

New Migrants in Primary Healthcare – How are services adapting?

Summary and Mini Case Book

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SUMMARY

INTRODUCTION

High rates of immigration in recent years in the United Kingdom presents service design and delivery challenges to primary care. At a time when resources are stretched, services must be both efficient and equitable for patients. Migrants are often healthy on arrival but some groups, such as refugees and asylum seekers, may have many healthcare needs. This study sought to explore how primary care is managing demand on its services by new migrants and how it addresses need in provision.

APPROACH

The research was exploratory and formative. It looked at the services delivered in primary care organisations. The study took place between November 2015 and March 2016. Its methods were:

- Survey and contact form: Non-probability sample of GPs, other health professionals, practice managers and third sector providers who had served new migrant populations in the last five years (n=70); Responses were sifted for contact details and selected for case studies.
- In-depth case studies: Documentary analysis and in-depth interviews and focus groups with eight case study primary care organisations.

KEY FINDINGS

- 84% of survey respondents reported migration had increased rapidly or steadily in their area in the past five years;
- One in five (21%) survey respondents did not identify any adaptations in service delivery for new migrant populations;
- On average, respondents identified four barriers to adapting services for new migrants. The most frequently cited barriers were lack of funding (73%), lack of time (64%), insecurity of funding (47%), lack of staff (43%) and personal fatigue/'burn out' (34%);
- Adaptations were varied, including signposting patients to support agencies, coordinating primary care services with other agencies e.g. housing associations, providing cultural competency training for staff and providing 'one stop shop' clinics for new migrant patients. Case study organisations adapted their services in multiple ways.
- Drivers for adapting services included practitioner, organisational and wider contextual factors. Organisational and practitioner commitment to equity appeared to be critical.
- Adaptations aimed to enhance patient access, identify complex need, address the social determinants of health and improve patient-practitioner communication and trust.

CONCLUSIONS

Adaptations to primary care services for new migrant populations are closely related to organisational and practitioner orientations to equitable care. Modifications are constrained by insecure and insufficient resources, especially funding and time. Adaptations require evaluation to establish effectiveness and cost effectiveness.



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MINI CASE STUDY BOOK

The following case studies provide detail of some of the adaptations uncovered by the research. Their purpose is to showcase modifications that were considered important to providing care to new migrant populations. The focus is on adaptations that represent a departure from routine GP practice and could be transferrable across settings. The first five case studies are of mainstream services; the latter three (Bethnal Green, Bevan Healthcare CIC and Mulberry Street) are specialist services mostly, but not exclusively, for asylum seekers, refugees, trafficked people and undocumented migrants.

1. Westmuir Medical Centre, Glasgow
2. Keppoch Medical Centre, Glasgow
3. Firth Park Surgery, Sheffield
4. Page Hall Medical Centre, Sheffield
5. Burngreave Surgery, Sheffield
6. Bethnal Green (Doctors of the World) Clinic, London
7. Bevan Healthcare CIC, Bradford
8. Mulberry Street Practice, Sheffield



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WESTMUIR MEDICAL CENTRE, GLASGOW

CONTEXT

Based in the East End of Glasgow, located in an area of severe deprivation; patient population c. 4000, of which approximately 700 refugees/asylum seekers; migrant patients from Lithuania, Poland, Slovakia, Greece Portugal

PRIMARY DRIVERS FOR ADAPTATION

Population-based driver: population change; patients with specific health needs, especially refugees and asylum seekers.

Organisational and practice effectiveness driver: originally one of the first Glasgow practices to register refugees and asylum seekers, this practice is now experienced in serving this group.

EXAMPLE OF ADAPTATION

Employing a specialist doctor and health visitor

The practice has been taking refugees and asylum seekers as patients since 2000/2001. As numbers grew, the GP partners employed a salaried GP with a special interest in the needs of these patients.

The role included:

- linking with other GPs, health care professionals, third sectors workers across the city who work in a similar role to create a network of specialist professionals across the city;
- liaising with a local church active in the community and connecting them to other individuals with knowledge and skills to facilitate provision of information about other services in the city;
- signposting patients to support services;
- providing information about migrant health and services to other GPs and staff in the practice.

The practice also employed a health visitor specifically for refugees and asylum seekers, providing practical support and information for patients and their families. The two 'experts' worked closely together, providing a dedicated resource for the practice.

LOGIC OF THE ADAPTATION

Refugees and asylum seekers are especially vulnerable and so require specialist health and support when settling in the city; patients arrived with multiple problems and risks to their health, a dedicated service ensured a more holistic approach to dealing with those complex needs.



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KEPPOCH MEDICAL PRACTICE, GLASGOW

CONTEXT

Based in Possilpark Health and Care Centre; patient population of 3307 (1 January 2016); 87.95% of the practice population belong to the most deprived 15% of the population in Scotland (ISD Scotland, 2014); ethnically diverse, large Chinese population; >1 in 20 patients are coded as needing an interpreter.

PRIMARY DRIVERS FOR ADAPTATION

Population change and characteristics: large increase in Chinese-origin patient population; many new vulnerable migrants especially refugees.

Organisational-level drivers: long-standing approach to addressing the social determinants of health; committed to social prescribing as a means of improving general health and wellbeing; partnership approach to practice.

EXAMPLE OF ADAPTATION

Working in partnership for effective social prescribing

The GPs and practice staff had a great deal of experience and knowledge of patients in vulnerable circumstances, which included asylum seekers, refugees and other migrants who arrived in the area. A partnership approach was considered key to providing effective holistic services:

- The practice actively worked with the city's Asylum Bridging Team (funded by the Glasgow Health Board) to ensure smooth settlement of refugees and asylum seekers into the practice area, and in their registration at the GP practice;
- The practice had strong social referral partnerships including relationships with social support services, community organisations, employability services, language services, counselling and addiction support;
- The practice worked with Glasgow City Community Health Partnership's local health improvement team, running a monthly meeting in the health centre with local practices, keeping the GPs and other practice staff updated with new developments, new support services, new projects etc. The team responded to requests from the GP group to help them cope with emergent problems e.g. identifying resources for migrant women who were victims of domestic violence;
- Administrative and reception staff received training, with regular updates, around the various services available locally for asylum seekers/refugees and their migrant population in general. Staff were therefore able to effectively signpost patients to support services.

LOGIC OF THE ADAPTATION

Support based in the wider community and in social services helped new migrants cope with interconnected challenges to their health e.g. housing, employment. The practice was well-placed to signpost in the knowledge that other organisations were better able to provide patients with the advice and support they needed. Such referral is aimed at improving self-sufficiency and confidence within the patient population.



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FIRTH PARK SURGERY, SHEFFIELD

CONTEXT

Area of significant deprivation; young age profile; patient population c.9,700; ethnically diverse; large Roma Slovak population in the past five years

PRIMARY DRIVERS FOR ADAPTATION:

Population change and characteristics: large new migrant population; especially socially deprived and excluded; high and complex patient need; high paediatric and family service demand; low levels of English proficiency and literacy in own language; low vaccination rates.

Practice-level functionality: need to change how services were offered to retain efficiency and effectiveness; high DNA at secondary care; low medication adherence resulted in repeat consultations.

EXAMPLE OF SERVICE ADAPTATION

Tuesday morning 'One Stop Shop' Clinic

Although this clinic was open to all patients, the 'one stop shop' was initially set up as a way of improving vaccination rates with the Roma community. Short-term funding for locum backfill was provided by the local funding organisation (Clinical Commissioning Group) to enable the set-up of the clinic. The characteristics of the clinic were:

- Block-booking of three interpreters for each Tuesday session;
- One receptionist; one healthcare assistant; one nurse; two GPs on duty to provide individualised patient care;
- Two paid wellbeing workers from a shared local Roma health project were present in waiting rooms to support and guide patients;
- Checks were routinely made on immunisation schedules, smear tests, infectious disease screens and contact tracing; with follow-up if they were incomplete;
- Interpreter staff were experienced and were able to take 'pen picture' information from patients before GP consultation so that basic information could be communicated immediately at the start of the consultation, reducing GP time;
- Interpreters were sufficiently experienced/empowered to provide simple explanations to patients during consultations e.g. getting a blood test, while GP completed necessary notes;
- Translated material and low-literacy health education materials were available in the surgery waiting rooms.

LOGIC OF THE ADAPTATION

The One Stop Shop helps the practice address patient need by ensuring patients know when a clinic is running; face-to-face interpreters aide communication; experienced and trusted interpreters can reduce GP consulting time (improve efficiency); block booking of interpreters reduced costs; workers from the community increased trust in primary care, an important factor for an especially marginalised group of migrants.



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PAGE HALL MEDICAL CENTRE, SHEFFIELD

CONTEXT

Area of significant deprivation; young age profile; patient population: 7,320; ethnically diverse – 2016 practice estimates: 83% black and minority ethnic practice patient list; 32% interpreted consultations.

PRIMARY DRIVERS FOR ADAPTATION:

Population change and characteristics: Long-standing ethnically diverse area; recent emergence of substantial Roma Slovak population brought new health needs High prevalence of certain conditions e.g. Hepatitis B; high interpreter need (audit of Roma Slovak consultations revealed 97% required interpreters).

Organisational drivers: Equity-focussed; institutional history of providing innovative approaches to delivering primary care to diverse groups; Need to reduce DNAs at clinic to retain effectiveness and efficiency; GP training practice – encouraged devising new solutions to problems.

EXAMPLE OF SERVICE ADAPTATION

Hepatitis B screening and vaccination programme

A clinic for the emergent Roma Slovak population was instigated as a response to population change and need and became a compulsory element of registration with the practice. This approach ensured all new patients received the full bundle of screening from the outset among a high risk group. It also meant that the practice could address issues of non-attendance for appointments made in the future. Hep B screening was an integral part of the programme. Key elements were:

- Nurse-led, reducing demand on clinical staff;
- Close relationship with the local hospital infectious disease department;
- Close-contact tracing, although this proved challenging among a transient group;
- Slovak interpreters available on-site at both reception and in the clinic;
- Slovakian leaflet devised for Hep B patient information;
- Clear protocols devised for Hep B screening and vaccination for both adults and children and for close contact tracing.

LOGIC OF THE ADAPTATION

The compulsory nature of the clinic ensured all high-risk patients were screened so that hidden health needs could be detected. Nurse-led nature promoted efficiency. On-site interpreters improved communication.



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BURNGREAVE SURGERY, SHEFFIELD

CONTEXT

Area of significant deprivation; young age profile; patient population: 6,433; ethnically diverse: black and minority ethnic groups represent 50% of its electoral ward population.

PRIMARY DRIVERS FOR ADAPTATION:

Population need: Predominant Pakistani, Yemeni and Somali population and new Slovak population brought specific health needs.

Practice/resource strain: Repeated presentations of minority ethnic, especially Somali, patients with chronic pain; resource limited to that available under general GP funding arrangements – need to ‘get by’; concern about treating all patients equally.

Individual GP specialist interest: Individual commitment to improving the lives of vulnerable migrants.

EXAMPLE OF SERVICE ADAPTATION

Development of practice protocols for Vitamin D deficiency

This adaptation emerged out of personal interest of one of the GPs at the practice who saw repeated presentations of ‘pain all over’ and fatigue within the migrant, largely Somali population. Armed with knowledge about the risk of Vitamin D deficiency among BME populations, the GPs instigated a protocol for identification and treatment. The protocol was developed by sharing practice with other surgeries in the Sheffield area who worked with similar populations. The protocol included providing patients with an easy-care plan that ensured high medication compliance. This was adapted in particular to meet the needs of young people who were at higher risk of not taking vitamin supplements regularly and those who were representing a few years later with similar pain due to poor compliance. The surgery operated on a lower GP:patient ratio than many of its neighbouring surgeries and a pragmatic, time saving approach was adopted. In this case, the GP was working in the context of limited resources and where additional support was being sought:

Issues come up like FGM or Vitamin D and we try and get ourselves sorted on it but I think we could do with some more support [...] in terms of joining up with other practices, using protocols from other practices or discussing stuff so we're not just making it up as we go along. (Burngreave GP)

LOGIC OF THE ADAPTATION

Recurrent presentations of an unfamiliar health problem were not being dealt with efficiently. Standardised procedures created efficiencies across the practice; standardisation helped address a recurrent issue; met need for consistent and best-practice handling of a health issue.



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BETHNAL GREEN (DOCTORS OF THE WORLD) CLINIC, LONDON

CONTEXT

Doctors of the World (DotW) is an international NGO that runs a clinic for migrants in three locations in the UK. Its clinic in Bethnal Green in the East End of London was created after a Needs Assessment revealed large numbers of undocumented migrants in the area. The clinic is not a standard GP practice but provides primary care on-site. Partnering up with the refugee organisation, Praxis, the clinic runs three afternoons a week and a family clinic twice a month. It seeks to help migrants access primary care. Estimates suggest 70% of undocumented migrants live in London.

PRIMARY DRIVERS FOR ADAPTATION:

Population drivers: Large undocumented migrant population in the city with limited access to healthcare.

Organisational drivers: NGO committed to improving the health of vulnerable migrants; advocacy role.

EXAMPLE OF SERVICE ADAPTATION

The central role of the Clinic Support Worker

The Clinic Support Worker (CSW) was central to the success of the clinic. As a first point of contact, CSWs were trained volunteers who were able to assess service-users' needs as a whole. A comprehensive training package for CSWs was developed by the organisation. It included aspects of cultural competency as well as operational protocols and policies. An important part of the CSW role was a 'social assessment' that captured critical elements of a person's history, safety, living arrangements, housing, family relations, migration status, intentions regarding citizenship or residency, friendship connections and other social support, reasons for entering and staying in the UK, experience of the migration process and any important other events such as trauma and violence. These histories were critical in understanding a service-user's healthcare and interconnected needs:

[Social assessment] brings up amazing stories and things that people have gone through that if you were just focusing on the physical symptoms you would be very unlikely to come across and I think particularly from a mental health perspective we can start to try and help them with some of the less specialist elements of mental health so the more preventative, supportive, community factors.

(Programme Lead)

LOGIC OF THE APPROACH

The 'holistic' assessment allowed for better referral to outside organisations. This means GPs were well-informed when the DotW service-user was then registered at their practice: social assessment records were available to GP practices with patient consent.



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BEVAN HEALTHCARE CIC, BRADFORD

CONTEXT

Bevan Healthcare is a Community Interest Company designed to meet the needs of homeless populations, sex workers and refugees and asylum seekers. They operate out of a city centre facility in Bradford that is co-located with a range of assistive services such as physiological support services and a housing association.

PRIMARY DRIVER FOR ADAPTATION:

Individual capacity: recognised risk of burnout and stress.

EXAMPLE OF ADAPTATION

Taking care of practice staff

In recognition of the strain of working in a challenging primary care environment, Bevan Healthcare invested in a series of support services for staff. Adaptations in taking care of staff included:

- Formal and informal clinical education for doctors to share information and concerns;
- Regular team meetings among practice staff (e.g. nursing staff, admin staff);
- Regular appraisals;
- Life coaching sessions for all staff.

Life coaching was a recent innovation that included a coach coming to the practice once a month. Staff had a 45 minute appointment to address any personal or professional issues they were experiencing. Initially the initiative was designed as part of a change management process when the practice moved to new premises and had a new intake of staff. Since then it has become embedded in practice life to support staff in their challenging roles. One of the practice GPs explained how it helped with professional 'burn-out':

It's only part of the solution but I think it stimulates people to think about solutions that they can make and helps people to be more empowered to make changes or request changes. [...] I think momentum is so important to tackling burnout, I think psychologically it makes a huge difference if you can see improvements. (Bevan GP)

LOGIC OF THE ADAPTATION

Stress and 'burn-out' was a risk to service delivery; the opportunity for counselling helped professionals deal with difficult cases (secondary trauma); support from within the organisation improved staff experience and reduce turnover.



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MULBERRY STREET PRACTICE, SHEFFIELD

CONTEXT

Mulberry Street is a dedicated refugee and asylum seeker service. It also serves other marginalised groups such as destitute refused asylum seekers and people who have been trafficked. It is currently undergoing re-commissioning so aspects of the service will change although it will still be a dedicated service. It has previously been identified as an example of good practice in this specialist field (Aspinall 2009).

PRIMARY DRIVER FOR ADAPTATION

Population-need: Patients were vulnerable and needed to feel trust in 'authority' figures.

EXAMPLE OF ADAPTATION

Making the physical environment safe and welcoming

Mulberry Street pays close attention to the physical environment to ensure it is welcoming for new migrants and other vulnerable people who enter the practice. Its city centre location close to the migrant service ASSIST helps ease of access, as does the mini-bus service used to transport new asylum seekers from their accommodation to the practice for their initial registration and health check (see Aspinall 2009). Key aspects of the physical environment in the clinic are:

- It was comfortable
- Bright and clean waiting area
- Open (e.g. no 'screen' between receptionists and patients)
- Welcoming – reception staff were trained to be welcoming and helpful and to put patients at ease.

Although these factors may seem marginal, these small details were important to encourage a sense of trust and safety among a population who may have experienced trauma and violence and may have mistrust in 'state' institutions. As explained by the GP:

There's generally a welcoming atmosphere there. They work with and openness to that population. There's not a defensiveness about people who are difficult or confused; patients tend to see it as a safe place to come. So the waiting room is a welcoming and friendly environment. In general they feel safe there. It's somewhere where they are feel known and respected. Having that welcome; trying to treat people with respect and dignity because that's what they're lacking so much. (Mulberry GP)

LOGIC OF THE ADAPTATION

Patients may often be fearful and mistrusting of professionals, particularly if they have experienced trauma. Good, comfortable physical environment encouraged better relationships and communication between health professionals and patients. Better overall experience of healthcare by patient.



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Reference:

Aspinall, P. (2009) Promising Practice. Inclusion Health. Available from:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/307376/Promising_Practice.pdf

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