Health Needs Assessment of Polish Migrants in Hertfordshire

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Summary of Findings and Recommendations

1) There are approximately 10,000 Polish migrants living in Hertfordshire. Most of these people are young single men and women aged 25-40, and young families with parents aged 25-40 and children under 10. The majority of these migrants have come since the year 2000.

2) There are high levels of employment among the population, who mostly live in the larger towns such as Watford, St Albans, Hatfield and Stevenage, as these areas have the greater accumulation of jobs and have good travel connections with buses and trains.

3) The major health needs currently in the population are obstetric and paediatric. The majority of people have a General Practitioner (GP) but most don’t have a dentist. Health needs likely to emerge as the population ages are hypertension, ischaemic heart disease and oncological disease (particularly respiratory and gastrointestinal).

4) In the younger urban population, particularly young single men, there are much higher rates of smoking, excessive drinking and mental illness. This is notable in Watford where there is also no longer a Polish association and perhaps the individuals are more isolated and lack social support.

5) The majority of migrants are used to the European model of delivering healthcare, where there is insurance-based healthcare and patients can have investigations and see specialists on demand. Greater efforts need to be made to educate migrant populations about the UK model of healthcare. Better understanding of the way service is provided, investigations are organised and what a GP is are essential in building up trust between migrants and healthcare bodies.

6) Migrants need to be encouraged to inform their GP of any tests they have in their home country and ideally to bring results back with them, to reduce the possibility of incorrect decisions being made in their care as a result of GPs not having important information regarding their health.

7) All migrants are entitled to free care under the National Health Service (NHS). Hertfordshire has 144 GP practices, 2 acute trusts with 7 hospitals between them, and is served by the East of England ambulance trust. There is one mental health trust for the whole county. There are migration partnership groups at county and regional level, and both aim to identify and serve the needs of migrants.

8) Information can be disseminated to the migrant populations via leaflets in GP practices. It can also be disseminated via websites such as the St Albans Polish Association, and magazines such as ‘The Migrant at Home’ and the ‘Migrant Workers Information Pack’.
Introduction

The purpose of a health needs assessment is to investigate with an aim to improve the health of a whole population and to target resources towards improving the health of those at specific risk or in under-served population subgroups. In this particular health needs assessment we will be considering the Polish communities in Hertfordshire.

Health is defined as a positive concept that emphasises social and personal resources, as well as physical capabilities. It involves the capacity of individuals – and their perceptions of their ability – to function and to cope with their social and physical environment, as well as with specific illnesses and with life in general. All government departments are now committed to closing the gap between the most advantaged sections of society and the least advantaged, as defined by childhood mortality and life expectancy. HNA can be a useful tool in this process through targeting services and support towards the most disadvantaged groups.

Needs can be:

- Perceptions and expectations of the profiled population (felt and expressed needs)
- Perceptions of professionals providing the services
- Perceptions of managers of commissioner/provider organisations, based on available data about the size and severity of health issues for a population, and inequalities compared with other populations (normative needs)
- Priorities of the organisations commissioning and managing services for the profiled population, linked to national, regional or local priorities (corporate needs). A HNA should involve comparing and balancing these different needs when selecting priorities. The information can then be used as a basis for bringing about change through negotiation with stakeholder groups.

HNA populations can be identified as people sharing:

- Geographic location – e.g. living in deprived neighbourhoods or housing estates
- Settings – e.g. schools, prisons, workplaces
- Social experience – e.g. asylum seekers, specific age groups, ethnicity, sexuality, homelessness
- Experience of a particular medical condition – e.g. mental illness, diabetes, respiratory disorders

Often a target population will be identified through a combination of main and subcategory groups, e.g. older people living in a deprived rural area and recovering from a stroke.

HNA is worthwhile undertaking only if it results in changes that will benefit the population. It is essential to be realistic and honest about what you are
capable of achieving. Four criteria should be used in selecting issues for intervention:

- Impact – which health conditions and determinant factors have the most impact, in terms of size and severity, on the health functioning of the population?
- Changeability – can the most significant health conditions and determinant factors be changed effectively by those involved in the assessment?
- Acceptability – what are the most acceptable changes needed to achieve the maximum impact?
- Resource feasibility – are there adequate resources available to make the required changes?

There are three levels at which interventions can be effective in tackling ill health for individuals and within populations:

- Occurring – preventing the problem occurring at all (primary prevention)
- Recurring – preventing the problem progressing or recurring by detecting and dealing with it (secondary prevention)
- Consequences – preventing the consequences or complications of the problem (tertiary prevention).

Diseases and health conditions experienced within a population are important when they affect health functioning. Diseases and health conditions can sometimes be caused or exacerbated by a determinant factor, such as poor housing or smoking. In the process of undertaking HNA, actions or interventions that can reduce disease and ill health should be considered at all three levels of prevention.

The health triangle is an analytical tool that can assist in:

- Identifying potentially important health issues for the population
- Reviewing the associations between health conditions, determinant factors and health functioning (see previous definitions)
- Structuring the collection and presentation of data to compile a useful profile.

The health triangle should be used with the target population and all main stakeholders to achieve consensus about priorities for action.

Partnership means local collaboration by statutory, voluntary, community and private sector organisations in planning and implementing economic, social and health programmes. Local strategic partnerships may commission HNAs. Partnership refers to the different partners or sectors who should be involved in decisions about health, regeneration and other programmes. Stakeholders for HNA may include representatives from local business, education, police, housing, transport, social services and leisure, as well as from health
agencies. Most importantly, they should include members and representatives from the target population. Community engagement is a general term used in this context to describe the active participation of local people in defining priority issues and being part of the solution-determining process.

HNA is one of several approaches being used across sectors to help improve health and reduce health inequalities. Other frequently used tools include health impact assessment (HIA), integrated impact assessment (IIA) and health equity audit (HEA). Although there are similarities in these approaches, a key difference is their starting point.

- HNA starts with a population – when the health needs of that population are known, proposals are put forward for the development and delivery of improved programmes and services.
- HIA starts with a policy or project, and predicts the impact on the health of the population.
- IIA starts with a policy or programme, and predicts the impact on economic, social and environmental outcomes.
- HEA starts with a defined population, and is a process whereby local partners systematically review inequities in the causes of ill health and in access to effective services for that population. HNA might be an action undertaken in response to inequities identified by HEA; or might be used to inform HEA about inequities in the population and how they might best be addressed.

Each of these approaches involves a variety of similar research methods, but it is important to select the assessment tool according to your aims and objectives. (1)

Population

The population to be assessed was initially defined as ‘Migrants of Eastern European Origin Settling in Hertfordshire’. Definitions of Eastern Europe may vary but generally it is seen as countries to the East of Germany and Austria and West of Russia (including the European portion of Russia). The United Nations (UN) defines Eastern Europe for the purpose of statistical compilation as:

- Belarus
- Bulgaria
- Czech Republic
- Hungary
- Poland
- Republic of Moldova
- Romania
- Russian Federation
- Slovakia
• Ukraine

In addition to these counties some people include:

• Albania
• Estonia
• Latvia
• Lithuania
• Former Yugoslavian countries

A migrant is defined by the United Nations Educational, Scientific and Cultural Organisation (UNESCO) as ‘a person who lives temporarily or permanently in a country where he or she was not born, and has acquired some significant social ties to this country’. (4)

Hertfordshire is defined as the ceremonial shire county of Hertfordshire in the East of England region. It has 10 districts, all of which are non-metropolitan districts and 1 of which has borough status. They are:

• Broxbourne
• Dacorum
• East Hertfordshire
• Hertsmere
• North Hertfordshire
• St Albans
Each of those districts has a council, and then there is a presiding council for the whole of Hertfordshire, meaning that the county has a two-tiered local government. (5)

Below is a table containing the largest 3 migrant populations in each district. As seen, Polish is the largest in all 10.

**Largest Non-UK National Populations by Local Authority**
<table>
<thead>
<tr>
<th>Location</th>
<th>Ethnicities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broxbourne</td>
<td>Polish, Lithuanian, Indian</td>
</tr>
<tr>
<td>Dacorum</td>
<td>Polish, Indian, Pakistani</td>
</tr>
<tr>
<td>East Hertfordshire</td>
<td>Polish, Italian, Spanish</td>
</tr>
<tr>
<td>Hertsmere</td>
<td>Polish, Slovak, Indian</td>
</tr>
<tr>
<td>North Hertfordshire</td>
<td>Polish, Indian, French / USA</td>
</tr>
<tr>
<td>St Albans</td>
<td>Polish, Slovak, Australian</td>
</tr>
<tr>
<td>Stevenage</td>
<td>Polish, Slovak, French</td>
</tr>
<tr>
<td>Three Rivers</td>
<td>Polish, Indian, Australian / Portuguese</td>
</tr>
<tr>
<td>Watford</td>
<td>Polish, Pakistani, Indian</td>
</tr>
<tr>
<td>Welwyn Hatfield</td>
<td>Polish, Pakistani, Chinese</td>
</tr>
</tbody>
</table>

In these statistics ethnicity refers to a person's ethnic origin whereas migration refers to a person's country of birth. Therefore if someone is a non-British national then they are included as an immigrant but if somebody is a British national then they are not included as an immigrant regardless of their ethnic origin, in concordance with UNESCO definitions. (5)

Initially this project was conceived as being a Health Needs Assessment on Eastern European migrants, however due to the relatively small numbers of migrants from other Eastern European countries and relatively small number of community events and projects in these groups, it was decided to mainly focus on the Polish community.

According to the 2008 Joint Strategic Needs Assessment (JSNA) for Hertfordshire, which obtained data from the 2006/7 Department of Work and Pensions (DWP) registrations and Chelmer Population and Housing models,
the numbers of Polish migrants in each of the districts was 210 in Broxbourne, 240 in Dacorum, 370 in East Hertfordshire, 220 in Hertsmere, 170 in North Hertfordshire, 340 in St Albans, 150 in Stevenage, 80 in Three rivers, 490 in Watford and 620 in Welwyn and Hatfield. Altogether this would make a total of **2890** Polish people in the County of Hertfordshire. (5) The number is probably larger than this however as firstly there will have been continuous migration since 2007 when these data were compiled, and secondly the data rely on people being registered as having a job or living in a house, which many are not. Current estimations put the figure at 10,000. However accurate and current information regarding population throughout the UK will be obtained in this year’s Office for National Statistics (ONS) Census. NHS Hertfordshire is also conducting a separate piece of work on population studies across the county, so further accurate information will be obtained from this in addition to ONS data.

**Methods**

There are two distinct Polish populations in the UK. The first is post-war migrants who have been in the UK for a long time and are very established. The second is the economic migrants, most of whom have come over during the last 10 years (and more so after 2004 when Poland became a full member of the EU). The first group are very old, but the second group are mostly young single men and women between 25 and 40 or young families with parents between 25 and 40 and children mostly in the toddler ages. This report mostly focuses on the second of the two groups.

The methods used for ascertaining the health needs of the Polish community were as follows:

1) Direct dialogue with various leaders in the Polish community including the Strategic Development Officer for Hertfordshire, the chairperson of the St Albans Polish Association, the Curator of the Polish Saturday School, and leaders of several Parents’ Associations, to ascertain what the perceived health needs are.

2) The filling out of a health needs questionnaire by as many Polish people as possible. This involved going out into the community and disseminating the questionnaire. The different sectors from which completed questionnaires were obtained included a parents and toddlers group in Broxbourne, a Polish Sunday Catholic mass in St Albans, Polish Saturday school in London Colney, a parents and toddlers group in Hatfield, various workforces in Hatfield, Polish patients admitted to Watford General Hospital (WGH), and young Polish workers in Watford.

3) Obtaining information from the West Hertfordshire Hospitals NHS Trust (WHHT) interpreter-booking department regarding the frequency with which Polish interpreters were booked and which specific clinics or departments they were booked for.
4) Using literature databases as resources to ascertain what health ailments are common in Poland itself, so that that information could be extrapolated to what health ailments would be common in Polish people living in this country.

Results

Direct dialogue: From speaking to people in the Polish community, there were several recurring themes about the health needs of Polish people in this county.

Many Polish do not understand the UK model for delivering health services. In Poland, as with many other countries in Europe, patients go directly to see specialists. When someone wants to take their child to the doctor, they go to a paediatrician. If a female patient is having a baby, she goes to see an obstetrician. If an elderly patient were having palpitations, they would go and see a cardiologist. Part of the reason for this is that other countries do not have an integrated health service that delivers all medical, nursing, hospital and community services. Instead they have private insurance, which covers them to see a doctor of their choosing. This relative patient autonomy is in contrast to the UK, where patients need to be referred to specialists. There is also no coordinated system of patient notes in Poland, again in contrast to here where general practices and hospitals all have a system of patient notes, which can be referred to repeatedly.

Another factor compounding this is the simple fact that people from outside the UK simply don’t understand what a GP is, why you would have one, and why someone would go to a ‘general’ doctor rather than a specialist who has the expertise. Many people are not even registered with a GP.

Another thing that many Polish people do, as with many other migrant communities, is they go back to their home countries for medical tests and to see their doctor. There are two reasons for this. Firstly there is the issue of language barrier and trust. But secondly, and herein lies another difference between the UK model and the European model of healthcare, back in their home countries they can have investigations on an on-demand basis as these tests are paid for by the patient. It causes frustration for Polish people living in this country that they cannot get access to these tests. Mostly when they have these tests abroad, they also do not bring the results back to their doctor here.

Many of the Polish people who live in Hertfordshire live in urban areas. Part of the reason for this is that the urban areas have the greatest density of jobs. But another reason is that a lot of the Polish migrants do not have cars, and it is therefore advantageous to live in the urban areas as they have access to trains and major bus routes.

Talking to Polish people who live in urban areas yielded some further issues. The younger people who are single and living in this country are often quite
isolated and vulnerable. They often live in unregulated accommodation and regularly move from one to the next. Feelings of isolation can perhaps lead to mental illnesses such as depression. There are also high levels of recreational drug use among the younger urban dwellers. This can exacerbate mental issues itself.

Regarding the population itself, many people agreed that the majority of Polish people living in Hertfordshire (and the UK in general) are young single people aged 25-40, and young families with parents aged 25-40 and children in the toddler ages. This also reflects that Poland itself is a ‘young country’ with 40% of the country being <45, owing partly to the huge numbers of lives lost in the Second World War. Most Polish people who have come to the UK have come for work or to study.

Questionnaire: As previously stated, the questionnaire was disseminated to as many Polish as possible across Hertfordshire. By the time of completion >100 questionnaires had been collected. Statistically this represents a 1% representation if current estimates of a population of 10,000 are accurate.

The average age of people who filled out the questionnaires was 34, the mode age was 30 (10%), and 83% of people were between the ages of 25 and 40.

The average year of arrival in the UK of people who filled out the questionnaires was 2003, the modal year of arrival was 2006 (22%) and 90% of people had arrived from the year 2000 onwards.

14% of the people in the questionnaires had ongoing medical conditions. These included epilepsy, asthma, irritable bowel syndrome, hypothyroidism and gynaecological issues in the younger people, and hypertension and ischaemic heart disease in the older people. There were incidences of sexually transmitted diseases in the younger urban populations.

15% of people were on regular medications, most of which was the equivocal therapy for their ongoing condition, such as diuretics to treat hypertension and thyroid hormones to treat hypothyroidism. There were incidences of oral contraceptive pill.

7% of people had an ongoing psychiatric problem, including depression, schizophrenia and anorexia. These people were exclusively confined to the younger Watford population.

37% of people had a family history of ongoing medical conditions, the most common of which were hypertension, cardiovascular disease, oncological disease and asthma.

27% of people admitted to smoking. Most of these people were from the younger Hatfield and Watford populations.
12% of people admitted to drinking excessively and the majority of these were from the younger Watford population.

7% of people admitted to using recreational drugs, including cannabis, cocaine, ecstasy and magic mushrooms. All of these were from the younger Watford population.

67% of people regarded their diet as healthy, and 39% of people said they take regular exercise. 80% of people are registered to a GP, but only 29% of people are registered to a dentist. There were very high rates of employment, with 87% of people having jobs that varied from waiter, to chef, to teacher, to health care assistant.

47% of people admitted to having medical tests or seeing their doctor back in Poland. Some people returned for simple blood tests, some people had their dental care in Poland (which would tie in to only 29% of people having a dentist here), and in some extreme cases people returned to Poland to have their children even though they had a fixed abode in the UK. Of the people having healthcare in Poland, only 23% brought the results back for their GP here or informed their GP.

65% of people who filled the questionnaires had children, of whom about half had had them in this country. Of the children that were here, almost all were registered to a GP, had had their vaccines, and were in school if of school-going age.

Interpreter information: During the financial year of April 2009 to March 2010, there were 1191 bookings for interpreters at WHHT. The top ten languages interpreters were booked for were as follows:

1) Urdu 183
2) Portuguese 164
3) Polish 161
4) British Sign Language 111
5) Bengali 86
6) Mandarin 61
7) Punjabi 35
8) Turkish 35
9) Arabic 33
10) French 30
Polish was the third highest language requiring an interpreter in WHHT for that financial year, with 161 bookings. This represented 13.5% of all bookings. Further breakdown of the Polish bookings revealed the following:

1) Antenatal 95
2) Adult Outpatients 14
3) Delivery Suite 6
4) Day Surgery 5
5) Radiology 4
6) Children’s Outpatients 3
7) Eye Clinic 3
8) Haematology Clinic 3
9) Postnatal 2
10) Special Care Baby Unit 2

It can be seen here that of the 161 bookings, 108 were for obstetric/paediatric purposes. This represents 67% of all bookings.

Literature search: Searching published literature using the Pub Med resource did not yield a huge amount, but the World Health Organisation (WHO) did have published data relating to causes of death in Poland.

According to the WHO the population of Poland in 2005 was 39 million. The average life expectancy for men was 71 and for women 79. Child (<5) mortality was 8 per 1000 live births. The top causes of death in 2002 were as follows:

1) Ischaemic heart disease (22% of the 351,000 deaths)
2) Cerebrovascular disease (12%)
3) Respiratory tract tumours (7%)
4) Gastrointestinal tumours (5%)
5) Lower respiratory tract infections (2%) (7) (8)
Discussion of Results

An attempt was made to find as broad a range of information as possible for this project. Ideally, published data would have been combined with information obtained from direct dialogue, questionnaires and hospital data in order to make accurate observations about the Polish community in Hertfordshire. As the Polish community in the UK is relatively new however, there is no published as yet as to what their differing health needs are. This left the other more direct methods of obtaining information.

In terms of speaking directly with leaders in the community, while this gives us no quantitative information such as whether the incidence of cardiovascular disease is higher in Polish immigrants than in UK-born people, it gives very valuable qualitative information. Migrants tend to form tight-knit groups and societies and they tend to have shared ideas and beliefs, especially regarding their new country. It was useful to hear from many Polish people that they do not understand the UK model of delivering healthcare, and to hear it echoed from several different groups. Information like this, while only qualitative, can help form an idea of what a particular community may need.

Questionnaires are a good way of obtaining information from people, and again the information is direct. The one weakness of questionnaires is that they rely on people being honest. The sorts of things that people may not be fully honest about are typically the amount they drink, but also matters such as whether they take recreational drugs. As the forms are anonymous hopefully this potential would be reduced to a minimum. The number of people who filled out the form represents a 1% proportion of the Polish community. If the questionnaires were the only way information was being obtained, it is clear that this would not be an adequate sample of the population, and a number like 10% would be an ideal minimum. However as it was going to be used in combination with other information, and the forms were not very easy to disseminate, the number of 100 questionnaires was deemed acceptable. In addition to the actual number, it is important when asking people to fill out questionnaires that attempts are made to choose a broad cross-section of the population. Ideally it would be a randomised section of the population. However as the forms needed to be disseminated physically this was not possible. The next best thing was to try and make sure different people of different ages and from different groups filled them out. In as much as this, a church group, Saturday school group, workers groups, and patients at WGH represented a good mix.

The information regarding interpreter bookings and what they were booked was extremely useful and quantitative. It was especially useful as it supported all the anecdotal evidence from direct dialogue and all the information from the questionnaires, which was that the community is mostly young families with young children.
The information about what ailments in Poland are common is also very useful. There is a lot of evidence to suggest that when people migrate from one country to another, they retain the disease incidences of their home countries. Once those migrants have children in the country to which they have migrated, the children then tend to have the same disease incidence of the country in which they were born. Exceptions to this would include diseases with a particularly strong genetic prevalence in a particular country or race, be they single-gene or polygene diseases. In this scenario, all people descended from a particular immigrant group would continue to have those diseases prevalences that were in their ancestral countries.

Services

The NHS is the co-ordinating body for the delivery of all health services in the UK. Currently, those who are entitled to NHS care free at the point of delivery are those who are deemed to be ordinarily resident in the UK. The DoH defines this as 'a common law concept interpreted by the House of Lords in 1982 as someone who is living lawfully in the United Kingdom voluntarily and for settled purposes as part of the regular order of their life for the time being, with an identifiable purpose for their residence here which has a sufficient degree of continuity to be properly described as settled'. (9)

By this definition it is clear that all Polish migrants in Hertfordshire are entitled to NHS care.

All services in Hertfordshire are commissioned and co-ordinated by the Primary Care Trust (PCT), NHS Hertfordshire, which in turn is presided over by the East of England Strategic Health Authority (SHA).

Hertfordshire currently has 144 GP practices, which are distributed across the county (10). Access to these is ready and everyone who is a resident in the UK has the right to sign up to their local practice.

There are 2 acute hospital trusts in Hertfordshire, the West Hertfordshire Hospitals Trust (WHHT) and the East&North Hertfordshire Hospitals Trust (ENHT). These trusts have 7 hospitals between them (Watford General Hospital, Hemel Hempstead General Hospital, St Albans City Hospital, Hertford County Hospital, Mount Vernon Cancer Centre, QEII Hospital and Lister Hospital). These two trusts deliver all A&E, acute care, and inpatient and outpatient care across the county. Further information regarding which services are best for patients’ needs can be found on the websites of the trusts. (11) (12)

Hertfordshire is served by the East of England Ambulance Trust, which takes patients to either of the acute trusts. Hertfordshire Partnership NHS Foundation Trust (HPFT) provides all NHS mental health and specialist learning disability services in Hertfordshire. Access to mental health services can be obtained via all GPs in Hertfordshire. (13) (14)
Hertfordshire County Council has a group entitled Herts Migration Group who meet regularly and discuss the needs of local migrant communities. There is also a regional group under the East of England Regional Assembly, entitled Strategic Migration Partnership in the East of England, which has a similar role. The considerations in this report will partly inform this year’s JSNA.

There are also several publications which are read by migrants living in the UK. ‘The Migrant at Home’ is a monthly magazine printed in Polish and English and distributed across the UK. Contacts in the Polish community have suggested that this would be a good avenue for dissemination of information that was aimed at the migrants at his has high circulation rates and is well respected in the community. There is also a ‘Migrant Workers Information Pack’ that Watford Borough Council circulates that gives valuable information about work, housing, health and transport. This could also be used in future to give education about UK healthcare and how it is delivered, in particular the ways in which it differs from the European model.

Conclusions

There are approximately 10,000 Polish migrants living in Hertfordshire. Most of these people are young single men and women aged 25-40, and young families with parents aged 25-40 and children under 10. The majority of these migrants have come since the year 2000.

There are high levels of employment among the population, who mostly live in the larger towns such as Watford, St Albans, Hatfield and Stevenage, as these areas have the greater accumulation of jobs and have good travel connections with buses and trains.

The major health needs currently in the population are obstetric and paediatric, based on information obtained directly and from interpreter-bookings. The majority of people have a GP but most don’t have a dentist. Health needs likely to emerge as the population ages are hypertension, ischaemic heart disease and oncological disease (particularly respiratory and gastrointestinal), based on family histories of migrants and mortality data for Poland obtained from the WHO.

In the younger urban population, particularly young single men, there are much higher rates of smoking, excessive drinking and mental illness. This is notable in Watford where there is also no longer a Polish association and perhaps the individuals are more isolated and lack social support.

The majority of migrants are used to the European model of delivering healthcare, where there is insurance-based healthcare and patients can have investigations and see specialists on demand. Greater efforts need to be made to educate migrant populations about the UK model of healthcare. Better understanding of the way service is provided, investigations are
organised and what a GP is, are essential in building up trust between migrants and healthcare bodies.

Migrants need to be encouraged to inform their GP of any tests they have in their home country and ideally to bring results back with them, to reduce the possibility of incorrect decisions being made in their care as a result of GPs not having important information regarding their health.

All migrants are entitled to free care under the NHS. Hertfordshire has 144 GP practices, 2 acute trusts with 7 hospitals between them, and is served by the East of England ambulance trust. There is one mental health trust for the whole county. There are migration partnership groups at county and regional level, and both aim to identify and serve the needs of migrants.

Information can be disseminated to the migrant populations via leaflets in GP practices. It can also be disseminated via websites such as the St Albans Polish Association, and magazines such as ‘The Migrant at Home’ and the ‘Migrant Workers Information Pack’.

A project like this can have many positive effects. Aside from the obvious benefit of knowing what the health needs of a particular community are, conducting such a project engages local authorities and services with the community. All the Polish people who knew about and helped with this project were extremely happy at its undertaking, and felt very touched that the NHS was doing something specifically aimed at them and to try and help them.

From speaking to Polish people about what the NHS is what it offers, and how it differs from their healthcare system, another thing became apparent. A lot of the people were mostly fixated on what the NHS didn’t offer and what it didn’t provide. This is actually a failing of the NHS itself. A lot of what doctors and managers and all other positions of people in the NHS tend to do is talk about which things are not available, such as which cancer drugs are not commissioned, or which therapeutic treatments are not available in your local area. In actual fact, the NHS offers one of the most fantastic and comprehensive services in the entire world, and all free at the point of care, which is also a unique privilege we have in this country. If a list was made of all the things the NHS does offer and provide, people would begin to see what an incredible service it is.

The limitations of this project were mainly the time available. Had there been more time, perhaps more community groups could have been attended, and more questionnaires could have been handed out. An attempt could have been made to get interpreter booking information from the ENHT, although this would have likely been very similar to that obtained from the WHHT. An attempt was made to speak with interpreters themselves, be it individually or in groups. However finding times when they available was difficult, and the matter of payment for those services was quite prominent for many of them. There was no funding for such payment however so a meeting never took place. An attempt was also made to talk to a prominent Polish GP in St
Albans who saw many of the Polish patients from around that area, but at the time of the project he was unavailable.

In time, once the population being studied have been here for longer, perhaps more data will be published regarding their differing health needs and disease prevalences.

Philip Coakley – FY2.
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Appendix: Health Needs Questionnaire

Questionnaire – Assessing the Health Needs of the Polish Community
(Kwestionariusz dotyczący Ocen Potrzeb Zdrowotnych Polskiej Spółeczności)

How old are you?
(Ile masz lat?)

Are you male or female?
(Plec?)

What year did you come to the UK?
(W którym roku przyjechales/las do Anglii?)

Do you have any medical condition?
   If yes, please say which ones
(Czy chorujesz na jakie choroby?
   Jesli tak, napisz jakie?)

Do you take any tablets/medication?
   If yes, please say which ones
(Czy bierzesz bierzesz jakie leki?
   Jesli tak, jakie?)

Do you, or anyone in your family have mental illness like depression or schizophrenia?
(Czy Ty lub ktos w Twojej rodzinie choruje na chorobe psychiczna jak depresja czy schizofrenia?)

Do you mother or father have any illnesses?
Or anyone else in your family? What are they?
(Czy Twoi rodzice choruje na jakie choroby?
Lub ktos inny w rodzinie? Jesli tak to jakie sa to choroby?)

Do you smoke?
   If yes, please say how many and for how long
(Czy palisz?
   Jesli tak, to jak dlugo i ile papierosow dziennie?)

Do you drink alcohol?
   If yes, please say how much in a week
(Czy pijesz alcohol?
   Jesli tak, ile drinkow w tygodniu?)

Do you take recreational drugs?
   If yes, please say which ones
(Czy uzywasz narkotyki?
   Jesli tak, jakie?)
Do you have a healthy diet?
(Czy zdrowo się odżywiasz?)

Do you take regular exercise?
(Czy regularnie cwiczysz?)

Do you have a GP?
(Czy masz lekarza GP w Anglii?)

Do you have a dentist?
(Czy masz dentystę w Anglii?)

What is your job?
(Jaki masz zawód?)

Do you ever see your doctor or have medical tests in Poland?
If yes, do you bring the results back to your doctor here?
(Czy nadal chodzisz na wizyty do lekarza, lub robisz testy medyczne w Polsce? Jesli tak, czy przywozisz swoje wyniki badan dla lekarza w Anglii?)

Do you have children? How many?
(Czy masz dzieci? Ile?)

If yes, (Jesli tak,)

Were they born here?
(Czy urodziły sie w Anglii?)

Do they have a GP here?
(Czy sa zarejestrowane u lekarza GP W Anglii?)

Have they had all their vaccines?
(Czy Twoje dzieci miały wszystkie potrzebne szczepienia?)

Are they in school? How old are they?
(Czy chodza do szkoły? W jakim sa wieku?)