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# Exploring healthcare priorities, barriers, access and experiences of a family-centred approach among families seeking asylum in North London

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## ABSTRACT

**Background** Children and families seeking asylum have significant unmet health needs. The Respond service was established in response to high numbers of families seeking asylum arriving in Camden (London, UK) in August 2021 and delivers hospital and community-based holistic assessment and infectious disease screening for this population. Families are seen in a joint appointment by a multidisciplinary team of adult and paediatric health professionals. We explored the priorities, barriers and experiences around healthcare access among families using the service and the acceptability and perceived effectiveness of a family-centred approach from the perspective of service users, service providers and key stakeholders.

**Methods** We employed qualitative and quantitative approaches. Questionnaires and semistructured interviews were completed between July and September 2022. Questionnaires were built on Google Forms and Envoy Messenger (Healthcare Communications). Thematic analysis was performed and structured by key themes. Data were analysed with the assistance of NVivo.

**Results** Access to dental care, primary care and immunisations were identified as key priorities for families. Significant barriers of access to care included understanding (language), situation (temporary accommodation) and awareness (unfamiliarity with systems, digital poverty, signposting). The Respond family-centred model was positively received by service users, service providers and stakeholders. Benefits included the provision of holistic family-centred care and support, efficiency and value-for-money for the health service. Areas needing ongoing input were language barriers, educational support for staff and service users and continued collaboration and co-creation between service providers and service users.

**Conclusion** Recognising the priorities and barriers identified in this study is crucial for enhancing access to and utilisation of services within this underserved community. The Respond family-centred model was well received and perceived as effective by service users, providers and stakeholders. It serves as a foundational framework for developing tailored services for children and families seeking asylum across the UK and internationally.

### WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ People seeking asylum and refugees (PSAR) are a vulnerable population with complex health needs. Many face barriers in accessing healthcare, which leads to health inequalities, exclusion, isolation and poor health outcomes. Existing research exploring the health priorities and experiences of PSAR largely considers the perspectives of children and adults separately, rather than as a family unit and little is known about the experience of a family-centred approach.

### WHAT THIS STUDY ADDS

⇒ This study contributes to understanding about the healthcare priorities of PSAR and barriers to access that they experience. Our findings suggest that a family-centred approach is both acceptable and perceived to be effective by service users, service providers and key stakeholders within North Central London.

### HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Understanding the healthcare priorities of PSAR and the barriers they face is essential for developing appropriate services for this population. Providing care to entire families in a single health encounter enhances efficiency, reduces duplication and promotes a coordinated approach. While further research is needed to evaluate this model, we recommend adopting a family-centred, inclusive approach when designing healthcare services for PSAR in the UK and beyond.

## INTRODUCTION

For the year ending June 2022, there were 75 181 asylum claims made in the UK; of these, 13 732 were from children and young people.[1]

People seeking asylum often have complex physical and mental health needs, both directly related to the effects of war, conflict or environmental disasters or secondary to the associated fracturing of healthcare systems. These complex needs include undiagnosed infections, missed routine health checks and immunisation administration, lack of access to medication for the management of chronic health conditions and the ongoing effects of trauma.[2–4] PSAR have been shown to have poorer health than the general UK population and to deteriorate over time after arrival.[5] This is likely to be exacerbated by long, gruelling journeys, living in overcrowded accommodation, poverty, language barriers, poor access to healthcare and the asylum process itself resulting in degradation of the 'healthy migrant effect'.[6 7]

Approximately 33%–50% of recently arrived asylum seekers in the UK are accompanied by a family member, categorising them as a family unit.[8] In London, many families continue to be housed in hotels and hostels for extended periods following the COVID-19 pandemic,[9] despite these accommodations originally being intended for temporary stays of up to 35 days.[10] While people seeking asylum are entitled to free National Health Service (NHS) care, general practitioners (GPs) and community health visitors have reported significant unmet health needs, particularly among children in temporary accommodations, along with a lack of resources to provide adequate care for these communities.[11]

Respond was established in 2021 to address the increasing number of families seeking asylum in Camden, North London. This rise was driven by both a backlog in Home Office processing[12] and the Afghan Relocation and Assistance Programme,[13] which supports Afghan citizens who worked for or with the UK Government by offering them relocation to the UK. Respond provides a dedicated service for people seeking asylum and refugees (PSAR), including outreach-based holistic assessments (online supplemental appendix A) and infection screening for those ineligible for holistic assessments due to alternative commissioning arrangements. These assessments take an innovative, holistic approach, covering physical health—including infectious disease screening—mental health and social needs of family units.

To optimise engagement, Respond employs tailored strategies such as preappointment telephone calls via interpreters, translated text reminders and flexible rebooking options. Families can also receive prefilled transport passes for hospital-based appointments and are seen together in a single visit by both adult and paediatric clinicians. Between November 2021 and March 2023, the service provided care to approximately 2000 patients, including 200 family units, across 13 sites in North Central London.

The aim of this study was to explore the healthcare priorities of families using our service, identify the barriers to addressing these needs and evaluate the acceptability and perceived effectiveness of this family-centred approach from the perspectives of service users, service providers and key stakeholders.

## METHODS

### Aims and objectives

1. To explore the healthcare priorities of families attending the Respond service.
2. To identify the barriers to addressing healthcare priorities of families using the Respond service.
3. To evaluate the acceptability and perceived effectiveness of the Respond service from the perspectives of service users, service providers and key stakeholders.

### Study design and recruitment

This evaluation of the Respond family-centred model of care was conducted using both quantitative and qualitative data collected from service users, service providers (healthcare providers employed by Respond) and stakeholders (defined as third party health and social care providers not directly employed by the Respond service) via a mixture of questionnaires and interviews conducted between June and September 2022. For full inclusion and exclusion criteria, see online supplemental appendix B. Data collection was performed by a senior nurse in the Respond team, a member of the medical team and five trained medical students.

1. **Service users:** all service users over the age of 18 years attending the Respond service, between June and September 2022, were invited to take part in one of two healthcare questionnaires. Open and closed questions as well as Likert scale responses were used (online supplemental appendices C and D). Participants were assigned to questionnaires A or B based on convenience. No participant was asked to complete both questionnaires to minimise the burden on participants.
   A. Health priorities and barriers of having these met, conducted prior to the Respond appointment.
   B. Experience of accessing healthcare and experience of the family-centred approach, conducted after the Respond appointment.
2. **Stakeholders:** purposive and snowball sampling of a cross-section of cross-sectoral health and social care providers regularly referred to by the Respond team. All identified potential participants from the following domains (primary care, early help teams, school nursing and health visiting teams in the London boroughs of Barnet, Camden and Islington as well as secondary care practitioners in Camden) were emailed and invited to take part in a questionnaire (online supplemental appendix E). 39 emails were sent initially and 34 follow-up emails were sent over a 4-week period, and individuals were asked to disseminate the invitation to appropriate colleagues. The questionnaire was designed to explore,
   - The perceived effectiveness of the Respond service.
   - Acceptability of the family model of care to PSAR.
3. **Service providers:** all members of the Respond team were invited to take part in semistructured interviews exploring the acceptability and perceived effectiveness of the family-centred model of care.

### Data collection

1. **Service users:** questionnaires for service users prior to the Respond appointment were built on Google Forms (V.134), while questionnaires conducted after the Respond appointment were built on Envoy Messenger (V.3 Healthcare Communications 2007–2025). The Envoy platform supported open-ended questions and qualitative analysis and allowed translation of questionnaires into several languages, increasing the possibility of participants being able to complete independently. Participants were also offered the option of having the questionnaire read to them, via an interpreter if required, and completed on their behalf.
2. **Stakeholders:** questionnaires for stakeholders were also built on Envoy Messenger (V.3 Healthcare Communications 2007–2025) and sent by email.
3. **Service provider interviews:** interviews were conducted by one researcher, a senior nurse within the Respond service. An interview guide was developed for the interview (online supplemental appendix F) and interviews occurred face to face or online via Zoom (V.5.11.2). Face to face interviews were recorded using iPhone recording software (V.15.8.3) and remote interviews were recorded via the Zoom recording function. All interviews were transcribed using Otter Online Transcription (Basic), verified and anonymised and original audio files were destroyed.

### Sample size calculation

As this was a service evaluation, no priori sample size calculation was performed.

### Informed consent

Written informed consent was obtained from all service providers taking part in interviews (online supplemental appendices G and H). Verbal and implicit consent was taken for individuals completing questionnaires. All participants were made aware that there was an exit option available at each stage of the process. Service users were made aware that they could withdraw from the evaluation at any time and their decision to take part would not affect their care.

### Data analysis

For service providers, one researcher thematically analysed the qualitative data using a modified Braun and Clarke's approach using Nvivo software (V.1.6.2). Braun and Clarke's approach provides a structure for analysis by identifying, analysing and reporting patterns (themes) within the data. The six phases of Braun and Clarke were adopted: (1) data familiarisation, (2) generating initial codes, (3) searching for themes, (4) reviewing themes, (5) defining and naming themes, (6) producing the report. Data were charted into a matrix to facilitate the recognition of typologies and themes. Themes were then reviewed and defined until the point of saturation, and a thematic map of the analysis was created relevant to the study aims.

For service users and stakeholders, anonymised responses were stored on Google Forms (pre appointment questionnaire) and Envoy platforms (post appointment questionnaire) and downloaded to Excel at the end of the data collection period. Descriptive analysis of the quantitative data obtained from questionnaires was carried out using Excel (V.2402). Open-ended questions that gave more information were analysed thematically with the information obtained from the service provider interviews to offer further insight and support to the themes being developed, as outlined above.

### Patient and public involvement

Patients were not involved in the design of this study. The learning from this work has been used to shape the model of care and has identified further gaps in research that we plan to address, with the involvement and engagement of patients and the public.

## RESULTS

### Respondents

64 study participants were recruited (figure 1). Participants were service users (n=42), service providers (n=8) and stakeholders working closely with the service (n=14) (online supplemental appendix I). 27 service users completed the questionnaire regarding healthcare priorities and barriers to addressing these. 15 completed the questionnaire regarding access to healthcare services and experience of a family-centred model.

The median age of service users was 34 years (range: 23–48) and 43% were female. Service users were from seven countries including Afghanistan (33/64, 52%), Nigeria (2/64, 3%), Eritrea (2/64, 3%), Bangladesh (1/64, 2%), Kuwait (1/64, 2%), Guinea (1/64, 2%) and Iran (1/64, 2%) (figure 2). The languages requested by service users for translation or interpretation services were Pushto, Arabic, Bangla, Punjabi, Tigrinya, Dari and French.

Service providers worked within Respond and were either hospital-based (5/8, 63%) or delivering outreach services (2/8, 25%). One service provider worked in both settings. Stakeholders were based in NCL boroughs (Camden 7/14, 50%), (Barnet 4/14, 29%) and (Islington 3/14, 21%). Half (7/14, 50%) were GPs/ practice nurses, 3/14 (21%) were secondary care clinicians, 2/14 (14%) were based within social care services and 2/14 (14%) from community nursing teams (online supplemental appendix I).

### Healthcare priorities

Dental services, access to general practice and immunisation clinics were most frequently reported as 'very important' by 25/27 (93%), 25/27 (93%) and 24/27 (89%), respectively (figure 3). Mental health, growth and development services were also all perceived as 'very important' by 16/27 (59%) of respondents.

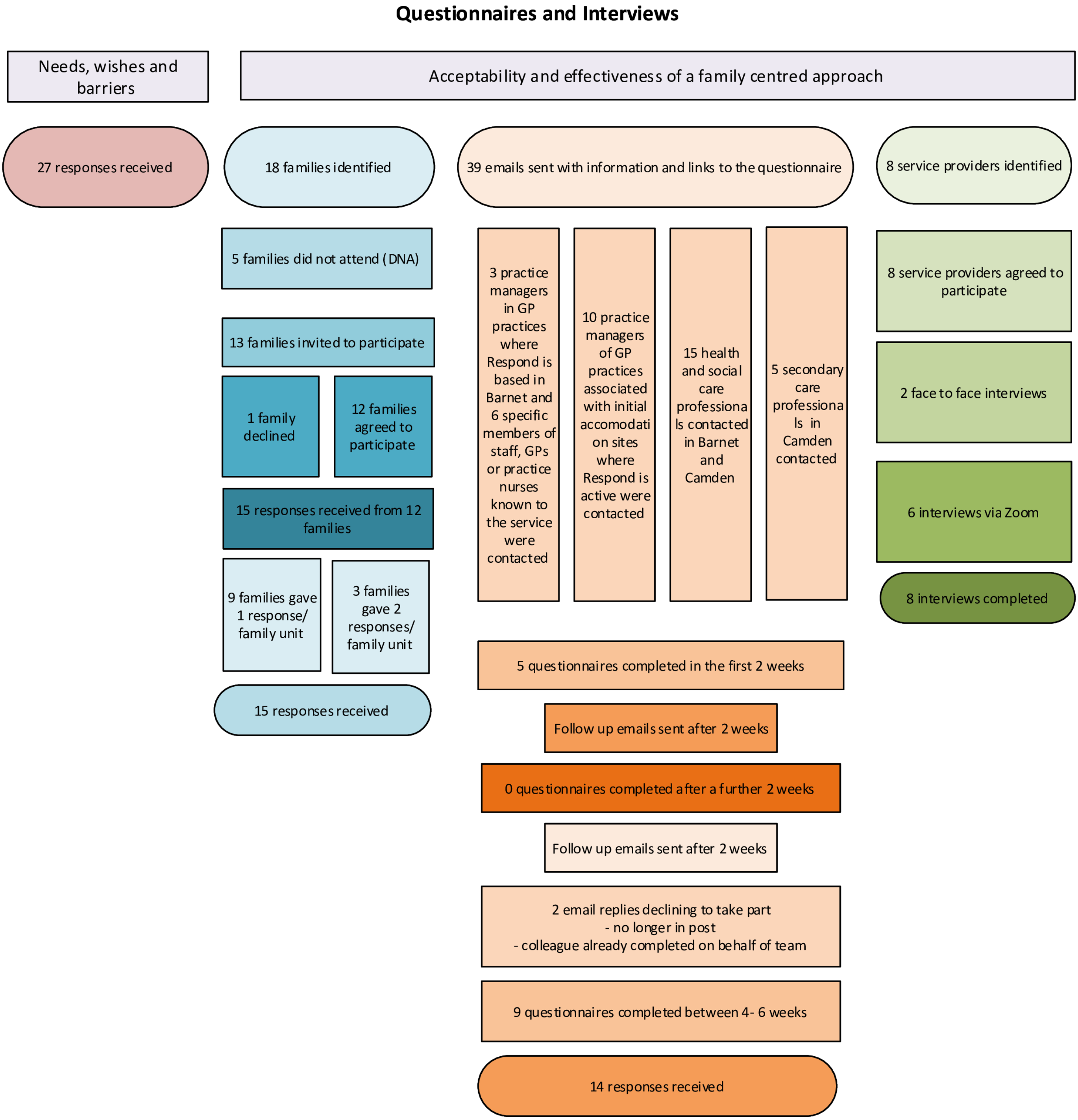

**Figure 1** Flow diagram of participants and respondents.

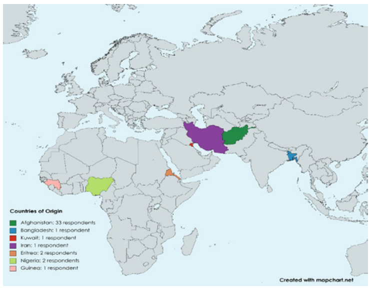

**Figure 2** Country of origin of service users. Created with *https://www.mapchart.net/*.

### Barriers to addressing health priorities

The majority of parents (18/27, 67%) perceived that language barrier and temporary nature of accommodation (14/27, 54%) were significant barriers to accessing services to address healthcare needs (figure 4). All 27 respondents (100%) reported a desire to access routine immunisations, though 2/27 (15%) reported not knowing how to do so. Challenges in accessing primary care appointments, registering at dental practices and lack of tailored advice for PSAR families were also mentioned in free text answers as barriers. 9/27 (33%) families reported the importance of

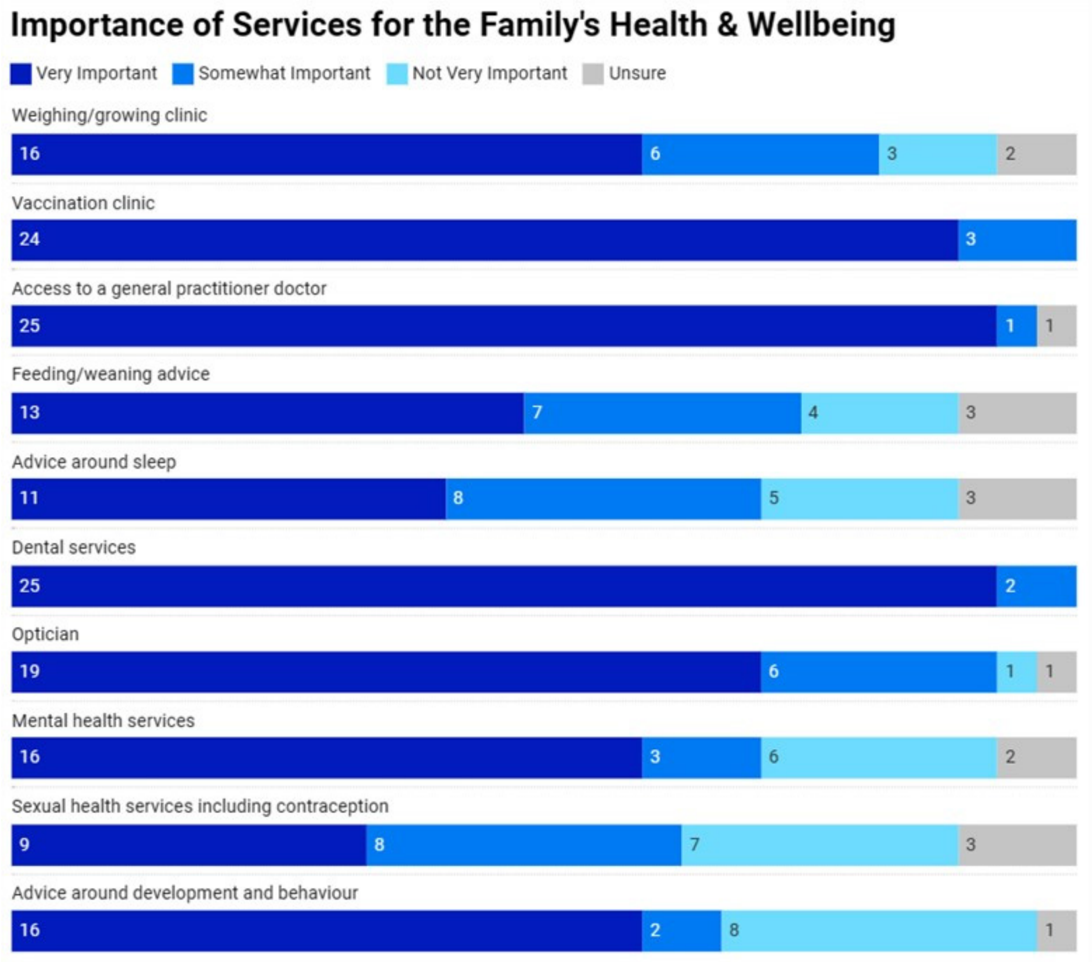

**Figure 3** Importance of services for family's health & wellbeing reported by service users (percentage of users reporting each rating).

approachability of staff as a facilitator to accessing health services and achieving their health priorities.

### Importance and experiences of access to healthcare

Although access to healthcare and freedom from disease was rated as most important by 6/15 (40%) service users, a greater number (8/15; 53%) prioritised a safe space to live as more important. A minority of service users (2/15, 13%) felt confident accessing NHS health services and 2/15 (13%) raised that accessing dental care was more difficult than accessing primary care. Nearly half (6/15, 40%) stated it is 'somewhat difficult' to access healthcare in London for them and their families, with 3/15 (20%) service users finding it 'extremely difficult' and only 2/15 (13%) finding it 'very easy'; 6/15 (40%) of respondents stated that appointments are not available when needed and reported delays. Suggested facilitators to healthcare access included provision of extra healthcare staff, transport to appointments, interpreters and information about local services and available local support.

### Acceptability and perceived effectiveness of a family-centred approach

The key themes identified in the analysis of data from participants from all three groups were high acceptability to patients, and promotion of family support and unity (being seen together and recognised as a family unit), administrative benefits, and challenges (table 1). Data on the perceived effectiveness of the Respond family model in identifying health needs for PSAR families collected from service providers and stakeholders aligned with the following themes: staff satisfaction, ability to work effectively, health system benefits and administrative benefits and challenges (table 1).

### Acceptability to patients

Among service users, 14/15 (93%) were satisfied with the Respond family model clinic experience and 100% felt that their needs were addressed. Service providers also perceived high patient satisfaction overall, although some described challenges in assessing this due to language barriers and the lack of non-verbal cues when using a telephone interpreter. 14/15 (93%) service users reported being comfortable being seen together in a family appointment. Only one participant stated they would have preferred a separate appointment, the reason for this was not given. All families stated they had enough time to discuss their needs and highlighted the support and unity they felt from having their family with them.

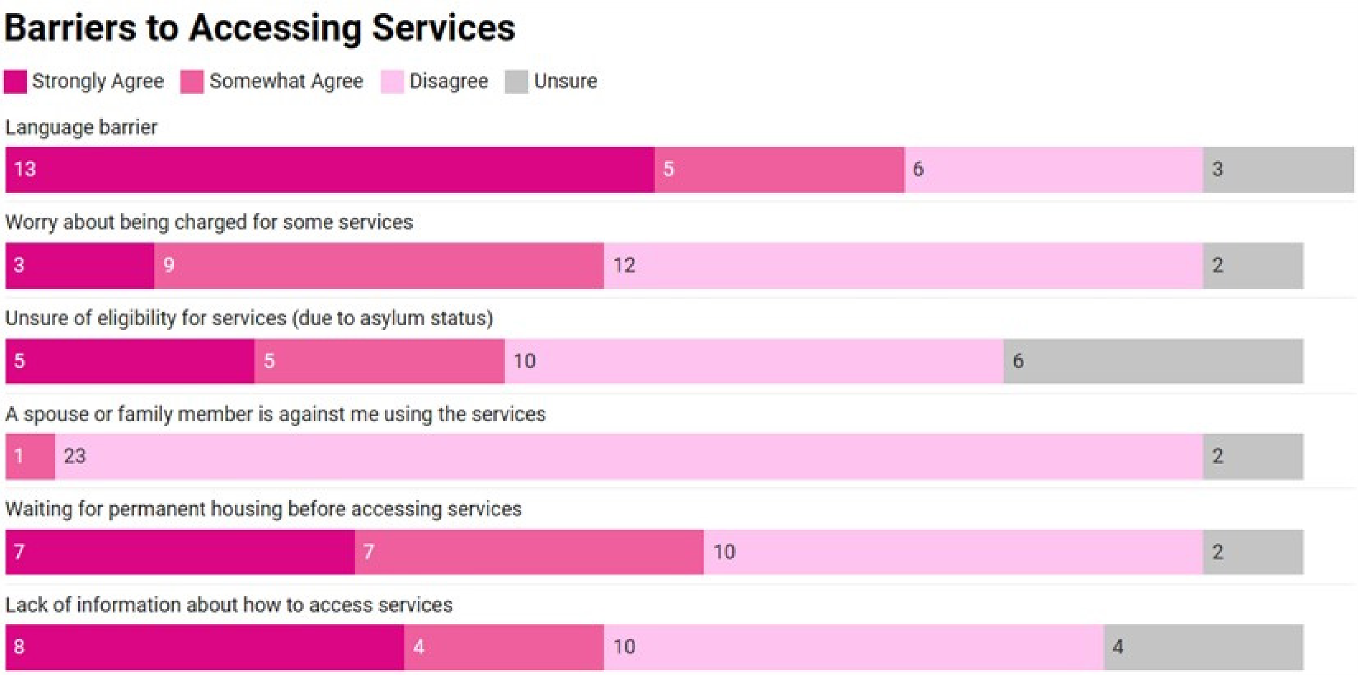

**Figure 4** Most important barriers to accessing health services reported by service users (percentage of users reporting each rating).

Service providers echoed this sentiment and reported that families were perceived to feel at ease (table 1).

### Staff satisfaction and ability for staff to work effectively

There was a high level of satisfaction among Respond service providers. They felt positive about the family-centred services they delivered and recognised and valued the potential impact they could have on this population. However, there was a recognition that family clinics could be noisy and busy with potential impact on care planning and documentation. The potential increase in workload within the single encounter due to multiple family members was identified as a theme from some responses.

Service providers reported that support with phlebotomy, information on community/third sector organisations, regular multidisciplinary staff engagement and education (specifically on trauma-informed care, mental health training and commonly reported complaints such as musculoskeletal pain) as well as more time for family appointments would be beneficial. Just under half (6/14, 43%) of stakeholders also felt they lacked adequate training and resources to look after this population. Further information on legal processes, entitlements and support services, psychological services available and information on specific referral routes and treatment pathways were identified as specific needs.

### Health system benefits

Service providers recognised the health system benefits of family appointments, including the ability to treat families as a whole for infections that may be transmitted within households. Service providers reported that a family approach provided an opportunity to gain a deeper understanding of the needs of the families within their unit by observing the family dynamic and interactions.

### Administrative benefits and challenges

4/8 (50%) of service providers reported that joint family appointments simplified childcare arrangements and logistics around attending appointments. 2/8 (25%) also noted that transport costs and logistics were difficult for families, and that family appointments reduced the number of trips to the hospital, reducing the overall cost. 3/8 (38%) raised potential negative impacts of family appointments, including examples of witnessing siblings having their blood taken, hearing difficult stories during the appointment and missing school. Service providers raised the difficulty of asking questions about children's developmental or behavioural concerns in front of the children, these concerns were not, however, raised by service users. Service providers reported that a joint appointment simplified the history-taking process, aligned to principles of Trauma Informed Care,[14] especially for potentially triggering questions such as regarding journey to the UK. However, some service providers felt that the documentation took longer when seeing families and that they were unable to complete their documentation within the appointment time frame.

## DISCUSSION

We explored health priorities, barriers and experiences of healthcare access and the family-centred model of families using the Respond service family clinic, in a UK (London) setting, from the perspective of service users, service providers and key stakeholders.

**Table 1** Quotations organised by themes on experiences of access to healthcare from service users, and the acceptability and perceived effectiveness of a family-centred approach from service users, providers and health and social care practitioners

| Theme | Source | Quotation |
|---|---|---|
| Barriers | Service user | ‘When you are sick, you need to wait to see a doctor, no appointments on the day.’ |
| | Service user | ‘It takes a bit of a while to have GP appointments and you only have to use the emergency contacts to access health care in most cases.’ |
| | Service user | ‘The language barrier makes it difficult.’ |
| Importance and experiences of access to healthcare | Service user | ‘Each of those are just as important, but the most important thing is having a safe space.’ |
| | Service user | ‘I am new to the area, I do not know where things are, unsure how to access all the services. Information about services would be useful.’ |
| | Service user | ‘Better investigations, my daughter has issues and has been 4 or 5 times and they have not arranged anything. I have been twice and have been brushed off with paracetamol and creams.’ |
| Acceptability to patients | Service user | 'I am satisfied with your healthcare system. You have also examined my family in detail. Thank you.’ |
| | Service provider | 'Overwhelmingly I think everyone’s been very positive…. A lot of people are very grateful that they're just thankful that their health is being thought of…’ |
| | Service provider | ‘…if you don't speak the same language, you don't know, you can't pick up like their tone, so it’s difficult to know, nobody has ever seemed unhappy as far as I can tell. Mostly people are quite thankful and grateful that, you know, they're being offered the screening tests.’ |
| | Service user | ‘We can explain and help each other in explaining the problems…’ |
| | Service provider | ‘… particularly for families from, like collectivist cultures, of course, you're going to do this together, like they're a family unit, they're moving together.’ |
| | Service provider | 'Sometimes if there’s one, one member of the family that speaks English, they'll want to translate for everyone…I don't mind doing that for the children but I do like to get a translator to give them that privacy.…' |
| Staff satisfaction and ability for staff to work effectively | Service provider | ‘I think the difficulty is, it can be quite hectic… I think time wise; I actually do think we've got enough time. I just think it’s more of a feeling of chaos, that makes me feel, like rushed…’ |
| | Service provider | ‘I think having staff wellbeing support is really important because you can feel very isolated, and you are hearing traumatic stories quite a lot. And it’s all fine, fine, fine till it’s not fine.’ |
| | Service provider | ‘…each family’s need is greater than with other families, this increases workload. Migrant families need more assistance with support to attend appointments, completing forms.’ |
| | Health and social care practitioner | ‘Some of the tests that the team do create work and it’s unclear why they are done. eg, lots of patients seem to get H. pylori tests by default and unclear indication…. patients are advised to book appointments with GP…and when capacity may not allow, so may set unrealistic expectations of ours and other onward services, especially psychology.’ |
| | Health and social care practitioner | ‘It is a good initial check of general health to initiate referral which does pick up lots of issues. However, it is only a reduction in the initial workload on registration not the ongoing workload.’ |
| | Health and social care practitioner | ‘Nothing has changed as we have people in the UK with a lot of mental health and traumas, so it doesn’t change workload.’ |
| | Health and social care practitioner | ‘We need care coordinators and more workforce eg, nurses and GPs. Due to workload pressures, there is not enough free time to attend training in all the areas where our practice could improve so the system needs to come up with better solutions.’ |
| | Service provider | ‘…if we had more time and access specific things at the hotels or social workers and Early Help, just to invest more in sort of early help for the families, then that would be really useful.’ |

Continued

**Table 1** Continued

| Theme | Source | Quotation |
|---|---|---|
| Health System Benefits | Service provider | 'In some ways, it's lovely, because you get to see a family dynamic. And you understand the interactions between them, you see a person as part of a family unit, as opposed to just an individual.' |
| | Service provider | 'And in terms of treatment then it will reduce the risk of reinfection. Because if you have a family of 10 people, if one child has giardia, it's likely that other children have giardia, if you treat one child and send them back into the family unit, then they're going to get reinfected. So, I reckon it just repeats the sort of constant cycle of infection, re-infection, treatment, re-infection, so that is really useful.' |
| | Service provider | 'And I just think, especially in this population, that have come from another country that don't understand the healthcare system, and don't maybe have a lot of trust, or you know, just know how to navigate it to then ask them a question. And then to say, "Oh, you need to talk to a GP about that". I just don't think it's very nice.' |
| | Service provider | 'So, it's kind of like the nurses, morally you want to help. And that's your thing, you want to do more.' |
| Administrative benefits | Service user | '…. due to lack of childcare, a good opportunity to be seen in one go. I did not have to worry about leaving my children alone or not making the appointment.' |
| | Service provider | 'I think because it's quite difficult for people and for children to actually attend the clinic, and sort of the childcare that's required, I think it's very useful that they all come as one family. So, you know, the mother can look after the children while the father's being seen and vice versa.' |
| | Service provider | 'It also reduces the cost of travel to the families and the inconvenience of taking that time off work or school, not work, but schooling, nursery and sort of other things that are like appointments for the home office or other GP appointments.' |
| | Service provider | '…. it saves time because in our screens were asking about their journey. They've all done the same journey…if the alternative is to see each family member separately, on different days, then you're asking them the same question every time.' |
| Administrative challenges | Service provider | 'I also sometimes feel uncomfortable when you're talking about the child's like behavioural problems or something sensitive that's happened to the parents that's very traumatic, it feels sometimes wrong to say that in front of the child. Obviously, you can put the child in a separate room if there's another adult but a lot of the time that's not the case, so, you've just got four screaming children while discussing very traumatic events.' |
| | Service provider | '…. the documentation is quite difficult to do for a family because obviously, you have a note for every person and you, you don't want them to sit there and wait while you transcribe your notes…' |

Self-reported health priorities of service users attending the Respond services align with previous peer-reviewed studies in this population[15 16] with an emphasis on the importance of preventative and primary care including access to dental services, GPs and immunisation clinics. It is recognised that, as found here, people-seeking asylum and refugees often place practical needs such as housing, education and safety, as key priorities ahead of their physical health and well-being.[17] For example, research among migrants in Italy[18] found that the need for inclusion within a community overshadowed physical need and greatly impacted accessing healthcare; and similarly, among migrants in Malaysia, access to healthcare was also found to be underpinned by complex social, cultural and economic factors.[19]

The principal barriers to achieving healthcare priorities reported by service users reflect those described in the literature for the PSAR community, including language barriers, living in temporary accommodation, long waiting times and difficulties registering and booking appointments with primary care.[20 21] These barriers are known to be exacerbated by systemic barriers such as racism, hostility and discrimination, which exist in many regions.[22 23] In Turkey, which has hosted the majority of Syrian refugees (63%) since the civil war began in 2011, research has shown this population may face challenges in expressing themselves to healthcare professionals, negatively impacting healthcare access. PSAR in these settings may bypass primary care entirely and instead seek secondary care when more acutely necessary.[24]

Healthcare expectations of PSAR families may also be heavily shaped by their previous experience of healthcare services in their home country and in other host countries. Many arrivals to the UK are accustomed to accessible specialists and secondary care services, and the role of the GP is novel for many people.[25 26] Therefore, perceived difficulties in directly accessing secondary care and complex medication[25] can result in a lack of confidence in GPs. This was reflected in our data, where service users reported the care they received in primary care was not as they expected, for example, being asked to take simple analgesia rather than being referred directly to a secondary care specialist.

Engagement with healthcare services can also be negatively impacted by the asylum process itself,[6 27] which is known to have a detrimental impact on families, resulting in poorer outcomes of healthcare interventions.[17] Facilitators suggested by our service users to counteract some of these barriers included face-to-face interpretation and help with logistical aspects around healthcare appointments such as transport. Translated written information about local services and support available when newly arrived in the area was also raised and information packs with health, education and food bank resources have been produced in some settings already.[28]

The family-centred approach was found to be acceptable and perceived to be effective. The model offered by Respond aligns with recognised key pillars of family-centred care,[29] including (a) cooperation between service users and healthcare professionals, (b) acknowledgement and understanding of the family's individual situation, (c) robust policies and guidelines to inform and support and (d) education for service users and professionals. Family-centred models have existed for some time, perhaps best exemplified by clinics established for families living with HIV in the 1990s.[30 31] Although these services, and the populations served by them, are in many ways very different, many challenges identified in these early family clinic reports are relevant to the PSAR family clinic setting, in particular with regards to shared impact of a situation within a family, frequent complexity surrounding social circumstances and the frequent presence of trauma and stigma associated with their status.[30 31] Likewise, the opportunities and advantages of the family-based approach in terms of improved patient experience, simplified logistics and better follow-up rates have also been highlighted in both settings.[30 31]

Parenting within the asylum context is fraught with challenges that can impact the family environment, including long periods in unsuitable living conditions, lack of access to child-friendly foods,[18] and parents struggling to manage their own mental health,[32] in addition to family disruption[17] and separation.[33] Even once granted asylum, many refugees still face difficulties navigating and accessing healthcare services with negative impact on capacity to integrate and find employment, housing, education and contribute to society.[17] A family-centred model allows professionals to engage with families at this early-stage post arrival, in a supportive environment. Such interactions have been shown to boost the well-being of parents with positive implications for emotional, physical and cognitive development of their children.[29 32 34] The ability to simultaneously assess whole families using a family-centred approach is also likely to have benefits in the treatment of infections transmitted within households, such as gastrointestinal parasites and skin infestations, which are common in this population[35] by reducing risk of re-infection.[36 37]

Family-centred appointments have also been reported to reduce non-attendance rates, often found to be because of financial constraints, childcare issues and time commitments.[38] Family appointments may be beneficial for families in reducing appointment burden, which is often significant among large families, and simplifying childcare arrangements. Many studies on non-attendance focus on the need for behaviour change from attendees,[39] but with Respond, the service has been designed to suit the needs of this population.[40] This includes speaking with patients in their own language, flexibility in rebooking appointments as well as having services based in initial accommodation sites to increase access for this population. The improved attendance rate has positive cost-saving implications for the health service with average non-attendances costing the NHS £1 billion[41] as well as reducing wasted appointments, increasing access and clinical capacity.[42]

One limitation of the family model raised by service providers was the increased workload of seeing multiple family members together within a single appointment. However, downstream workload may be reduced, as issues and individuals are dealt with together rather than separately, reducing duplication. It is also possible that the perception of increased workload in a family model is confounded the complexity of the population, and the inevitable generation of tasks by proactive screening, rather than relating to the family model itself. Perceived increased workload is also in part due to the fact that NHS electronic medical record systems do not allow for linkage of family records, and this necessitates the inputting of data for each family member separately. This, however, would also be the case if each family member was seen individually in separate appointments. Another potential limitation is the lack of interfamily confidentiality and the risk of vicarious trauma in the children attending the appointments, a phenomenon well-recognised in the literature.[43–45] This was not raised by service users in our study but reinforces the importance of trauma-informed care training for staff working in these settings, in order to be best prepared to identify when these situations might arise and manage them in a sensitive manner.[14] There is also a risk that family members may be informally used as translators, against best practice guidelines and instead of the use of a trained interpreter.

Although both service providers and stakeholders expressed high levels of satisfaction in delivering and supporting the Respond service, many felt further education to better understand the asylum process, entitlements and referral pathways specific to this population was needed. Empowering and educating service providers are well recognised as crucial for improved efficiency and staff morale.[46] Engaging with staff regularly and having a forum for staff feedback and discussion is crucial in this context to avoid staff becoming frustrated, disengaged and less efficient when seeing refugee and asylum-seeking families.[47] The Respond service organises regular information sessions with GPs and health and social care staff as well as reflective practice sessions, which provide an opportunity for shared learning between the different teams and allow for better understanding of the pressures faced.[48 49]

Limitations of the study include our modest sample size, limited by feasibility constraints and available resources during establishment of a novel clinical service. The use of two separate questionnaires, arising from the need to minimise survey fatigue in a vulnerable population after a busy and complex appointment, mean that denominators for some domains vary. Generalisability beyond the study population, which may not be representative of all sanctuary seekers, may be limited. Indeed, the experience of those most in need and most underserved may not be captured here, as these are likely those not engaging with healthcare services at all. Future work is planned to explore the voices of those who struggle to access health services.

The involvement of some of the Respond team in elements of the design, analysis and collection of the data may contribute to response bias. Service users may have been subjected to response and courtesy bias as questionnaires were completed in the clinical setting; it is possible that service users may have felt influenced to respond more favourably due to concern their answers would be seen by their healthcare professional. In addition, due to their ongoing asylum claim process, and despite reassurance during consenting, there may have been hesitancy to be honest and openly critical in case this could affect their claim.

As no new themes emerged throughout the coding of the data, it is likely that saturation was reached. However, an important limitation of the study is possible reflexivity, as coding was performed by healthcare professionals, with limited lived experience of relevance to the service users.

Longitudinal follow-up of larger participant cohorts to better understand the longer term impact of the family model for PSAR families and a comparison study in a parallel setting would increase the utility and generalisability of the results together with a cost analysis of the service, which was beyond the scope of this work. Future projects will include exploring the cultural beliefs surrounding healthcare and understanding what good-quality healthcare means for different populations. We aim to involve key stakeholders and individuals with lived experience of migration in the design and analysis of the research to optimise the relevance of the data obtained and ensure equitable dissemination of the results.[50]

## CONCLUSION

Understanding the healthcare priorities and barriers experienced by this vulnerable population is essential to underpin the development of effective services to provide care for them. Our work provides early exploratory learning around the use of a family-centred model, suggesting that this is both acceptable and perceived to be effective to service providers, users and stakeholders. Further research is needed to evaluate the longer term benefits and cost-effectiveness of this model and its application to services serving PSAR.

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