

ppre Limited

Department of Health

Refugee Health Professional Steering Group

Writing up the work of the Group

Summary Report

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1. Background

The Department of Health (DH) established the Refugee Health Professionals (RHPs) Steering Group in 2001. The Steering Group disbursed £2m that enabled some projects to use DH funds up until March 2007 although DH funding ran out for most a year earlier. It also endeavoured to influence policy and have a lasting impact on practice. Limitations on the availability of data and resources meant that a full evaluation of the programme was not possible but using an evaluation model a review of the programme has been carried out.

This report summarises the main findings of the evaluation undertaken by ppre Limited. The full evaluation report can be obtained from ppre@onetel.com.

2. The context

When the programme began little was known at national level about how many refugee health professionals there were, what the best mechanisms were for using their skills are and whether employers would want to employ them. Supply and demand for these particular health professionals are fuelled by wider forces and drivers:

- The numbers of health professionals coming to the UK and being granted refugee status
- Overall policy and practice on refugee integration including for example Dispersal
- NHS workforce planning including changes to the methods and numbers of people recruited and trained
- How health professions are regulated
- Issues about how to ensure the best patient care is accessible to all sections of the community
- The availability of funds within the NHS and outside

These factors created a highly dynamic set of circumstances for the programme. The programme and the projects often had to influence and adapt to changes.

3. The Structure of the programme

The Steering Group, chaired by Dame Lesley Southgate, included people chosen for their knowledge and influence in the areas of concern. They planned to operate both as a strategic body influencing policy and practice and to oversee the identification, selection and performance of funded projects. With limited input from DH officials this meant that (some) Steering Group members were directly involved in encouraging bids for funds,

assessing them, visiting the projects when underway and in events either organised as part of the programme or arising from it. With more than 50 projects across England covering doctors, nurses, dentists and allied health professions these were demanding roles – for which Steering Group members were not paid.

4. Mechanisms

The model of evaluation used for this review focuses on how activities impact on outcomes rather than simply describing the activities.

4.1 Influencing policy

The Steering Group members held events to draw together the experience of the projects. Key stakeholders (such as regulators, professional, training bodies, employers and funders) were invited. Attendance was not always as full or at a level that is necessary to influence policy. Follow-up of issues raised was also patchy or not evident. Engaging regulatory bodies and other central government departments was particularly difficult.

Members of the Steering Group often had more informal opportunities, through other roles, to raise issues. In the nature of things, these are more difficult to track.

4.2 Encouraging initiatives and good practice

The availability of funds was clearly in itself an incentive to undertake projects. This was most evident in

- Extending activity outside London
- Professions beyond doctors
- Collaboration between sectors e.g. Education bodies and the voluntary sector working with professional bodies and Strategic Health Authorities.

4.3 Developing health professionals

The programme supported projects in developing a number of different strategies to help RHPs into jobs or at least be ready for clinical jobs:

1. Directions, signposting, pathways and opening gates

Projects provided information and advice to RHPs. At the beginning of the programme information and advice was often far from comprehensive, reliable and useful. RHPs experienced major difficulties accessing regulatory and professional bodies and even such basic resources as libraries in order to read professional books and journals.

2. Professional and communications competences

All the health professions require (in one way or another) demonstrations of professional competence in the UK context and ability to communicate with

colleagues and patients (often specifically the IELTS test). This is generally done through classroom learning, workplace observation and experience that may or may not be formally assessed or tested. The methods used ranged from the didactic through peer learning to self-directed learning and private study.

3. Increasing confidence & managing expectations

From evaluations of specific schemes, it is clear that RHPs, colleagues and service providers also attach great importance to (restoring) an appropriate degree of self-confidence. For many RHPs while they recognise they may need to learn or refresh specific professional or communications skills they also feel demoralised and deskilled and under-valued. It is also clear that many health professionals need to consider alternative or interim careers. Mentors, advisers and peers all play an important role in addressing these issues.

5. Outcomes

There were problems in collating comprehensive up-to-date and robust data about what was achieved. Like all such programmes there are also issues in attribution – what happened for other reasons, what would have happened anyway? Nevertheless some relevant outcomes can be discerned.

5.1 In jobs and job-ready

The final year of DH funding for most projects coincided with intense financial pressures for some trusts resulting in freezes on recruitment and shedding of agency posts for example. There were also major changes in the way that junior doctors specifically are recruited to posts including more or less total exclusion of overseas-qualified doctors. Although this did not apply to refugee doctors this was not always understood. Despite this challenging environment the programme had some success.

For London there was a data collation exercise going on in parallel with the DH programme that meant that more robust data is available for doctors than for other professions and areas. In London a total of 347 doctors, 21 nurses, 11, dentists and two allied health professionals are recorded as being in NHS jobs. Overall this represents about one in five of the participants in the projects. However this is likely to be an underestimate, particularly for professions other than doctors. The data shows doctor participants being twice as likely as nurses to get a job which is counter-intuitive. Even so these figures give an average cost of getting an RHP into an NHS job of £2,625. Based on costings of individual programmes the cost of getting a refugee doctor into a job is between £2.5k and £17k depending on what route is followed (the latter is for when a doctor re-qualifies rather achieves recognition of an existing qualification). This compares to £250,000 for training a doctor from scratch. The costs of getting a refugee nurse into a job have been estimated as £2,000. This compares to £36,000 for training a nurse from scratch.

Outside London the tracking information is less satisfactory. The following estimates for selected regions are based on work carried out for NHS Employers.

Table 1: Estimates of refugee doctors in work

| | Passed PLAB | In Jobs | Total | Methods and source |
|---------------|-------------|---------|-------|---|
| West Midlands | 22 | 10 | 103 | Based on West Midlands project + 10% estimated undercounting. |
| North East | 10 | 52 | 88 | Based on North East RHP project +10% estimated undercounting. |
| North West | 13 | 75 | 132 | Based on Reache + 10% estimated undercounting. |

5.2 Long-term provision

In London 14 out of the 21 projects that were funded were still in existence a year after the DH funding officially ended. The continued existence of two of these is in particular doubt. In the South West and South Central for example only mentoring and English language classes have endured – and the latter are under threat from changes to ESOL rules. On the other hand for example the North West Dental Deanery has picked up funding for the R2D2 programme formerly getting all of its funding from the DH.

5.3 Additionality and Infrastructure

For some of the projects it was not the amount of DH funding that was significant but the way it could be used

- To attract or maintain the interest of regional and local funders
- To encourage collaboration and networking to share good practice and information and promote policy change

As the experience with the Building Bridges initiatives below illustrates this function remains significant and is missed.

5.4 A model for refugee integration

The Building Bridges initiative has clearly learned a number of lessons and drawn on the work of the DH programme. In particular Building Bridges started from the view that professional bodies and employers needed to be more closely involved. As an initiative with primary funding sought from the Home Office it is also clearly seeking to address some of the issues identified here about collaboration within central government

5.5 Policy changes

Influence on policy is hard to measure for a number of reasons. The Steering Group sought to influence the Department of Health. Ministers (even the

Prime Minister) received briefings on refugee health professionals and spoke at conferences on the subject. The programme's life was prolonged beyond that initially envisaged. A senior civil servant attended the final celebratory event. These facts suggest that at the very least the Steering Group was well-connected and well-regarded. During the programme there was little evidence of impact on other government departments such as the Home Office and Department for Work and Pensions. On the other hand the ARRIVE programme is a Home Office initiative.

Influence on the regulatory and professional bodies is a mixed picture. The RHP programme had partly come about because of the interest of the BMA and it and the GMC played an active part in discussions initiated by the Steering Group. Members of the Steering Group felt that they had productive discussions with the Nursing and Midwifery Council (and the RCN) but that discussions with the Dental and Allied Health Professions regulators and professional bodies had been not occurred or been less fruitful.

5.6 Learning what doesn't work

Across the programme there are examples of learning what does not work. One project realised that the intended provision of language and communications training for a group of nurses was unnecessary. Another project found that parts of its curriculum were irrelevant to participants.

6. Difficulties faced by the programme and projects

6.1 Critical Mass and cross-boundary working

Recruitment and providing a sufficiently comprehensive range of provision were problems for smaller and more isolated projects. On the other hand projects that operated over wider areas had difficulties with different boundaries of various stakeholders and inevitably local stakeholders wanted to see local results.

6.2 Sustainability

The DH funding was partly intended to pump-prime. However changes in NHS structures and funding (as well as short-term financial pressures meant that as the programme came to an end mainstream NHS funding was not available. The agencies that had been responsible for overseeing the programme (usually Workforce Development Directorates in the old (smaller) Strategic Health Authorities) were generally being abolished. Successor bodies knew little about the programme and either felt it was not their responsibility to fund such projects or that they did not have (confirmed) budgets to do so.

Although some these were potentially short-term issues, individual staff faced with uncertainty or no funding have inevitably left. This may mean that expertise is diluted or lost. The development of the ARRIVE and regional Building Bridges projects seems to indicate that in some cases the expertise

is not lost altogether.

6.3 Links with Employers

While the programme often forged good relationships at the regional level with SHAs and Deaneries, links with local trusts were less consistent. This meant, for example, that obtaining sufficient numbers of appropriate work experience/observation opportunities was often a problem. With the leadership now being given to this area of work by *NHS Employers* this problem may diminish.

6.4 Developing alternative and interim careers

A number of projects tried to develop pathways into other occupations either to provide temporary opportunities for refugees, or to provide work experience in the UK that might be relevant or provide contacts or might be a long-term alternative careers. Such roles included Phlebotomists, Physician's Assistants and Dental Hygienists. In some cases they seem to have been a dead-end and in others, it proved impossible to find an affordable route into another career.

Conclusions and Recommendations

1. **Background**

The Department of Health Refugee Health Professionals Steering Group programme operated at a time when the DH was clearly concerned about a number of issues

- Shortages of health professionals
- Refugee integration
- Addressing health inequalities

The context has changed. There is debate about whether and what 'affordable demand' there is going to be for health professionals and what the supply will be. There are immediate issues about how many training post for doctors there are and how they are filled. Corporate social responsibility, compliance with Equality Duties and reducing health inequalities may still be priorities but responsibility for achieving them is devolved from the DH to Strategic Health Authorities and trusts. They will increasingly need to be addressed by Practice Based Commissioning. The model of a central fund to promote initiatives of the kind supported by the Steering Group is not likely to be repeated in the near future.

Nevertheless there are important lessons to be learned from the experience of the Group and the programme and there are some measures required to ensure that the valuable work done is not wasted. In particular the *Building Bridges* initiative can learn much from what has happened.

2. **National Leadership, management and support**

The Steering Group sought to play a dual role of championing policy and practice change through liaising with key agencies and also selecting and overseeing projects. In practice few members of the Steering Group were able and willing actively to play both roles. Also the range of skills and knowledge useful to carry out the tasks could have been wider but only with a large and possibly unwieldy membership. A two- tier structure might therefore be more appropriate.

Recommendation 1

Building Bridges and proposed *ARRIVE project* should collaborate to develop a two tier structure

1. A *strategic advisory board* that would include government departments, the key professional, regulatory, funding and planning agencies and that would identify the key policy issues arising from and impacting on refugee health professionals.
2. An *operational board* responsible for funding, supporting and monitoring projects that are funded by any of the partners in the advisory board. The operational board members should be willing to undertake Audit Visits as

the DH Steering Group did.

Action: NHS Employers

There is clearly willingness by other national and regional funders to consider funding programmes for refugee health professionals. They will however be concerned that they are not replacing funding that the DH should be providing and/or do not think it is important. The DH also has an important role in advising on relevant structures and policies.

Recommendation 2

The DH should identify someone at a senior level who will be able to assure potential partners of a high level commitment to work with Refugee Health Professionals. The Department should also identify someone at a less senior level to liaise with partners on a regular basis.

Action: DH

3. *An infrastructure*

The team reviewing the work of the DH Steering Group were unable to get full information about what some funded projects did. In part this was because they had closed and there was no one there to provide the information. In part it was because there has been no common set of data that all projects have agreed to keep. There is now enough knowledge about what sort of information is useful to collect. There is also knowledge about the limitations of voluntary databases (those maintained by the BMA, RCN and BDA for example) that clearly underestimate the numbers of refugee health professionals and also their success in being job ready or in jobs.

Recommendation 3

The Operational board proposed above should draw up a list of items for a common data set. The bodies represented in the Strategic body should be asked to endorse it. Funding Bodies should require its use by service providers. Regulatory bodies should be asked to collaborate in sharing information.

Action: NHS Employers

One of the needs clearly highlighted by the Steering Group programme was for comprehensive, up-to-date, accurate, accessible information about issues affecting refugee health professionals. The ROSE website has the potential to do this for refugee health professionals and their advisers but the evaluation of the website has highlighted the importance of making it accessible outside and inside the NHS. It also needs to include alternative or interim careers.

Recommendation 4

The DH should fund the maintenance of the ROSE website under an arrangement that ensures that it reaches both inside the NHS and outside. NHS Employers might be asked to collaborate with a national voluntary organisation to achieve this.

Action: DH

At the moment there are a number of more or less regular meetings of service providers, professional bodies, refugee organisations such as the BMA Liaison Group, The Silver Lining Conferences and the Building Bridges group. Some organisations are asked to be part of all of them and other organisations are not part of any of them. A more systematic network is required. There is duplication, lost opportunities for working on common problems and gaps.

Recommendation 5

A single multi-professional Liaison Group should be established. Within it there might be profession-specific interest groups or task groups on particular issues such as assessing and developing communication skills.

Action: BMA, Employability Forum

4. The shape of programmes

The Steering Group programme funded 51 projects. Some can clearly be demonstrated to have worked well. With others either it is not clear or they did not work well. While there is no single model that can be said to be effective in all contexts some observations can be made. There were some places or professions where there were fewer refugee health professionals who needed and were able to access projects. Trying to run projects in each of the nine English Regions for example is probably unnecessary and undesirable. It would be more cost-effective to run programmes in a smaller number of regions but to pay for additional costs of travel, childcare, virtual access and overnight accommodation for people further away. Local and regional funders would have to be prepared to contribute to projects that might not be within their area.

Recommendation 6

Fewer, larger projects should be supported while ensuring access for people who do not live near them.

Action: Building Bridges, ARRIVE, Strategic Health Authorities

We also have a good idea now of all the stages (not all needed by every individual) on the road to recognition and jobs. Some of them are most

effectively done by organisations run by or for refugees; others require a strong input from clinicians or educators. The whole process requires a partnership of different agencies and sectors. Often individual projects will benefit from a consortium approach but this is not always required. However it is essential that any project has links with the organisations 'up and 'down' stream i.e.

- Orientation and introduction services
- Initial awareness of requirements for professional recognition
- Financial assistance
- General support on integration issues
- Development and assessment of Language and Communication skills
- Up-to-date and relevant professional knowledge, skills and attitudes
- Understanding of operation of NHS and partner agencies
- Peer support
- Clinical observation/experience
- Careers advice and mentoring
- Alternative and interim careers preparation
- Recruitment, selection and interviewing preparation for clinical jobs

Recommendation 7

Projects being considered for funding should be assessed for their ability to deliver on specific stages of the path to jobs and for their links to organisations providing complementary support.

Action: Funders