

A Targeted Health Needs Assessment of the Eastern European Population in Warrington

Final Report

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EXECUTIVE SUMMARY

This needs assessment aimed to understand the health and wellbeing needs of Eastern European migrants who live in Warrington. This was done by;

1. Reviewing current evidence about health needs of Eastern European populations in the UK and identifying any health interventions aimed specifically at Eastern European populations in the UK.
2. Exploring health attitudes, beliefs and knowledge of healthy living among Eastern European populations in Warrington.
3. Exploring knowledge and experience of health and wellbeing services among Eastern European populations in Warrington.
4. Identifying barriers to accessing health and wellbeing services experienced by Eastern European populations in Warrington.

In order to address points 2, 3 and 4, a qualitative data were collected from 61 members of the Eastern European community in Warrington. The majority of participants were Polish but the sample also included participants from Belarus, Hungary, Latvia, Russia, Slovakia and Ukraine. The majority of participants spoke English but focus groups included some participants with very little English. The focus group participants translated for each other and therefore we have included the views of many people who struggled with English. Three different data collection methods were used:

- Five focus groups (35 participants)
- Five one-to-one or small group interviews (7 participants)
- Two community engagement events (19 participants)

Data were also collected during a stakeholder meeting with 11 individuals who worked in statutory, health, council and 3rd sector organisations. Further information was received from three stakeholders who did not attend the event.

The findings of the literature review, qualitative data from engagement with the Eastern European community and the stakeholder findings are summarised below. Recommendations are also provided.

SUMMARY OF KEY FINDINGS

EVIDENCE REVIEW

The national evidence on the health of Eastern European communities living in the UK is mainly focused on epidemiology, rates of illnesses and language issues. Little research has focussed on the experiences of these communities in relation to public health and what would encourage more healthy behaviour.

The national evidence base shows that, when compared to the UK-national population, Eastern European populations have: poorer mental health; higher mortality dues to heart attacks and stroke; higher levels of obesity; increased risk of sexual ill-health; higher smoking rates and higher lung cancer prevalence. Evidence is mixed on rates of alcohol and drug use in this population. These health inequalities are compounded by poor or insecure housing, low pay, isolation, unemployment or underutilisation of skills and prejudice.

Barriers to accessing health services included language problems, not understanding the UK health systems and lack of money, as well as cultural differences such as differing prescribing practices and frustration with the GP referral model (as opposed to directly accessing specialist care). There are very few published evaluated interventions aimed at Eastern European populations.

STAKEHOLDER ENGAGEMENT EVENT

Stakeholders reported that the Eastern European population in Warrington mainly reside in the more deprived areas and, in addition to a well-established Polish community, there are newer Belarussian, Bulgarian, Czech, Hungarian, Lithuanian, Latvian, Romanian, Slovakian and Ukrainian populations. The stakeholders involved in the engagement event also suggested that the latest available census data on the Eastern European population in Warrington did not reflect their own experiences of the community and the majority believed these data are likely to underestimate the size and diversity of the population.

Stakeholders discussed how the health needs across the Eastern European population would vary and that it was important to acknowledge these diverse needs. Smoking and drinking prevalence was thought to be higher in the Eastern European community. Poor mental health and wellbeing was considered an important issue, particularly for young males who had moved to the UK alone who could experience loneliness and social isolation. Stakeholders felt many people would not access mental health services until they reached “crisis point” due to the stigma attached with mental health amongst Eastern European communities.

It was widely believed that there was a good range of appropriate services available in Warrington but that there was a need to engage with the Eastern European population to promote these services and encourage attendance and appropriate use. Signposting between services needs to be improved and increased.

It was felt key barriers to accessing services included: language; lack of trust in service providers and law enforcement; cultural differences in service delivery and health messages; stigma associated with mental, sexual and alcohol dependency services and, immigration status.

Community cohesion and engagement was believed to be key to ensuring that the Eastern European population and service providers understood cultural differences in health beliefs and healthcare systems and to enable individuals to self-manage their health and access services when appropriate.

IN-DEPTH QUALITATIVE DATA COLLECTION

The main issues raised by members of the Eastern European community related to their experience of General Practice and their dissatisfaction with the service they receive. Few participants understood the concept of public health and most participants were unable to discuss health beyond their experience of the GP.

The majority of participants believed that the Eastern European population is healthier than the UK-national population; this was due to healthier diet and more active lifestyles. Use of alcohol, smoking and drugs was thought to be similar to that of UK-nationals.

Participants felt mental ill-health was a taboo subject in the Eastern European community and not a topic people talked about. Participants talked about how, in their country of origin, most people could access a psychologist or psychiatrist directly if they wanted to and did not need GP referral. Most participants thought people would try to deal with mental ill-health themselves or may talk to family or friends. Participants thought few people were likely to access a mental health service. However it was suggested that any mental health services needed to include health professionals who speak their language and ideally have a similar cultural background to the patient. This would put them at ease and allow more relaxed communication.

Language was thought to be a barrier for some people, especially when needing to discuss complex or sensitive health topics. Some participants had used interpretation services but many relied on family and friends to translate. Language was thought to be a barrier mainly when people first moved to the UK as

language skills improved once they had lived in the UK a couple of years. Interpretation and translation services were thought to be less important than seeing a health professional from the same country as oneself. The ease of communication, shared culture, body language and facial expression of someone from the same country was discussed as being very important. Many Polish participants expressed disappointment that there were no Polish GPs working in Warrington.

Although the participants described that they now understood the UK health systems they had found it confusing when they first moved to the UK. They had not been able to find any official literature (from the council, Department of Health or GP) about the UK health services available and relied on advice from friends and work colleagues.

All participants were registered with a GP and most fully understood how to access primary care and secondary care. However the majority of participants were dissatisfied with the system and expressed frustration at not being able to access secondary or acute care without a referral from the GP. The GP themselves was seen as a barrier to access with participants feeling their GP was too powerful and sometimes obstructive. There was a lot of discussion about how this differed to the ease of access to services in their country of origin. There was a lack of awareness which public health and prevention services could be accessed without GP referral.

All focus groups and six out of seven interview participants were unhappy as they felt the GPs did not take their health complaints seriously and usually suggested paracetamol and rest. They felt GPs in the UK were disinterested in their patients and not as competent as the doctors they saw in their country of origin. Interviewees referred to the GP in terms of their health and wellbeing needs, therefore many were not able to talk beyond their experience of primary care and the difference between prescribing practices in their country of origin and the UK. For some participants this distrust in their GP discouraged attendance at their GP.

Although not included on the discussion guide, pregnancy care was brought up by all focus groups. Antenatal care was thought to be inferior to the care received in their country of origin. All four focus groups discussed how pregnant women were unable to have as many scans in the UK and they expressed frustration that the system stopped them receiving the scans they wanted. Gynaecological care was discussed by many women who felt frustrated they were not able to access annual cervical screening like in their countries of origin. Most participants were unaware that sexual health services offered many of the services that are offered by gynaecologists in their country of origin.

Participants reported that, although waiting times at A&E were too long, they had a generally positive experience of hospitals. Most Polish participants thought dentists in the UK were not as well trained or competent as dentists in Poland. Although they took their children for free dentistry in the UK, many adults accessed the dentist when they returned to their home country on holiday. Few participants used pharmacy services.

It was challenging to lead participants to discuss topics beyond their dissatisfaction with primary care, hospitals and dentists. There was limited understanding of wider public health and health promotion and participants struggled to discuss these topics.

Eastern European Attitudes to Healthcare in Warrington

A Community Engagement Exercise

General Practitioners

What do you think of GPs in Warrington?



Happy Neutral Unhappy

100% respondents registered with a GP

Some participants felt UK healthcare professionals, and doctors in particular, were more helpful than in country of origin. Polish doctors were described as distant and viewed as an authoritative figure

The majority of participants felt that registering with their GP was easy, although one family had not been able to register with the practice nearest to their home. However, the majority of participants found it difficult to get an appointment and thought waiting times were too long

One participant felt they received "the same advice, the same treatment and no referral" everytime they visited their GP. Individuals felt confident voicing their concerns but felt unhappy that they had to suggest potential causes and treatments

Prevailing opinion was UK GPs were reluctant to give antibiotics and "always prescribe paracetamol". Antibiotics were reported to be easier to access in Poland. Awareness of viral illness and antibacterial resistant was low. Instead this was attributed to a cultural focus on self-care and professional caution to prevent abuse of a free healthcare system

Hospitals

Several individuals had experienced long waiting times

Majority who had visited a local hospital described a good experience with high quality care

What do you think of Hospitals in Warrington?



Good Neutral Bad

Dentists

What do you think of Dentists in Warrington?



Good Neutral Bad

Main barriers to accessing UK dentist were lack of trust, feeling Polish dentists were more knowledgeable, cost and bad experiences with UK dentists in the past

A small number of individuals said they used and were happy with their dentist in the UK. The majority of respondents took their children to a UK dentist

The majority of respondents said they accessed the dentist in Poland

##

TRIANGULATIONS OF FINDINGS

The findings from the various research components were triangulated to enable identification and exploration of common themes.

HEALTH PROMOTION AND PREVENTATIVE HEALTH SERVICES

Most participants found it difficult to discuss public health and preventative services; there was little understanding of these types of service and for most they understood healthcare as only the services provided by the GP and hospital. Most participants talked about smoking and alcohol in relation to how many people engaged in these behaviours; when questioned about support to reduce drinking few felt this was something a service would help with. Alcohol problems were thought to be something a person sorted out for themselves, however there was more interest in and acceptance of smoking cessation services.

Few participants were able to offer an opinion on what could make mental health services effective; few participants knew anybody with mental health problems, they felt it was rarely talked about and that people tended to sort out problems on their own. However the literature shows a high prevalence of mental health problems in the Eastern European migrant population in the UK (Toni et al 2010; Patel 2012). Participants felt the Eastern European community was unlikely to use mental health services, however any counselling or support services needed to be provided by a professional who spoke their language if they were going to be taken up. Evaluation of a smoking cessation service in Crewe has shown a Polish speaker providing support increased uptake and effectiveness of the programme (Eida and Ehata 2010).

Lack of trust in their GP seems to be acting as a barrier and may stop Eastern European population from seeking help for issues like mental health or for help with smoking or alcohol. This may be exacerbated by their experience that their GP is reluctant to refer them to a specialist. The data we have collected show that this population does not prioritise preventative healthcare and would rarely access services to help with mental health or alcohol, this is even less likely if they would have to request this from their GP. It was not clear to participants which services they could access independently of their GP and they were unlikely to seek out any additional health care services independent of their GP. To encourage access to public health and preventative healthcare services (i.e. IAPT, sexual health, smoking cessation, drug and alcohol services) potential patients need to understand the care pathways in place that do not need GP involvement.

Dissatisfaction with being unable to access gynaecology services may be due to lack of understanding of what are offered by sexual health services. Differences in terminology may contribute to this as in the UK most women will not regularly see a health professional with the job title 'gynaecologist'. However in the UK many women receive 'gynaecology' services from their GP, community contraceptive clinics and the genitourinary clinic. Promotion of sexual health clinics as providing many of these 'gynaecology' services could improve access for Eastern European women.

PRIMARY CARE AND SELF-CARE

Although we found a small amount of literature about dissatisfaction with GP attitudes and prescribing practices, this was by far the main issue focused on by participants in this needs assessment. We did not ask any direct questions about medication and participants started discussing GPs as soon as they were asked the initial questions about their understanding of health and being healthy. Throughout the focus groups and interviews the conversation regularly returned to primary care and prescribing, even when researchers were asking unrelated questions.

The majority of participants focused their discussions on dissatisfaction with primary care and prescribing practices. Almost every participant reported they regularly felt their GP did not take their concerns seriously and advised them to 'take paracetamol and rest'. This caused a lot of frustration within the Eastern European community and many participants spoke about how their friends and colleagues reported the same experience. Although this issue is mentioned in the wider literature, the importance of this to the Eastern European community in Warrington cannot be understated. Many participants reported their GP had refused to prescribe antibiotics when requested and they felt very frustrated by this; some thought the GP was trying to save money. The literature also highlights a lack of understanding of the appropriateness of antibiotics in the UK national and Eastern European population (ECDC 2014) and specific work needs to target the Eastern European community in the UK to reduce antibiotic resistance.

This difference in ethos and approach to healthcare is causing distrust in their GP which creates barriers and can stop patients accessing other healthcare services. If a patient feels dismissed and not listened to by their GP they are unlikely to approach their GP for support for issues such as mental health, alcohol or smoking cessation.

Although some of this may be due to actual GP behaviour, their perception of disinterest and dismissal by their GP suggests the problem is twofold. Firstly the Eastern European communities appear to access GP services for issues and illnesses that can be treated at home or by a pharmacist. Experience in their country of origin may have encouraged individuals to attend their GP for all health concerns and participants reported more varied medication being prescribed; more promotion of self-care needs to be targeted at this population. Secondly the GP needs to promote the importance of self-care and the efficacy of paracetamol. The affordability and availability of paracetamol seems to suggest to people in the Eastern European community that paracetamol is a very basic and ineffective drug.

SERVICE DESIGN AND GP AS GATEKEEPER

Although the literature shows Eastern European migrants to the UK do not understand the UK health system and use inappropriate services this was not the case for the participants in this needs assessment. The majority of people we spoke to are registered with a GP and understand the role of the GP in the UK health service. However, as mentioned in the literature, the GP was often seen as a barrier; they were seen to hold the power to refer for specialist services and many participants talked about having to 'prove' how ill they were before they could be referred. This general role of the GP is different to the family doctor in many participants' country of origin and the majority of participants expressed dissatisfaction with this.

The literature states this dissatisfaction and frustration is a result of not understanding the UK health system, however we found good understanding of the UK health service amongst the participants. Therefore it is not that they do not understand the system, it is that they do not like it and think it is inferior to the system they are used to. The reasons for the design of the UK health system and the ethos behind the NHS need to be communicated and explained including what is appropriate use of primary, secondary and acute health services. On top of this the role of the GP also needs to be better communicated to ensure that people understand the GP has very broad training and can treat the majority of illnesses and most patients do not need to be referred to a specialist.

Although the majority of participants with whom we had conversations at the engagement events reported a positive experience of their GP, when this was discussed in depth in interviews and focus groups the majority of participants revealed they were unhappy about the service they receive from their GP.

RECOMMENDATIONS

HEALTH PROMOTION AND PREVENTION SERVICES

1. Public health messages around healthy eating, alcohol consumption, smoking and drug use need to be consistent and inclusive across the whole Warrington population particularly in the most deprived wards. Ensure that messages are translated into the appropriate languages and are visible in areas that are accessed by the Eastern European population. Build on existing campaigns such as The Five Ways to Wellbeing or Happy Sad Ok and translate these into key Eastern European languages.
2. Consider adapting current smoking cessation services to ensure promotion is in the appropriate languages and appears relevant to Eastern European populations. The published literature suggests that smoking is higher among Eastern European migrant populations in the UK; however opinion on smoking prevalence among study participants was mixed with some citing cost as a limiting factor. Both the published literature and study participants agree that Eastern European populations would be unlikely to access smoking cessation services; although awareness of such services and stop smoking messages seemed fairly high. Findings from a smoking cessation pilot for Polish communities in Crewe (Eida and Ehata, 2010) could be used to inform this development.
3. Promote sexual health services as an appropriate alternative to gynaecology services. Different terminology and expectations of service is leading many Eastern European women to feel they cannot access any gynaecology services without referral to a specialist by the GP. Promote what gynaecology services are available within sexual health services in Warrington and promote Warrington Centre for Sexual Health as a holistic service, not just for the treatment of STIs.

MENTAL HEALTH SUPPORT

4. There are a good range of mental health services available in Warrington many of which have signposting/self-referral mechanisms in place. However, there is a need to engage with the Eastern European population to promote these services and encourage attendance and appropriate use. Exploring existing models, such as Wellbeing Mentors, will ensure that the Eastern European population are supported in accessing the services they are signposted to.
5. As stigma, shame and distrust of their GP can stop some people accessing mental health services, pathways need to be as simple as possible to ensure potential users do not feel they have barriers to overcome to access services. Warrington Psychological Services (IAPT) accept self-referrals; promote this to the Eastern European community so they understand they do not have to ask their GP for a referral.
6. Explore the feasibility of employing wellbeing mentors or psychological wellbeing practitioners who speak Eastern European languages, especially Polish. Health professionals who speak Eastern European languages were thought to be more important and approachable than translation services, this is particularly important when discussing sensitive and distressing mental health issues.
7. Consider ways in which social isolation can be reduced particularly among young, single males. This could be through the introduction or funding of formal Eastern European organisations/support services/social

groups. Currently the only formal organisations are church and school based which may not be appropriate for some younger people.

8. Increase support for employers and recruitment agencies to recognise mental health problems. Some evidence from participants, stakeholders and literature shows that young males who are more isolated suffer higher levels of mental health and that this topic is not frequently discussed in the Eastern European community. The workplace may be a key setting to intervene, so ensure that HR in big employers like warehouses and recruitment agencies are prepared to respond and recognise mental health problems. The latest DH Mental Health Policy document (Closing the Gap, 2014) recommends that employers not only promote workplace wellbeing but also improve information available to managers so they can recognise the signs of stress and mental health problems and talk about them with staff.

HEALTH SYSTEMS IN THE UK

9. Increase communication around how prescribing and medication is approached in the UK. This is especially important around the practice of self-care, recovery from viral illness and the benefit of paracetamol for many ailments and illnesses. The effectiveness of paracetamol needs to be more clearly communicated and people made aware that, although cheap and easily available, paracetamol is highly effective for many health conditions. Our needs assessment found that this lack of communication appears to be causing distrust in GPs for the majority of the Eastern European population we spoke to. Although this was mentioned briefly in the literature this is a key issue for the Eastern population in Warrington.
10. There needs to be clear promotion of self-care and signposting to appropriate services, including when it is appropriate to visit a pharmacist or your GP. The promotion of self-care, self-management and independence across the population is a key role of the Director of Public Health under the Coalition Government's vision (DH, 2010). Promote the importance of self-care and the role of the pharmacist in treating minor ailments, coughs, colds and high temperatures. Specific promotion could link in with the NHS [self-care week campaign](#) which runs from 17th-23rd November 2014 and encourages individuals to 'Be healthy this winter'. Translate the levels of care information and promote to Eastern European communities. Promote the NHS Choices website which includes translation into many different languages, and advice for visitors to the UK.
11. Develop printed information about antibiotic resistance in key Eastern European languages explaining resistance, differences between bacterial and viral infections and reasons for not prescribing antibiotics. Reducing antibiotic resistance is a key concern both nationally (CMO, 2014) and internationally (WHO, 2014). Provide information sheets to all GP practices to ensure patients understand why they are not being given antibiotics and why paracetamol is often appropriate. These should be provided as standard as many Eastern European people will not challenge the care they receive when they feel the GP has tried to appease them.
12. Encourage GPs to engage with activities for European Antibiotic Awareness Day (EAAD) on November 14th and in particular to ensure these activities are relevant, accessible and visible to Eastern European populations in Warrington. Evidence from this needs assessment and the literature suggests that expectations and misconceptions about antibiotic prescribing in General Practice are particularly high amongst the Eastern European population. The CMO encourages all GPs in the UK to join the EAAD pledge

and make use of the [online resources](#) (CMO, 2014) and this presents an ideal opportunity to raise awareness among the Eastern European population in Warrington.

13. Increase understanding of the role of primary care in the UK and referral systems to secondary care. This needs assessment found that many members of the Eastern European population do not understand the role of primary care in referral to other health services. GPs should provide clear communication about referral pathways and the timescales involved. Continuation of translation services across appointments is needed.
1. Develop a website about health services in Warrington that is available in multiple Eastern European languages (or with a Google Translate button as a minimum) to include information about UK health systems design, the role of the GP and antibiotic resistance. The website would not necessarily contain information about specific services but could link to the NHS Choices list of services. The site should include detailed explanation about why patients cannot access all secondary care directly, which services they can self-refer to (especially highlighting mental health, smoking cessation, sexual health and drug and alcohol services) and the effectiveness of paracetamol. Widely promote the website to the Eastern European community in Warrington. Lancashire Council has produced a website and information pack for migrants new to the area. . (Available at: www.Lancashire.gov.uk)
14. Train health care professionals, especially GPs, on the differences between health systems and culture around medication. This would enable them to more effectively explain why they may not be prescribing antibiotics, explain the effectiveness of paracetamol and explain why the patient cannot make an appointment directly with specialist services.
15. Improve monitoring and recording of country of origin and migrant status of patients accessing healthcare and social support services. Currently most monitoring computer systems only collect ethnic origin which often does not capture whether a patient is of Eastern European origin. Improving monitoring would allow services to understand the population using their services, where they are not meeting the needs of specific groups and where they need to target services. Housing associations are collecting this information about their tenants and use it effectively to target and improve their services; this could be used as a model for collecting data within statutory and third sector organisations.
16. Building on the experience of this needs assessment, effective communication channels for health promotion and promotion of services include; Polish Saturday School, selected recruitment agencies, SureStart centres and groups, Warrington.pl online forum, leaflets within the Polish section and computer areas of Warrington Library and the church.

LANGUAGE AND TRANSLATION

17. Look at ways to increase the number of primary care health professionals who speak Eastern European languages, particularly Polish, working in areas with high numbers of Eastern European migrants. This should include GPs and nurses. This could be achieved through including Eastern European language as a desired skill on a job description and advertising directed at the Eastern European community to encourage applicants who happen to be bilingual.

18. Look at ways to increase the number dentists in Warrington who speak Eastern European languages, especially Polish. This is especially important for NHS dentists as cost is another strong barrier to use. This could be achieved through targeted recruitment of bilingual staff. Dental practices with bilingual staff should actively promote this on their websites.
19. Ensure interpretation services are easily available, well-advertised and accessible. Highly visible advertising (in multiple languages) should be displayed in GP waiting rooms, IAPT, in hospital entrances and on practice websites.
20. Review language line contracts to see if this interpretation service can be unified under a single contract. Set a minimum requirement in all service specifications to ensure that interpretation services are available across all services including smaller community organisations.
21. Ensure all letters about personal screening (such as cervical, breast and prostate screening) include information about interpretation services as standard.

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1. INTRODUCTION

In April 2014 Warrington Public Health (Warrington Borough Council) commissioned the Centre for Public Health, Liverpool John Moores University to conduct a Targeted Health Needs Assessment of the Eastern European population in Warrington.

BOX 1. BACKGROUND TO THE RESEARCH (FROM NEEDS ASSESSMENT SERVICE SPECIFICATION)

In Warrington, patterns of overall immigration are declining. Despite this, evidence suggests Eastern European immigration is growing in particular areas. New migrants typically live in disadvantaged and deprived neighbourhoods, often characterised by poor housing, high levels of unemployment, limited service provision and poor local amenities.

We know that these issues are risk factors for what has been referred to as acculturative stress; adverse effects including anxiety, depression or other mental and physical problems associated with adapting to a new cultural context. Living in close proximity to people from the same country of origin or from a shared ethnic background can help limit such challenges, and a full understanding of health needs can help ensure that the integration experience is positive for both the migrant and settled communities.

To help develop understandings about the health needs of the Warrington population, a comprehensive large scale lifestyle survey of a random sample of adults in Warrington was undertaken early in 2013, where 6,673 valid returns were received. All survey results were weighted to account for different response rates in sub-groups of the population. 101 questionnaires were from residents of Eastern European origin. The results showed that, as expected a large proportion of this population resided in the most deprived areas of Warrington; 65% of respondents of Eastern European origin live in quintile 1 (most deprived), with a further 24% in quintile 2. Further breakdown within the Eastern European group was not possible due to the small number of respondents.

Results from Eastern European respondents were compared to Warrington as a whole. Also, as such a high proportion resided in quintile 1, results were compared to results for all Warrington respondents from quintile 1 (in order to check whether the results for Eastern Europeans were different from those for people living in similarly deprived areas).

The analysis of the Warrington 2013 Lifestyles survey shows that, after comparing Eastern European respondents with all respondents across Warrington and all those in quintile 1, Eastern Europeans have:

- A much higher smoking prevalence
- A lower alcohol risk
- A better diet and eating habits and less obesity
- A better emotional wellbeing than people in quintile 1 but not as high as Warrington as a whole
- A high rate of contact (91.3%), including face-to-face contact, with family, friends or neighbours; however they have less face-to-face contact than quintile 1 (95.7%) and Warrington (97.3%)
- Feel less likely to have people they can talk to with their problems
- The rate living alone is similar to Warrington levels
- Are less lonely than people in quintile 1 and in Warrington
- Are more likely to have poor neighbourhood connections and/or perceptions
- Eastern European respondents are also relatively young, with 69% (70) being aged under 40

Given the risk factors associated with Eastern European populations, and the Warrington Lifestyle Survey findings, Warrington Borough Council commissioned a Targeted Health Needs Assessment specific to the Eastern European population in Warrington. Needs assessments are a valid method for understanding the health needs of populations within a specific demographic, and enabling the development of recommendations to inform the delivery and development of local services.

1.1 RESEARCH OBJECTIVES

Warrington Borough Council identified five key objectives for the needs assessment to address:

- To review current evidence about the health needs of Eastern European migrants in the UK.
- To identify health interventions aimed specifically at Eastern European populations in the UK.
- To explore health attitudes and beliefs among Eastern European populations in Warrington.
- To explore knowledge of healthy living and health services among Eastern European populations in Warrington.
- To identify barriers to accessing health services for Eastern European populations in Warrington.

This report provides an overview of the needs assessment framework, methodology, findings, discussion and recommendations for practice.

2. ESTIMATING THE SIZE OF THE EASTERN EUROPEAN POPULATION IN WARRINGTON

2.1 DEFINING EASTERN EUROPE

In order to develop a comprehensive framework for this needs assessment, an understanding of the demographics and characteristics of the Eastern European population was required. The term ‘Eastern Europe’ in its simplest form is used to describe countries in the Eastern part of the European continent but generally defined as those countries which were under former Communist Rule during the Cold War period (the so called “Eastern Bloc”). However, the exact boundaries of Eastern Europe are not well defined with many organisations presenting conflicting lists of the countries which form Eastern Europe.

The United Nations (UN) Statistical Division definition of Eastern Europe includes ten countries (UN, 2013a). However, in the UN listing of member states the Eastern European group membership features 25 countries. Similarly, the Multilingual Thesaurus of the European Union (2013) lists 21 countries which make up Eastern Europe. A full summary of these definitions are included in table 1 below:

TABLE 1: COUNTRIES DEFINED AS EASTERN EUROPEAN BY INTERNATIONAL ORGANISATIONS

United Nations Statistical Division	United Nations Regional Group Membership	Thesaurus of the European Union
	Albania	Albania
	Armenia	Armenia
	Azerbaijan	Azerbaijan
Belarus	Belarus	Belarus
	Bosnia and Herzegovina	Bosnia and Herzegovina
Bulgaria	Bulgaria	Bulgaria
	Croatia	Croatia
Czech Republic	Czech Republic	Czech Republic
	Estonia	
	Georgia	Georgia
Hungary	Hungary	Hungary
	Latvia	
		Kosovo
	Lithuania	
	Montenegro	Montenegro
Poland	Poland	Poland
Republic of Moldova	Republic of Moldova	Republic of Moldova
Romania	Romania	Romania
Russian Federation	Russian Federation	Russian Federation
	Serbia	Serbia
Slovakia	Slovakia	Slovakia
	Slovenia	Slovenia
	The Former Yugoslav Republic of Macedonia	The Former Yugoslav Republic of Macedonia
Ukraine	Ukraine	Ukraine

For the purpose of this report, any data reported will include any nation included in the UN or EU definitions of Eastern Europe. Where possible, a country level breakdown will also be included.

2.2 MIGRATION IN THE UK

The foreign-born population in the United Kingdom has grown substantially in the past 20 years; with the foreign born population nearly doubling from 3.8 million in 1993 to 7.7 million in 2012 and the number of foreign citizens rising from 2 million to 4.9 million in the same period (Rienzo and Vargas-Silva, 2013). There has been a year on year increase in the numbers of foreign-born people in the UK in practically every year over the past two decades and the greatest annual increase was seen between 2005 and 2006 (900,000 people; 15%); coinciding with a significant increase in Eastern European migrants following the European Union Enlargement in 2004 (Rienzo and Vargas-Silva, 2013).

Poland (8.7%) is among the top three countries of birth for foreign-born individuals in the UK along with India (9.1%) and Pakistan (5.8%). Poland represents the largest proportion of foreign born citizens living in the UK (14.9%; table 2)

TABLE 2: TOP TEN COUNTRIES OF UK MIGRATION BY COUNTRY OF BIRTH AND CITIZENSHIP

Country of birth	% of foreign-born population	Country of Citizenship	% of all foreign citizens
India	9.1	Poland	14.9
Poland	8.7	India	7.3
Pakistan	5.8	Ireland	6.9
Ireland	5.1	Pakistan	3.6
Germany	3.9	United States	3.2
United States	3.0	Lithuania	2.9
South Africa	2.7	France	2.8
Bangladesh	2.7	Germany	2.4
Nigeria	2.4	Italy	2.4
Kenya	1.9	Nigeria	2.3

Data source: Migration Observatory, 2013

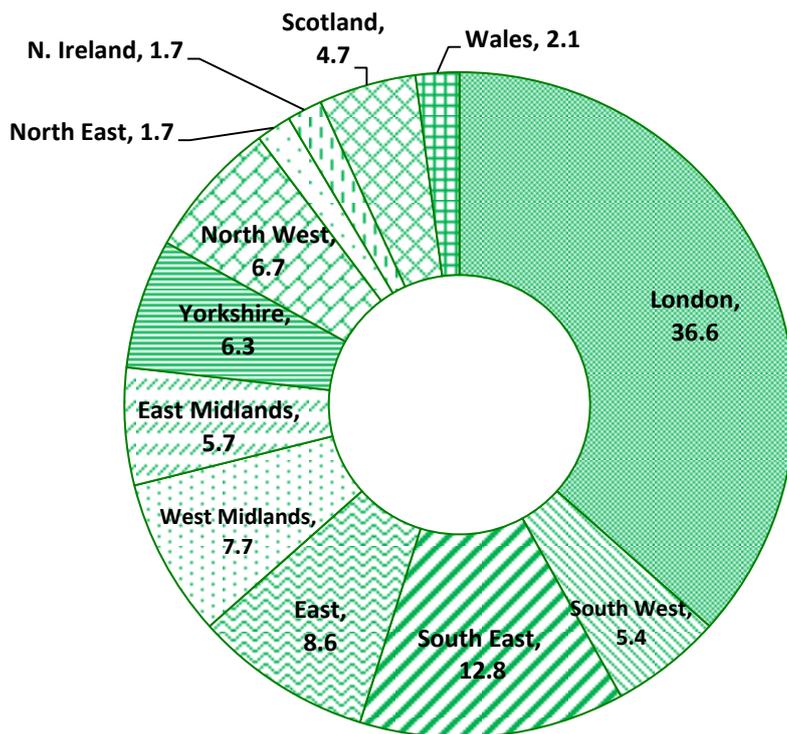
The distribution of foreign-born populations varies across the UK with around half of the foreign born population residing in London (36.6%) and the South East (12.8%). The North West of England is home to 6.7% of the UK foreign born population (518,801 individuals; figure 1) of which 60% live in Greater Manchester and 12% live in Merseyside. Between 1995 and 2012, the foreign born population in the North West has increased by 53% (table 3).

TABLE 3: FOREIGN BORN POPULATION BY REGION, NORTH WEST 1995-2012

	1995	2000	2005	2009	2012	1995-2012 % change
Greater Manchester	165,990	141,808	215,707	296,982	313,711	89%
Merseyside	34,696	39,025	61,184	55,401	63,732	84%
Rest of North West	102,607	104,538	134,609	165,536	141,358	38%
North West Total	303,293	285,371	411,500	517,919	518,801	53%
UK Total	4,128,738	4,625,349	5,734,786	6,952,170	7,711,543	87%

Data source: Migration Observatory, 2013

FIGURE 1: FOREIGN-BORN POPULATION IN THE UK BY REGION OF RESIDENCE (PERCENTAGE)



Data Source: Migration Observatory, 2013

2.3 THE EASTERN EUROPEAN POPULATION IN WARRINGTON

According to the 2011 Census, there were 404,456 individuals residing in Warrington of which 2,538 were recorded as Eastern European origin. The majority of Eastern European residents recorded were Polish (62%). A full breakdown of the Eastern European population by country of origin is illustrated in table 4.

TABLE 4: EASTERN EUROPEAN POPULATION IN WARRINGTON BY COUNTRY OF ORIGIN

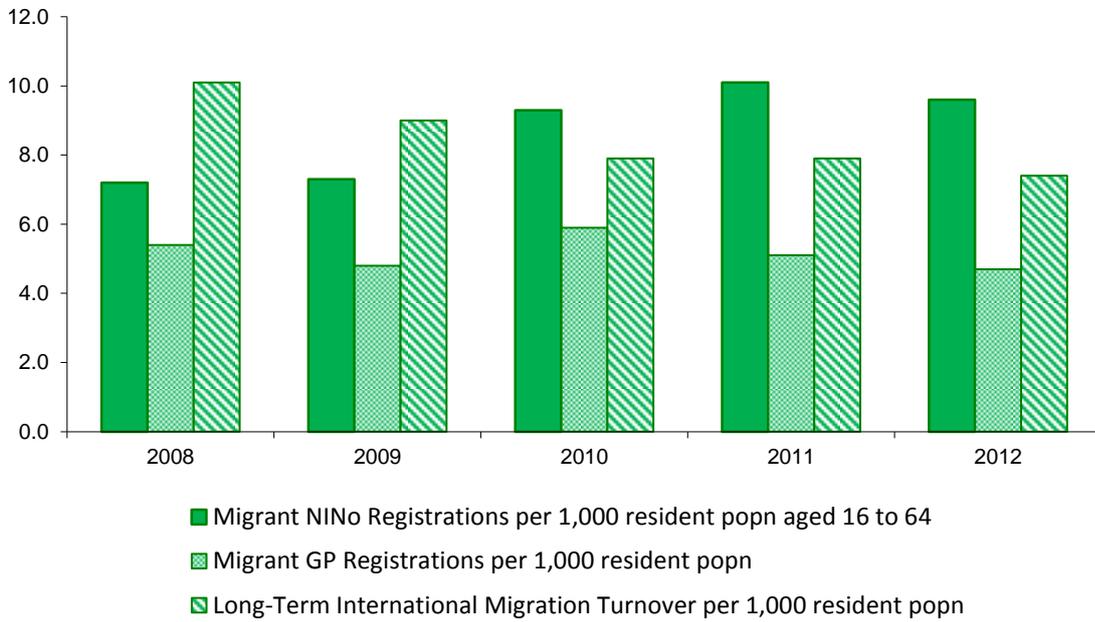
Country of origin	Residents
Polish	1,569
Baltic States	244
Commonwealth of Russian Independent States	76
Serbian	7
Albanian	5
Croatian	2
Bosnian	1
Other Eastern European	634
Eastern European (total)	2,538

Data Source: ONS, 2013

The rate of long-term international migrant turnover in Warrington in 2012 was 7.4 per 1,000 adult population (aged 16 to 64 years); lower than the England average (14.1 per 1,000 population). In 2012, there were 1,250 migrant National Insurance Number (NINo) registrations; a rate of 9.6 per 1,000 population and

951 new migrant GP registrations; a rate of 4.7 per 1,000 population (ONS, 2013; figure 2). Both rates are lower than the national average (13.5 per 1,000 population and 10.8 per 1,000 population respectively).

FIGURE 2: MIGRATION INDICATORS, WARRINGTON 2008-2012



Data Source: ONS Labour Market Statistics, 2014

3. METHODOLOGY

In order to fully capture the health needs of the Eastern European population in Warrington, a mixed-methods approach was employed. A review of the literature was complemented by engagement with key stakeholders and members of the Eastern European population. The rationale and details of the data collection methods are fully explained below.

3.1 LITERATURE REVIEW

The first stage of this needs assessment involved undertaking a review of all relevant literature, including academic peer reviewed journals and grey literature. The review considered literature on Eastern European migrant populations, and focused specifically on: health needs; experiences and perceptions of health; health behaviour; health promotion and health service use. The search focused mainly on evidence from the UK as many of the issues relating to health and wellbeing of migrants are very specific to EU migration to the UK, and to the UK health system. Some articles from Western Europe were also identified and included when appropriate. Only literature published after 2000 was included. The review covered all age groups and considered interventions which had short and long term impacts on behaviour. The findings from the literature review were used to inform the development of topic guides for the qualitative element of the research. A full detailed review of identified papers is available on request and a summary of the key findings is presented in section 4.

3.2 STAKEHOLDER ENGAGEMENT

In order to further inform the scale and the scope of this needs assessment, and to explore appropriate and feasible methods for data collection, a stakeholder event was held on 6th May 2014. The purpose of this engagement was to elicit data to supplement the literature review and population data, by gathering information about stakeholder experiences, views and perceptions about the health needs of Eastern Europeans in Warrington.

Stakeholders were identified in collaboration with the commissioners of this needs assessment, and the Warrington Eastern European Task Group. A mixture of frontline workers, service providers, commissioners and third sector organisations were invited to attend the event. In total, 11 stakeholders attended the event from a range of local organisations.

The engagement event was facilitated by the LJMU research team. Attendees were asked to form three groups; each group comprised a range of professional experiences. The groups were asked to discuss the following:

- 1) Who are the Eastern European population in Warrington?
- 2) What are the health and wellbeing needs of the population?
- 3) Do you have appropriate services for this population and are they accessible?
- 4) What are the barriers to access and what needs to change?

The groups were given twenty minutes to discuss each question. Prompts were included to facilitate the discussion and participants were encouraged to summarise key findings using flipcharts. After each question a ten minute whole group feedback session allowed each group to report back their discussion to the other attendees. A researcher from LJMU provided support for each of the three groups and took detailed notes. The data were analysed using a thematic framework analysis.

The stakeholder event also provided opportunity for the LJMU research team to discuss the proposed approach for engagement with members of the Eastern European community. A number of key gatekeepers were identified at the event who provided advice regarding the most appropriate methods of data collection.

3.3. QUALITATIVE ENGAGEMENT WITH MEMBERS OF THE EASTERN EUROPEAN POPULATION IN WARRINGTON

DESIGN

A range of qualitative methods were employed to enable a comprehensive understanding of the health needs of the Eastern European population in Warrington. In order to elicit the required data, the study initially proposed to undertake three focus groups with a minimum of five participants, and ten one-to-one interviews with Eastern European and individuals who lived, worked or studied in Warrington.

Following discussions with key stakeholders, and an iterative recruitment process, the data collection process evolved to ensure that all methods were appropriate and feasible, and to ensure that a fully representative view of the population was explored. Focus groups and one-to-one interviews were undertaken where appropriate. Some participants did not wish to participate in either option, and requested to share their views using alternative methods; the methodology was expanded to include paired interviews, small group interviews, and community engagement. A detailed description of sampling and recruitment methods are presented below. Table 5 provides an overview of the data collection methods employed, along with sample characteristics.

Three quarters of the participants who took part in the qualitative engagement were Polish (n=46), which is broadly representative of the Eastern European population in Warrington; the 2011 census revealed 62% of the Eastern European population in Warrington are Polish (see table 4). The Polish population in Warrington is the longest established and have the most formal and informal groups and networks. Thirteen participants came from other countries including Belarus, Hungary, Latvia, Russia, Slovakia and Ukraine.

TABLE 5 BRIEF DESCRIPTION OF THE FINAL SAMPLE

Data collection method	Gender	Age Range	Nationalities	Label
Youth Focus Group (n=10)	Eight males and two females	Aged 16 -19	All Polish	Youth focus group
Mothers 1 Focus Group (n=6)	Six females	Aged 18 - 65	All Polish	Mothers 1
Mothers 2 Focus Group (n=4)	Four females	Aged 18 - 65	All Polish	Mothers 2
Mothers 3 Focus Group (n=10)	10 females	Aged 25-45	All Russian speaking. Mix of Russian, Latvian, Ukrainian and Belarussian	Mothers 3
Mixed focus group (n=5)	Three males and two females	Aged 25-60	All Polish	Mixed focus group
One-to one- interview	Female	60s	Polish	F1
One-to one- interview	Female	50s	Polish	F2
One-to one- interview	Male	Early 20s	Polish	M1
Small group interview	Three males	Aged 21-35	Latvian	M2, M3, M4
One-to one- interview	Male	30s	Hungarian	M5
Community engagement events N=19	Mix male and female (~40% male)	18-65	Polish One Slovakian Male	
Total = 61				

FOCUS GROUP SAMPLING AND RECRUITMENT

Most focus groups were recruited through three existing groups; a Polish youth group, parents at a Saturday School and a mothers group who meet at a Children’s Centre, all of which were based in Warrington. All of the groups had been established for over a year and participants in each group already knew each other. Focus groups with individuals who know each other (as opposed to groups of strangers or a random sample) reveal prevailing opinions held by the group, and this allows for a consensus to be reached. The mixed focus group was recruited through the flyers/advertising originally intended to recruit interview participants. However when communicating with the participants they requested a focus group rather than interviews. The members of the mixed focus group also knew each other before the discussion began.

The research rationale and proposed methods were agreed with the gatekeeper to ensure feasibility. Gatekeepers were offered written information in other languages if they thought it was appropriate; only Polish was needed. The gatekeeper then discussed the invitation with the group, explaining the rationale for the research to the group members and providing each individual with a participant information sheet. Participant information sheets were given in both Polish and English however it was made clear to participants that the focus group would take place in English. It was also made clear to individuals that they did not have to take part even if the rest of the group wanted to do so. The focus group was then arranged for a time within the normal weekly meeting of each group. Although all parents were invited to take part, the focus group at the Saturday School consisted of only mothers as none of the fathers wished to stay and participate. The focus group started as one discussion but after 15 minutes was split into two groups to ensure all voices were heard.

Two researchers from the Centre for Public Health, LJMU, facilitated each focus group. One researcher led the discussion and the other researcher observed and recorded the dynamics of the group and the non-verbal communication. A British youth worker was present at the young people's focus group. A worker from the drug service was present at the group interview with Latvian men. The focus groups were conducted in English and participants assisted each other with translation. Each focus group lasted between 30 minutes and one hour.

All participants who took part in a focus group were given a £10 Love2Shop voucher to say thank you for their time.

The original specification commissioned 10 interviews and three focus groups. However five participants did not want to take part in interviews and requested to do a small focus group instead. The mixed focus group was conducted as a result of this request.

INTERVIEW SAMPLING AND RECRUITMENT

Interview participants were adults aged over 16 years who identified as Eastern European or Polish and lived, worked or studied in Warrington. The interviews aimed to recruit individuals who were not part of the organisations involved in the focus groups and participants were screened by age to ensure a range of local views were captured.

Interview recruitment was done in collaboration with local stakeholders and was advertised through a number of channels and local networks. Local stakeholders were asked to identify potential avenues for recruitment and posters and flyers were distributed by a number of organisations including libraries, churches, shops, the Saturday School and at community events. Recruitment information was also included on the Warrington online Polish Forum and the website of a local housing association. Snowballing techniques were used to increase recruitment. Potential participants were directed to a poster or flyer (printed in English and Polish) and asked to contact the researcher either via telephone or email if they wished to take part in an interview. Participants expressing interest in an interview were provided with a participant information sheet and a one week cooling off period was allowed when arranging a date for interview.

Interviews were conducted by the principal researcher face-to-face in a quiet area in a suitable local venue. The participants decided whether they wanted to do the interview face-to-face or over the phone and if they wanted to do a one-to-one or a paired/small group interview.

Paper and electronic leaflets and posters were distributed through a number of organisations. Table 6 below describes the success and challenges associated with each distribution method.

All participants who took part in an interview were given a £10 Love2Shop voucher to say thank you for their time.

TABLE 6. RECRUITMENT AND PROMOTION DISTRIBUTION METHODS

Organisation/ recruitment route	Recruitment method	Effectiveness
Golden Gates Housing Trust	Email sent from GGHT to tenants who were recorded as Eastern European.	One interview and one small focus group were organised with GGHT tenants who had seen the recruitment email.
CRI Pathways to Recovery	Leaflets and posters displayed in service. Specific Eastern European service users invited for interview.	A small group interview was conducted with three services users. Most service users did not wish to participate in the research despite CRI staff encouragement.
Polish Forum	Advert placed in classified section of Polish forum website. Advert text same as leaflet and provided in Polish and English.	Post viewed 128 times, however no participants recruited as a result of this method.
Polish Saturday School	Leaflets and posters displayed at Saturday school and at Polish Family Fun Day. Parents invited to focus group by email from Saturday School coordinator.	Two focus groups conducted whilst children were in classes. The mothers are a particularly engaged group and were happy to stay in the school and engage with researchers whilst their children were in classes. Fathers did not wish to stay or engage.
Churches	Posters and leaflets displayed at St Benedict's Church. The needs assessment was mentioned during the Polish, Slovakian and Czech Mass'.	No participants were recruited as a result of promotion at the churches.
Recruitment agencies	List of recruitment agencies was provided by a stakeholder in the Polish community. This list comprised agencies that were felt to be the most commonly used by Polish/Eastern European migrants. Five recruitment agencies were approached. Two agreed to distribute/display leaflets.	Although no interviews or focus groups were arranged as a direct result of this engagement, the two agencies (Gap Personnel and Gi Group) would be worth approaching with any health promotion material as they saw high numbers of Eastern European clients.
Shops	Posters displayed in the three Eastern European shops in Warrington.	Although staff in shops were helpful, no participants were recruited as a result of this method. Participants described shops as a vital way of communicating to the Eastern European community. This could be a potential avenue for the promotion of health messages and events, and further harnessed by Warrington Borough Council.
Warrington Library	Posters and leaflets displayed on general notice boards and on shelf amongst Polish language books. Two researchers also spent a morning in the library to distribute flyers and try to recruit potential participants to interviews.	Displaying posters and leaflets in the library was successful. This is an effective way of reaching the Eastern European community as many people come to use the free computers or the Polish language section. Two interview participants said they had learnt about the needs assessment from seeing posters/leaflets in the library. Approaching people in the library was not effective; it was difficult to identify users who were from Eastern Europe and most people had booked timed computer slots so did not have time to talk to researchers.

Schools/family support worker It was originally anticipated to include the schools/family support workers as a potential method of recruitment. However there were difficulties making contact with the appropriate contact. Other recruitment methods were prioritised as the sample already included a large number of parents.

FOCUS GROUP AND INTERVIEW DISCUSSION TOPICS

A focus group and interview discussion guide was developed, informed by the literature review and engagement with local stakeholders, to explore health needs. Topics for discussion included:

- Perceptions of health and “being healthy”
- Attitudes and health behaviours in the Eastern European community including mental health, alcohol and smoking
- Awareness of health services including GPs, hospitals, dentists and pharmacies
- Any experience and opinions of local health services
- Barriers to accessing health services
- How to reduce barriers to access for Eastern European people to services such as mental health, smoking cessation, drug and alcohol services
- How to improve public health services and health promotion to make it more appropriate and applicable to the Eastern European community in Warrington
- Views of published interventions and ideas and suggestions for development of local services aimed at Eastern European and Polish populations

Questions focused participants’ opinions, perceptions and knowledge of health and where they had obtained these views, rather than about their own health. However, during the course of the discussion some participants volunteered information on their own service use and experience. The focus groups were run in an informal relaxed style with prompting when necessary.

The role of the GP was only a small part of the discussion guide and only a few questions related to this topic. However the majority of participants only wanted to talk about their GP and the conversation regularly came back to the role of their GP. In The UK health service the GP has an important role in wider primary and secondary care services by providing advice, support and referrals for health and wellbeing. Although not an original priority of the needs assessment the importance of this topic to participants was explored to understand how their experience of the GP impacts on their health and their experience of the whole of the UK health system.

FOCUS GROUP AND INTERVIEW ANALYSIS

Focus groups and interviews were recorded and transcribed from the recordings. Framework analysis was used to analyse the data (Spencer and Ritchie, 1993). Framework analysis begins inductively with a preset group of aims and is considered particularly appropriate for policy related or applied qualitative research (Pope et al, 2000). The analysis is presented with illustrative quotes to highlight key findings.

COMMUNITY ENGAGEMENT EVENT

Although a wide range of recruitment methods were employed via a range of established networks and organisations, interviews and focus groups were not appropriate or feasible for all members of the Eastern European population in Warrington. Discussions with stakeholders revealed that formal interviews and focus groups would not be appropriate for engaging with all members of the local community; this was felt to be

due to members of the population not acknowledging their health needs as a key area of importance to warrant such lengthy discussion. Long working hours and little spare time was also suggested as a reason people were reluctant to take part in interviews.

In order to ensure that a range of engagement methods were offered within the scope and framework of the project, it was decided that research would also be undertaken at a Polish Family Fun day which had been organised at a local school. Attendance at this popular event also provided a vehicle for the research team to further promote the study and support additional recruitment to the interviews and focus groups. A local stakeholder invited the researchers to attend and a stall was set up alongside other local organisations.

A mixture of qualitative and quantitative survey methods were used to collect data from key areas which had emerged through the stakeholder event and ongoing data collection. One key theme which was elicited through the data pertained to access and perceptions of the GP.

Data collection from stakeholder engagement events and qualitative interviews highlighted that specific cultural attitudes towards ill-health contribute to poor access and uptake of services. Further research was undertaken at the community engagement event to explore whether people were reluctant to visit their GP and dentist, and to understand whether public health service provision for Eastern Europeans in Warrington is appropriate in terms of both accessibility and relevance. These areas were explored further at the community engagement event for the reasons that this needs assessment had already highlighted this as a key issue; further, primary health care services play a key role in determining population health and wellbeing.

Public health is delivered by a wide range of stakeholders within local authorities, the voluntary sector, and wider community health providers (including GPs, dentists and pharmacists). GPs and GP consortia have a key role to play in supporting activities to improve health, reduce inequalities, prevent disease, and protect the health of the public (NHS, 2011). From a public health perspective, supporting people to stay healthy and actively involved in their community for longer involves active support from primary health care services, with the GP most often forming the first port of call. Timely and appropriate interventions are key to ensuring that people receive the support they need to remain healthy and independent, and reduce the utilisation of hospital based services and lower readmission rates. Understanding behaviours related to GP and dentist provision helps to ensure that services are responsive and appropriate to the needs of the community. GPs have the ability to provide support and signposting from the public health and health promotion perspective. These actions work towards ensuring people take positive steps in relation to their health, and prevent avoidable hospital admissions; this is particularly pertinent given NHS budget restraints, an increasing ageing population, and the demand for care closer to home (Mytton et al., 2012).

The community engagement event collected evidence on the following issues:

- What do you think of health services in Warrington *including GPs, dentists and hospital* (a “smiley face” voting exercise)
- Are you registered with a GP? (yes/no voting exercise)
- What stops people using health services?
- What could make health services better?

A range of data collection methods were used to capture these data. Participants were invited to share their views on post-it notes, and to use “smiley faces” and yes/no voting tokens alongside these. Responses relating to service barriers and GP use were collected in covered boxes whilst opinions of services and improvements

were displayed openly on the stand. This was to ensure anonymity of responses around these possibly sensitive topics and encourage participants to be open about their experiences.

These additional methods of data collection were identified as most appropriate in providing a wide range of people with the opportunity to engage in the needs assessment using an interactive and time-effective method. This approach also enabled some responses to be immediately shared with other event attendees.

LANGUAGE AND TRANSLATION

The research aimed to capture the views of the Eastern European population who do not speak English as well as those with good English skills; however the researchers only speak English. All recruitment materials (posters and leaflets), the participant information sheets and consent forms were translated into Polish by a native speaker. Gatekeepers and participants were asked if they would like these translated into other languages when interviews and focus groups were arranged, however this was not requested.

All interviews were conducted in English with any issues about unknown words being resolved between the interviewer and participant using rephrasing and hand gestures. Only one of the focus groups was conducted entirely in English (the Russian speaking group, mothers group 3). The majority of the participants in the other focus groups spoke English and these discussions took place mainly in English, however conversations occasionally took place between participants in Polish. When this happened one of the participants then translated back to the interviewer what was being said. This was particularly important for more complex issues where some participants did not know some of the medical terms in English. Mothers group 1 included four women who spoke little English so one participant who was very confident with English translated the questions and the responses. During the mixed focus group one participant used a laptop to translate occasional words from Polish to English (i.e. 'empathy', 'apprentice', 'thyroid' and 'disease') then read out in English to the researcher.

ETHICS

Ethical approval was granted by Liverpool John Moores University Research Ethics Committee (ref: 14/EHC/042). A further Research Ethics Committee amendment was submitted to allow for recruitment through the Family Fun day.

All participants were provided with a participant information sheet at least a week before the focus group/interview and written consent was obtained from all interview and focus group participants. The gatekeeper for each focus group was provided with a gatekeeper information sheet. All identifiable information was removed and anonymity and confidentiality maintained.

4. NEEDS ASSESSMENT FINDINGS

The findings of all the data collection methods are outlined in this section.

4.1 LITERATURE REVIEW

A search was carried out for peer reviewed journal articles as well as grey literature. Key search terms included 'Eastern European', 'health', 'needs', 'wellbeing', 'migrants', 'Polish', 'Poland', 'smoking', 'cigarette', 'alcohol', 'drugs', 'obesity', 'outreach', 'cessation', 'housing' and 'primary care'. Evidence was restricted to research that focused on health of Eastern European migrant populations, not the health of the general black and minority ethnic population in the UK. Research that focused specifically on gypsies and travellers (that may include Eastern European Roma) were excluded. Details and key findings of all the studies are available on request.

Four needs assessments focusing on the health of Eastern European migrants in the UK were also identified; these included a needs assessment in Devon (Tolley 2009), in Barking and Dagenham (Tobi et al 2010), in Herefordshire (Patel 2012) and North East Lincolnshire (Duckworth et al 2012). Disease specific and service user statistics are not routinely broken down by country of origin or immigrant status so accurate information about the health status of Eastern Europeans in the UK is limited.

4.1.1 HEALTH AND WELLBEING NEEDS

The health of the population in country of origin can have an impact on the health of migrants in the UK, and are exacerbated by barriers to accessing healthcare and lifestyle in the UK. It is currently difficult to gain a comprehensive account of the health of migrants because much of the evidence relies on ethnic group and does not include migration information such as country of birth, length of residence in the UK, or immigration status (Jayaweera 2011).

MENTAL HEALTH

The majority of research into the mental health of migrant populations in the UK focuses on asylum seekers and refugees (Health Protection Agency 2010). Poor mental health has been found to be prevalent within Eastern European communities in the UK (Patel 2012). The stress and anxieties carried from home countries can combine with new stresses of immigration and adaptation (Tobi et al 2010; Patel 2012). Experiences in migrants' home countries influences their mental health, as well as the process of migration itself and by the living conditions in the new country (Lindert et al 2008). Economic migrants may experience loneliness, anxiety and depression – sometimes compounded by excessive drinking (Moore 2007). Use of services by migrants from Eastern Europe is not easy to establish as the Department of Health's Mental Health Minimum Dataset records ethnicity and not country of origin (HPA 2010).

OBESITY

Obesity is a substantial contributor to the burden of ill-health. Transition to a 'free-market economy' after the collapse of the Soviet Union led to the promotion of a westernised high fat/sugar diet (Webber et al 2012). Eastern Europe has a particularly high mortality rate from heart attacks/strokes (Rabin et al 2007). Central and Eastern European countries have higher prevalence of obesity than in Western Europe and obesity is more prevalent in women (especially Russian); however, Russian men were less likely to be obese compared to their Polish and Czech counterparts (Pikhart et al 2007).

SEXUAL HEALTH

Eastern Europe has the highest rate of HIV across Europe and this epidemic is believed to be caused by injecting drug use, however, heterosexual transmission is also on the increase (EuroHIV 2007). However Poland has one of the lowest prevalence rates of HIV. The collapse of communism led to socioeconomic change throughout Central and Eastern Europe, which led to a marked deterioration of public health services, including the surveillance and treatment of STIs. Thus awareness about STIs and consequences are low, and antibiotic resistance is high in Eastern European countries. A culture of drug use and needle sharing also exists (Burns et al 2008).

The most recently available evidence suggests Ukraine and the Russian Federation have the highest numbers of people living with HIV infection in Eastern Europe (UNAIDS 2014). The epidemic is no longer concentrated amongst intravenous drug using young men and is spreading through unprotected heterosexual sex. Prevalence is highest in young adults but awareness is low in this group (Debell & Carter 2005). Eastern European migrants may be aware of their HIV infection, but may choose not to access services in the UK, and continue to access healthcare in their own countries and use the internet to obtain medication (Burns et al 2011).

Migration is associated with a rupture and re-establishment of sexual relationships, and has also been identified as a critical factor in high risk sexual behaviour, suggesting that migrants from Eastern European countries are at an increased risk of developing sexual ill-health (Burns et al 2008, Patel 2012). Eastern European migrants, especially males, report high rates of risky behaviours associated with increased HIV and STI transmission (drinking alcohol 3+ days a week, recreational drug use, anal sex and paying for sex; Burns et al 2011). The high background prevalence of STIs and HIV back in their home countries combined with poor knowledge and experience with the British health systems, places these individuals in a vulnerable position (Burns et al 2011). Eastern European women are more likely to attend GUM clinics in comparison to their male counterparts, despite that a majority of Eastern European migrants being men (Burns et al 2008).

The British Pregnancy Advisory Service reports that they have seen an increase in Eastern European Women asking to talk over their pregnancy options and requesting termination of pregnancy (Moore 2007).

Homosexuality is a 'taboo' subject for Eastern Europeans and lesbian, gay, bisexual and trans people face stigma and discrimination which can lead to negative health outcomes (e.g. self-harm and suicide; Tobi et al 2010). As homosexuality remains highly stigmatised amongst the Eastern European population LGBT people may be more likely to favour emigration (Burns et al 2008).

DRUGS AND ALCOHOL

Behavioural and lifestyle health problems, such as drinking and drug use, are common amongst Eastern European men (Tolley 2009). Alcohol is a major cause of ill-health in the Eastern European region (Nemtsov 2001), and the social and health impact of this is partly due to the pattern of binge drinking (Bobak et al 2004). However, in the UK those of Polish origin do not appear to be overrepresented in alcohol related hospital admissions (Bunting 2010) though needs assessments find higher rates of alcohol use in migrant populations (Patel 2012).

Alcohol may be used as a way to deal with mental ill-health and depression, or mental ill-health may be a consequence of men's drinking behaviour (Bobak et al 2004).

Alcohol dependency has been found to be linked with homelessness; it is a significant health problem amongst the homeless Eastern European population in London (Collinson & Ward 2010) and Eastern Europeans form part of the visible street drinking population in Haringey. Haringey have developed a street outreach programme to target individuals from Poland and Eastern European communities. (Haringey Council 2014).

SMOKING

Eastern European countries have high rates of smoking (Moore 2007) and lung cancer rates are higher in Eastern European nations (55-80/100,000) compared with Western Europe (35-40/100,000; Malvezzi et al 2013). Aside from tobacco, unfavourable working conditions (i.e. indoor air pollution and asbestos) contribute to lung cancer mortality amongst Eastern European nations (Malvezzi et al 2013). Migrants to the UK have higher rates of smoking (Patel 2012).

The majority of people from Eastern Europe who live in the UK who smoke did so before coming to the UK and prevalence is highest in those in more routine and manual jobs or with weaker language skills (Eida & Ehata 2010).

Language difficulties may mean migrants are unlikely to access smoking cessation classes unless they are tailored to them. Many Eastern European people who do speak English also want to feel confident and comfortable talking with smoking cessation advisors. This has been a factor for not accessing mainstream services (Eida & Ehata 2010). To overcome this in some areas, for example Crewe, smoking cessation classes are organised with the local Polish Society (Moore 2007; Eida & Ehata 2010).

HOUSING

Environmental factors such as overcrowding, poor housing and low income have a negative impact upon health (Tolley 2009). Many economic migrants and 'New Communities' do not have access to good housing advice, often due to language barriers, uncertainties about entitlement, and opening hours to the services (Kofman et al 2007). The standard of private rented housing that migrants live in is often unsatisfactory with migrants settling for poor quality or overcrowded accommodation (Kofman et al 2007; Shelter 2008; Ricketts 2008). Migrants in tied accommodation may be exploited by working excessive hours which they have little control over because their employment is linked to their accommodation (Shelter 2008).

There is a common perception that migrant workers are prioritised for social housing over British-born individuals, however the system is complicated, thus, in practice, the number of migrant workers allocated social housing is negligible. Migrants who are unable to find work or lose their jobs can easily become destitute and rules restrict eligibility to housing, benefits and hostel places (Shelter 2008). Migrants without recourse are believed to account for 15% of those sleeping rough in London (Shelter 2008).

EMPLOYMENT

A study carried out in Nottingham in 2008/2009 showed that more than 50% of migrants (Polish making up the majority of migrants) had experienced a reduction in their occupational level since coming to the UK (Bunting 2010). Eastern European migrants in the UK report earnings relatively low compared with the national average for their occupation, often close to the minimum wage. Across all sectors, migrants were working longer basic hours and longer total hours than average for their occupation (Anderson 2006). A higher proportion of migrants are in unregulated or high risk occupations; though it is not possible to identify levels of occupational harm, many migrants may be susceptible to exploitation (Ricketts 2008).

4.1.2 HEALTH SERVICES

UNDERSTANDING OF THE UK HEALTH SYSTEM

Migrants may have a lack of knowledge regarding how the UK health system is organised and the role of the GP and primary care (Tobi et al 2010; Spencer et al 2008; Patel 2012). This affects use, expectation and experience of primary care (Collis et al 2010). Those with fluent English have more understanding of the NHS (Spencer et al 2008). Lack of information can lead to inappropriate use of services. For example, some A&E departments are seeing Eastern European patients (Madhil et al 2011) who do not understand the UK health system and may find it hard to register with a GP because of language difficulties (Moore 2007; Tolley 2009). Evidence about GP registration levels is mixed (Collis et al 2010; Collis et al 2010) but individuals who were not registered cited ignorance to the process, never tried or bothered and language as main obstacles (Tobi et al 2010). It has been suggested that migrants need information on health service design when they enter UK (Spencer et al 2007).

This lack of understanding of the system can lead to dissatisfaction and frustration with the UK health system. Eastern Europeans may have a negative perception about the UK health system. Many are used to a different model of healthcare under which they may not be used to the concept of a GP as a 'gatekeeper to other services'. They may be used to direct access to hospital services and a lower threshold for investigations than in the UK – for example, more scans in pregnancy (Moore 2007). There are also different expectations about prescribing and availability of medicines, which may be due to different experiences and cultures practiced by health care systems in participants' countries of origin (Duckworth et al 2012, Collis et al 2010).

An article in the British Medical Journal written by a GP in London discussed her experience; her experience was that Polish patients thought that in Poland GPs take illness more seriously and make more specialist referrals, postnatal care continues for longer periods, and sick children can access a paediatrician immediately as opposed to having to wait for several weeks. The GP reported she has experienced 'travel agent' consultations where the patient's sole goal has been to 'get past me (and my health visitor, community midwife, practice based counsellor, podiatrist, physiotherapist, etc) in order to access proper medicine in a centre of excellence'. Her experience was that Polish immigrants brought with them 'memories of a healthcare system in which general practice is often the last refuge of the failed physician' (Greenhaigh 2006).

Migrants are unlikely to access services until their health problem has become serious, which not only affects the health outcome of the individual, but also the cost to the health service (Tolley 2009).

Primary health care services play a key role in determining population health and wellbeing. Public health is delivered by a wide range of stakeholders within local authorities, the voluntary sector, and wider community health providers (including GPs, dentists and pharmacists). GPs and GP consortia have a key role to play in supporting activities to improve health, reduce inequalities, prevent disease, and protect the health of the public (NHS, 2011).

BARRIERS TO ACCESSING HEALTHCARE

Entitlement to health care and benefits depends on migration status (Jayaweera 2010), this is not always understood and patients from Eastern Europe are often unaware of the European Health Insurance Card (EHIC) and that the proportion of patients with an EHIC is very low; 5-10% at the most (Creative Research 2013). Cultural insensitivity and culturally specific taboos about certain subjects, (e.g. sexuality & domestic violence) means it is often difficult to discuss these issues with Eastern European patients (Tobi et al 2010).

Additionally, cultural norms may prevent some migrant groups from accessing services, (e.g. women unable to discuss some sexual health issues with a male doctor; Tobi et al 2010).

Barriers accessing mental health services are particularly strong for many ethnic minorities and migrants including different understandings of mental health problems, lack of acknowledgement, discussion and prioritisation of mental health problems, lack of knowledge of services, stigma, fear of authority and lack of trust. These can be compounded by previous negative experiences of accessing NHS services, lack of interpreting and translation services, resource limitations, and practical barriers such as transport and timing of appointments (Frank et al 2009).

Many migrants from Eastern Europe countries work in agricultural and food-processing industrial sectors located in largely rural or semi-rural areas some distance away from the metropolitan urban centres of past immigration waves. This can cause problems with healthcare due to resources and capacity within the local healthcare systems and transport issues (Jayweera 2010). Structural barriers preventing healthcare utilisation also impact upon health status these include low income; poverty; cultural insensitivity by healthcare providers; lack of knowledge about entitlement to healthcare services and poor health and safety practices in some industries employing migrants (Jayweera 2010).

PRESCRIBING AND ANTIBIOTIC USE

Reducing antibiotic resistance is a key concern both nationally (CMO, 2011) and internationally (WHO, 2014) and data suggest daily antibacterial prescribing is considerably higher in many Eastern European countries (ranging from 21.9 per 1,000 inhabitants in Poland to 30.9 per 1,000 inhabitants in Romania) than the UK average (18.8 per 1,000 inhabitants; ECDC, 2014).

The Department of Health's recently published framework for antimicrobial resistance (AMR) calls for increased education around the impacts of AMR for both health professionals and the general public (DH, 2014). A UK study found that 38% of UK adults surveyed believe antibiotics will cure most viral infections and one in five participants had accessed their GP with a respiratory tract infection of which 53% expected an antibiotic prescription (McNulty et al, 2013). This study did not break down data by country of origin and it may be that knowledge is lower in patients from Eastern Europe. Data from a recent PHE study suggests that prescribing antibiotics for coughs and colds amongst GPs has risen by 40% since 1999 (Hawker et al, 2014).

IMPROVING HEALTHCARE FOR MIGRANTS - 10 HIGH IMPACT CHANGES

Ricketts (2008) identifies ten changes that would improve the health of migrants in the North West of England.

- 1. Carry out multi-agency mapping of local communities** (through Joint Strategic Needs Assessment) - how many recent arrivals from overseas, gender, where they live, what their needs and potential contributions are with a particular focus on marginalised groups; horizon scanning and incorporating flexibility into Local Area Agreements, PCT and NHS Trust Service Plans
- 2. Strengthen the collection, analysis and interpretation of ethnic group data** better understand the health and well-being needs of local communities and for equitable, effective provision of services.
- 3. Strengthen links and partnerships with migrant groups, voluntary organisations and social enterprises** working with recent arrivals from overseas, to enable services to listen, respond to needs and positively influence health outcomes.
- 4. Incorporate Health Equity Audits and Equality Impact Assessments as normal practice**
- 5. Better signposting for recent arrivals** and better information for staff to raise awareness about services available, how the NHS works and how to access it
- 6. Provide accessible, locally appropriate interpreting service in all departments** - a telephone interpreting service as a minimum provision will enable assessment, care and support to be shaped around individuals
- 7. Make cultural competency a regular and mandatory part of staff training** built into equality and diversity strategies
- 8. Identify senior level champions** to ensure commitment to migration issues and their incorporation into policy development, planning and forecasting
- 9. Develop strategies to attract and retain migrant workers** within the NHS and partner organisations in order to reflect local community profiles and contribute to filling posts that cannot be filled by local recruitment
- 10. Review the impact of community cohesion on local health and health service provision and consider strategic contribution**

www.northwestrsmp.org.uk/rsmp4/info/5/health_and_social_care/11/health_and_migration_in_the_north_west_of_england_an_overview

4.1.3 EFFECTIVE INTERVENTIONS

We identified very few evaluated interventions aimed at improving the health and wellbeing of Eastern European populations in the UK. Given the relatively recent arrival of some migrant populations it is unsurprising that available literature about effective interventions is limited. In an article in the Health Service Journal in 2007 Moore discussed the impact of Eastern European migrants on NHS health services and

described some specific programmes aimed at Eastern European migrant communities. The interventions discussed below have often only been described and presented as examples, rather than evaluated.

- In NHS Highland – with a Polish community of 4,500 – leaflets were provided in Polish and translators were available at clinics where a large number of Polish patients are expected. Leaflets also covered topics specific to pregnant Polish women such as: routine blood tests, special screening tests and also more in-depth books such as a guide to parenting from birth to three years old. This intervention received positive feedback (Moore 2007).
- NHS Scotland had a website describing the Scottish health service and how to access it; this was available in different languages and covered subjects from the need to register with a GP to where to go for marriage guidance.
- In Norfolk – where there is a large Eastern European community – the PCT commissioned an interpreter to run sessions at GP surgeries. Medical practices also had access to a communicating/interpreting service and frontline healthcare officials were given language cards so migrants could point to the language they speak (Moore 2007).
- In Reading, the PCT worked with various agencies including the Catholic Church, to inform the Polish community about the health system. It also used health advisers from within the community, based on a scheme developed with its local black and minority ethnic community (Moore 2007).
- Norfolk PCT held a ‘Migrant Workers Day’ where the PCT discussed and provided advice on issues such as diet, lifestyle, sexual and mental health and social care. The feedback the PCT had from its migrant community led to changes in its service-level agreements with providers to help ensure migrant workers receive appropriate care (Moore 2007).

POLISH SMOKING CESSATION PILOT

We identified an evaluation of the Smokefree Northwest project targeted at a migrant community with a known high prevalence of smoking. They aimed to understand whether a community-specific service was an effective method for reducing levels of smoking. The project was trialled in Central and Eastern Cheshire PCT with the focus on the Polish community in Crewe (Eida and Ehata 2010).

Background of the scheme:

- TS4SE (the third sector provider) supports the integration of new communities, helps improve communication and understanding. They assist service providers to deliver new services, improve access to existing services and help organisations engage with new clients.
- Central and Eastern Cheshire Primary Care Trust (CECPCT) were selected to trial this project. The project delivered a service based strongly on the mainstream smoking cessation model, but with predominantly language-related adaptations to suit the target audience.

Key Findings:

- 92% of participants smoked before coming to the UK. More than half of these had tried to quit before.
- 65 people accessed the service with a 40% quit rate overall.
- 55% of service users were male.
- The highest quit rate was for woman – at 55%.
- The male quit rate overall was 28%.
- The majority of service users (66%) fell into the 18-34 years age bracket.
- 77% of all Polish service users were recorded as doing routine or manual jobs.

- The most common work pattern was fixed day time shifts at 29%. This pattern as well as fixed night shifts and own choice shift patterns produced the highest quit rates (50% each)
- Those in the 'no choice shift pattern' category produced a zero quit rate.
- 90% of service users said that they would recommend the service to a friend.
- The service's greatest publicity tool was 'word of mouth' – referrals from health service providers were particularly low and self-referrals from paper/internet publicity were relatively low.

Issues with the scheme:

- The geographical spread of the target communities; although the Polish community in Crewe is compact, this may not be the case in other areas which would mean a different approach/additional efforts would be needed to engage with the community.

Key Points for action

- More consideration should be given in the toolkit for the need for translation/interpretation.
- It is important to consider the heterogeneity of migrant community populations.
- The cost and resource implications of the research phase mean that, in practice, few PCTs are likely to carry out all aspects.
- Greater inclusion of third sector organisations at a project partnership level.
- The service needs to address the issue of appropriate appointment times to ensure broad accessibility and reduce withdrawals.
- The appropriateness of the service for male service users requires consideration in the face of their relatively low quit rates compared to both the mainstream male population and the female service users participating in this project (Eida and Ehata 2010).

4.2 STAKEHOLDER EVENT FINDINGS

This section provides a summary of group work and discussion that took place at the Eastern European health needs assessment stakeholder event on Tuesday 6th May 2014. Stakeholders with an insight into the needs of this population were invited to contribute and the event was attended by 11 people from a number of areas covering: Warrington Borough Council; a Housing Trust; Child and Adolescent Mental Health Services; Leisure, Library and Lifestyles services; Drug and Alcohol services and a representative from the Polish Community. Following the event further stakeholders were invited to provide information via email or telephone. Information was received from the Drug and Alcohol Action Team (DAAT), Warrington Primary Care Psychological Service and Improving Health and Wellbeing in Bewsey and Dallam. This additional information has been combined with the information obtained at the event.

This section contains information provided by key stakeholders who work with a variety of populations in Warrington. It must be highlighted that these insights are based on individuals' experiences and their personal understanding of the local Eastern European migrant community. Many stakeholders reported they often did not have the data to evidence their experience as this information is rarely routinely recorded.

4.2.1 POPULATION: WHO ARE THE EASTERN EUROPEAN POPULATION IN WARRINGTON?

THE SIZE OF THE EASTERN EUROPEAN POPULATION

Stakeholders provided their views and perceptions about the Eastern European populations that access services in Warrington. The population was identified by stakeholders as being predominantly Polish (who were also considered to be the most established/settled community), but also originating from Belarus, Bulgaria, Hungary, Lithuania, Latvia, Romania, Slovakia and the Ukraine. However, it was highlighted that it is difficult to actually quantify. It was thought the Czech and Latvian community is growing quickly and specific shops and Masses reflect these growing populations.

It was widely felt that current Census population data do not accurately reflect the Eastern European population and that it is very difficult to get a true indication of the population. There were a number of reasons given for this by the stakeholders:

- The Eastern European population in Warrington is changing, in terms of there being an increasing trend for people beginning to settle in the area (evidenced by, for example, school records and a high proportion of Eastern European children in attendance). A specific example given here was St. Albans school in which 47% of children speak English as a second language .
- There is still, however, a large transient migrant population and much displacement within the area, making it difficult to establish a definitive picture of the Eastern European population and how long they stay in the area.
- Census completion rates are low due to language barriers and lack of knowledge of what a Census form is or why it needs to be completed. Census completion rates were thought to be particularly low in rented accommodation with multiple occupants who rent single rooms but share communal facilities or hallways.
- Some people who are classed as Eastern European would actually class themselves as Central European. For example some, though not all, Polish people would say they are from Central Europe not Eastern Europe.

SOCIALISATION (EMPLOYMENT, HOUSING AND COMMUNITY)

It was recognised by the stakeholders that many of the Eastern European population lived, worked and socialised in the more deprived areas of Warrington – e.g., Bewsey, Dallam, Town Centre, Alston Grange, Woolston Grange and Orford Lane.

Word of mouth and informal networks (e.g. the internet based Warrington Polish Forum) were thought to play an important role in helping the Eastern European population find employment and housing. Other mechanisms included employment/recruitment agencies¹ and advertisements in shops. Where housing was provided with employment this could create issues as once the job was finished, (through end of contract or if an employee quits) the housing provision was taken away and therefore potentially people made homeless.

It was suggested that many lived in small flats or rented rooms (rather than self-contained premises) from private landlords rather than social housing associations. Some stakeholders shared their experience and knowledge as to how some people had housing arranged before arriving in the UK, but others were thought to meet and talk to work colleagues to find places to stay. Housing was also advertised in shops, which were described as a 'lifeline' and acted as a 'hub' for communication and information within Eastern European communities. It was suggested that for Eastern European populations moving in to the area, housing was a key area in terms of accessing the community and their needs.

It was highlighted that the majority of the population are employed and are in low paid work (mainly in warehouses, construction and care work). Stakeholders felt that people were often over-qualified for this employment, possibly due to their qualifications not being valid in this country or language barriers. Much of this work was initially sourced through agencies, however, it was suggested that once work and community relationships had been established, further work was sought through informal connections. It was also highlighted that contracts may be short-term, after which individuals may return back to their country possibly returning at a later date or move to other areas where there is work.

GAPS IN EVIDENCE

The stakeholders were asked to provide their views on how to accurately measure and understand the Eastern European population living in Warrington; this included consideration of issues such as how long people stay in the area before moving on to live somewhere else or going 'home'. Suggestions made by the stakeholders included:

- Ensuring all services collect more detailed information on ethnicity, including Eastern European, and that it is a consistent process of data collection across all services.
- Using the electoral register and council tax records to help gain a clearer picture of the Eastern European population.

¹ Some recruitment agencies provide employment and a property together and therefore social housing presence was diminishing for these populations. Some anecdotal evidence of Polish rough sleepers suggested that rough sleeping could be due to this recruitment model - if something went wrong with an individual's employment it would also affect their housing.

4.2.2 NEEDS: WHAT ARE THE HEALTH & WELLBEING NEEDS OF THE EASTERN EUROPEAN POPULATION IN WARRINGTON?

PHYSICAL HEALTH

Overall the stakeholders considered that health needs should be looked at on a case by case basis as they felt there is a very mixed picture of health in the Eastern European population. Like all communities, stakeholders felt they are a diverse group with diverse needs and should not be thought of as a homogenous group. As with other populations it was considered that those in the most deprived areas had the greatest needs.

It was suggested by a number of the stakeholders that Eastern European populations are healthier in that they are less obese (supported by the findings of the Lifestyle Survey, see box 1). This was attributed to healthy eating – for example, healthy cooking and children eating fewer high sugar foods. It was, however, highlighted that this has the potential to change because of the areas in which they live. For example, it was suggested that the Longford area of Warrington has the highest concentration of obesity, cardiovascular disease and dental caries. It was felt that it is important to acknowledge the potential impact their area of residence this may have upon behaviour and health. For example, dental health and an increase in poor dental health and dental caries, if the population are unable to access dental care.

SUBSTANCE USE

Stakeholders were asked about their views around substance misuse and the Eastern European population. When looking at substance use, it was widely agreed that there were issues present with alcohol, smoking and drug use:

- It was suggested that within the Polish population, although not evident in the Lifestyle Survey (box 1), overall alcohol consumption levels were higher across both men and women and not necessarily age dependent; however, binge drinking was more likely in younger, single males.
- Although services report being informed of people in the Eastern European community with problem alcohol use, locating and engaging with this population is difficult. There is a lack of awareness around the issue amongst staff or any appropriate signposting for this community.
- Smoking rates were considered to be high, including smoking in pregnancy. This was perceived as being due to cultural differences and a low awareness of the risks in the community.
- Cannabis use and other recreational and experimental drug use was said to be apparent in younger people. Illegal highs that were cited by the stakeholders included Methamphetamine (Crystal Meth) in the Slovakian community² and Krokodil (a morphine-like opioid) in the Russian community.
- There was thought to be a higher prevalence of Hepatitis C and injecting drug use in those from Central and Eastern European Communities and individual's from these communities were more likely to share needles. Data provided by CRI showed 17/447 people receiving treatment from CRI were Eastern European, with the majority from Latvia, but also Czech Republic, Lithuania, Romania, Poland and Slovakia.
- Amongst heroin users in Warrington Eastern European users are more likely to inject, whereas British users are more likely to smoke heroin.
- Warrington was said to have a high benzodiazepine use across all communities, which was linked to the number of pharmaceutical warehouses in the area.

² It was suggested that the manufacturer of Methamphetamine in Warrington was Slovakian.

- The Warrington DAAT is currently circulating some information about cannabis in Polish to different services and providers. A member of the DAAT has highlighted the communication and marketing of campaign material to such communities and, as a DAAT, are keen to progress this in response, hopefully, to this research.
- The Head of Service for the DAAT sits on the Warrington Children's Safeguarding Board. Recent national Serious Case Reviews have cited Eastern European individuals who have been in family settings where children have died and where services (including health and substance misuse treatment) had sent information out in English for appointments or meetings which have been missed. From a safeguarding perspective it is critical within the broader health architecture that such information is followed up so that children and young people who are vulnerable and at risk, and for whom English may not be a first language, are not falling through the net.

MENTAL HEALTH AND WELLBEING

There were a number of issues that stakeholders highlighted that were raised in relation to the mental health and wellbeing of the Eastern European population:

- It was felt that isolation and lack of social networks caused poor emotional health. In addition to this any existing mental health problems may be exacerbated when initial expectations of life in the UK are not met. This population were considered to be IT savvy and well-connected to online communities, e.g. using Facebook and online networks, this was not considered to be the same as seeing friends and family in person.
- Mental health issues were thought to be linked with feeling settled and social networks. It was thought that this would be easier for families with children, but for young males it was unknown how they would meet other people especially if they were working unsociable hours.
- People from the Eastern European community were not sure how to access appropriate mental health services. There was anecdotal evidence provided around adults accessing secondary services, with cultural differences in expressing themselves/communicating meaning that services were not accessed until they were at crisis point.
- The data about those Eastern European people accessing mental health and wellbeing services underrepresents the problem, probably because of the stigma of accessing mental health services.
- There is a direct link between jobs and mental wellbeing. It was felt that mental wellbeing was particularly low in those whose skills and expertise were not being used or are who are unable to get a job to meet their skills and expertise. Underutilisation of skills and low paid employment is particularly common in migrants.
- Faith and engagement with church communities has an important impact upon mental health and general wellbeing by reducing social isolation. It was discussed that faith often had a strong role in people's lives and that its importance from the viewpoint of a secular society should not be dismissed. It was suggested that due to the long distances travelled by the Polish and Latvian priests the church community was not established in Warrington, which may have led to some disconnection from those who would practice in Poland.
- Recent data on suicides in Warrington included a higher than expected number of young Polish men, but no people from other areas of Eastern European. It was suggested that this may be as although the Polish community are more established (which would suggest greater communication and community support), there is a larger proportion of young males in the country without family compared to, for example, Latvians who tend to come as a family unit.

SOCIAL CARE

Stakeholders felt that there was not much evidence of adult social care needs and it was suggested that this may be due to reluctance to admit a problem or accept support due to mistrust of social services.

It was also highlighted that lack of use of these services may be due to the age of those Eastern European individuals coming over to the UK (i.e., younger adults, with few new migrants aged over 50).

OTHER HEALTH ISSUES

Evidence from services and a domestic violence forum suggested higher levels of domestic violence in the Eastern European population.

There was also talk about the negative impact of recent political campaigns, for example the targeting of UKIP and BNP campaigning in the deprived areas in which the Eastern European population reside. This type of discrimination has negative impacts on health and wellbeing as well as potential impacts on community cohesion.

AREAS FOR FUTURE CONSIDERATION

The stakeholders identified a number of areas that may be considered when addressing the health and wellbeing needs of the Eastern European population/community:

- Encouraging individuals to fully utilise the services that are available, especially mental health services, to receive appropriate access and support before reaching 'crisis' point.
- Improve access to food banks/clothes bank vouchers.
- More employment and volunteering opportunities, although it was acknowledged that Disclosure and Barring Service (DBS) check can be a barrier to this.
- Mechanisms for keeping in touch with family and friends at home.
- A more in-depth examination of mental health issues to identify what are the underlying causes of poor mental health.³
- Bridging the gap and providing support to attend services. It was suggested that this could be done, for example, through supporting 'health trainers' to accompany clients to GPs to provide moral support.
- Health education and health promotion (preventative model) – to try and address issues around for example, smoking in pregnancy, safe sleeping for babies and children⁴, smoking and alcohol consumption and drug use. However stakeholders were unsure if any health promotion was currently being aimed at this population.
- Benefits – helping people to navigate the benefits system and see what they are entitled to claim.⁵

³ This included more information about the four members of the Eastern European community who had committed suicide, so that lessons could be learned. For example, social contact but lack of social support; living in shared housing etc.

⁴ It was relayed that midwives and health visitors reported concerns about different practices in relation to safe sleeping and avoidance of cot death as it was culturally normal in some Eastern European communities for mothers to sleep with their babies.

⁵ An example was given about several Latvian neighbours who had had issues with child tax credit and ended up accidentally owing a large sum; these financial issues especially for those with low wages were thought to impact upon individual wellbeing.

4.2.3 ACCESSIBILITY: ARE THERE APPROPRIATE SERVICES AND ARE THEY ACCESSIBLE?

The emphasis of the stakeholder group discussion was mainly on the provision of joined up and integrated services as well as increasing awareness of existing services through education, knowledge and community assets (looking what services are already available).

It was widely felt that there was a good range of appropriate services available in Warrington, but that adaptability and flexibility of these services was key to accessing services, improving service provision and meeting the needs of this population. It was also apparent that the key to accessing services was the initial link-in service and joined-up service provision so that individuals are not being passed from service to service and having to explain their story in full at each stage.

It was, however, suggested that there was much work to be done in terms of engaging with the Eastern European community to promote services and encourage attendance and appropriate use of services. It was mentioned by the majority of stakeholders that there was a lot of 'hand holding' needed, currently there is a lot of signposting being done but people need more support than this, they often do not attend the services they are signposted to. Anecdotal evidence from the Polish Saturday School suggests that attendance is low at health promotion events organised for the Polish community.

Services that were accessed included shops, Children's Centres, libraries, schools, community centres, GPs, housing associations, employment agencies, Job Centres, Wellbeing Mentors and Community Connectors who are more service driven. It was suggested that people found out about these services through word of mouth, social connections and networks (e.g. the Polish Forum), the Polish and Slovakian shops and notice boards.

There were a number of ways in which the stakeholders felt current service provision and accessibility of services could be improved and information could be gathered that could inform future service provision and practice:

- Specifically target Eastern European groups with promotion messages and service information.
- Raise awareness around pathways in place for accessing services. For example it was suggested that mental health would be accessed by different pathways in Eastern Europe; it was thought likely that individuals in Eastern Europe would simply access a psychologist or mental health professional directly. In Eastern Europe they would not need to be referred by a GP; the referral pathways which exist in the UK may seem complicated and difficult to navigate.
- Provision of new services was mentioned, specifically relating to primary care walk-in services that are not generally available in Warrington. It was considered that introducing or increasing this type of service and drop-in sessions would improve access.
- Frontline staff, where applicable need to be given appropriate training and improve their understanding of different cultural needs.
- Produce a single directory that delivers joined up and consistent messages and sign-posting across all key services, ensuring that the information within it is accurate and up-to-date. It was acknowledged that all the services present were currently interacting with a select group of clients depending on their needs and that this would be a key opportunity to signpost these individuals to other services.
- Utilise community areas (e.g. community centres and libraries) and existing networks (e.g. Polish Forum, shops, mother and toddler groups, church groups) to provide support and information.
- It was suggested that it may be beneficial to conduct a mapping exercise/audit of services (along with contact information) to identify what provision is in place within these for members of the Eastern

European community. For example, Golden Gates Housing Association has members of staff who are bilingual and therefore can speak directly to customers and are also available to translate. This also has positive cost implications.

- Look at the information that is given to people upon entering the UK around accessing health and social care services.
- Language Line is being used by a number of services. It was asked whether there is a way to pool this resource and have a single contract for the services.
- Investigate GP registration levels - seeking advice for a health problem was not considered a key area of access and it was thought that if someone did have a health problem they would be more likely to turn up at hospital even if primary care would be appropriate.
- Second generations of the Eastern European community have more interaction, greater identity and integration, so it may be that they can be involved in a role such as community champions or ambassadors.

4.2.4 BARRIERS & PRIORITIES FOR THE FUTURE

A number of barriers to accessing services were identified including:

- **Language** - Language and literacy were highlighted by all of the stakeholders as the main (and increasing) barrier to accessing services. For example it was felt that Hungarian, Latvian, Czech and Slovakian populations, although not as long established, have better language skills than the Polish. Therefore the Polish communities are more likely to find language a barrier than the other communities. Many patients use friends and families to translate when attending health services. As a result of which, it was cited that people were going back to Poland to be treated. It was also highlighted that whilst an individual may be able to speak English, they may struggle to communicate in English in times of stress and are likely to revert back to the native language when upset, distressed or angry. Lack of a native speaker may be a particular barrier to accessing psychological and mental health services. Having materials, especially mental health treatment resources, only available in English can mean Eastern European patients are prevented from fully engaging and may not receive all the treatment they need. This was acknowledged to be a problem for IAPT nationally not just in Warrington.
- **Referral pathways** –some potential participants are discouraged from attending services, especially mental health services, due to lack of understanding of referral pathways. Some services, i.e. psychological services, take self-referrals but members of the Eastern European community may not understand this. They may also require different referral pathways which are not possible within the current service model.
- **Law and legislation** – in particular the police were mentioned as an organisation which was mistrusted and associated with fear and negative attitudes within the Eastern European community. It was suggested there would be community backlash from accessing services such as police due to a historical relationship of mistrust, so they deal with issues within the community.
- **Lack of awareness and/or knowledge** - people may be aware of a service, but do not necessarily know how/where to access it.
- **Cultural assumptions, issues and stigma** - communities may not relate to the UK culture of help and paternalistic advice as to how to behave in a healthy way. So for example, UK campaigns such as stop smoking, reducing drinking etc. mean that it is socially accepted for a GP to ask a patient how much

they smoke or drink at a consultation for other reasons. However for an Eastern European person these questions may seem strange and intrusive. There also appeared to be stigma attached to accessing certain services e.g. alcohol services, mental health services, sexual health services and cervical cancer screening. It was considered that the cultural stigma surrounding mental health was a barrier to people seeking help.

- **Immigration status** - illegal immigrants may be less likely to access services.
- **Lack of infrastructure** to support people as they lived in the more deprived areas.
- **Self-awareness** – there may be a lack of awareness of health conditions amongst the community and reluctance to change behaviour.

It was acknowledged that many of the barriers to accessing services would be the same across the Eastern European and white British population. All campaigns should focus on selling the benefits of health services rather than just translating information into different languages. Translation, it was thought, would make little difference if individuals did not want or perceive a need to access the service.

There were a number of ways in which stakeholders suggested barriers to accessing services could be addressed:

- **Promoting self-management** – it is important that individuals are encouraged to self-manage their health with an emphasis on prevention services and health improvement messages.
- **Promote trust in the UK health system** – it was suggested that wider neighbourhood teams may be a way to approach this, for example, providing a physical presence and giving the opportunity to speak to people and build up trust and provide ad hoc information. Also discussed was the possibility of introducing local and community ambassadors.
- **Equality of access for all population groups** - it was also discussed that although there was a legal requirement to ensure equality of access, this legislation did not apply to smaller, community-sector groups and not-for-profit organisations will have the relevant language provision. It was thought that awareness-raising for these groups would be important in case this was the first point of access for an Eastern European individual.
- **Early intervention and prevention** - it was also suggested, however, that European communities do not seem to access services until they are at crisis point, by which time the interventions needed are more expensive (health care and after care) and usually involve a greater number of services. Health promotion campaigns to help people recognise mental health problems would help. People from other cultures sometimes do not have the same insight and understanding that mental health conditions are treatable.
- **Manage people's expectations** – it is important to manage people's expectations, e.g., in terms of current financial climate and not to create unrealistic expectations of a service that would not be always available.
- **Multi-agency approach** – pooling of monies between organisations.
- **Bilingual members of staff** could act as translators and provide services to Eastern European service users and this should be at no extra cost to the service.
- **Encourage community cohesion and integration**, networks and establishing relationships, linking in with the settled community. If the Eastern European community has more information support networks and ways to make friends this could combat isolation. However it was acknowledged that services have been organised in the past and then underused; any additional services would need to be designed in collaboration with the community.

- *Utilise the power of word of mouth and established networks*
- *Educating community and services of each other's cultures*

BOX 2: SUMMARY OF KEY FINDINGS FROM STAKEHOLDER CONSULTATION EVENT

Who are the Eastern European Population in Warrington?

- Stakeholders believe there is a growing and changing Eastern European Population in Warrington, but this population is difficult to quantify especially in sectors where there is a large transient migrant population. There is a well-established Polish community as well as newer Belarussian, Bulgarian, Hungarian, Lithuanian, Latvian, Romanian, Slovakian, Czech and Ukrainian populations.
- Evidence from local engagement suggests that the Eastern European population largely reside and socialise in the more deprived areas of Warrington. Housing was believed to be largely privately rented and in some circumstances linked to employment which was largely manual work for which many individuals were over-skilled.
- The Census figures were thought to underestimate the numbers of Eastern Europeans residing in Warrington; this was due to the low completion rates amongst this group and the increase in migration in the last two years.

What are the health and wellbeing needs of the population?

- Stakeholders acknowledged that health needs across the Eastern European population would vary and that it is important to acknowledge these diverse needs.
- Evidence from stakeholders working in services suggested that Eastern European communities had lower levels of obesity and healthier diets. Smoking and drinking prevalence was thought to be higher in the Eastern European community. For those engaging with drug and alcohol services risk behaviours such as unsafe injecting practices and needle sharing were of particular concern.
- Poor mental health and wellbeing was considered an important issue, particularly for young males who had moved to the UK alone who could experience loneliness and social isolation. It was believed that mental health service use did not truly reflect the need within the community and that support would not be sought until individuals reached "crisis point". This was believed to be due to the stigma attached with mental health services amongst Eastern European communities.

Are there appropriate services and are they accessible?

- It was widely felt that there was a good range of appropriate services available in Warrington but that there was a need to engage with the Eastern European population to promote these services and encourage attendance and appropriate use. Signposting between services needs to be improved and increased; the example of Wellbeing Mentors was mentioned as a potential practice model.
- It was acknowledged that all of the services attending the event were interacting with a select group of clients from the Eastern European community with diverse needs and that this presented a key opportunity not only for signposting but for sharing knowledge of local needs and gaps in provision.

Barriers and priorities for change

- Key barriers to accessing services included: language; lack of trust of service providers and law enforcement; cultural differences in service delivery and health messages; stigma associated with mental, sexual and alcohol dependency services and, immigration status.
- Community cohesion and engagement was believed to be key to ensuring that the Eastern European population and service providers understood cultural differences in health beliefs and healthcare systems and to enable individuals to self-manage their health and access services when appropriate.

4.3 IN-DEPTH QUALITATIVE DATA COLLECTION

4.3.1 SAMPLE

This section outlines findings from the in-depth qualitative data collection. Table 7 provides details of the participants who took part in the focus groups and interviews.

TABLE 7: DESCRIPTION IN-DEPTH QUALITATIVE SAMPLE

Group/ participant	Description
Youth (n=10)	<ul style="list-style-type: none"> Participants had lived in Warrington between 6 months and 9 years. Most had lived only in Warrington since coming to the UK. All but one participant were in Further Education. Most of the group had made friends at school/college and through the Warrington.pl forum. There were eight males and two females. All participants spoke English, there was some discussion in Polish which was then fed back by one of the group members.
Mothers 1 (n=4)	<ul style="list-style-type: none"> The participants had lived in Warrington between 6 months and 7 years. Two had lived only in Warrington since coming to the UK. One participant discussed living in London but leaving because it was too expensive. One participant had lived in another city in the Midlands before moving to Warrington. All participants spoke English and all discussions took place in English. Most women discussed how they had come to the UK when their husbands got jobs in Warrington and surrounding towns/cities. Some discussed how they already had friends or family in Warrington so chose to settle near them.
Mothers 2 (n=5)	<ul style="list-style-type: none"> The participants had lived in Warrington between 6 months and 7 years. Most had lived only in Warrington since coming to the UK. Only two of this group spoke fluent English, the other four spoke some English but discussed issues in Polish and one of the other women fed back. Four of the group were mothers and two were grandmothers. Most women had come to the UK when their husbands got jobs in Warrington and surrounding areas. Some discussed how they already had friends or family in Warrington so chose to settle near them.
Mothers 3 (n=10)	<ul style="list-style-type: none"> Females aged 25-45 with children under four. Mix of Russian, Latvian, Ukrainian and Belarussian women. Had lived in Warrington between 2-10 years. All participants spoke English and all discussions took place in English. Most of the participants were married to British men
Mixed group (n=5)	<ul style="list-style-type: none"> Five adults aged 25-55, three males and one female. An older married couple, a younger couple with a baby and the father of one of the younger couple. All Polish. They had lived in Warrington 1-3 years. They chose to come to Warrington because they already had friends here and moved to find employment. They liked that Warrington is a small town so they felt it was better for their children. One member did not speak any English and only one group member spoke fluent English. Some of the discussion took place in Polish and the other group members interpreted back to the researchers. One group member used a translation website to find the English term for some specific medical terms.
F1	<ul style="list-style-type: none"> Polish female participant was in her 60s. Had lived in Warrington for over 40 years. Retired

- F2**
- Polish female participant in her 50s.
 - Had lived in Warrington for 20 years.
 - Works full time.
 - Came over to Warrington to visit a Polish friend and liked the town so decided to stay. Her husband and child then joined her.
- M1**
- Polish male participant in his early 20s.
 - Had lived in Warrington for 10 years.
 - Works full time.
 - Came to Warrington with his parents when he was a teenager.
- M2, M3, M4**
- Three Latvian males ages 21-35.
 - Had lived in Warrington 5-7 years, came over to UK for work.
 - One had lived in Manchester previously.
- M5**
- Hungarian male participant in his 30s.
 - He had lived in Warrington for 3.5 years.
 - Works full time and lives with his wife and children.
-

4.3.2 FINDINGS FROM IN-DEPTH QUALITATIVE DATA COLLECTION

The qualitative findings have been analysed thematically, and an overview of key findings are presented below. Quotes are used to illustrate key points, and have been coded to provide details of their characteristics, and to ensure anonymity.

Understanding of health

Interviews and focus groups started with some questions about general understanding of health and whether the participants thought people from Eastern Europe were healthy. The majority of participants focused their discussion on physical health and only discussed mental health, alcohol, tobacco, exercise or drugs when directly prompted or questioned about these topics.

Understanding of what comprised 'good health' was mixed. Adult participants mainly focused on physical health and talked about health in relation to medication and being free from disease, with some mention of diet and physical activity.

The younger participants and some of the mothers' focus groups had a more holistic understanding of health, not just as health as an absence of disease. The youth group had a very good understanding of health – including the social determinants of health (e.g. physical and mental health, wellbeing, physical activity, diet, housing and financial security).

Just being healthy you know, moving, working, wellbeing, getting up. Not going to McDonalds every day or KFC.... how you feel inside like in your head, no injuries like the physical, mental injuries... mental is about how you feel in your head yeh (youth focus group)

Prioritising and discussing health and wellbeing

Participants were all asked how important health was to the Eastern European community and if they regularly talk about health.

Opinion was mixed on whether the Eastern European community was concerned about health or was good at talking about health. Some participants believed they were open about health and discussed it regularly with friends and family, some thought it was rarely mentioned. Most felt people only talk about health if there is something wrong, they did not talk about keeping healthy.

In the Polish community speaking about health is a much more on the level of friends rather than we'd rather speak with friends than go to the doctors....We only go to the doctors if a friend says 'right this is serious' and for myself if I need help I ask, simple as that. (M1)

The mother's focus groups mainly talked about their children's health and most of their experiences came from using primary and acute care for their children.

The Russian speaking mothers group felt that Russian speaking people were aware of health and discussed it regularly.

Most participants agreed that there were personal differences with some of their friends being very open and some being very private.

(See below for discussion of talking about mental health.)

Awareness of services/understanding the UK health service

Participants were asked if they had used any health services in the UK and which services they were aware of. Overwhelmingly participants focused their discussion on primary care services with some participants discussing hospitals and dentists. Even once the discussion topics were changed the majority of participants would return to the topic of the design of the UK health services, their dissatisfaction with the systems and the problems they had encountered.

All groups were very aware of GP services, hospitals and dentists.

The vast majority of participants and groups discussed being registered with a GP (however we did not directly question every focus group participant so this will not be 100%). Only a small minority were not registered; reasons for this included not having been in the country very long or not having been ill.

Most participants felt it was difficult to understand the health system when they first moved to the UK, all participants reported it is very different to the health system in their home country. It was felt to be confusing, vague and difficult at first. Friends, family and work colleagues who had lived in the UK for longer were invaluable in helping new migrants understand how to register with a GP, where to go when they are ill etc. Some employers also instructed them to register with a GP but they do not tell them how to do this.

This information is not easy to find online and was not thought to be available in their language. The information available online was thought to be inaccurate or out of date. Language was felt to be a barrier to understanding health systems when people first arrive in the UK, friends and family with better English skills are often relied upon to help registration (see below for further discussion of language).

The majority of participants understood the design of the UK health service, including the role of the GP in referring to specialist services and secondary/acute care. However most were unhappy with this system as it differed from the system in their country of origin (see below).

There was low awareness and use of pharmacy services with most participants saying they visit their GP if they or their children are unwell.

Awareness of other services such as smoking cessation, sexual health and DAAT services were low.

'You need to register with a GP'. That is not telling you anything. How? What is a GP? (M5)

Participant - Yes, everybody understands [the role of GP] and also if you go to work, taking a job they asking me, 'are you registered with GP?' because if there's any accident or anything, they want people to be registered with the doctors so they know but they don't want to do it

Researcher - Right okay, so what stops them? Why don't they want to do it?

Participant - I don't know, but they know how to register for fact but they're not (F1)

Just by chatting to other people and the longer you stay then you understand better than friend's as doctors maybe English doctors but maybe Russian speaking friends who came in started working in the system ..they explain why it is a great thing the NHS and why you don't need access to all those things specialists but why but obviously it's supposed to be efficient (Mothers 3)

Understanding differences between country of origin and UK health services

Much of the discussion focused on the differences between health systems in the UK and in the participants' country of origin. This topic was not included on the discussion guide but was an important issue for the majority of participants who discussed it in great detail with little prompting.

There was much discussion around the differences between the health systems in UK and in the Eastern European countries participants had migrated from. The majority of these discussions focussed around how the health system in the UK was inferior to the system in their home country.

Many participants discussed how the role of the GP meant it was more difficult to see a specialist in the UK and in Eastern Europe they could access many more health services directly. In the UK the GP blocked their access and many participants appeared to resent to power of the GP. They wanted to be able to self-refer to secondary care when they felt it necessary. They felt that GPs in the UK are also reluctant to order blood tests and prescribe antibiotics.

Some participants thought the doctors in their home countries were better trained, had more knowledge and were more competent. However many acknowledged that the facilities and equipment in the UK is of a higher standard than their home country.

Some participants felt that the GPs in the UK were too rushed with the consultations, did not examine patients properly and only relied on description of symptoms. This was particularly difficult if patients did not have very good English to describe the symptoms.

There was confusion over private healthcare in the UK and some participants discussed how much more expensive private care was in the UK compared to Eastern Europe.

Many participants discussed the difference in medication and prescribing habits between Poland and the UK (see above) and expressed frustration that GPs were reluctant to prescribe drugs.

A minority of participants discussed traditional medicines that were used within the home and often described as more help than the advice from the GP (paracetamol and rest).

Participant: This is different cos in England your body have to help itself you know, it's a different way of thinking, you wait and your body should help yourself.

Researcher: Kind of heals yourself?

Participant: Yeah, yeah. They don't help you too much if you feel really bad they will help you but in Poland they help all the time with medicine, medicine, medicine.... (Mothers 1)

[In Poland] knowledge is better, medicine study is very difficult. (mixed focus group)

-Ah, here doctors are so rushed, if you have a cold they don't even bother, don't even make an appointment with you... Just wait for a couple of weeks, cough may last for six weeks, in Russia, they always prescribe medicine. Okay

- Even if it's mild fever or something, so here and for me at first it was very surprising, I thought 'what', and English health system is supposed to be, it's famous for being better than Russia (Mothers 3)

Experience of health services

The majority of the conversations focused on participants' experiences of healthcare and particularly primary care. Only a short section of the discussion guide focused on GPs and only included two questions directly asked about their GP (*Are you registered with a GP? What has been your experience of your GP?*). However the majority of the conversations focused on the GP, participants' experiences, concerns and dissatisfaction with their GP and the role of the GP. Hospitals and dentists were discussed only when prompted directly. The discussion guide contained no questions about medication or prescribing however this was discussed by all focus groups and all but one interview participant, and was a topic the participants discussed in great deal without any prompting by the researchers. Even after other questions and regular prompting on different topics the conversation regularly came back to the GP and medication; for example when talking about pharmacies or maternity care the conversation would come back to something their GP had said or done.

GP and primary care

Most of the discussion about experience of services focused on negative experience and dissatisfaction with GP services.

A minority of participants reported a positive experience of their GP and felt they were friendly and supportive.

However the majority of participants expressed general dissatisfaction with their GP. They felt their GP did not take their health complaints seriously and many participants felt the GP was dismissive, uninterested and short on time. They felt they were wasting the GP's time and the GP wanted them to get out of the office. They felt too often they were advised by the GP to go home and their illness would get better in time. Examples of this included adult chicken pox, childhood asthma, childhood dermatology, high fevers and back pain.

This perceived lack of interest was particularly frustrating for parents as they felt the GP did not take concerns about their children seriously. Many participants said they had taken their child to the GP with a high temperature or with a bad cough and the GP had told them the child would get better on their own. They felt the GP was disinterested and made the parents feel like they were wasting the GP's time. This did not reassure parents and many reported that they resorted to visiting A&E.

Linking in with this feeling of the dismissive GP attitude was that the GP usually told them to take paracetamol and would not prescribe any other drugs. They felt this was not taking their concerns seriously and they should be given stronger drugs. The concern about over-reliance on paracetamol was mentioned in all focus groups and by all but one interview participant (see below for more information).

Many participants reported they felt the GP him/herself was a barrier that stopped them accessing other specialist services which they needed. Some participants discussed how they had specifically asked to be referred to services such as gynaecology or endocrinology and their GP had refused. There was a lot of frustration that there is not another way to access specialist services other than by GP referral. Many of the mothers felt they had to return to the GP regularly with the same problem

Sometimes I feel like they [GP] are saying 'why are you coming to see me?' (M5)

It is just 'next' [dismissive hand gesture] 'next' (mixed focus group)

So we feel like they [GP] are not interested in us, just like 'you are fine go away'. Cos this is the thing we have got at the moment, we are coming and saying 'we have an issue' and they're [the GP is] saying 'oh you're fine'. (mothers 1)

- To get the specialist you need to prove it long period.

- But really if you've got some symptoms which are really worrying...

- You have to prove it long but with asthma or something they will go straight away maybe to hospital... (mothers 1)

Participant: [in Poland it is better] It's er the conversation between the doctor and the personal is bigger [longer conversation]

Researcher: Okay, so is it about, it's not listening more

Participant: Listening and talking and...take care and took me a lot of time ...But in England, in my opinion, cos it is 'this this and this and go' [quick brief appointment then you leave] (mother 2)

Well actually dentists well I know that a lot

to 'prove' how ill their child was before the GP would refer them to a specialist. The majority of the participants understood how the health service worked, but they disliked the UK system.

Many participants discussed the difficulty of booking a GP appointment at short notice, it was acknowledged this varied between practices and some participants had changed to a GP practice where it was easier to get an appointment.

Some participants suggested that the GP needed to spend more time examining and understanding their condition before dismissing them – it was felt that telephone consultations (without seeing a patient) were inappropriate and when they were in the office the GP rarely gave a physical examination.

In contrast, three participants in two different focus groups involving mothers discussed how they preferred the approach of UK GPs. They felt it was difficult to understand when first arriving in the UK but once people have lived here a number of years they understand that the UK system prioritises self-care, prevention and minimal use of drugs where possible. These three women all spoke very good English and had lived in the UK for 7-10 years. They felt the approach to healthcare in their home countries (Poland, Russia and Ukraine) was too reliant on medication and making money for the pharmaceutical industry.

Some participants discussed that they had a mixed experience of UK GPs and felt it depended on the GP's personality.

Another concern discussed by many participants, especially parents, related to the difficulty in obtaining a same day or same week appointment. This varied between participants and depended on the practice at which they were registered.

Many participants felt the UK system, particularly the quality and role of the GP, was inferior to the health system in their country of origin. This is discussed below.

One focus group discussed how they felt unhappy that they did not get paper copies of blood test results or scans.

Dentists

Participants reported a mixed experience of UK dentists and the majority went to the dentist when they returned to Poland for holidays. They felt Polish dentists were cheaper, had better skills and were more trustworthy. However they felt UK dentists were very good for children as they were free and friendly.

Hospitals

All participants with experience of using hospitals reported long waiting times at A&E which discouraged them from using it. The majority of participants felt the quality of care was very good in hospital though waiting times (in A&E and for specialist services) were unacceptable.

of people in England a lot of English people go to a dentist from Poland because our dentists are much higher level we just struggle, see in England the equipment is good and the money's good in Poland the dentist's good. (M1)

– Yes every time I called in the morning, I called at 8, I can't call before half past cos it's so busy then when I can speak to the receptionist she says there is no appointments but if I've got a child with a fever....

– It is not possible, last time my son he have five days his temperature 41 it was really high and they said sorry but we don't have any place for him and call Tuesday, Wednesday and Thursday after that I'm going to the hospital cos I don't have any place for me

– For me it is ok. Yes because when I ring about the children they go in straight away. And if I went about myself they would probably give me the next day. (Mothers 1)

– We prefer [the dentist] in Poland cos for it is cheaper and private for a smaller price and you can get very good quality, high standard dentist but here I would have to pay one thousand pound for work but in Poland it would be one hundred pound. ...

– For the children I am happy...

– Yes for the children I am happy....

– Yes it's free but dentist, sometimes with children is very delicate. They know how to treat them [children] well....(mothers 1)

The majority of participants felt that specialist services in hospitals were of a high standard however they felt the challenge was getting a referral to these from their GP.

Some participants described UK hospitals as well equipped and modern however one interview participant felt they were not clean.

Pharmacy

Awareness and use of community pharmacy services was very low. Only a minority of participants used pharmacy services, and those that did only attended the pharmacy for minor ailments like cuts; few would ask the pharmacist for advice on a fever or cough. Two mothers discussed using pharmacy and both were dissatisfied as they felt it was not possible to obtain the same over-the-counter medications and herbal treatments as in Poland. For some groups it was difficult for researchers to explain what they meant when talking about pharmacy services, participants just thought of the medication aisle in a supermarket.

Medication and prescribing.

All focus groups and all but one interview participant mentioned paracetamol and their dissatisfaction with the common suggestion of 'paracetamol and rest' that they receive from their GP. They felt GPs do not take their concerns seriously and they regularly leave consultations with the advice to take paracetamol for the pain and their health complaint will heal itself. They felt they struggle to convince the GP to prescribe them stronger/appropriate drugs and that GPs should prescribe more antibiotics. They felt it is easier to get the appropriate drugs (especially antibiotics) in Eastern Europe and the ethos in the UK is too focused on 'wait and see'. This was expressed by participants from different countries and only participant F2 did not discuss this.

When questioned participants reported this was something they had experienced themselves and that their friends talked about a lot. Often when one participant in a focus group mentioned paracetamol the other participants would laugh and join in chorusing 'always paracetamol', as if it was a common joke.

Participants were frustrated as they felt they had wasted time attending the GP practice just to be told to take medication they have at home.

Some participants felt that GPs were reluctant to prescribe other medications because they were trying to save money.

The expectation that the GP will only prescribe paracetamol would discourage some participants from visiting their GP.

Many participants suggested in their country of origin they would have been prescribed specific drugs for their health complaints and they did not understand why these were

What they said before when they find the problems they go in to care about you [once diagnoses specialist care is good], yeh, you know, it's better yeh. But we said problem first contact the doctor because the first time they ignoring you, 'they say nothing wrong with you, nothing wrong with you', but after when they find what's going on [it improves]... (mothers 2)

- *We wait too long in [A&E]*
- *With a broken arm, watching TV, started crying, watch back the TV cos I couldn't look at it, 6 hours sitting there waiting*
- *I had to wait as well, I had like appendix and I had to wait 12 hours (youth focus group)*

Because sometimes they think, the Polish always think that they are better sometimes than the doctor, the Polish people sometimes don't listen to the doctor, they like 'oh I know better' you know, 'oh I'll buy this one, I'll use this one like home medicine' I don't know, if they come here and they get paracetamol again they think 'oh I'm not going again cos we will just get the paracetamol again and I can buy on my own'. (Mothers 1)

They give you paracetamol, they always do .Headache paracetamol. Stomach pain paracetamol. Temperature paracetamol (youth focus group)

Participant: If you have sniffs or something go to doctors, if you have really very high temperature or infection, but they say 'ahh take paracetamol for three weeks'

Researcher: Do you think that this idea that you're kind of just given paracetamol and you're sent home stops people going [to the GP]?

Participant: Yeh, you still go but maybe what would be helpful, not just 'oh, there's nothing wrong with you' to explain why the person may be worried, just giving

unavailable in the UK.

A minority of participants did feel that the UK's approach to medication and promotion of self-care was appropriate and better than their home country. One Polish participant in the focus group mothers 2 felt that the health system in Poland was too focused on medication and antibiotics were over-prescribed. She felt this was because it was a way for doctors to make money and the Polish system was focused on the novelty of medication. Two mothers in the Russian group (mothers 2) felt that their home countries also had an over-reliance on medication and they, after living in the UK for many years now felt that self-care and allowing the body's natural immune system to fight off infection was better. One interview participant discussed how the Polish community want a 'miracle' and quick easy fix to problems which led them to an over-reliance on medication. However these views were very much the minority.

more explanation. (mothers 3)

The smallest [child] had a temperature of forty degrees he [GP] said to give paracetamol. That is not an explanation, he have fever give paracetamol. But why? (M5)

Always paracetamol...they give them paracetamol but they're taking paracetamol for everything, for everything...[in Latvia] they give you medicine for headache, you've got stomach pain they give you medicine for stomach pain but [in UK] they just give paracetamol.(M2)

It is getting crazy now, cos it's free and now everything is going medicine they want to sell it in Poland and want to recommend everyone, the doctor want to give you everything all the time, medicine, medicine, medicine and with pregnancy is really crazy now, really crazy...(mothers 2)

Mental health

Most participants needed a lot of prompting, rewording of questions and suggestions around the topic of mental health. Researchers phrased questions to discuss 'stress', 'worry', 'feeling happy', 'being anxious' and 'not sleeping' to ensure participants understood the topic. Every participant was asked what they felt could be done to improve the mental health of the community and how Eastern European people could be supported or who they could talk to. The majority of participants fully understood what the researchers were asking but when it came to services or what could improve mental health few had much to say about the topics. It was not something participants had many particular opinions on and the discussion usually stopped quite quickly despite prompting from the researchers.

Attitudes and knowledge of mental health differed between groups and interview participants. Some participants discussed mental health very openly and were happy talking about stress, depression, emotions and anxiety and what someone could do to overcome these problems. However few people talked about their own experiences, and we did not ask people about their experience of mental ill-health. Other groups did not have much to say about these issues and felt as they had not experienced them they could not comment. The youth group discussed the idea of mental health (mainly depression and anxiety) very openly, though only one participant briefly discussed his own mental health.

Participant: Well we do not tend to treat it [mental ill-health] as an illness.

Participant: We try to treat it ourselves. Doing something for us like....

Participant: Going shopping hahaha.

Researcher: How do people cope with things then do you think?

Participant: We usually stay in a home and fight through it.

Participant: When you're ill we take some medicine to make us feel better but with mental it's more of a problem (mothers 1)

Most participants felt that mental health was not something

that was talked about very often in their communities. Many Polish adults felt that mental health was not a topic Polish people talk about until crisis point. This lack of openness was due to stigma and shame and the approach that people do not complain and should deal with their own problems.

The Russian speaking group thought that although talking about mental health is taboo in Russia people are more open in the UK, both people from the UK and Russian speaking people who now live in the UK. This group discussed how some of their friends went to a Russian speaking counsellor.

Most participants felt talking to family, friends and, for the youth group staff at college, was the best way to deal with mental health issues. It was suggested that most people rely on support from family or friends and talking to a health professional was unlikely. Many Polish participants reported that Polish people are very private and do not like to talk about things, this linked in with shame and stigma. As 'Talking Therapies' are uncommon in Poland, people do not see this as an effective treatment option and are unlikely to take this up. Few participants would go to see their GP if they needed support around mental health.

Some participants discussed how mental health was influenced by isolation, work stress, disappointment as expectations of UK are not met and difficulties with jobs/finance. In contrast, one group felt that Eastern European people in the UK had fewer mental health problems than at home because life was easier, there was less stress, people had more money and they were generally happier when they lived in the UK.

Alcohol, and to a lesser extent cigarettes and drugs, were discussed by some participants as a common coping strategy people use when they are depressed or anxious.

Mental health services

When asked what could help people who were experiencing mental ill-health or what services are needed the most common suggestion was having health professionals who speak your native language, be this psychiatrists, counsellors or more general support workers. Common language and culture was thought to be very important when discussing issues like mental health. Not having to concentrate on speaking in English would help people relax. However many participants acknowledged that a lot of people would not use the service even if the workers spoke their language as stigma and shame would discourage them from attending. One mothers focus group felt that health visitors were well placed and had encouraged mothers to discuss mental health problems.

Another common suggestion was ways of overcoming isolation and loneliness by increasing social activities and ways to meet other people from your country. Social media was mentioned as already providing ways of meeting other Eastern European

People talk about that rarely. Depression in the Polish community is, well not in the Polish community, in the younger Eastern European community it is very common. One it's the language barrier of finding friends, two it's the fact of feeling left out in another country, three it's the fact of feeling left out by other Eastern Europeans in a foreign country. (M1)

More and more actually...Some of friends here are Russian speakers I know cos I think people openly talk about here to work, the difference here I notice again...in Russia its more taboo people would not talk with friends but here definitely its more kind of people ask for support... Traditionally in Russia there's no such word as depression. Just get on with life that kind of attitude...Yeh they don't talk about it (Mothers 3)

Yes, people think you know, 'oh there's plenty job I could pick and choose job and the money very good' and everything and houses and everything just waiting for them, it's not like that. And lots of people coming here have really good education and they've finished university, everything and they working in factory, they complain...they are shocked. (F1)

If there is some problem I try to solve the problem myself. Then after if I can't I start to speak to other. But I not see any of my friends or family talk...I have my problem, everyone has their problem, I not share with others (M5)

Yea if you come alone and you got to have problem with language then it's difficult, you need to find some friend or something who understands anything and then can sort out anything, if you come from Latvia to England if you no understand anything, I don't know people who do like that...Anyways over here there is

people in Warrington. Increasing your social life and circle of friends was thought to be a good way to find more support, and also make people happier generally.

Some groups thought the council and NHS need to do more to promote positive mental wellbeing in the Eastern European community in Warrington. The youth focus group suggested promoting positive wellbeing messages and ways people could keep happy (music, friends, activities) and one interview participant suggested asking employers with large numbers of Eastern European workers to host mental health days.

communities very good, very nice community but if you no understand that language that community not help you anything because you no understand what they're saying (M4)

[We need] activity in community centre, programmes in Slovakian, Polish, Latvian...cos people can go and talk. (M5)

Other friends recommended our kind of Russian speaking psychologist worker...She's registered here, she's Russian speaker when people went there it's very different kind of...but then you also need to know the reality so it's not just Russian speaking but should be a Russian person or a Polish person...And so they know the reality as well so it's always like cultural connections (Mothers 3)

I think it will be better if we maybe have some Polish doctors so there will be more confidence and they will go to doctor and say I am depressed or I have some problems can you help me, because I don't think they would do the same with the English doctors. More Polish doctors or Polish GPs or specialists so they will go. (F1)

Language

All participants were asked a few questions about whether language caused barriers for using services, any experience of translation/interpretation services and how this could be improved. Most participants had many opinions on the topic of language and translation and talked freely with little prompting.

Language and challenges with communication was discussed by all participants. Poor spoken English skills, lack of confidence and difficulty in understanding health professionals was felt to be a barrier to service use. It was thought to be distressing for some people if they could not explain their health problems, and might stop some people from attending services.

Few participants had used any interpretation services within healthcare, and those that had used these services reported a mixed experience. Telephone interpretation services were thought to be time consuming and could cause disconnection between the health professional and the patient. Interpreters

The language issue, I am very often helping friends to go with them as they don't understand much of what GP is saying. GPs must try as much as they can but they can't avoid the words we don't understand like so if there would be any possibility to use someone who speaks the language that would help a lot. (Mothers 1)

Sometimes to explain a problem in the GP is too difficult – you need the words. The

who sit in the room with the patient and doctor were preferred. There was a lot of confusion over what interpretation services are available and how they can request these. Some thought this was easy and other participants did not know such services were available.

Most participants felt that language caused a big barrier for people when they first moved to the UK and this was when they were most likely to rely on friends, family or interpretation services. However it was felt that once most people had lived in the UK for a year or so their English was good enough to allow them to communicate with most health professionals, about simple issues at least. Some participants thought it was important for migrants to the UK to learn English; however some complex medical terms were always going to be difficult.

Most participants reported having accompanied friends and family members and act as an interpreter in health and council services and with business issues. The majority were happy to do this, especially the younger people. However some participants felt for more personal health issues (such as mental health or gynaecology) taking a friend or family member to translate was not always appropriate.

Participants felt some people struggled so much or had so little confidence in their understanding of English that they would wait until they are back in their home country as they would feel more at ease and understand a health professional more easily.

Many participants discussed the importance of facial expressions, accents and body language. Even when participants were confident in their English skills they sometimes struggled to communicate with health professionals with strong accents. Even when people had lived in the UK for a long time many still preferred to speak with health professionals from the same country/culture as them and many participants expressed a wish for more Eastern European doctors, nurses and dentists. The focus of the need was more on health professionals who were from their home country or spoke their language; this was felt to be more important than having more widely available interpretation services. They felt this need for shared culture and relaxed communication would not be overcome by simply providing interpreters. Speaking to a health professional who spoke your native language was thought to be particularly important for sensitive issues such as mental health; this was not so much due to the language but more the cultural connection and relaxed communication.

In an attempt to overcome this many participants said they had looked for a GP and a dentist who was from their country of origin. Some reported attending Polish dentists however no participants had been able to identify an Eastern European GP.

Some participants discussed seeing written information in

organs and the problems with the organ it is too difficult (M5)

Actually I've noticed like the small clinics yeh you go like the touchscreen computers and you got like English, Arabic and Polish. That's what I noticed recently in like small clinics...but like in hospitals when you go to reception and talk about they got no translator at all. So like got to concentrate on big like big hospitals...like for example the one near Whitecross, they still not got a translator. [The hospital is the first place] a person goes when you got a problem (youth focus group)

Participant: She said about, she last time had got a letter about the smear test...She don't going because she doesn't want to go with some of her friends...And that way she going to Poland and pay for that like in Poland, it doesn't make here because its problem there speaking English

Researcher: So, with the GP, if you can't take a friend with you is the only way to get translation?

Participant: She didn't want to take a friend because she said it was something like personal, she wants like some translation, if somebody from a doctor or something like nurse, who would be speaking Polish, would be better for her, yeh (mothers 2)

Participant: I know people who had problems with language and they can't chat with different people but if they need something they ask and somebody go and translate or something like that.

Researcher: If you had a problem like that what would you do, you said like someone would translate would you get a friend to do it or?

Participant: Yea friends

Researcher: Would someone be more likely to use friends or translation services?

Participant: Yea more to use friends but sometimes they get translation through the phone. (M2)

I know a few people that don't go to services because they can't even explain

Polish and Slovakian which was thought to be very helpful, this was often provided by employers. Some of the more minority groups, such as Russian, Latvians or Hungarian speakers rarely saw written material in their first language.

what's wrong with them. My friend once had some stomach problems she just didn't go to the doctor cos she just didn't know what was happening to her well she didn't know how to say what was happening to her...she just didn't wanna go in and start babbling. She's one of those if she doesn't know what to say she won't say it...And that's often the case that's very often the case if they don't know what to say they won't say anything at all. (M1)

Smoking, alcohol and drugs

All participants were asked about levels of smoking in their community and how people could be helped to quit smoking. Most participants spoke about this topic easily and had opinions on the topic. All participants were asked their perceptions on levels of alcohol use in their community and about support for people with alcohol problems. Although they talked easily about levels of alcohol consumption participants did not have as many opinions or idea about services and supporting people to drink less alcohol. Some groups were asked about drug use and drug services, however only one interview participant talked about this in any detail. When the youth group were asked about illicit drug use there was laughter and they were reluctant to discuss the topic, however there was some discussion between members in Polish that they dismissed when researchers asked if someone wanted to translate what had been said. There was a youth worker present in the room.

Smoking

Opinion was divided on whether Eastern European people smoke more tobacco than British people. Some people thought it was more common amongst Eastern Europeans, especially men, whereas some people thought few Eastern European people could afford to smoke. Some of the younger participants thought smoking was more common in Eastern European young people. Many participants mentioned how expensive cigarettes are in the UK and thought this discouraged people from smoking more frequently. Few of the female participants smoked but some mentioned their Eastern European husbands/partners smoked. Many participants mentioned that it varies from person to person and it was difficult to talk about trends.

Difficult to say if Eastern European is drinking more or smoking more....it depends on the man or the woman, what she wants. (M5)

And also there is more [smoking cessation messages] too I see there like everywhere in hospitals, in shops, in chemists like there is a stop smoking groups and like that but in my country I not see. Nothing like this (M2)

When asked if Eastern European people would use NHS smoking cessation services most people thought they probably would not. This was thought to be due to language barriers but also because they would not be interested. A few participants discussed how quitting smoking was something people made an individual decision to do and they would not access services. However for the few that might want support having a native speaker would be very beneficial.

Some participants mentioned legislation like smoking bans and health warnings on cigarette packages had discouraged a lot of people from smoking.

Alcohol

All groups felt that Polish people have a reputation for drinking excessively and two groups joked about how English people often ask them if they drink a lot of vodka. However they felt this reputation was unfounded. They thought currently Polish people do not drink more than British people but this may have been the case with previous generations. Some participants thought life was harder in previous generations and when there was little money or hope for the future people would drink more. However they felt that having jobs, money, plans for the future and families meant that now Eastern European people do not drink that much, especially not when they are in the UK. It was acknowledged that some people use alcohol as a way to cope with mental health problems.

Some participants discussed the differences in drinking cultures between the UK and Eastern Europe with the UK community being focused on the pub. They thought Eastern European people tend to drink at home and at family occasions.

When asked if people would access an alcohol support service the majority said this is not something people would be interested in, because the majority of those who drink too much do not think they have a problem.

Illegal drugs

Most participants did not have much knowledge about drug use and had little to say about drug use. However one young interview participant (M1) and the youth focus group thought drug use was common amongst Eastern European youth. Drugs were thought to be easily accessible, very cheap in the UK (though weaker than in Poland) and punishment is less severe in the UK. Interview participant M1 discussed people he knew who used cocaine at work to give them energy during a shift. Again few people would access help for this because most of them would not acknowledge they had a problem. The youth focus group were amused by questions about drug use and were reluctant to engage in a conversation about this topic.

Encouraging healthy behaviour

Many participants discussed how it is difficult to change people's behaviour, they felt people need to make a decision to change and be healthier. Examples of this included people having to make a decision to quit smoking; one focus group discussed that no matter what services are available it is up to the individual to make the choice to quit smoking.

Some participants mentioned that the UK health services are very proactive and focused on promoting healthy behaviour, not just on curing disease. This was different to their countries of origin where healthcare is based on treating disease.

We start laughing because some of the stories like 'Polish people like vodka', everybody know about that one, but something changed, maybe that was the old people, but yeh, long time ago, I think [alcohol use is] the same as the English. (Mothers 2)

– I think you Brits drink more than we do.

– Yes.

– In bars and every weekend.

– We are not going to copy, we are more in the home. We just drink a little at home with just friends. (Mothers 1)

Participant: I can tell you straight away Polish people do loads of drugs, straight forward, young people in Poland do loads of drugs.

Researcher - In Poland and in Warrington?
Participant: Yea the drugs in Poland are much, much stronger. So the drugs that they get here if they've had it before in Poland is nothing.... but there's not that much of a problem. As I say there's gonna be just individuals who are gonna have a problem with drugs maybe or alcohol but there's not going to be a large number of Polish people that are gonna be struggling with those things.... Yea they are extremely cheap over here, so access to it is also easier and they're cheaper and the Police is less brutal towards drugs than in Poland or most Eastern European countries. (M1)

Food, diet and physical activity

Food, diet and physical activity were talked about by the majority of participants; most of this discussion was due to direct questioning and prompting by researchers. This topic was not something participants thought of often when asked about the topic of health.

All participants who talked about diet and food felt that Eastern European people had healthier diets than British people. They believed that their diet was based around fresh fruit, vegetables and meat, whereas British people were thought to eat mainly fast food. This was thought to be due to the history of traditional Eastern European cuisine and many participants mentioned that they had grown vegetables at their homes before they moved to the UK. This culture of food had transferred into the way they ate in the UK.

One group discussed how few people ate fast food or highly processed food, and they thought the school dinners in the UK were of low quality and very unhealthy. They commented on how expensive fresh fruit was in the UK and how chocolate and crisps are cheaper.

Some participants discussed that Eastern European people are very active; they often work long hours or have physical jobs and you see very few obese people in the Eastern European community

The youth focus group was very aware of keeping healthy, the importance of diet and physical activity and the impact this had on positive mental health. They had been taught this at college and school.

*Participant: Polish people every day cooking...I'm cooking every day. English people cooking buying the easy junk food
Researcher: So do you think Polish people eat healthier?*

Participant: Yeh because we think like that, for example we cooking for ourselves... No like we're going fast food buying.... It's not like we don't ever go...but not like 4 times per week or something. Because for us when you food shop for example, Tesco has got loads ready food for you, takeaway...We buy vegetables, meat, potatoes, pasta. (mothers 2)

A load of people I know do a load of physical activity like I said I rarely see Polish people not doing something because if they're not working their arses off they're always doing something like anything...I realised that Polish people don't like having nothing to do. (M1)

Eating healthier because in Russia most of the families have got a 'dasha' which is like a country house, they grow their own vegetables. So every second family has got an allotment. So we're very switched on, make our own preserved food for winter and eat you know natural, hardly any preservatives (mothers 3)

Maternity care and women's health

The discussion guide did not include any questions about maternity services or gynaecology and women's health. Although no direct questions were asked about antenatal care, all four focus groups brought up the topic and discussed it in detail when talking about difference between healthcare in their country of origin and the UK.

Many female participants felt the care they received during pregnancy in the UK was not as comprehensive as they would have received in their country of origin. Participants reported they receive more regular scans, up to five in Poland, and more blood tests and regular monitoring. They expressed frustration that they were unable to access more regular scans and this 'caused worry for some pregnant women. Some women mentioned how they would return to Poland for treatment and care if they had any problems with their pregnancy. Some of the groups discussed how the quality of care in hospital during care was very high although they disliked how quickly they were discharged.

The subject of gynaecologists came up in many focus groups and interviews. Many women were accustomed to annual check-ups with the gynaecologist in their home country and expressed concern and frustration that they could not access gynaecology services in the UK. One interview participant and one focus group also discussed frustration at not being able to access smear tests and breast examinations as frequently as in Poland. No participants seemed to understand why this was the case and presumed that the GP did not care or was trying to save money. No participants discussed using sexual health services for gynaecology care.

But then obviously if people have some sort of scan for example it's very difficult you need proper specialist help...Even for women in Russia women's health is quite important just even going to gynaecologist but here never get a specialist referral you can't just go and check yourself (Mothers 3)

[In the UK] if you need you go you must go to the doctor you must go see gynaecologist, because in Poland we see gynaecologist like straight away, not like here, here you must go to first doctor [GP] and they will tell you need to see that gynaecologist or doesn't need gynaecology. [In Poland] you have the choice to go straight away because in Poland it's erm a private practice, a lot of private practice (Mothers 2)

4.4 COMMUNITY ENGAGEMENT EVENTS

Experience of healthcare was also chosen as a topic for discussion at the engagement events as the conversations were brief (usually less than 5 minutes) so researchers could not go into more complex issues. Given the role of the GP and wider primary and secondary care services in providing advice, support and referrals for health and wellbeing, a large focus of these community engagement events centred around understanding if, how and why members of the Eastern European population in Warrington access their GP.

4.4.1 OPINIONS AND EXPERIENCE OF HEALTH SERVICES

GENERAL PRACTICE

All participants (n=19) stated that they were registered with a GP. Opinions of GPs were also generally quite high with six individuals responding their experience of General Practice in Warrington was good and four individuals stating neutral opinions. One participant had a negative opinion of his GP. The majority of individuals had found GP registration to be an easy process and most felt that their GP was friendly and helpful. Several individuals mentioned that they could not always get an appointment with their GP when they wanted it as their practice was very busy. The most commonly mentioned issue connected with general practice was prescribing practices; the majority of respondents felt they did not receive antibiotics or other medication when it was needed and were frequently advised to take paracetamol when they thought other medication was appropriate. A more detailed summary is included in table 8 below:

HOSPITAL SERVICES

Fewer respondents had experience of hospital care although the majority who had visited a hospital recalled it being a positive experience with five individuals describing their experience as good and two describing having neutral views of their experience. The majority of individuals who had attended hospital had done so to access care for their children. Those who had visited hospital felt that the quality of care they received was very good, however the majority felt that the waiting times were too long.

DENTISTS

A large number of participants said that they did not use the dentist in the UK, preferring to access dental care in Poland. Overall opinions of the dentist were also more mixed with three individuals reporting good opinions, two reporting neutral opinions and one reporting a poor opinion. In general, Polish dentists were seen to be more trusted and knowledgeable and were also reported to be cheaper than UK dentists. The main barriers to accessing UK dentists were bad past experiences. A more detailed summary is included in table 8 below:

TABLE 8: ATTITUDES TO HEALTH SERVICES

Theme	Commentary	Illustrative examples
GP attitudes	The majority of individuals described their GP as friendly and professional.	One individual felt their GP in the UK was friendlier than their GP in Poland. They said their experience of Polish GPs was that they were still held in high regard as figures of authority and could often be quite distant towards their patients.
GP registration	All respondents felt that registering with a GP had been an easy process however not all respondents had registered with their first choice of practice.	One family mentioned that they were not able to register with the practice nearest their home as the practice was full. However, they were happy with the practice they attended.
Making an appointment	A number of individuals mentioned that it was difficult to make an appointment, especially on the same day, as their practice was very busy	One individual spoke of an instance when they had telephoned their practice before 8am but still had not been able to get an appointment for the same day.
Prescribing	<p>The most commonly discussed issues in relation to general practice were prescribing. Most individuals felt that their GP “always” told them to take paracetamol and there was a general feeling that this advice was inappropriate and that antibiotics or other medication was more appropriate but not prescribed. One individual said they knew this only by hearsay but four participants said they had experienced this directly. Many compared this with the ease in which they could access antibiotics in their home country.</p> <p>There seemed to be low awareness of the difference between viral and bacterial illness and antibiotic resistance with none of the participants responding to researcher prompts.</p> <p>When asked why they thought GPs were reluctant to prescribe antibiotics, the majority thought this was due to cultural differences. Reasons given included an emphasis on self-care in the UK and doctors trying to protect the free NHS system from exploitation. When asked in what ways the system could be exploited it was suggested that individuals not truly experiencing symptoms may attempt to access treatment in order to avoid work or claim social</p>	<p>One individual said she had been advised by her GP that her illness would clear up naturally when she had previously received medication from a Polish doctor for the same issue.</p> <p>One individual spoke of a friend who had visited a GP with symptoms and received no treatment. She had then sought advice from an alternative medicine practitioner who told her that she had Lyme Disease. The individual then went on to access medication in Poland as they believed their diagnosis was due to a reluctance of English GPs to treat Lyme Disease.</p> <p>A Slovakian man thought that the NHS was trying to save money which is why they would suggest paracetamol and not prescribe antibiotics or other medication. He felt UK GPs are overly focused on money and business and do not take their patients seriously.</p>

service support.

Referrals	Several individuals mentioned it was difficult to obtain a referral from their GP to the appropriate specialist. This was compared to experiences in Poland, where it is common for patients to self-refer and access a specialist directly.	One woman discussed recurrent visits to her GP for a respiratory condition, she felt she should have received a referral to a specialist and instead received “same advice, same medication, no referral”.
Knowledge and Trust	A number of individuals stated they preferred their Polish dentist because they trusted them and felt they were more knowledgeable than dentists in the UK. This opinion was influenced by bad past experiences.	One woman spoke of visiting her dentist with her nine year old daughter who was experiencing substantial pain due to a double tooth. She felt that her dentist didn't listen to her and didn't do anything to relieve the pain her daughter was experiencing. As a consequence she said that she would continue to take her children for dental check-ups in the UK, but if any treatment was needed for her children she would refuse it and access care in Poland instead. One man mentioned that although he used a dentist in Warrington his wife accessed the dentist in Poland because of a bad experience with an English dentist.
Translation issues	It was mentioned that dentists had a responsibility to make translation services available, as there could be miscommunication.	One woman gave an example of a friend who had attended a follow up appointment for a toothache and had had a tooth removed without realising the procedure was going to take place. The participant acknowledged that this was likely to be a translation issue and said that the friend felt they understood what was happening prior to the procedure but realised too late that she had misunderstood.

6. TRIANGULATIONS OF FINDINGS

The findings from the various research components were triangulated to enable identification and exploration of common themes.

HEALTH PROMOTION AND PREVENTATIVE HEALTH SERVICES

Most participants found it difficult to discuss public health and preventative services; there was little understanding of these types of service and for most they understood healthcare as only the services provided by the GP and hospital. Most participants talked about smoking and alcohol in relation to how many people engaged in these behaviours; when questioned about support to reduce drinking few felt this was something a service would help with. Alcohol problems were thought to be something a person sorted out for themselves, however there was more interest in and acceptance of smoking cessation services.

Few participants were able to offer an opinion on what could make mental health services effective; few participants knew anybody with mental health problems, they felt it was rarely talked about and that people tended to sort out problems on their own. However the literature shows a high prevalence of mental health problems in the Eastern European migrant population in the UK (Toni et al 2010; Patel 2012). Participants felt the Eastern European community was unlikely to use mental health services, however any counselling or support services needed to be provided by a professional who spoke their language if they were going to be taken up. Evaluation of a smoking cessation service in Crewe has shown a Polish speaker providing support increased uptake and effectiveness of the programme (Eida and Ehata 2010).

Lack of trust in their GP seems to be acting as a barrier and may stop Eastern European population from seeking help for issues like mental health or for help with smoking or alcohol. This may be exacerbated by their experience that their GP is reluctant to refer them to a specialist. The data we have collected show that this population does not prioritise preventative healthcare and would rarely access services to help with mental health or alcohol, this is even less likely if they would have to request this from their GP. It was not clear to participants which services they could access independently of their GP and they were unlikely to seek out any additional health care services independent of their GP. To encourage access to public health and preventative healthcare services (i.e. IAPT, sexual health, smoking cessation, drug and alcohol services) potential patients need to understand the care pathways in place that do not need GP involvement.

Dissatisfaction with being unable to access gynaecology services may be due to lack of understanding of what are offered by sexual health services. Differences in terminology may contribute to this as in the UK most women will not regularly see a health professional with the job title 'gynaecologist'. However in the UK many women receive 'gynaecology' services from their GP, community contraceptive clinics and the genitourinary clinic. Promotion of sexual health clinics as providing many of these 'gynaecology' services could improve access for Eastern European women.

PRIMARY CARE AND SELF-CARE

Although we found a small amount of literature about dissatisfaction with GP attitudes and prescribing practices, this was by far the main issue focused on by participants in this needs assessment. We did not ask any direct questions about medication and participants started discussing GPs as soon as they were asked the initial questions about their understanding of health and being healthy. Throughout the focus groups

and interviews the conversation regularly returned to primary care and prescribing, even when researchers were asking unrelated questions.

The majority of participants focused their discussions on dissatisfaction with primary care and prescribing practices. Almost every participant reported they regularly felt their GP did not take their concerns seriously and advised them to 'take paracetamol and rest'. This caused a lot of frustration within the Eastern European community and many participants spoke about how their friends and colleagues reported the same experience. Although this issue is mentioned in the wider literature, the importance of this to the Eastern European community in Warrington cannot be understated. Many participants reported their GP had refused to prescribe antibiotics when requested and they felt very frustrated by this; some thought the GP was trying to save money. The literature also highlights a lack of understanding of the appropriateness of antibiotics in the UK national and Eastern European population (ECDC 2014) and specific work needs to target the Eastern European community in the UK to reduce antibiotic resistance.

This difference in ethos and approach to healthcare is causing distrust in their GP which creates barriers and can stop patients accessing other healthcare services. If a patient feels dismissed and not listened to by their GP they are unlikely to approach their GP for support for issues such as mental health, alcohol or smoking cessation.

Although some of this may be due to actual GP behaviour, their perception of disinterest and dismissal by their GP suggests the problem is twofold. Firstly the Eastern European communities appear to access GP services for issues and illnesses that can be treated at home or by a pharmacist. Experience in their country of origin may have encouraged individuals to attend their GP for all health concerns and participants reported more varied medication being prescribed; more promotion of self-care needs to be targeted at this population. Secondly the GP needs to promote the importance of self-care and the efficacy of paracetamol. The affordability and availability of paracetamol seems to suggest to people in the Eastern European community that paracetamol is a very basic and ineffective drug.

SERVICE DESIGN AND GP AS GATEKEEPER

Although the literature shows Eastern European migrants to the UK do not understand the UK health system and use inappropriate services this was not the case for the participants in this needs assessment. The majority of people we spoke to are registered with a GP and understand the role of the GP in the UK health service. However, as mentioned in the literature, the GP was often seen as a barrier; they were seen to hold the power to refer for specialist services and many participants talked about having to 'prove' how ill they were before they could be referred. This general role of the GP is different to the family doctor in many participants' country of origin and the majority of participants expressed dissatisfaction with this.

The literature states this dissatisfaction and frustration is a result of not understanding the UK health system, however we found good understanding of the UK health service amongst the participants. Therefore it is not that they do not understand the system, it is that they do not like it and think it is inferior to the system they are used to. The reasons for the design of the UK health system and the ethos behind the NHS need to be communicated and explained including what is appropriate use of primary, secondary and acute health services. On top of this the role of the GP also needs to be better communicated to ensure that people understand the GP has very broad training and can treat the majority of illnesses and most patients do not need to be referred to a specialist.

Although the majority of participants with whom we had conversations at the engagement events reported a positive experience of their GP, when this was discussed in depth in interviews and focus groups the majority of participants revealed they were unhappy about the service they receive from their GP.

7. RECOMMENDATIONS

HEALTH PROMOTION AND PREVENTION SERVICES

1. Public health messages around healthy eating, alcohol consumption, smoking and drug use need to be consistent and inclusive across the whole Warrington population particularly in the most deprived wards. Ensure that messages are translated into the appropriate languages and are visible in areas that are accessed by the Eastern European population. Build on existing campaigns such as The Five Ways to Wellbeing or Happy Sad Ok and translate these into key Eastern European languages.
2. Consider adapting current smoking cessation services to ensure promotion is in the appropriate languages and appears relevant to Eastern European populations. The published literature suggests that smoking is higher among Eastern European migrant populations in the UK; however opinion on smoking prevalence among study participants was mixed with some citing cost as a limiting factor. Both the published literature and study participants agree that Eastern European populations would be unlikely to access smoking cessation services; although awareness of such services and stop smoking messages seemed fairly high. Findings from a smoking cessation pilot for Polish communities in Crewe (Eida and Ehata, 2010) could be used to inform this development.
3. Promote sexual health services as an appropriate alternative to gynaecology services. Different terminology and expectations of service is leading many Eastern European women to feel they cannot access any gynaecology services without referral to a specialist by the GP. Promote what gynaecology services are available within sexual health services in Warrington and promote Warrington Centre for Sexual Health as a holistic service, not just for the treatment of STIs.

MENTAL HEALTH SUPPORT

4. There are a good range of mental health services available in Warrington many of which have signposting/self-referral mechanisms in place. However, there is a need to engage with the Eastern European population to promote these services and encourage attendance and appropriate use. Exploring existing models, such as Wellbeing Mentors, will ensure that the Eastern European population are supported in accessing the services they are signposted to.
5. As stigma, shame and distrust of their GP can stop some people accessing mental health services, pathways need to be as simple as possible to ensure potential users do not feel they have barriers to overcome to access services. Warrington Psychological Services (IAPT) accept self-referrals; promote this to the Eastern European community so they understand they do not have to ask their GP for a referral.
6. Explore the feasibility of employing wellbeing mentors or psychological wellbeing practitioners who speak Eastern European languages, especially Polish. Health professionals who speak Eastern European languages were thought to be more important and approachable than translation services, this is particularly important when discussing sensitive and distressing mental health issues.
7. Consider ways in which social isolation can be reduced particularly among young, single males. This could be through the introduction or funding of formal Eastern European organisations/support

services/social groups. Currently the only formal organisations are church and school based which may not be appropriate for some younger people.

8. Increase support for employers and recruitment agencies to recognise mental health problems. Some evidence from participants, stakeholders and literature shows that young males who are more isolated suffer higher levels of mental health and that this topic is not frequently discussed in the Eastern European community. The workplace may be a key setting to intervene, so ensure that HR in big employers like warehouses and recruitment agencies are prepared to respond and recognise mental health problems. The latest DH Mental Health Policy document (Closing the Gap, 2014) recommends that employers not only promote workplace wellbeing but also improve information available to managers so they can recognise the signs of stress and mental health problems and talk about them with staff.

HEALTH SYSTEMS IN THE UK

9. Increase communication around how prescribing and medication is approached in the UK. This is especially important around the practice of self-care, recovery from viral illness and the benefit of paracetamol for many ailments and illnesses. The effectiveness of paracetamol needs to be more clearly communicated and people made aware that, although cheap and easily available, paracetamol is highly effective for many health conditions. Our needs assessment found that this lack of communication appears to be causing distrust in GPs for the majority of the Eastern European population we spoke to. Although this was mentioned briefly in the literature this is a key issue for the Eastern population in Warrington.
10. There needs to be clear promotion of self-care and signposting to appropriate services, including when it is appropriate to visit a pharmacist or your GP. The promotion of self-care, self-management and independence across the population is a key role of the Director of Public Health under the Coalition Government's vision (DH, 2010). Promote the importance of self-care and the role of the pharmacist in treating minor ailments, coughs, colds and high temperatures. Specific promotion could link in with the NHS [self-care week campaign](#) which runs from 17th-23rd November 2014 and encourages individuals to 'Be healthy this winter'. Translate the levels of care information and promote to Eastern European communities. Promote the NHS Choices website which includes translation into many different languages, and advice for visitors to the UK.
11. Develop printed information about antibiotic resistance in key Eastern European languages explaining resistance, differences between bacterial and viral infections and reasons for not prescribing antibiotics. Reducing antibiotic resistance is a key concern both nationally (CMO, 2014) and internationally (WHO, 2014). Provide information sheets to all GP practices to ensure patients understand why they are not being given antibiotics and why paracetamol is often appropriate. These should be provided as standard as many Eastern European people will not challenge the care they receive when they feel the GP has tried to appease them.
12. Encourage GPs to engage with activities for European Antibiotic Awareness Day (EEAD) on November 14th and in particular to ensure these activities are relevant, accessible and visible to Eastern European populations in Warrington. Evidence from this needs assessment and the literature suggests that

expectations and misconceptions about antibiotic prescribing in General Practice are particularly high amongst the Eastern European population. The CMO encourages all GPs in the UK to join the EAAD pledge and make use of the [online resources](#) (CMO, 2014) and this presents an ideal opportunity to raise awareness among the Eastern European population in Warrington.

13. Increase understanding of the role of primary care in the UK and referral systems to secondary care. This needs assessment found that many members of the Eastern European population do not understand the role of primary care in referral to other health services. GPs should provide clear communication about referral pathways and the timescales involved. Continuation of translation services across appointments is needed.
2. Develop a website about health services in Warrington that is available in multiple Eastern European languages (or with a Google Translate button as a minimum) to include information about UK health systems design, the role of the GP and antibiotic resistance. The website would not necessarily contain information about specific services but could link to the NHS Choices list of services. The site should include detailed explanation about why patients cannot access all secondary care directly, which services they can self-refer to (especially highlighting mental health, smoking cessation, sexual health and drug and alcohol services) and the effectiveness of paracetamol. Widely promote the website to the Eastern European community in Warrington. Lancashire Council has produced a website and information pack for migrants new to the area. . (Available at: www.Lancashire.gov.uk)
14. Train health care professionals, especially GPs, on the differences between health systems and culture around medication. This would enable them to more effectively explain why they may not be prescribing antibiotics, explain the effectiveness of paracetamol and explain why the patient cannot make an appointment directly with specialist services.
15. Improve monitoring and recording of country of origin and migrant status of patients accessing healthcare and social support services. Currently most monitoring computer systems only collect ethnic origin which often does not capture whether a patient is of Eastern European origin. Improving monitoring would allow services to understand the population using their services, where they are not meeting the needs of specific groups and where they need to target services. Housing associations are collecting this information about their tenants and use it effectively to target and improve their services; this could be used as a model for collecting data within statutory and third sector organisations.
16. Building on the experience of this needs assessment, effective communication channels for health promotion and promotion of services include; Polish Saturday School, selected recruitment agencies, SureStart centres and groups, Warrington.pl online forum, leaflets within the Polish section and computer areas of Warrington Library and the church.

LANGUAGE AND TRANSLATION

17. Look at ways to increase the number of primary care health professionals who speak Eastern European languages, particularly Polish, working in areas with high numbers of Eastern European migrants. This should include GPs and nurses. This could be achieved through including Eastern European language as a

desired skill on a job description and advertising directed at the Eastern European community to encourage applicants who happen to be bilingual.

18. Look at ways to increase the number dentists in Warrington who speak Eastern European languages, especially Polish. This is especially important for NHS dentists as cost is another strong barrier to use. This could be achieved through targeted recruitment of bilingual staff. Dental practices with bilingual staff should actively promote this on their websites.
19. Ensure interpretation services are easily available, well-advertised and accessible. Highly visible advertising (in multiple languages) should be displayed in GP waiting rooms, IAPT, in hospital entrances and on practice websites.
20. Review language line contracts to see if this interpretation service can be unified under a single contract. Set a minimum requirement in all service specifications to ensure that interpretation services are available across all services including smaller community organisations.
21. Ensure all letters about personal screening (such as cervical, breast and prostate screening) include information about interpretation services as standard.

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