

Arrival

**The General Practice for new refugees in
Stockton-on-Tees**

**Annual Report
2003/2004**

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Annual Report to March 31 2004



Foreword: Dr Paul Williams

The Arrival practice is achieving what it set out to do. All newly-arrived people seeking asylum in the Stockton area are getting well-organised health care. When they cannot speak English, interpreters are used, when they first arrive they have a comprehensive and holistic health assessment, and when problems with mental health, sexual health or legal and immigration issues arise they are tackled with enthusiasm and dedication.

Refugees are getting a better deal, but so are all the other people in Stockton. The time that was being spent managing the health problems of newly arrived refugees in mainstream practices has been released. Some GP's and practice nurses felt that they lacked the skills to manage some of the complex issues that arise from torture, rape, imprisonment and migration. Others who had the ability did not have the time because of competing priorities in primary care. Many of the 'problems' involved in delivering health care to this particularly challenging group of people have been solved.

Arrival is a fascinating project to be involved with. I see patients every day from many different countries. There is so much cultural diversity. Every individual comes with a world view very different to my own, and I can't afford to make any assumptions about priorities, beliefs or understanding. There is something to learn from everyone. Many of the people that come to the practice are troubled or traumatised by things that have happened in their own country or their experiences here. While this may seem depressing, because of the destitution and desperation of most refugees very small interventions make large differences. It's heartening to see how people respond when treated with respect. I will never forget the relief on the face of a person who has been raped when she finds out that she does not have HIV, the gratitude received when someone who has suffered pain for years has their symptoms alleviated, or the appreciation when time is taken to listen.

Thank you to all in Stockton who have supported this project, or merely tolerated it. Thank you all of the staff who have worked for or with Arrival in the Primary Care Team. Thank you also to the voluntary agencies who give their time and efforts to help this unusual, unpredictable and needy group of individuals from all over the world who have found their way to Stockton-on-Tees.

A handwritten signature in blue ink, appearing to read "Paul Williams".

Background information

There are around twelve million refugees in the world. Most of them are ordinary people who have fled from their own countries because of war, or because their religion, political beliefs, ethnic group or way of life puts them in danger of arrest, torture or death.

In 2003 61,050 refugees found their way to Britain and applied to the Immigration and Nationality Directorate (IND) of the Home Office for refugee status (during which time they are known as 'asylum-seekers').

At the moment about 88% of people who apply for refugee status are initially refused. In 2003, 23% of the appeals against refusal resulted in a positive decision.

Introduction

When refugees arrive in the UK they are dispersed to different areas of the country by the National Asylum Support Service (NASS).

Stockton-on-Tees is a designated dispersal area for asylum seekers. Accommodation and housing is provided through the local authority and private housing providers. There is also a 76 bedded hostel providing temporary accommodation for 2-3 weeks before more permanent housing is provided throughout the region. Early expectation was that only a small number of hostel residents would be housed locally but reality is that 40-60% remained in the North Tees area

In 2001/02, 578 asylum seekers were allocated to GP practices throughout the North Tees PCT area. It was acknowledged that cultural differences and communication difficulties meant that many GP practices were experiencing difficulty in meeting the needs of the refugee patient group. Through no fault of their own many such patients required additional time and resources, which was stretching the capacity of the local primary care service.

A significant number of refugees enter this country with health problems and many are the survivors of imprisonment, torture or rape or have fled the mental and physical trauma of living in a war zone. Some have suffered under oppressive regimes and women in particular are reluctant to trust health care professionals. The effects of displacement on the mental health of refugees can be profound, as evidenced by high levels illnesses such as depression and Post Traumatic Stress Disorder and cultural expressions of distress.

Initial health assessment on registration of patients needs account for diversity of backgrounds that patients may have come from. Children may not have the full range of immunisations delivered in the UK and cases of Hepatitis B, HIV/AIDS and parasitic bowel infections are common.

It was acknowledged that there were substantial inequalities in access for services for this patient group, with particular difficulties in attracting them to initial appointments with letters written largely in English and without understandable directions.

Against this backdrop, Arrival was conceived. An application was submitted by North Tees Primary Care Trust to set up a 'Greenfield' Personal Medical Services Pilot to commence in October 2002.

In the Beginning

In October 2002 Dr Paul Williams was appointed as GP Principle to establish and run a practice dedicated to the care of newly arrived refugees and asylum seekers to the North Tees Primary Care Trust area. Work on the project began immediately with Dr Williams taking up post from 1 December 2002. Early tasks involved:

- Engaging with the PCT to determine the objectives to be met.
- Meeting with other organisations that contribute to the care of refugees and asylum seekers to be clear about common goals and complementary roles.
- Identifying premises with the PCT and planning changes to make them 'fit for purpose'.
- Finding resources to enable communication in the patients' own language.
- Consulting with community representatives to ensure understanding of what was to be provided.
- Preparing literature for patients
- Locating and recruiting staff to deliver the service

The Practice

The practice was established to meet the special health care needs of refugees when they first arrive in the North Tees PCT area. These may include language barriers, mental health problems, the need for catch-up immunisation and screening, sexual health problems, lack of experience of using primary care services and some infectious diseases.

The commencement date for the PMS agreement was 1 December 2002 and the practice began registering patients on 10 April 2003.

We are a transitional practice. Arrival has the potential to register up to 1000 newly arrived refugees each year, with the aim of preparing people to be integrated into mainstream primary care when their initial health care problems have been addressed.

PRACTICE LIST SIZE

The target ceiling on list size is 500 patients.

Arrival Staff

Paul Williams
General Practitioner



Bill Williams
Practice Manager



Karen Galloway
Principle Nurse



Pat Holliday
Practice Nurse



Shupikai Maposa
Receptionist



Debbie Whaley
Administrator



Ruth Johnson
General Practitioner



THE PRACTICE OBJECTIVES

The broad objectives are

- To provide a first point of contact with health services for newly arrived asylum seekers in the North Tees PCT area
- To improve access to health care for newly arrived asylum seekers
- To provide a comprehensive health screening service
- To improve health promotion and chronic disease management
- To improve communication
- To improve joint working between health services, local authority and voluntary sector
- To reduce pressure on mainstream primary care services

How we operate

Arrival operates in a similar way to other General Practices, but there are a few important differences;

- Arrival only registers newly arrived refugees. It does not register people who are not refugees, and it does not usually register people who are refugees who have been in Stockton for some time.
- Arrival has a maximum list size of 500 patients. This is because many of the patients do not speak English and will need long consultations, there is a large turnover of patients, and many patients will have varied and complex problems.
- Arrival is a transitional practice. It aims to provide immunisations, screening and health advice for newly-arrived refugees. It aims to deal with mental health problems and other long-term medical problems. We provide regular appointments with doctors and nurses.
- When our maximum number of patients is exceeded, it would be expected that most refugees would then register with 'normal' General Practices. This should be after a period of between about 3 and 9 months registered at Arrival.
- As Arrival passes patients on to other practices it frees up spaces on the list for newly arrived refugees.
- Arrival has very close links with Social Services and Housing Providers for refugees. We also work very closely with Refugee Community Organisations (RCO's) and several voluntary sector bodies.
- Arrival works very closely with a counsellor, the community nurse for refugees in Stockton, a health visitor, the TB nurse in Stockton and many other allied professionals.
- Part of the work of the team involves preparing medical reports for people who allege torture.

What does the practice do?

All members of the local population are entitled to equal access to health care services and this includes refugees. However they often arrive in this country without any knowledge of our language, culture, customs, and especially our health service. Many of them have not received preventative health care such as vaccinations, screening or health promotion.

Because of these reasons initial contact with primary health care frequently takes much longer than the usual GP appointment time. Consequently, patients of some GPs have had to wait for longer periods of time for appointments with their family doctor and GPs have had increasing pressures on their time and workloads. Through channeling new refugees to this practice, other GPs' can offer more time or reduce waiting times to their other patients.

We are charged to provide the same core services to patients as are currently provided under GMS including—

- Delivering services to patients who believe themselves to be ill and arranging investigation, treatment and referral as appropriate.
- Supplying and prescribing medicines and appliances.
- Management of ongoing chronic illness and terminal care.
- Providing routine health screening for new patients.
- Provision of child health surveillance.
- Provision of maternity services.
- Provision of contraceptive services.

The particular needs of new arrivals to the practice requires particular initial focus on:

- A health assessment
- Addressing acute medical problems and making appropriate referrals when necessary
- Provision of health advice, ensuring immunisation is up to date and encouraging screening
- Testing for and providing access to appropriate treatment for communicable diseases such as HIV and Hepatitis
- Working in close partnership with other agencies to ensure problems which may impact on health are dealt with
- Being a source of expertise and advice to other health professionals working with refugees
- Ensuring all refugees are registered with a local general practice and 'handed over' with full details and a management plan for any outstanding problems.

Features of our service

- Equitable access to all through partnership working with their housing providers and the Local Authority,
- Innovative use of translated materials
- Well-organised system for arranging health assessments on all new patients with interpreters present.
- New patient health assessment (template-driven - designed in-house)
- Written and verbal information given to all new patients about how to use the NHS and in particular Primary Care, use of OOH services and booking appointments
- Use of interpreters, Staff training on use of interpreters. Use of translated materials
- STI screens, postnatal care, diabetes care
- Full use of computers for consultations and all patient-related documents.
- Partnership working with NHS services - Psychiatry - meet with consultant every 8 weeks, Diabetes clinics with specialist nurse, Physiotherapy access through telephone pre-booking of appointments, Hearing and Vision clinics, regular meeting with the Health Visitor, BCG clinic in the practice
- Partnership working with Social Services (meet with Asylum Support Team and liaise closely with them and through nurse working in the community with AST)
- Partnership working with solicitors – frequent communication with caseworkers when health problems affect claims for asylum.
- Partnership working with voluntary agencies (Teesside Positive Action, Mental Health Matters, Tees Valley Arts, North of England Refugee Service, International Family Centre, Mary Thompson Hardship Fund, SEARCH

Human Resource Management

We comply with all national statutory employment requirements and related NHS policy:

- All staff have contracts of employment.
- Policy and procedures are in line with the Employment Rights Act 1996 and Employment Relations Act 1999 regarding Disciplinary and Grievance procedures and appeals process.
- Recruitment and selection procedures are open and transparent and are applied equally to all applicants irrespective of race, religion, sex colour, disability, age or sexual orientation.
- Clear processes have been introduced for the production of job descriptions, person specifications and assessing the eligibility of individuals to apply for posts.
- We have adopted objective selection procedures, including short-listing, interview process and composition of interview panel
- We are familiar with the NHS HR Performance Framework and the "Improving Working Lives" standards and have reflected these in the systems and policies we have implemented.
- Our GP has produced a PDP
- Our nurses are given time for professional development and are working with their clinical supervisor from the PCT to complete a PDP.
- We have introduced a system of appraisal for all staff members, incorporating individual learning plans.

Pre-opening preparations

Recruitment of staff began following Dr Williams' taking up his post. The first appointment was a practice manager to assist with creation of the practice. Bill Williams, an experienced NHS manager with both practice and PCT experience was appointed on a part-time basis and before starting on 1 January 2003 assisted with recruitment of the rest of the team. The remaining members of the team include a whole time receptionist, part time administrator and two part time nurses. These were appointed with staggered start dates to enable development of the systems and processes and orientation and induction prior to receipt of the first patients.

Early work of the team included preparation of templates for clinical staff and literature for patients. We also produced a range of policies to ensure that we comply with good employment practice and high standards of Health and Safety. Patient literature has been translated into several languages to facilitate access and understanding.

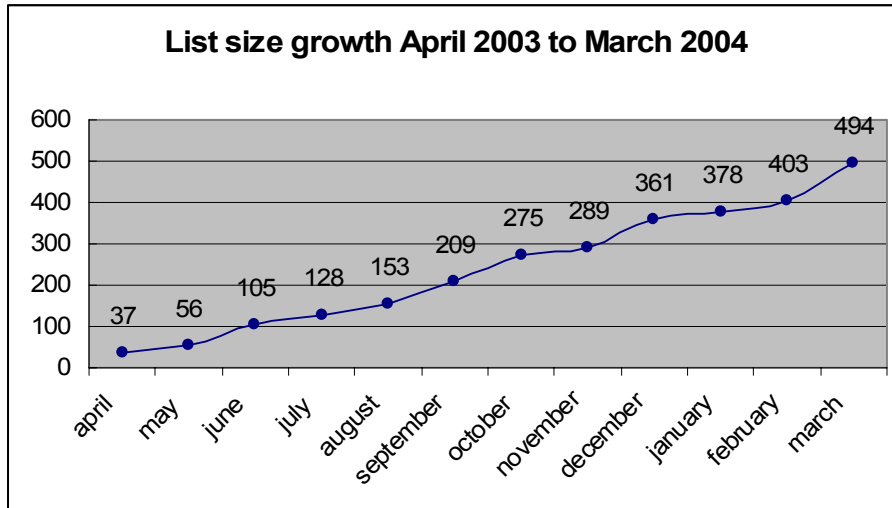
During this time of preparation a high priority was liaison with other healthcare providers, community representatives, housing providers and refugee organisations. As new team members joined they were given the opportunity to spend some time with groups and individuals according to their role. Dr Williams visited all practices who would receive him to explain the purpose of Arrival and to pave the way for future co-operation. This foundation work has proved invaluable as we reach the point of moving patients into mainstream practice.

The greatest difficulty we met was concerned with premises. The building identified first by the PCT as potentially suitable for the practice needed substantial modernisation to render it fit for purpose. Rather than delay opening to patients we entered an agreement with the out-of-hours service to temporarily have shared use of their premises. Once agreed equipment was acquired and telephones and computer systems installed. The premises have been made available to Arrival from 8.30a.m. to 6p.m. each day, excluding Thursday afternoons and when cover is required for PCT Time-outs and Time-ins.

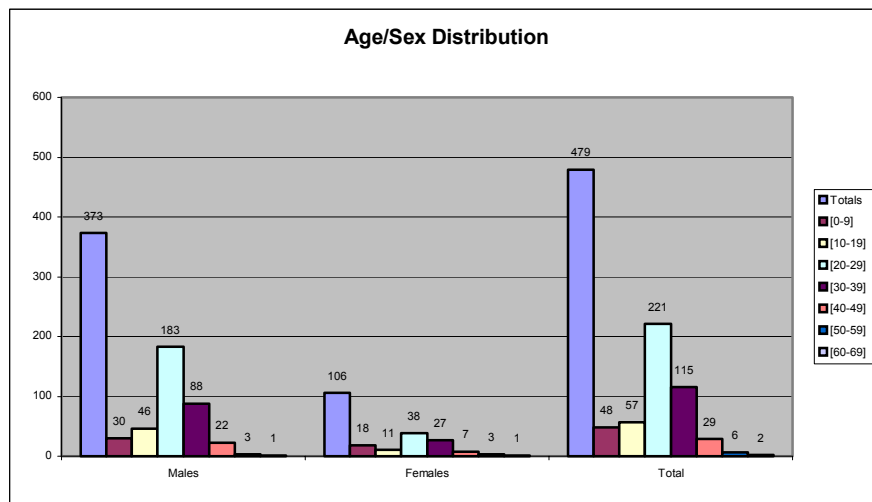
Arrival eventually opened its doors to patients on 10 April 2003. There was immediate influx of patients due to the closure of the Sangatte camp in Calais and the UK's agreement to accommodate refugees who were resident there.

Progress report 10 April 2003 to March 2004

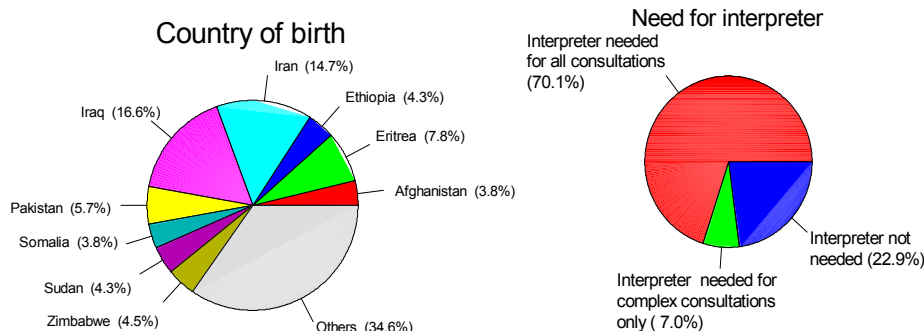
List size growth



Patient profile



Languages spoken and need for an interpreter



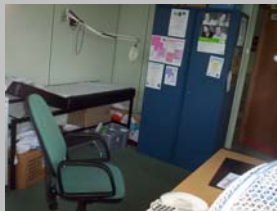
Since the practice opened on 10 April 2003 there were 494 patients registered to the end of the year on 31 March 2004.

Early registrations were largely young male patients in the 20 to 35 age bracket. More recently we have received a number of expectant mothers and families so the profile of registered patients is changing. One characteristic that continues is that we have few older patients.

Patients registered at Arrival originated in 46 different countries and there were 38 different main languages spoken. This means that around 70% of consultations require an interpreter in attendance.



Arrival/Out-of-Hours premises



Nurse consulting room



Office



Waiting Room



Mobile notice boards

Premises

Arrival operates from the Primecare Out-of-Hours premises in Massey Road, having shared use of the waiting room/reception and two consulting rooms and sole use of a small office.

Sharing premises has been far from ideal. Consulting room equipment has to be locked away each night and even the telephones unplugged so that the rooms are cleared for the out-of-hours doctors to provide their service. Reception also has to be cleared and vacated all Health Promotion information and mobile notice boards have to be cleared and put away.

Computer servers are located in the office and this is our only administration area that is not overlooked by patients. When Primecare require daytime use of the premises, this is our only dedicated space and all of the team battle for desk space and use of a computer.

We have also been unable to make the waiting room sensitive to patients, as the décor is general purpose and notice space limited. Although we are constrained we have endeavoured to overcome difficulties with mobile notice boards, information folders instead of wall and leaflet displays and a portable sound system for patients to select music or bring their own to play.

Far too much time has been dedicated to preparation for permanent location with several false starts on route.

The first problem concerned the agreement of the lease for the original location with Education, the owners. Then plans were prepared but these alterations proved far more expensive than the PCT could afford. Re-drafting and reducing the specification seemed to make the proposition more acceptable but the results of tendering again elevated the cost, requiring further Board consideration.

In the meantime, much of the equipment and furniture purchased is in storage and we are using Primecare's.

The new out-of-hours contact for Primecare made possible permanently locating the practice in the premises we were using temporarily, with sole use of the facilities in time. A feasibility study was undertaken but no decision on outcome has yet been made by the PCT

Twelve months after opening to patients, the short-term arrangements are ongoing, to the frustration of staff and the detriment of services available to patients. We hope a resolution is imminent.

Service to Patients

All refugees who arrive in the NTPCT area who are supported by NASS are registered at Arrival by their housing provider, who provides information to the practice about languages spoken and the need for an interpreter. People who arrive in the area by other means informally become aware of the practice through social networks. All new arrivals are sent a Welcome Pack, which consists of a practice information leaflet, a map of the area showing the location of the practice and written instructions as to how to find the practice building, a welcome letter and an invitation to attend a nurse-led Health Assessment. This Welcome Pack is provided in the patient's own language in the majority of cases.

On arrival at the practice, and during the Health Assessment, data is collected about the patients' age, sex, country of origin, ethnicity, religion, marital and family status, main spoken language, second languages, ability to speak English, ability to read their main language and English, and their need for an interpreter. Data is also collected about the length of time a person has been in the United Kingdom and their immigration status. All of this information is Read-coded.

During the Health Assessment data is collected about smoking behaviour, alcohol use, height, weight, blood pressure, urinalysis, immunisation history and presence of a BCG scar, previous illnesses, present physical health problems, present mental health problems, family history, previous HIV testing, history of torture or imprisonment, risk-factors for sexually-transmitted infections and previous smears.

Patients with problems identified at Health Assessment requiring medical assessment or treatment are offered an appointment with a General Practitioner (one male offering five or six sessions per week, one female offering one session per week) at Arrival. All patients are able to make appointments at any time to see a GP or practice nurse. Half of all appointments are 'released' the previous day, and half are bookable in advance. Appointments are also made, by referral, with a counsellor in the practice and a Respiratory Nurse (for those without BCG scars). All of these appointments are computer-recorded making it possible to describe patterns of usage of health-services. All diagnoses, tests requested, results, medications prescribed and referrals made by GP's and practice nurses are Read-coded. All notifications of usage of the 'out-of-hours' GP deputising service and Accident and Emergency departments are recorded.

From a sample of 288 adult patients registered to December 2003, 11.5% described being tortured in the past, 17% had been in prison in their country of origin or in a third country and 9% have disclosed being raped or sexually assaulted.

Following sexual health counselling patients are given a condom card.



When they show this card at reception, they will be given a supply of condoms without the need to explain their requirements.

Clinical priorities

1. Mental Health

Around 40% of the patients registered have presented with or declared some degree of mental health problem. Many have been imprisoned, tortured or raped but for others leaving their family and friends for their own security often leaves feelings of guilt and worry about loved ones.

Arrival in the UK often compounds these problems. Mental well-being and social circumstances are intertwined. Refugees often live in poor housing stock in the more deprived areas, suffer social isolation and sometimes racist attacks and low income.

The practice is working with the consultant psychiatrist to develop a screening tool that shows sensitivity to non-western cultures so that appropriate care can be provided.

Where referral outside the practice is thought to be beneficial, our counsellor acts as the conduit to other professional and voluntary sector input

2. Sexual Health

There is a strong awareness culture in the practice around issues relating to sexual health and this forms an important element of our initial appointment. We ensure understanding of the age of consent in this country; we emphasise the need to use condoms and make these readily available; we discuss the symptoms of STIs and the fact that many STIs are asymptomatic; we encourage HIV/Hepatitis/Syphilis testing for those at risk.

3. Immunisation

History is recorded
Needs are identified
Immunisations are given
Hand-held immunisation record is given which clearly shows plans for the future

Care Standards

A young population, being largely single males and all being refugees and asylum seekers means traditional methods of evaluating care standards are not applicable. We have started to look at our own quality measures and to identify those that are relevant from the Quality and Outcomes Framework. This work will be ongoing.

Prescribing

The need for medication was an unknown quantity during the practice preparatory period. The target prescribing budget was set to ensure that clinicians were not constrained in the treatments they could offer.

The reality is that few of our patients have high need for medication, many of the problems they experience being social rather than medical. From an assigned budget of up to £200,000 the first year saw expenditure of only £13,896 for the year. This was, of course, a year in which the practice list rose from a standing start so is not reflective of a full year's costs and later months showed costs of about £2,000 per month.

Despite this low expenditure the practice did not achieve the prescribing award. This was largely because of evidence-based prescribing that met the needs of this patient group but fell outside the determined criteria.

Complaints

The practice has received no formal complaints to date. On the surface this may appear to be positive but we are concerned that it may be because we have not provided a sufficiently easy route for expression of dissatisfaction. Complaints are a means of obtaining feedback on services and we would welcome the opportunity to use this mechanism for improving what we do.

Communication and team meetings

Although our team is small, communication remains a significant challenge as most members are part-time. Extensive use is made of electronic communication to safeguard message transfer and regular meetings are an important feature of our teamwork.

Two-weekly practice meetings are held with all staff present and key attached staff attend when agenda items are of relevance to them (agendas and minutes are stored in a 'shared folders' file on the computer server). Significant events are discussed at each practice meeting.

Interpreter statements of support

The Arrival practice has made health care more accessible to refugees and asylum seekers in Stockton. The doctors, nurses and reception staff are all very pleasant and helpful and make time available to every individual patient that seeks assistance. Clients I have worked with all say that they are pleased to be registered with the practice and how caring the staff are.

Sukhwinder Chahal
Interpreter

The staff at Arrival have greater understanding of the different cultures of their patients and their experience of working with interpreters improves communication between the patient and the clinician. Patients feel more at home in the multi-cultural environment of the practice when they first arrive in Stockton. In other practices they would be a minority and feel uncomfortable and vulnerable. Time to adjust to the health system in a secure setting is of great benefit.

Yasser Saeed
Interpreter

Visiting organisations

Some of the organisations that have visited Arrival include:
The North of England Refugee Service
The Red Cross
SEARCH
Teeside Positive Action
Mental Health Matters
Tees Valley Arts
The Lighthouse Project

Clinical team meetings including the nurses and doctor occur regularly to consider clinical protocols and for educational purposes. There is also a fortnightly meeting of the Health Visitor and doctor.

A bi-monthly meeting of the extended nursing team including practice and attached nurse takes place at the Arrival premises. We have also had the first wider Primary Care Team meeting which we plan to hold once every 4-6 months. This will be mainly social to introduce new team members and develop stronger understanding.

Management meetings with the Practice Manager, Senior Practice Nurse and Doctor are currently ad-hoc but we intend to regularise these for the future.

Practice team members do seek to interact with peer groups within the PCT and other agencies through attending a variety of external meetings. We have also initiated a program of inviting community organisations to visit the practice, meet our team and discuss ways of improving our working together.

Through these meetings our understanding of the contribution others can make has been extended and closer working has resulted.

Education and Training

We encourage the furtherance of knowledge, skills and understanding and have supported staff in attending conferences and undertaking courses. Each staff member has, in the main, identified their own learning needs as part of their personal development planning. For the future it is hoped that we can link the staff appraisal process, in which personal objectives are set, to the preparation of a personal development plan and selection of training. Just a few examples of some of the opportunities pursued include:

An MSc in Public Health
The AMSPAR receptionist course
A day conference on 'The health of female refugees'
Basic Counselling Skills
Medical word processing
CPR training for all staff
Child Protection training for nurses
Microsoft Outlook
Microsoft Excel
Emis Computer training