment, work abuses, agencies practices, language barriers and misunderstandings of “how we live in this country rules, laws and general societal practices”.

8. Conclusion and discussion

8.1 Conclusion

This needs assessment accessed a broad range of data which build a picture of a significant and diverse CEE community in Bradford District. An estimate of numbers of the CEE population can be gained using the numbers of CEE people registered to vote (7,063) plus 15% (1,059) as we know the electoral data misses between 10 – 15% of the population. We have precise figures for children on roll in Bradford District schools (3,050) and births to mothers from the new EU in 2011 (409) which gives an estimate, which is almost certainly a low estimate of 11,581.

The largest populations consistently identified through all data sources are Polish and Slovakian. There is a significant Czech community who have a shared experience of persecution in their country of origin to the Slovakian community. The CBMDC Education Service estimate between 90 and 95% of Slovakian and Czech children are Roma. The fourth largest community identified through electoral roll data, Census data and NINOs data are Latvians, suggesting they are a settled worker population.

In general, CEE migrants speak the language of their country of origin for example 98% of Polish people speaks polish, 95% of Czech speak Czech and 85% of Slovakians speak one of three Slovak dialects and 10% speak Hungarian. However in Latvia only 59% of the population speak Latvian, 28.9% speak Russian and there are a number of other languages spoken by smaller proportions of the population.

In Bradford District, four wards are home to 42% of the CEE population on the electoral roll, these are City, Little Horton, Manningham and Bowling and Barkerend.

In terms of quantifying Bradford District's CEE community, 3.2% of the school population are CEE, 2% of the registered electorate were born in a CEE country. These are good data sources providing accurate data because they are complete, collate data by country of origin and are legally required. However they will undercount the CEE population as they will not include some groups of CEE migrants, for example undocumented migrants, trafficked workers, children not in education, and people living in houses of multiple occupation.

Looking at trends, the CEE population in Bradford District is increasing.

- In 2003 there were 70 CEE children on roll in Bradford District, there were 3,050 in 2014.
- In 2003 there were 42 CEE NINo registrations, in 2013 there were 2,436.
- In 2003 there were 24 births to New EU Mothers mothers, in 2011 there were 409.
- In 2003 there were 60 White Other JSA claimants, in 2013 there were 970.

Not all CEE communities have the same needs. All migrants will require information and sometimes support to settle, however this will be required at different levels. The findings from the corporate needs assessment, which includes views of health care workers, CEE community members and frontline staff who work with CEE communities point to Roma communities having more needs compared to the whole CEE community. Examples of racism, persecution and poverty were articulated along with the resultant consequences.

The needs described will evolve given the backdrop of austerity and change to welfare entitlements for migrants. Whilst most CEE migrants have settled into life in the UK, there is a minority who have struggled. The changes to entitlement to Jobseekers Allowance and housing benefit are beginning to take effect and will continue to. The result will be a cohort of CEE migrants with no access to funds who are in effect destitute. The rate of sanctioning has increased dramatically between 2010 and 2013. There has been a 50% increase in sanctions for all ethnic groups but an 84% increase for White Other claimants.

The needs assessment was not able to produce quantitative data describing the health status of Bradford District's CEE migrants, however WHO data describes the health status in country of origin using key indicators. In very general terms, compared to the UK, the CEE countries of origin under study have lower life expectancy and higher levels of smoking, alcohol use, TB, infant mortality and CVD mortality. Bulgaria, Romania, Estonia, Lithuania and Latvia have been identified as high burden MDR TB countries with 20% of new TB cases having MDR TB.

There is a broad range of mainstream and targeted services available to CEE migrants in Bradford District. Some appear to be underused, for example only 2.9% of the population registered with a GP and only 1.7% of people on the mental health register in Bradford District are White Other. Some services are reporting increased demand and high levels of need for example secondary care (5.5% White Other), teenage pregnancy support (32% CEE), alcohol treatment (9% White Other), rough sleeping (50% CEE), missing education (43% CEE), not on school roll but living in Bradford (32% CEE), subject to a child protection plan (16% White Other or Gypsy Roma). Some services do not have data available however anecdotal data or data from the literature suggests there is a potential unmet need amongst the CEE community, for example amongst dentists.

Common themes have emerged from CEE community members, voluntary sector staff working with CEE communities and health care staff. Findings of the two dissertations undertaken in Bradford in 2013 were presented at the Ten Years On event to a table of delegates, the majority of whom were workers of CEE origin. Themes agreed include:

- Differences in culture between CEE communities.
- Patterns of culture attributed to Roma including underage pregnancy, taboo discussing sexual health and homosexuality.
- Transience of Slovakian and Czech communities.

- Traditional gender roles ascribed to men and women.
- Poor health, lack of access to contraceptive services, unhealthy diets due to cost, poor dental health, high levels of smoking.
- Poor housing and poverty were identified as serious problems.
- Poor educational attainment.
- Taking lower skilled jobs, poor pay and examples of and exploitation through employment in the grey economy and through slavery and trafficking.
- Instances of neglected children.
- Language as a barrier to communication and difficulty accessing services, lack of trust in social services and fear of children being taken into care.
- Poor knowledge of some health care staff of support services available to CEE migrants.
- Experience of prejudice against Roma.

8.2 Discussion

This needs assessment aims to present a holistic view of the needs and assets of the CEE communities in Bradford District to enable CBMDC to plan a strategic response.

The strengths and weaknesses of this needs assessment should be stated in order to enable a judgement to be made on how robust the findings are. The strengths of the needs assessment are that it is current and up-to-date, using reliable, referenced data from a range of sources to enable triangulation of facts focusing on a broad range of needs. It builds on a strong tradition of partnership working, created by the CEE working group which has shared intelligence and understanding of the CEE community in Bradford which is included in the needs assessment.

The weaknesses of the needs assessment include its breadth, each area could have been explored in more depth if there was more time or capacity to do so. Data are available for some services, but there was not capacity within the timescale to gather robust service usage data from the VCS. In addition the list of services available to CEE communities may not be complete. The needs assessment is driven by quantitative data, rather than qualitative community voices. Solutions to need will partly come from the CEE communities themselves and the approach taken by this needs assessment missed opportunities to gather community ideas directly. There was not time or capacity to review how other cities in England are responding to new communities which means learning from other areas could not be included. Only a few data sources are collected by nationality. Most data is recorded by ethnicity. As previously discussed self-reporting as Gypsy Roma is low and most CEE individuals will be recorded as White Other. The category White Other will result in over-counting as it is broader than CEE, however White Other has been used to look at trends in demographic changes since Accession. In addition, interestingly although not scientifically robust, staff working in children's social services report that 90% of children's names in the White Other category appear to be Eastern European.

It should be noted that not all CEE communities have the same level of need and will require different levels of support to achieve equity. There is a continuum of need with a significant cohort of families currently facing JSA sanctions. Consequently they are in the greatest need of support at one end, and CEE individuals and families with no additional needs at the other. The findings of the needs assessment could be considered using different models e.g. Dahgren and Whitehead's Factors Influencing Health or Maslow's Hierarchy of Need; in order to prioritise needs and plan a response accordingly. These models highlight the need to respond to need at both strategic policy, individual and community level.

There are opportunities for CBMDC staff to respond to needs which can be met by doing things differently within existing resources. These include ensuring migrant families are aware of their responsibilities and entitlements; ensure all staff have information to plan and provide services in a culturally sensitive way and ensure services work together to provide a joined up and holistic response to the needs of CEE families and individuals.

New needs are emerging from CEE communities for example the 483 families who were sanctioned in Bradford District between April and October (described on page 53). These numbers will increase when the changes to entitlements to welfare benefits for CEE migrants bed in. Sanctions have a knock on effect including losing all other benefits including free school meals. There will be an increasing cohort of CEE families who are destitute, have no recourse to public funds and whose children are at increased risk of neglect. This may be compounded by national plans to charge migrants for some NHS services.

Within CBMDC, there is no current agreed strategic responsibility for this cohort of people. Currently, destitute migrants can access support from the voluntary, community and faith sector and friends and family; however there is growing need against a backdrop of reducing resources. There is a need for a citywide policy response agreed between CBMDC and partners.

One option would be to offer to repatriate destitute migrants. An alternative option would be to plan to create jobs and provide innovative housing solutions. There may be opportunities to develop job creation schemes through external sources of support including the European Structural Fund and the Better Business Compliance Partnership Project. Other local authorities have framed their response to destitute families through human rights and child protection perspectives. It would be useful if CBMDC directors and councillors debated the needs of CEE communities within the context of the National Assistance Act, Children Act and Human Rights Act to agree a response to new communities in Bradford District and to communicate this to all service providers so responsibilities are understood.

It is crucial within the context of austerity and culture of reducing dependence on welfare and supporting sustainable empowering approaches, that the assets of the CEE communities in Bradford are recognised and built on. Aspinal (2014) describes asset mapping as a process which identifies the

capacity, skills, knowledge, connections and potential of social capital in a community. This should be coupled with a culturally sensitive approach and commitment to understand minority cultures as described by Matras (on pages 36 and 37), for example the importance of extended family networks amongst the Roma community.

The needs assessment has been shared with key staff from the CEE working group throughout its development. Priority areas identified by working group, confirmed by the needs assessment data include:

- Mapping of strengths and skills and a focus on community self help. This approach is being undertaken in Bradford as well as in other cities including Manchester and Sheffield. VCS colleagues in Bradford District have established relationships with many CEE communities and should be invited to work in partnership with CBMDC in any response to CEE communities needs.
- Awareness training for CBMDC, NHS and VCS staff at all levels about CEE communities in Bradford District, including Roma communities. Including elected members, front line workers, and senior managers.
- The need for better integration between CEE communities and host communities in Bradford District, and the promotion of tolerance and mutual respect. Other cities have trained Roma community mentors and community navigators, Bradford District may chose to explore this option. Increase availability of English language classes.
- An agreed CBMDC response of how to support the increasing numbers of people who face Jobseekers Allowance sanctions and are destitute. A single point of support for advice workers as well as community members.
- Education and training to support CEE migrants into work including the provision of volunteering opportunities, development of targeted childcare and creation of apprenticeship posts.
- Clarification and communication on the options for voluntary repatriation for those who cannot afford to pay for their own transport.
- There are anecdotes that a greater proportion of CEE migrants are settling in the North of England due to cheaper housing prices. Research this further and if true, raise with central government to draw attention to the disproportionate impact of reforms on Bradford and other northern cities.
- Tackle trafficking, slave labour and child sexual exploitation. Involve community, voluntary and statutory partners. Send clear safety messages to CEE communities and trusted sources of where to report concerns should be set up an advertised.
- Identify and tackle domestic abuse.
- Continue to deliver targeted work to support people using illicit drugs.
- Address housing and homelessness issues. Develop a multi-agency response to rogue landlords.
- Support young people who have a key role in supporting their families' communities to integrate. Increase aspiration and opportunities; provide sex education and teenage pregnancy education.

- Plans underway to develop a timely multi-agency response immediately when concerns are raised with children's social care staff to continue, linking to the broader agenda of integration, cultural sensitivity and any empowerment projects undertaken.
- Bradford District NHS partners to consider the implications of this report and to improve CEE communities access to health care. Map need for dentists and take action to meet this need. Review which CEE countries have TB prevalence high enough to trigger BCG vaccination; and whether there is a case for routine Hepatitis B vaccination for targeted communities. GP surgeries to consider the language needs of CEE patients which are likely to increase in the short to medium term and consider approaches other cities have taken, e.g. Sheffield's CEE specific clinic.
- Contribute to the reduction of health inequalities in Bradford District. Target public health action at CEE communities focusing on smoking, alcohol, teenage pregnancy, drug use as well as a focus on community empowerment and tackling broader determinants of health such as unemployment, parenting and housing.

9. Recommendations

	Recommendation	Lead
1	CBMDC CMT to note the findings of this report and agree a response to the needs of CEE communities.	*Steve Hartley Strategic Director of Environment and Sport*
2	CBMDC CMT to agree how ongoing CEE needs are responded to at a strategic level, including monitoring change using an agreed set of indicators.	*Steve Hartley Strategic Director of Environment and Sport*
3	CBMDC to build strategic alliances with other organisations form a response to the priority areas identified on pages 98/99.	*CEE Working Group with Public Health Adult Services Children Services, VCS and CCGs & Health providers*
4	Training to be delivered to raise awareness amongst CBMDC elected members, directors, managers and front line staff.	*All partners via CEE Working Group*
5	Public Health and Adult Services to ensure commissioned welfare advice services take account of the identified needs of CEE communities .	*Public Health & Adult Services*
6	CEE communities are made aware of their responsibilities and entitlements and are supported to access all benefits available and employment opportunities.	*CEE Working Group with all key partners*

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Appendices

i) Languages spoken

Country	Languages	Source
Czech Republic	95% of the population speak Czech. 3% of the population speak Slovak, which is closely related to Czech. 2% of the population speak Czech but are also mother tongue speakers of German, Hungarian, Romani and Polish.	http://www.bbc.co.uk/languages/european_languages/countries/czechrepublic.shtml
Estonia	Since Estonia's independence from Russia in 1991, Estonian has become the country's only official language. Even during the Soviet occupation, when it was not banned, Estonian was widely used in business and education. The language, closely related to Finnish, is spoken by over two thirds of the population (particularly younger and older people; Russian is spoken by about a quarter of the population. Other minority languages include approximately 3% Ukrainian speakers, 2% Belarusian, 1% and a smaller number of Hebrew speakers.	http://www.bbc.co.uk/languages/european_languages/countries/estonia.shtml
Hungary	The official language of Hungarian is spoken by 98% of the 10.3m population. Minority languages have become more prominent in recent years, and include German, Croatian, Romani, Slovak, Romanian, Serbian and Slovene. Attempts are being made to protect these languages, as many members of the ethnic groups actually do not speak them.	http://www.bbc.co.uk/languages/european_languages/countries/hungary.shtml
Latvia	Since independence in 1991, the official language of Latvia has been the Baltic language of Latvian, a language closely related to Lithuanian. Latvian is spoken by the ethnic population, known as Letts, who make up 58.6% of the population. Russian is spoken by over 28.9% of the population, mainly Russian immigrants who live in the urban areas of the country. Minority languages include Belarusian, spoken by 3.9% of the population, Ukrainian, spoken by 2.6%, Polish, spoken by 2.5% and Lithuanian, spoken by a smaller population.	http://www.bbc.co.uk/languages/european_languages/countries/latvia.shtml
Lithuania	Since 1991, the official language of Lithuania is the Baltic language of Lithuanian, a language closely related to Latvian. More than 80% of the country's 3.8m population speaks Lithuanian as their first language. Minority languages include Belarusian (1.5%), Polish (7.7%),Russian (8%). Others, most notably Ukrainian and Yiddish make up a further 2.1%.	http://www.bbc.co.uk/languages/european_languages/countries/lithuania.shtml
Poland	98% of Poland's 39m population speak the official language of Polish. The remaining 2% speak minority languages including German, Ukrainian and Belarusian.	http://www.bbc.co.uk/languages/european_languages/countries/poland.shtml
Slovakia	85% of the 5.4 m population of Slovakia speak one of the three	http://www.bbc.co.uk/language

	Slovak dialects as their first language. These are the Central, Western and Eastern dialects which are mutually intelligible. Minority languages are predominantly spoken in the south of the country and include Hungarian (10% of the entire population), and in lesser numbers Romani, Czech, Ukrainian, German and Polish. An "official" Slovak language being taught at school.	s/european_languages/countries/slovakia.shtml
Slovenia	Over 90% of the population speak Slovene, the official language since independence from the former Yugoslavia in 1991. In areas where Italian or Hungarian ethnic communities reside, the official language is also Italian or Hungarian. Serbian, Croatian and German are widely spoken minority languages.	http://www.bbc.co.uk/languages/european_languages/countries/slovenia.shtml
Bulgaria	85% of the approximate 8.7m population of Bulgaria speak the official language, Bulgarian. 2.5% speak Macedonian, considered in Bulgaria as a dialect of Bulgarian and not as a separate language. Other minority languages include Romani, Turkish, spoken by 9% of the population, and the related languages of Gagauz, Tatar, and Albanian.	http://www.bbc.co.uk/languages/european_languages/countries/bulgaria.shtml
Romania	The official language is Romanian, which is spoken by approximately 89% of the 23m population. Hungarian is spoken by around 7% of the population, mainly in Transylvania. There is also a population of German speakers who make up around 1.5% of the national population.	http://www.bbc.co.uk/languages/european_languages/countries/romania.shtml
Croatia	Figures are unclear since independence from Yugoslavia and the following war, but three similar southern Slavic languages can be found in Croatia: Croatian, Bosnian and Serbian. The main difference between these languages is that Croatian and Bosnian use the Roman alphabet, while Serbian uses the Cyrillic script. For political reasons, deliberate attempts have been made to highlight and create distinctions between the languages.	http://www.bbc.co.uk/languages/european_languages/countries/croatia.shtml

Appendix ii) Rights and responsibilities of CEE migrants

An initial draft of this section was written using information from Migration Yorkshire and Citizens Advice. We are deeply grateful to Jana Elles, a freelance welfare advice expert, who checked this section in July 2014, for accuracy and real world applicability and added in more detail around the benefits system as applied to EEA nationals.

The UK can place restrictions on the rights of people coming from outside of the EEA; the EEA includes all EU countries as well as Norway, Lichtenstein and Iceland. It can set its own rules on who it chooses to allow to enter or stay in the UK, and can deport people who breach UK rules. However, 'free movement' agreements within the EEA mean that the UK can only require an EEA national to leave the UK in very exceptional circumstances, so EEA nationals are not subject to any immigration conditions when coming to or living in the UK. However, agreements between EEA states mean that, although the UK cannot make an EEA national leave the UK, they can restrict their access to some forms of support while they are here.

When new countries join the EU each existing member state can impose restrictions on people migrating from those new states, for up to five years after those countries join. As these measures can only be temporary, they have been lifted for all the newer EU member states except for Croatia. This means that in general all EU nationals should be treated the same regardless of where in the EU they come from, with the exception of Croatian nationals. A summary of the restrictions on other EEA states which have now ended can be found in appendix iv.

All EEA *nationals* have the right to come to the UK. However, only EU *workers* have guaranteed rights to be treated in the same way as UK nationals, and have the same rights to employment, services and benefits wherever they are within the EU. These are part of the fundamental 'free movement' principles of the EU. Originally the term 'worker' was not defined, but over time it has been established that 'worker' should also include self employed people, work-seekers, close family members of EU workers and people who can be treated as workers, e.g. retired or temporarily unable to work due to ill health. Importantly too, part time workers can also be included, so long as their work is 'genuine and effective' and not 'marginal and ancillary'.

From March 2014 there was a new 'Minimum Earnings Threshold' rule which means that if the EEA national has earned enough to pay NI for at least 3 months they will be automatically accepted as a worker. However, it does not change the existing test so that part time or new workers can still be workers. The new guidance and publicity imply that it is a new definition of who is a worker so it is likely that the DWP, local councils and EEA nationals may misunderstand this rule, which may make it harder for part time or newly arrived workers to prove that they have the rights of a worker.

EEA nationals who can be classed as 'workers' and their family members generally have the same rights as UK nationals. However, these people's

rights to certain benefits and services can be restricted - so long as the measures apply to all EU nationals, including UK nationals. For example, many benefits have 'residency tests', so that someone needs to have 'habitually resided' in the UK for a time before they can access certain benefits, even if they are British.

The current government is introducing measures to narrow down the very broad definition of 'worker', in particular to limit the rights of work seekers and part time workers.

Recent fear that migrants from the newer EU states, in particular the poorer Eastern states, will create a drain on resources has led the current government to impose restrictions aimed at reducing the benefits that some EEA nationals can claim.

Croatia joined the EU on 1 July 2013. Croatian nationals do not yet have the same rights to claim benefits in the UK as other EEA nationals. From 1st July 2013, Croatian nationals, or certain family members of a Croatian national, have the right to reside and are therefore able to claim certain benefits and help with housing if they: are working in authorised employment, have completed 12 months' authorised employment with fewer than 30 days of non-working time within that period, are self-employed, are self-sufficient or are a student or are a family member of an EEA national in the UK who has a right to reside. Croatian national who wishes to work in the UK and who is subject to the worker authorisation requirement will need to obtain an Accession worker authorisation document (permission to work) before starting any employment. An Accession worker authorisation document will normally take the form of a worker authorisation registration certificate (or "purple registration certificate") which the Croatian national must apply for.

Health care

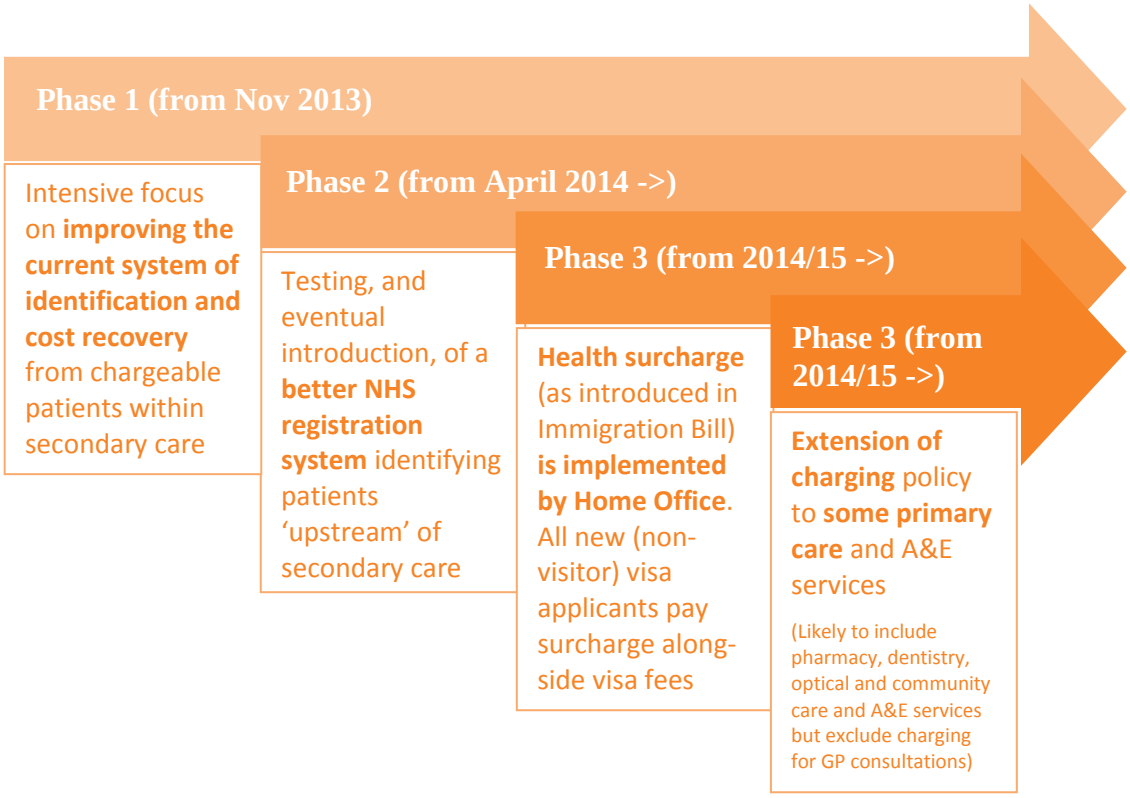
NHS care is for those "living lawfully" and considered to be "ordinarily resident" in the UK. Individuals can demonstrate they are living lawfully in the UK through showing a passport, visa or EU identity card. In order to be considered ordinarily residence an individual needs to show they are here for a settled purpose for six months or more. This could include demonstrating employment, acceptance onto an academic course or a tenancy agreement. An individual demonstrating they are ordinarily resident is entitled to free primary and secondary health care.

Where an individual is not entitled to NHS care they will be chargeable for the treatment they receive except:

- Treatment through A&E or walk in centres.
- Treatment that is determined to be immediate and necessary or life saving.
- Treatment for certain communicable diseases.
- Treatment for sexually transmitted infections.
- Treatment required under the mental health act.

EEA short term visitors can access temporary care for any new condition that occurs following arrival in the UK, the treatment of which can not wait until they return home. A separate system coordinating sickness insurance schemes exists at EU level for EEA nationals temporarily in another member sate. The European health Insurance Card (EHIC) enables EEA nationals to access all types of medical care and treatment that the patients state of health necessitate enabling them to continue to stay in the country under safe medical conditions. The EHIC system is also meant to cover unemployed individuals seeking work in another member state. (Bunting, 2010)

The Department of Health has been reviewing access to NHS services for other nationals (December 2013). In terms of EEA nationals, the main focus is on improving cost recovery through the EHIC scheme which will require the health service providers to identify who are EEA nationals. DH plans are illustrated below. These plans apply to all migrants, not just EEA migrants.



Emergency services

All migrants can access emergency services such as fire and police services.

Education

EEA nationals in the UK can bring any family member to join them if they are also an EEA citizen, since they both have the same freedom of movement across the EEA. If their family member is a third country national, they do not have to apply for a visa, which a UK national would for their family member from outside of the EEA. The child of an EEA worker in the UK has the right to enter and complete a course of non-advanced education in the UK. This can mean that an EEA national who might not otherwise be able to claim benefits, e.g. because they are not a worker, may be able to claim them if they are the

parent who is the primary carer of an EEA child who is in non-advanced education in the UK. .

All EEA nationals pay home fees as students in higher education. Access to student support depends on whether a family member is working in the UK or whether you have resided in the UK for three years. All EEA nationals are eligible for SFA-funded further education courses.

Benefits

The rights of EEA nationals to claim benefits are extremely complicated. Frequently, judge's decisions in complex cases change the interpretation of the rules or decide that the rules have been misapplied. This needs assessment can only summarise the main rules, and the recent changes and their implications. New measures are being introduced to restrict the ability of EEA nationals to claim benefits in the UK. There are some groups who can continue to claim any benefit, some for whom there is no change and some who are now facing much reduced rights:

EEA nationals who can claim benefits:

- EEA workers can claim any benefit in the same way as a UK resident national. This extends to cover most close family members of the worker (and can sometimes continue to cover them even if the worker separates from the family member). However, as mentioned, there are changes to who can be considered a 'worker'.
- EEA nationals who have the 'right to reside' and pass the new residence rules.
- EEA nationals who have contributed enough National Insurance can claim contributory benefits

The right to reside test applies to all means tested benefits, disability and child benefits. UK nationals are exempt from this test. The term 'right to reside' is confusing as it does not refer to an immigration condition, as there are no immigration conditions on EEA nationals coming or remaining in the UK. To have the right to reside, an EEA national must be:

- A worker / self employed or have retained worker status
- A work seeker
- A student (but many benefits can't be claimed by any student)
- Self sufficient and have health insurance, i.e. are able to meet their own needs without becoming 'an unreasonable burden' on social assistance
- Or be a close family member of someone with the right to reside.
- Or have had the right to reside here for 5 years so have gained a Permanent right to reside, even if they no longer fit into one of these categories.

The right to reside rules mean that most EEA nationals who are not working have to claim JSA to show that they are work seekers. This is why EEA nationals who look after young children or are sick have a lot of difficulty getting benefits.

New rules for EEA nationals who claim income based, rather than contribution based, JSA after January 2014, because most out of work EEA nationals rely on having the right to reside as work seekers, the government has introduced new rules to limit the ability of EEA work seekers to get benefits:

- From January 2014 no one can claim income based JSA unless they have been in the UK for the past three months. This applies to UK nationals too.
- From April 2014 most EEA nationals who claimed JSA after January 2014 cannot get Housing Benefit.
- From July 2014 most new EEA job seekers cannot claim child tax credits or child benefit.
- From July 2014 most new EEA job seekers will only be allowed JSA for a maximum of six months unless they can show they have a 'Genuine Prospect of Work'. The DWP will be interviewing all such claimants and stopping their JSA unless they have an imminent job offer. It was announced on 29th July that this period will reduce to three months.

These new rules only apply to JSA claimants who have not been working, so some EEA work seekers should not be affected by these rules if:

- They are working part time as you can work up to 16 hours per week and still claim JSA. Many part time workers could have 'worker' rights even though they are also jobseekers.
- They have 'retained' their worker status.
- They have paid enough national insurance to get 'contributory JSA'.

Anyone who has paid enough National Insurance (NI) can be entitled to claim a 'contribution based' benefit. NI paid in other EEA countries (or in countries where there are 'Reciprocal Agreements' such as Turkey, USA, Macedonia etc) can be taken into account when calculating someone's NI contributions. This means that if someone ceases work, due to old age, loss of job etc, the country where they last worked (or where they are settled) can use NI paid in other EEA countries to help someone to qualify for a 'contributory benefit.

To provide an example, if a person works and pays NI for a year in France, then 11 months in the USA, then returns to the UK and works for a month: their total NI contribution record is two years. They can claim contribution based JSA in the UK as this is the last place where they worked. Without these contribution-co-ordination rules they would not be able to claim JSA. As they can claim contribution based JSA - rather than income based JSA - they can claim HB, child benefit / child tax credit even though they had not been in the UK for the last 3 months before they claimed.

Social services

All EEA nationals can access all relevant social services.

Housing

Housing rights differ according to migrant category. EEA nationals with the permanent right to reside are eligible for council housing and homelessness assistance. Workers/self-employed people, including Accession nationals subject to transitional controls (i.e. Croatians), are eligible for council housing

and homelessness assistance. A student can apply for council housing and get homelessness assistance if habitually resident. A self-sufficient person can apply for council housing and get homelessness assistance if habitually resident. A work-seeker does not have the right to reside for purposes of housing and homelessness services, but a work-seeker can rent privately, take up a hostel place, or apply directly to a housing association.

Migrants with no recourse to public funds

People who come to the UK from outside the EEA are called Third Country Nationals (TCN), who need to have a visa to come and remain in the UK are referred to in this document as or Persons Subject to Immigration Control (PSIC). The most common immigration control is a restriction on claiming any public funds. Some PSIC may also include another restriction such as not being allowed to work. At the expiry of their visa many PSIC apply for further Leave to Remain. If they are granted indefinite leave to remain they are no longer subject to immigration control, and any immigration restrictions are lifted. This indefinite leave is less likely to be awarded if they have breached the terms of their visa (e.g. by claiming public funds).

In practice, many local authorities are faced with individuals who are destitute but have no recourse to public funds. This term refers to a person who is subject to immigration control and has no entitlement to benefits, public housing or asylum support. This may include, for example, migrant families with children, or looked-after children who arrived as unaccompanied migrants and are turning 18. This is a complex area, and causes confusion as each local authority deals with these cases differently, cases can be complex and the legislation and developing case law is complex. The No Recourse to Public Funds Network is a national network of local authorities coordinated by Islington Borough Council. The network provides practical guidance for assessing people with NRPF, runs training and regional associations for local practice sharing; there are networks in the North West and in Yorkshire and Humber. The network also engages with government regarding costs incurred in supporting people with NRPF.

Changes to the welfare system

There have been a number of recent policy changes which impact on the benefits CEE nationals are eligible to claim, for example; Simplifying the welfare system and making sure work pays (2014) and Securing borders and reducing immigration (2013). These policies have resulted in new regulations around the welfare system including universal credits, changes to disability living allowance and the cap on benefits. There has been an explicit policy drive to stop new migrants claiming benefits.

New work seekers coming to the UK are no longer able to claim benefits. Prior to January 2014 this group could claim JSA, for the work seeker and their family. They could also have Housing Benefit to pay towards their rent. Now they will only be able to claim any benefits if they in employment. On 29th July 2014 it was announced that European job seekers could only claim Jobseekers Allowance or Child Benefit for a maximum of three months reduced from six months (BBC, 29th July).

The benefits for EEA nationals who cannot work because they are too unwell to work or are looking after pre-school children or someone with a disability; (Employment Support Allowance and Income Support) cannot normally be claimed by an EEA national unless they are working part time or have lived here already for a long time. In practice this group tends to be people who used to manage but need to claim due to a change, for example women who lose their job due to pregnancy, or who separate from a partner who worked, or people who have worked here for years but become long term sick or a carer.

New rules mean that most people must have lived here for at least two years before they can claim disability benefits. This has an impact on disabled workers, or on those with a family member who has a disability. Someone who needs to provide care for that person will not be able to claim Carers Allowance if the disabled person does not have the right to the disability benefit.

Many EEA nationals have casual, low paid work or unofficial work, or who do not have proof that they have worked here for more than 3 months. New definitions of 'worker' will make it much harder for these people to prove they have been working and to claim benefits during periods of lower wage / out of work, making it harder to sustain a tenancy.

Previously a worker who loses their job here can claim 'out of work' benefits for a long time whilst seeking a new job (the same as a UK national). From July there is a 6 month limit on the support they can get, regardless of how long they have worked here or reasons for losing the work. This will begin to impact over the coming months.

Many people have the right to claim benefits but are unable to establish their rights. Case examples:

- a woman splits up from her working EEA husband but cannot prove that she has retained the right to claim benefits via her ex husband / father of her children
- a 19 year old who has left her parents explains to the DWP that she has lived here since she was 14 and has the right to claim benefits but cannot prove it
- a Polish man who has worked here full time for 8 years but never registered his work on the old 'workers registration scheme' may find those years of work don't count as years of working in the UK for benefit purposes
- an agency worker who cannot get guaranteed work fails to build up the 3 months continuous work needed to be treated as a 'worker' for benefit purposes (a UK national in the same position could claim between jobs)
- an EEA national who has never had to claim benefits before, falls sick. Losing their rights whilst in hospital means they are unable to be discharged due to loss of tenancy / lack of financial support. Because an EEA national cannot be deported there are no national funds

available to repatriate an EEA national who is unable to manage here (unlike a third country national).

Each of the above groups are likely to face total loss of benefits. However, within each of these groups are potentially many EEA nationals who could claim, but would be told by the job centre that they cannot. Good advice could secure benefit support for significant numbers of these people.

iii) Delegates who validated the Bradford dissertations findings at the “Ten Years On” event

- Agnes Andryzewski - Outreach adult services
- Martina Prochazkova - Horton Housing
- Patrik Makula - CEELS - Healthy Lives
- Roma Kotlar - Girlington Community Centre
- Manahil Siddiqi - Community Health Student, Bradford Trident
- Helen Speight, Thornbury Centre
- Sean Dobiech, Sharing Voices

Appendix iv) Restrictions which have now ended:

A8 nationals from the EEA states which joined in 2004 had to register any work they did in the UK and until they had done a year of registered work they could not claim many types of benefits. These restrictions ended in 2011.

A2 nationals from Romania and Bulgaria could only do certain types of work when they came to the UK, and could not claim many types of benefits. These restrictions ended in January 2014.

Appendix v) People on the electoral register in Bradford by CEE Nationality

	Total Electorate	Polish	Romanian	Lithuanian	Czech	Latvian	Slovakian	Bulgarian	Estonian	Hungarian	Slovenia	Croatian	Total (C-M)	% of Electorate
Baildon	11923	27	<5	5	<5	<5	0	0	0	0	0	0	36	0.3%
Bingley	14360	59	<5	<5	<5	<5	<5	0	<5	0	0	0	79	0.6%
Bingley Rural	13905	24	<5	0	1<5	0	0	0	0	<5	0	0	32	0.2%
Bolton and Undercliffe	11264	54	13	8	10	10	12	0	0	6	<5	0	114	1.0%
Bowling and Barkerend	12615	211	10	22	71	36	108	<5	<5	19	0	0	481	3.8%
Bradford Moor	11901	89	58	<5	21	24	51	<5	0	7	<5	0	255	2.1%
City	12355	378	49	91	37	273	164	34	21	19	0	<5	1067	8.6%
Clayton and Fairweather Green	11443	103	8	16	24	65	66	0	<5	<5	0	0	287	2.5%
Craven	13050	22	5	<5	<5	<5	5	<5	0	<5	0	0	42	0.3%
Eccleshill	12173	209	9	5	4<5	24	26	<5	0	11	0	0	289	2.4%
Great Horton	11308	83	0	9	23	61	137	0	0	<5	<5	0	315	2.8%
Heaton	11088	87	8	<5	37	9	223	0	<5	<5	<5	0	373	3.4%
Idle and Thackley	12381	26	5	<5	<5	<5	0	0	<5	0	0	0	43	0.3%
Ilkley	11894	38	6	<5	0	<5	<5	0	0	5	0	0	54	0.5%
Keighley Central	11906	86	<5	8	37	5	123	0	0	14	0	0	274	2.3%
Keighley East	12147	32	<5	<5	17	<5	12	<5	0	8	0	0	76	0.6%
Keighley West	11630	71	<5	11	<5	0	7	0	<5	<5	0	0	95	0.8%
Little Horton	11678	351	<5	37	101	73	233	0	<5	<5	<5	<5	810	6.9%
Manningham	11504	217	8	14	52	61	217	<5	7	11	0	0	590	5.1%
Queensbury	12101	19	1	<5	<5	<5	0	0	<5	6	0	0	35	0.3%
Royds	12156	133	3<5	9	5	35	7	0	<5	<5	<5	<5	198	1.6%
Shipley	11415	89	7	<5	<5	7	6	0	<5	5	0	0	121	1.1%

Thornton and Allerton	11655	81	5	9	5	12	13	0	<5	<5	0	0	130	1.1%
Toller	12083	133	18	25	56	28	222	<5	<5	<5	0	0	487	4.0%
Tong	11767	275	<5	22	14	54	33	0	5	5	0	0	410	3.5%
Wharfedale	9449	16	5	<5	<5	<5	<5	0	0	0	0	0	29	0.3%
Wibsey	10703	68	6	<5	18	15	18	0	<5	<5	<5	0	129	1.2%
Windhill and Wrose	11119	110	6	6	5	9	5	0	<5	0	0	0	142	1.3%
Worth Valley	10803	7	0	0	<5	0	<5	0	<5	<5	0	0	12	0.1%
Wyke	10458	47	<5	5	<5	1	<5	<5	0	<5	0	0	58	0.6%
TOTALS	354234	3145	251	324	561	818	1699	45	60	147	10	<5	7063	2.0%

Appendix vi) Alcohol interviewees

Matt Birch	Lifeline Piccadilly
Mohamed Shabir	Sharing Voices
Adam Clark	Hope Housing
Ellie McNeil	Project Six
Mike Cadger	Project Six
John Royal	The Bridge
Sue Rana	Bradford NHS Care Trust
Margaret Blenkinsopp	LACO
CEE Team	Horton Housing
Kevin Pickles	West Yorkshire Police
Peter Roebuck	Horton Housing

Appendix vii) Percentage of people on GP practice lists who are CEE

Practice code	Total	%
B83005 Thornbury Medical Centre	438	5.6%
B83006 Silsden Health Centre	187	1.8%
B83007 Heaton Medical Practice - Haworth Rd	316	4.6%
B83008 Ling House Medical Centre	146	1.3%
B83009 Sunnybank Medical Centre	112	1.0%
B83010 Parklands Medical Practice	407	3.8%
B83011 Woodroyd Centre - Fenwick	448	8.1%
B83012 Carlton Medical Practice	182	3.4%
B83013 Westcliffe Medical Centre	297	2.7%
B83014 Bingley Medical Practice	156	1.3%
B83015 Tong Medical Practice	226	2.8%
B83016 Farrow Medical Centre	84	1.6%
B83017 Horton Bank Practice	96	1.2%
B83018 Idle Medical Centre	136	1.2%
B83019 Grange Park Surgery	53	0.8%
B83020 Willows Medical Centre	60	0.8%
B83021 Farfield Group Practice	182	1.4%
B83022 The Surgery, Newton Way	70	0.8%
B83023 Holycroft Surgery	189	1.9%
B83025 Little Horton Lane Medical Centre	156	4.0%
B83026 Primrose Surgery	182	4.0%
B83027 Haworth Medical Practice	28	0.3%
B83028 Wibsey & Queensbury Medical Practice	113	1.0%
B83029 Low Moor Medical Centre	86	1.0%
B83030 Thornton Medical Centre	61	0.7%
B83031 Oak Glen Surgery	47	1.5%
B83032 The Bradford Moor Practice	53	1.4%
B83033 Kilmeny Surgery	30	0.2%
B83034 Grange Medical Centre	59	1.0%
B83035 Horton Park Surgery	859	10.3%
B83037 Wilsden Medical Centre	65	0.7%
B83038 Leylands Medical Centre	98	1.0%
B83039 Windhill Green Medical Centre	188	1.6%
B83040 Saltaire Medical Centre	193	1.8%
B83041 Bowling Hall Medical Practice	293	4.2%
B83042 Rooley Lane Medical Centre	222	3.4%
B83043 Woodroyd Centre - Longfield	361	7.7%
B83044 Highfield Health Centre	291	4.0%
B83045 Mayfield Medical Centre	127	1.9%
B83049 Cowgill Surgery	24	0.6%
B83050 Grange Practice	187	2.5%
B83051 University of Bradford Medical Centre	1265	12.0%
B83052 Kensington Street Health Centre -	314	3.6%

Wilson		
B83054 Haigh Hall Medical Centre	55	1.1%
B83055 The Ridge Medical Practice	1042	4.1%
B83056 Moorside Surgery	53	0.8%
B83058 The Avicenna Medical Practice	912	14.0%
B83061 Oakworth Health Centre	8	0.2%
B83062 Ashcroft Surgery	220	2.7%
B83063 Shipley Medical Practice	350	4.3%
B83064 The Rockwell and Wrose Practice	142	1.5%
B83067 Springfield Surgery	130	1.8%
B83069 Whetley Medical Centre - Basu	53	3.0%
B83070 Mughal Medical Centre	123	3.1%
B83071 Phoenix Medical Practice	236	6.2%
B83602 North Street Surgery	17	0.2%
B83604 Westbourne Green Community Health Centre	35	1.4%
B83611 The Bluebell Building - Eliwi	<5	-
B83613 LCD Bradford at Manningham Medical Centre	50	1.5%
B83614 Picton Medical Centre	246	5.1%
B83617 Whetley Medical Centre - Mahmood	56	3.3%
B83620 Addingham Medical Centre	24	0.8%
B83621 Horton Park Centre	278	9.3%
B83622 Kensington Street Health Centre - Iqbal	421	8.6%
B83624 Ilkley Moor Medical Practice	109	0.8%
B83626 Valley View Surgery	82	1.3%
B83627 Frizinghall Medical Centre	353	10.6%
B83628 Clarendon Medical Centre	89	2.1%
B83629 Peel Park Surgery	56	2.3%
B83631 Woodhead Road Surgery	342	10.3%
B83638 LCD Bradford at Hillside Bridge Healthcare Centre	369	8.8%
B83641 Ashwell Medical Centre	181	2.4%
B83642 Whetley Medical Centre - Masood	31	1.3%
B83653 Little Horton Lane Medical Centre - Dr Gilkar	286	3.7%
B83657 Bevan House Primary Care Centre	88	5.1%
B83659 Park Grange Medical Centre	17	0.7%
B83660 Bilton Medical Centre	42	0.8%
B83661 The Bluebell Building - ElAzab	<5	-
B83700 Fountains Hall Medical Centre	352	23.1%
Y01118 Hamdani SHM	73	2.2%

Glossary

A2 migrant
A person from the A2 countries that joined the European Union (EU) in January 2007. The A2 members are: Bulgaria and Romania.

A8 migrant
A migrant from the A8 countries that joined the European Union (EU) in May 2004. These countries are: Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia. The A8 are all members of the A10.

A10 migrant
A person from the A10 countries that joined the European Union (EU) in May 2004, including the A8 Cyprus and Malta. The A10 includes: Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia.

European Economic Area (EEA)
Countries include all those in the European Union (EU) as well as Norway and Liechtenstein. Switzerland is not in the EEA but Swiss nationals and their families have the same rights of entry and residence as EEA nationals. In this document we refer to EEA to include all of these countries. EEA nationals do not need any visa to come to the UK and have no immigration conditions on being here.

EEA co-ordination rules
The national insurance contribution record of someone who moves around the EEA can be combined. This means that if someone ceases work - due to old age, loss of job etc - the country where they last worked (or where they are settled) can use NI paid in other EEA countries to help someone to qualify for a ‘contributory benefit. For example, a person who works for 20 years in the UK and 20 years in France could still claim a state pension based on 40 years of contributions.

EU 15 Migrant
A person from the 15 countries that were EU (European Union) members before the EU Accession countries joined in 2004 and 2007. The EU 15 includes: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden, United Kingdom.

EEA Migrant
A person from countries that are members of the European Economic Area (EEA) which includes the EU plus Iceland, Liechtenstein and Norway. The members of the EEA are: Austria, Belgium, Bulgaria, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, United Kingdom.

EU migrant
A person from a European Union (EU) member state, including the EU 15 and the EU Accession countries. The 27 EU states are: Austria, Belgium, Bulgaria, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, United Kingdom.

EU Student
A student from the EU (European Union). This often also refers to people from the EEA (and Switzerland) who have similar rights as members of the EU to financial support.

EU Accession
A person from one of the countries that joined the migrant[1] European Union (EU) in 2004 (A10) and 2007 (A2). The Accession countries are: Bulgaria, Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Romania, Slovakia and Slovenia.

Family Migrant
A person who has come to the UK to join a member of their family, and given a right to live in the UK. This term does not normally apply to EU migrants as they are able to enter the UK in their own right.

Habitual residence test
Most means tested and disability benefits can only be claimed if the person is settled or normally lives in the UK.

International passenger survey
A sample survey of people arriving at and departing from UK main airport and sea routes and the Channel Tunnel carried out annually by the Office of National Statistics (ONS). It covers three main areas expenditure, tourism and migration.

Means tested benefits
These are the benefits which are paid if someone has no or little other income or savings and include Housing Benefit, income based Jobseekers Allowance, tax credits etc. These are different from contributory benefits, which someone can get if they have paid enough National insurance, in the UK or elsewhere in the EEA.

Migrant
A person who leaves one country and resides in another. In the UK this refers to all people who have entered and live in the UK (i.e. immigrants). People are usually classed as migrants if they stay for at least one year.

Migrant worker
A person who has left their country of origin to work in another. In the UK, this includes people entering as European Economic Area (EEA) migrants.

National Insurance Number

A National Insurance Number (NINo) is unique individual Identifier and a personal account number used throughout someone's life to ensure National Insurance Contributions (NICs) and tax are accurately recorded. It is also used as a reference number for Social Security benefits and tax credits.

National Insurance Number Allocation

Individuals resident or present in Great Britain and over 16, who are employed or self employed or who wish to pay voluntary (Class 3) National Insurance contributions, and who are not already in possession of a NINO, are required to make an application for one, under reg 9(1)(1A)(2) of the *Social Security (Crediting and Treatment of Contributions and National Insurance Numbers) Regulation 2001/769.*

Persons subject to immigration control

People who come to the UK from outside the EEA who have to have a visa to come and remain in the UK are referred to in this document as 'third country nationals' or 'Persons subject to immigration control' (PSIC). Some non-EEA countries have 'reciprocal arrangements' with the UK, for example to enable someone to combine the national insurance they have paid several countries to entitle them to contributory benefits such as a retirement pension.

Public Funds

Most visas are granted for a limited time, with conditions such as having no recourse to public funds. Claiming them usually breaches their visa and usually means that their visa is not renewed at the end of its term, and can lead to deportation, what are 'public funds' are defined in the government document at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/284160/Public_funds_v12_0EXT.pdf).

Right to reside

This is a UK benefit term and does not refer to immigration rules (there are NO immigration conditions on EEA nationals coming or remaining in the UK). UK nationals automatically have the right to reside, as do people from the EEA who are workers, work seekers, students, or self sufficient.

Roma

The term "Roma" refers to Roma, Sinti, Kale and related groups in Europe, including Travellers and the Eastern groups (Dom and Lom), and covers the wide diversity of the groups concerned, including persons who identify themselves as "Gypsies". There are approximately 10 million Roma in Europe**,** although estimates vary from 8 to15 million. They are mainly found in the Balkans and in Central and Eastern Europe. Most of them speak Romani.

Trafficked Person

A person who is a victim of human trafficking and, in this context, moved from another country to the UK. The UN defines trafficking in persons as 'the recruitment, transportation, transfer, harbouring or receipt of persons, by

means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation.'

Undocumented Migrant

A person who does not have a valid immigration status either through entering the UK without permission, or because they entered under another status and have stayed beyond the period of time allowed.

Worker Registration Scheme

The Worker Registration Scheme was introduced in May 2004 to regulate access to the scheme labour market of migrants from the A8 countries and to restrict their access to benefits. Under European Union rules of Accession, the transitional arrangements under which the Worker Registration Scheme was established expired after 7 years. The scheme was originally scheduled to terminate in April 2009 but was extended until April 2011. Since that date, A8 nationals have enjoyed the same rights as those of the older member states.