

Primary Care Services

Caring for Vulnerable Patients Policy Version 1.0

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1. Executive summary

Practices have a contractual duty to provide emergency and immediately necessary treatment. This is free of charge for everyone. They cannot refuse to register someone because of any 'protected characteristic' under the Equality Act 2010, other grounds such as social class, appearance or medical condition (NHS constitution), and should register patients without requiring any documentation. Practices should fulfil the fundamental standards of patient equality:

- Regulation 10 – treating people with dignity and respect
- Regulation 13 – protecting people from abuse and improper treatment.

Practices should be aware of additional responsibilities regarding the registration of anyone considered vulnerable including, but not limited to, the following patient diagnoses or situations:

- Learning Disability
- Dementia
- Asylum Seekers
- Failed asylum seekers/undocumented people
- Refugees
- Sex workers
- Trafficked people
- Domestic abuse victims
- Victims of torture
- Ex-prisoners of war
- Homeless
- Veterans
- Ex-offenders
- Those released from immigration centres and secure facilities
- Looked after children
- Care leavers

2. Mental Health

Mental health includes our emotional, psychological, and social well-being. Mental health is linked to our physical health and our physical health is linked to our mental health. Mental health is influenced by our cultural, political and social contexts. Mental health affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood.

There is a higher prevalence of mental health needs in all vulnerable groups because of a range of factors including:

Discrimination
Adverse childhood experiences
Trauma
Poverty

Mental Health service users are likely to have long standing, complex multiple needs that require input from services across the traditional primary care, secondary care and third sector as well as geographical boundaries.

Key protective factors for good mental health and wellbeing are inclusion in multiple social groups, a sense of purpose, being valued and access to meaningful occupations, volunteering, education, activities and interests. Social prescribers, community navigators, befrienders, support services and local community groups including faith based or spiritual communities are invaluable.

Being up to date with local safeguarding, risk assessment and management processes and procedures is essential. As is discussing with the patient confidentiality and informed consent at the earliest opportunity and reviewing this in an ongoing manner.

IAPT Services

<https://newhamtalkingtherapies.nhs.uk/>

<https://towerhamletstalkingtherapies.nhs.uk/>

<https://www.iaptportal.co.uk/ch.html>

<https://bedfordshirewellbeingservice.nhs.uk/>

3. Veterans and Defence servicemen and women

After leaving the services, responsibility for the veteran's healthcare rests with the NHS. To ensure veterans are offered priority treatment, it is essential that staff understand how priority treatment is determined. Being a veteran does not automatically warrant priority treatment; understanding the criteria will ensure timely referrals and subsequent treatment for veterans. Prior service should be recorded on registration and allocated the correct read code. This should enable access to specialist or bespoke care or charity support as necessary for such patients and for the delivery of the armed forces covenant.

A veteran is defined as anyone who has served for at least one day in HM Armed Forces (Regular or Reserve) or Merchant Navy Seafarers and Fishermen who have served in a vessel at a time when it was operated to facilitate military operations by HM Armed Forces. All people leaving the armed forces are given a summary of their medical records, which they are advised to give to their new GP when they register. The practice will also normally be advised automatically of prior registration with Defence Medical Services (with a summary of their in-service care).

In accordance with the Armed Forces Covenant, 'Veterans receive their healthcare from the NHS, and should receive priority treatment where it relates to a condition which results from their service in the Armed Forces, subject to clinical need. Those injured in Service, whether physically or mentally, should be cared for in a way which reflects the nation's moral obligation to them whilst respecting the individual's wishes. For those with concerns about their mental health, where symptoms may not present for some time after leaving Service, they should be able to access services with health professionals who have an understanding of Armed Forces culture'.

The 2015 update of the NHS Constitution supports the Armed Forces Covenant by stating that 'the NHS will ensure that in line with the Armed Forces Covenant, those in the armed forces,

reservists, their families and veterans are not disadvantaged in accessing health services in the area they reside’.

The following are examples of conditions that may be attributable to service:

- Audiology – noise-induced hearing loss
- Mental health – PTSD, stress, anxiety
- Orthopaedic – trauma-related injuries

It can be difficult to establish if a condition is attributable to service as patients may not have been seen during their military career for the condition with which they are presenting and may only seek support many years after.

Referral process

Should a GP determine that priority treatment is appropriate, they are to ensure that:

- The patient’s veteran status is recorded in the referral (ensuring they obtain patient consent)
- They explain that the condition the referral is related to is linked to military service
- They select the appropriate referral priority when using e-RS
- They advise patients that the priority referral is based on clinical need and those with more urgent clinical needs will be given priority

Veterans’ Trauma Network

The Veterans’ Trauma Network, hosted by NHS England, provides specialist care for patients with service-related traumatic injuries and has ten major trauma centres across England.

The network acts as a hub with links to other services and charities and can be contacted at:

england.veteranstraumanetwork@nhs.net

The umbrella charity for this network is BLESMA (The Limbless Veterans) who also can be contacted for advice on 0208 5847080 or by email at: bsoprosthetics@blesma.org

Veterans with physical injuries or mental illness attributed to service life are eligible for priority treatment. Ensuring that veterans are offered priority treatment will undoubtedly benefit the patient as they will be seen sooner and will be able to begin the recovery process in a timely manner. For further information on armed forces healthcare, veterans and their access to NHS care, see the following: www.nhs.uk/using-the-nhs/military-healthcare/priority-nhs-treatment-for-veterans/

4. Dementia

Dementia is a syndrome (a group of related symptoms) associated with an ongoing decline of brain functioning. Dementia is a growing challenge and the number of people with dementia in the UK is estimated to be 850,000. It is therefore imperative that staff fully understand the care pathway for dementia to ensure that dementia sufferers receive an optimal level of care at all times.

Dementia has been identified as a key priority for NHS England and the Government; this is reflected in the [Challenge on Dementia 2020](#) which outlines the following targets to be achieved by 2020:

- To be the best country in the world for dementia care and support for individuals with dementia, the carers and families to live; and
- To be the best place in the world to undertake research into dementia and other neurodegenerative diseases

As part of the challenge, key aspirations include:

- Equal access to diagnosis for everyone
- GPs playing a leading role in ensuring coordination and continuity of care for people with dementia
- Every person diagnosed with dementia having meaningful care following their diagnosis
- All NHS staff to have received training on dementia appropriate to their role

Alzheimer's Society






A UK-based charity that provides information and support to those suffering from dementia, including their families and carers. <https://www.alzheimers.org.uk/>

Dementia UK

Dementia UK provides specialist dementia support for families through their Admiral Nurse service. <https://www.dementiauk.org/>

The Well Pathway for Dementia illustrates the appropriate care pathway for patients, including reducing the risk and end of life care, ensuring that patients with dementia die with dignity. The pathway is shown below:

NHS ENGLAND TRANSFORMATION FRAMEWORK – THE WELL PATHWAY FOR DEMENTIA

PREVENTING WELL	DIAGNOSING WELL	SUPPORTING WELL	LIVING WELL	DYING WELL
 Risk of people developing dementia is minimised	 Timely accurate diagnosis, care plan, and review within first year	 Access to safe high quality health & social care for people with dementia and carers	 People with dementia can live normally in safe and accepting communities	 People living with dementia die with dignity in the place of their choosing
"I was given information about reducing my personal risk of getting dementia"	"I was diagnosed in a timely way" "I am able to make decisions and know what to do to help myself and who else can help"	"I am treated with dignity & respect" "I get treatment and support, which are best for my dementia and my life"	"I know that those around me and looking after me are supported" "I feel included as part of society"	"I am confident my end of life wishes will be respected" "I can expect a good death"
STANDARDS:	STANDARDS:	STANDARDS:	STANDARDS:	STANDARDS:
Prevention ⁽¹⁾ Risk Reduction ⁽²⁾ Health Information ⁽⁴⁾ Supporting research ⁽²⁾	Diagnosis ⁽¹⁾⁽²⁾ Memory Assessment ⁽¹⁾⁽²⁾ Concerns Discussed ⁽²⁾ Investigation ⁽⁴⁾ Provide Information ⁽⁴⁾ Integrated & Advanced Care Planning ⁽¹⁾⁽²⁾⁽³⁾⁽⁵⁾	Choice ⁽²⁾⁽³⁾⁽⁴⁾ , BPSD ⁽³⁾⁽²⁾ Liaison ⁽²⁾ , Advocates ⁽²⁾ Housing ⁽²⁾ Hospital Treatments ⁽⁴⁾ Technology ⁽²⁾ Health & Social Services ⁽²⁾ Hard to Reach Groups ⁽²⁾⁽³⁾	Integrated Services ⁽¹⁾⁽²⁾⁽³⁾ Supporting Carers ⁽²⁾⁽⁴⁾⁽⁵⁾ Carers Respite ⁽²⁾ Co-ordinated Care ⁽¹⁾⁽³⁾ Promote independence ⁽¹⁾⁽⁴⁾ Relationships ⁽²⁾ , Leisure ⁽²⁾ Safe Communities ⁽²⁾⁽³⁾	Palliative care and pain ⁽¹⁾⁽²⁾ End of Life ⁽⁴⁾ Preferred Place of Death ⁽²⁾
References: (1) NICE Guideline. (2) NICE Quality Standard 2010. (3) NICE Quality Standard 2013. (4) NICE Pathway. (5) Organisation for Economic Co-operation and Development (OECD) Dementia Pathway. (6) BPSD – Behavioural and Psychological Symptoms of dementia				
RESEARCHING WELL				
<ul style="list-style-type: none"> Research and innovation through patient and carer involvement, monitoring best-practice and using new technologies to influence change. Building a co-ordinated research strategy, utilising Academic & Health Science Networks, the research and pharmaceutical industries. 				
INTEGRATING WELL				
<ul style="list-style-type: none"> Work with Association of Directors of Adult Social Services, Local Government Association, Alzheimer's Society, Department of Health and Public Health England on co-commissioning strategies to provide an integrated service ensuring a seamless and integrated approach to the provision of care. 				
COMMISSIONING WELL				
<ul style="list-style-type: none"> Develop person-centred commissioning guidance based on NICE guidelines, standards, and outcomes based evidence and best-practice. Agree minimum standard service specifications for agreed interventions, set business plans, mandate and map and allocate resources. 				
TRAINING WELL				
<ul style="list-style-type: none"> Develop a training programme for all staff that work with people with dementia, whether in hospital, General Practice, care home or in the community. Develop training and awareness across communities and the wider public using Dementia Friends, Dementia Friendly Hospitals/Communities/Homes. 				
MONITORING WELL				
<ul style="list-style-type: none"> Develop metrics to set & achieve a national standard for Dementia services, identifying data sources and set 'profiled' ambitions for each. Use the Intensive Support Team to provide 'deep-dive' support and assistance for Commissioners to reduce variance and improve transformation. 				

Promoting a healthy lifestyle is the recommended approach to reduce the risk of, or delay the onset of, disability, dementia and frailty by helping people to:

- Stop smoking
- Be more active
- Reduce alcohol consumption
- Improve diets
- Lose weight and maintain a healthy weight if necessary

[One You](#) has been introduced by Public Health England (PHE) to help individuals become healthier and to reduce the risk of dementia. Initial assessment should be undertaken in accordance with NICE guideline NG97, which also includes guidance regarding management and support for people living with dementia and their carers.

In addition to the NICE guidance, clinicians can also use the [Dementia diagnosis and management guidance](#) issued by the NHS.

Pharmacological intervention

Recommended medication can be found at paragraph 11.5.2 of NG97.

Involving the patient's family members

Recommendations within the guideline state that the clinician should:

- Arrange an initial assessment of the person's needs, which should be face-to-face if possible
- Provide information about available services and how to access them
- Involve the person's family members or carers (as appropriate) in support and decision-making
- Give special consideration to the views of people who do not have capacity to make decisions about their care, in line with the principles of the Mental Capacity Act 2005
- Ensure that people are aware of their rights to, and the availability of, local advocacy services and, if appropriate to the immediate situation, an independent mental capacity advocate
- Develop a care and support plan

Care planning

Effective care planning is essential; each care plan must be bespoke and meet the needs of each patient with dementia. Practices should use the Dementia: Good Care Planning guide, the aim of which is to enhance the provision of care offered by GPs, incorporating a standardised approach to dementia care planning.

The [Dementia Roadmap](#) is a resource that has been produced to support primary care staff in diagnosing, supporting and signposting people with dementia. It provides high-quality information about the dementia journey alongside local information about services, support groups and care pathways to assist primary care staff to more effectively support people with dementia and cognitive impairment, their families and carers.

5. Sex Workers

Sex workers are an under-served group and a high-risk population. They are at risk due to an increased prevalence of intravenous drug use and poorer engagement with health care. Sex workers have specific health needs relating to their lifestyle and occupation, as they are more likely to use drugs, have a less stable home environment, and experience occupational violence. Sex workers often have chaotic lifestyles and complex socioeconomic backgrounds, factors that may have initially led them into prostitution. Sex workers commonly experience social exclusion and stigma related to their occupation, and belonging to a marginalised group subject to socioeconomic disadvantages is in itself detrimental to health

Sex workers suffer physical, as well as psychosocial, comorbidities and can have poor knowledge of their physical conditions and how to optimally manage them. Their chaotic lifestyle, and limited perceptions of the seriousness of their health problems, can result in help-seeking at a time of crisis and often resorting to the use of unscheduled care. Access to primary care is described as difficult due to barriers in the system (the need for an address, the telephone system) and in personal interactions with GPs. The 10-minute consultation may not allow for the discussion of

multiple problems and they may perceive judgement by the GP or fear the disclosure of their occupation.

The concealed nature of the industry makes commissioning specific services for this patient group challenging, and sex workers may not wish to access a service that would mean disclosure of the nature of their work. However, being able to access a specific service might improve access to care, enabling sex workers to avoid disclosure to all but a specialist team of practitioners.

Much of the work that GPs can do to make a difference in reducing health inequalities needs to be taken forward in collaboration with, or signposting to, other professionals. This should include the third sector (or so-called 'voluntary services'), which plays a key role in supporting people in groups from under-served populations.

Hestia Newham – Domestic & Sexual Violence

<https://www.hestia.org/newham>

0808 196 1482

Open Doors City & Hackney

<https://www.opendoors.nhs.uk/>

07852 918 404

Beyond the Street Tower Hamlets

<https://beyondthestreets.org.uk/>

0800 133 7870

Azalea Luton

<https://www.azalea.org.uk/home>

01582 733200

iCaSH

<https://www.icash.nhs.uk/>

0300 300 3030

Luton Sexual Health

<https://www.lutonsexualhealth.org.uk/>

01582 497070

6. Looked after children/ young people and care leavers

Looked after children/young people and care leavers share many of the same health risks and problems as their peers but often to a greater degree. Children/young people enter the care system with a worse level of health than their peers due to the impact of poverty, poor parenting, chaotic lifestyles and abuse or neglect. Longer-term outcomes for looked after children/ young people and care leavers remain worse than their peers. They are less likely to engage with universal health services such as GP's, dentists and sexual health advisors and are likely to have missed health promotion and prevention opportunities.

GP practices have a vital role in the identification of the health needs of children and young people who are looked after or leaving care. The practice should:

- Act as advocates for the health of each looked after child or young person and care leaver
- Make sure there is timely, sensitive access to a general practitioner or other appropriate health professional when a looked after child/young person or care leaver requires a consultation
- Make sure referrals made to specialist services are timely, taking into account the needs and high mobility of many looked after children/young people and care leavers
- Provide, when needed, summaries of the health history of a looked after child/young person or care leaver, including their family history where relevant and appropriate, and ensure this information is passed promptly to health professionals.
- Maintain a record of the health assessment and contribute to any necessary action within the health plan
- Make sure that the clinical records make the 'looked after' or 'care leaver' status of the child/young person clear so that their particular needs can be acknowledged
- Make sure the general practitioner-held clinical record is maintained and updated. This is a unique health record and can integrate all known information about health and health events during the life of any child/young person, enabling GP's, dentists, nurses and others in primary care to have an overview of health priorities and to know whether health care decisions have been planned and implemented
- Accept the child/ young person as a registered patient of the practice and seek the urgent transfer of the medical records from the previous practice
- Contact the child/young person's allocated social worker or allocated health practitioner when a concern arises

Maintaining confidentiality, information sharing and consent for a looked after child/young person
These are three key issues which arise in the provision of effective health care to looked after children/young people.

Disclosure is allowed where:

- The child/young person has given you their consent to share the information (or a person with parental responsibility has given consent if the information is about a child/young person who does not have the capacity to consent)
- The information is required by statute or court order
- It is justified in the public interest – for example, if the benefits to a child/young person that will arise from sharing the information outweigh both the public and the individual's interest in keeping the information confidential.

<https://www.careleavers.com/>



RCPCH Looked After
Children.pdf

7. Domestic violence and abuse

The cross-government definition of domestic violence and abuse is 'any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality'. The abuse can encompass, but is not limited to:

- psychological
- physical
- sexual
- financial
- emotional

Domestic abuse is rarely confined to a single incident and typically forms a pattern of coercive or controlling behaviour. This policy is therefore applicable whatever the nature of the intimate relationship, and includes young people as both victims or perpetrators. We recognise that the issue of forced marriage falls within the broad definition of domestic abuse and will treat any reported occurrence within this process.

A senior person within the practice should be identified to take the lead for domestic abuse within the practice. This person should be a practice nurse or GP who is trained to undertake this role.

The responsibility of the domestic abuse lead should be to:

- Identify existing domestic abuse services available locally and nationally
- Engage with local domestic abuse services to develop an effective working partnership
- Organise training for the practice team
- Establish a simple care pathway for patients, who disclose domestic abuse
- Provide a single point of reference, and information, with regards to domestic abuse to ensure legal compliance both within the practice and for external agencies.
- Ensure that the practice's response to disclosure always adheres to its information sharing protocols.

The practice's healthcare team's role is to:

- Recognise patients whose symptoms mean they might be more likely to be experiencing domestic abuse
- Talk to the patient sensitively and provide a safe and empathetic first response
- Understand the practice's process for responding to disclosure and know what to do when there is an immediate risk of harm to patients and their children
- Know who the designated person for their practice is and seek advice where necessary
- Understand the practice's process for arranging an initial assessment with the designated person
- Document domestic abuse in the patient's record safely and keep records for evidence purposes
- Share information appropriately. Information must only be shared with the consent of the patient, subject to Trust policy on child protection and adult safeguarding. Only in exceptional circumstances may information be shared without the patient's consent.

When undertaking an initial assessment of the patient, the designated person will:

- In the first instance, ensure the patient is seen alone where possible or offered support if required. A chaperone could be used.
- Conduct a risk assessment
- Advise the patient about available services according to the level of risk assessed. This may result in:
 - Referral to an appropriate local specialist domestic abuse service, if the patient consents

- Signposting to domestic abuse resources and provision of a basic safety plan, if the patient is unwilling to engage with services at this time
- Ensure that child protection and adult safeguarding procedures are initiated where required, especially where there is immediate risk of harm to patients and their children, this includes an unborn child if the woman is pregnant, even if no other children are living in the household

National Domestic Abuse Helpline

<https://www.nationaldahelpline.org.uk/>

0800 2000 247

Respect – helpline for male victims of domestic abuse

<https://mensadviceline.org.uk/>

0808 801 0327

Women's Aid

<https://www.womensaid.org.uk/>

Respect – help for domestic violence perpetrators

<http://www.respectphonenumber.org.uk/>

0808 802 4040

8. LGBTQ+

Lesbian, Gay, Bisexual, Transgender and Queer/Questioning (LGBTQ) people are at heightened risk for bullying, victimisation, homelessness, and being subjected to harmful therapies and associated physical and mental health issues. Health disparities in these populations are strongly associated with increased vulnerability based on stigma and discrimination due to their sexual orientation, gender identity, and gender expression.

LGBTQ patients often are overlooked as a vulnerable group that faces disparities in care and can face stigma and insensitivity to their needs. A significant proportion of LGBTQ patients report experiencing discrimination in healthcare settings and some avoid seeking healthcare for fear of discrimination from staff.

LGBTQ patients are more likely than the wider population to be affected by depression and anxiety. A significant proportion of trans patients surveyed (Stonewall LGBT in Britain – Health Report 2018) are recorded as considering or attempting suicide.

Significant proportions of LGBTQ people report having experienced inappropriate curiosity from healthcare staff because they're LGBTQ. Additionally, LGBTQ people report being outed without their consent by healthcare staff in front of other staff or patients. Similarly, significant numbers of LGBTQ people state that they've experienced a lack of understanding of specific lesbian, gay and bi health needs by healthcare staff. The majority of Trans people said they've experienced a lack of understanding of specific trans health needs by healthcare staff.



lgbt_in_britain_health
.pdf

There are a number of ways to demonstrate an open and inclusive clinical environment to LGBTQ patients:

- Allow LGBTQ patients to self-identify on new patient enrolment forms if they choose to do so
- Consider how to record or code that patients are LGBTQ after gaining consent to do so from the patient
- Reception staff should demonstrate positive attitudes and use sensitive language
- Sexual orientation training should be considered for all staff
- Posters and leaflets reflecting LGBTQ issues can be displayed in the waiting room
- Sexual orientation and gender should be included in the anti-discrimination policy and it should be clearly displayed
- Include LGBTQ patients in patient participation groups

During a consultation, it is important not to make assumptions about a patient's sexual orientation or to assume they are heterosexual. It is important to facilitate disclosure but also to respect non-disclosure. A GP can make it easier for patients to disclose or talk about their sexual orientation by:

- Assuring the patient that consultations are confidential
- Adopting a non-judgemental attitude
- Using open questions such as "Do you have a partner?"
- Using gender-neutral, inclusive terminology
- When treating a child with same-sex parents, family diversity can be respected by involving the non-biological parent in the discussion

9. Neurodiversity

Neurodiversity is the diversity of human brains and minds, the variation in neurocognitive functioning within our species.

Neurodiversity is an essential form of human diversity. There is no "normal" or "healthy" type of brain or mind or one "right" style of neurocognitive functioning. The classification of neurodivergence (e.g. autism, ADHD, dyslexia) should not be treated as a medical/psychiatric pathology. The social dynamics around neurodiversity are similar to the dynamics that manifest around other forms of human diversity. These dynamics include unequal distribution of social power.

It is estimated that roughly 1 in 7 people in the UK are neurodivergent, meaning their brain functions, learns and processes information differently than others.

Those with neurodivergent conditions are often more at risk at risk of suffering from mental illnesses or poor wellbeing. This is often due to a lack of support, and the stress of 'masking' —

acting neurotypically in order to avoid negativity. The stress and strain this causes stops neurodiverse people performing as well as they can.

Examples of neurodiverse conditions are:

ADHD: affecting around 4% of the population, ADHD can cause issues with impulse control, attention, and concentration.

Autism: affecting 1-2% of the population, autism affects the way someone perceives the world. People with autism can find social interaction and change difficult and uncomfortable.

Dyslexia: a condition that gives someone language processing difficulties that cause issues with reading, writing, and spelling.

Dyspraxia: affecting around 5% of the population, dyspraxia affects physical coordination. People may seem clumsy, disorganised, and have trouble with structure.

Dyscalculia: a specific learning disorder with impairments in learning basic arithmetic facts, processing numbers and performing accurate and fluent calculations.

Dysgraphia: a specific learning disability that affects written expression. Dysgraphia can appear as difficulties with spelling, poor handwriting, and trouble putting thoughts on paper.

Tourette Syndrome: a neurological condition where there are tics they can't control - sounds and movements.

There are many ways to support neurodivergent patients:

Be Clear and Concise: Neurodivergent people can tend to be process driven; be clear in your explanations. They often think literally so be careful not to use idioms or figures of speech.

Social Interaction: Neurodivergent people often have issues with social interaction. They may avoid eye contact or experience anxiety in group settings and gatherings. Some people may prefer not to talk, whereas others may overcompensate and can be seen as if they are trying to take-over a situation. Be patient and tactful.

Auditory/Verbal Processing: Auditory processing can be a problem for neurodivergent people. They may have difficulty hearing conversations in noisy environments or struggle to follow verbal instructions. Try to always provide information in a visual format as well as verbal e.g. in writing or pictures, and make sure they can take notes if they need to.

Schedules and Changes to Routine: Neurodivergent people may prefer routine, and sudden changes can be extremely disturbing for them. Communicate any planned changes well in advance if possible and keep reiterating these changes.

Safe Space: Many neurodivergent people suffer from some form of sensory overload at times. Providing a quiet and not too bright space can help with sensory overload. Some people like to pace up and down, others may like to sit still to get their thoughts in order. Try to accommodate these needs.

Things to remember:

- There is no one-size-fits-all solution – just because someone is neurodivergent or has a neurodevelopmental condition does not mean they will need the same adjustments as someone else with the same condition.
- Adjustments shouldn't be prescriptive – do not impose adjustments unilaterally. Where possible, ask the individual what their needs are and – where reasonable – provide them with tools or adjustments to support these needs.

10. Learning Disabilities

People with learning disabilities have a right to the same level of health care as that provided to the general population. This care should be flexible and responsive and any diagnosis or treatment must take account of specific needs associated with the person's learning disability. The term Learning Disability is used to describe a person who has developmental delay or intellectual disabilities which are usually evident from birth or early childhood. There are three core criteria, which must be used for the term learning disability to apply:

- Significant impairment of intellectual function
- Significant impairment of adaptive and or social function (ability to cope on a day to day basis with the demands of their environment and the expectations of age and culture)
- Age of onset before adulthood

Learning disability does not include:

- The development of intellectual, social or adaptive impairments after the age of 18
- Brain injury acquired after the age of 16
- Complex medical conditions that affect intellectual and social/adaptive functioning: e.g. Dementias, Huntington's Chorea
- Specific learning difficulties, e.g. Dyslexia, literacy or numeracy problems, or delayed speech and language development

People with learning disabilities may present as having:

- Difficulties communicating and expressing choices and needs, including pain management
- Difficulty understanding their diagnosis, treatment options or services available to them
- Difficulty understanding the consequences their decisions can have on their health status

Practice staff should be able to provide a range of services including:

- communication support and easy read information
- reasonable adjustments for appointments
- support the completion of risk assessments to ensure the person has appropriate support where necessary
- flagging of individuals on the Trust's information systems
- signposting to other appropriate professionals or services
- support and advice in relation to the Mental Capacity Act (2005), access to Independent Mental Capacity Advocate (IMCA) service and best interest decision making
- provide education and accessible information to patients with a learning disability and their families/carers to prepare for any medical interventions or procedures
- identify any reasonable adjustments that may need to be made
- support and provide information in relation to safeguarding concerns

- act as an advocate for patients with learning disabilities

It is the responsibility of clinicians and nursing staff to adapt their communication style and follow guidelines for effective communication based on the individual's communication needs.

Many people with learning disabilities have difficulties with communication. This may include problems with expression, articulation, comprehension and coping with social situations. People with learning disabilities have difficulty understanding complex sentences and abstract concepts with time being a particularly difficult concept to comprehend. This should be considered when discussing appointments. They may also have difficulty understanding written communication and this should be taken into consideration when arranging appointments, particularly if pre-appointment instructions are included. Reasonable adjustments may include longer appointment slots to enable more time to explain and discuss treatment options. If staff identify someone with a learning disability who is due to attend an appointment, they should view the flagging information to see if there are any reasonable adjustments that need to be made.

Staff may also be contacted by carers or family members to request that reasonable adjustments are made and these should be accommodated wherever possible.

Other examples of reasonable adjustments are:

- Where patients present with phobias/extreme anxieties or challenging behaviour consideration to necessary adjustments are needed in order to ensure their health needs are met.
- Avoid having the patient kept waiting as this may increase the anxiety levels further - offer first or last appointments when the practice is quieter.
- Where available, a single quiet room to be offered or suitably quiet waiting area and this will reduce anxiety and possible distress to other patients.
- Where a patient has challenging behaviour the person's carer should be present to support.

Sharing Information

All patients have a right to privacy and to control information about themselves. Where the person lacks capacity, this right must be balanced with the protection of their interests. Although carers will be involved in best interests' decisions there should not be widespread disclosure of personal health information without the person's valid consent and information should be shared on a need to know basis. Information pertinent to any change in the person's support needs should be shared with the person's carer, but detailed clinical information should be treated sensitively and disclosed only when necessary and on a need to know basis. It must not be assumed that the person's next of kin is the primary carer. Many people with learning disabilities live in registered care homes or in supported living environments and in these cases the care provider is responsible for the health and wellbeing of the service user.

Service users should be consulted about who they wish to be included in discussions about clinical matters where possible. Clinical information should be shared as appropriate by professional colleagues, i.e. therapist to therapist, etc. to ensure continuity of care.

RCGP health checks for people with Learning Disabilities toolkit:

<https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/health-check-toolkit.aspx>

11. Ex-Offenders

Health inequalities experienced by ex-offenders are well above the average experienced by the general population. Evidence illustrates that as a group, those who have or are at risk of offending frequently suffer from multiple and complex health issues, including mental and physical health problems, learning difficulties, substance misuse and increased risk of premature mortality. These underlying health issues are often exacerbated by difficulties in accessing the full range of health and social care services available in the local community.

Mental health needs among ex-offenders are often complex, with comorbidity the norm. The presence of concurrent mental health and substance misuse problems can lead to difficulties in accessing support from either service. Many ex-offenders have experience of interpersonal trauma, particularly women offenders. This has been linked to the onset of a range of mental health problems including post-traumatic stress disorder, depression, anxiety disorders and substance misuse.

Released prisoners who are homeless and who apply for help from their local authority are often not deemed to be in 'priority need', may be considered as 'intentionally homeless', or may struggle to prove a local connection to the area they have returned to and therefore are not offered accommodation. A criminal record can also act to exclude them from housing association, private landlord and supported accommodation providers.

Patients who do not have a registered GP or are being released to a different area should be registered as usual. Records should be requested (with consent) from discharging facility if the patient does not have them.

12. Refugees, Asylum Seekers and Refused Asylum Seekers

Overseas visitors do not need to provide proof of identity or immigration status. Refugees, asylum seekers and refused asylum seekers can register for and receive primary care free of charge in the same way as any other patient in any nation of the UK. Asylum seekers may have an 'application registration card' (ARC) from Immigration Services. Practices can register asylum seekers and refugees who are not in permanent housing, this is because immigration and residency status have no bearing on a patient's entitlement to register with a GP practice.

All refugees and asylum seekers with an active application or appeal can access the full range of secondary care services free of charge in any nation of the UK. In England, refused asylum seekers are not necessarily entitled to secondary NHS care free of charge. Their ability to access care depends on:

- whether the care is immediately necessary/urgent or non-urgent
- whether specific exemptions apply.

Practice staff do not have to make any assessment of immigration status or eligibility for NHS care; they are not expected to act as immigration officials. The following services are free for everyone:

- treatment for COVID-19
- free testing and free treatment for paediatric multisystem inflammatory syndrome (that results from COVID-19).
- vaccination against COVID-19

- Primary care such as:
 - GP services
 - primary dental and ophthalmic treatment
 - accident and emergency (A&E) services
 - family planning services (not including termination of pregnancy)
 - diagnosis and treatment of specified infectious diseases
 - diagnosis and treatment of sexually transmitted infections
 - palliative care from a registered palliative care charity or a community interest company
 - NHS 111 telephone advice line treatment for a physical or mental condition caused by:
 - torture
 - female genital mutilation
 - domestic violence
 - sexual violence

unless the overseas visitor has travelled to the UK to seek that treatment.

In addition to the services above, some overseas visitors are also exempt from the charges which would otherwise apply to overseas visitors:

- refugees and their dependents
- asylum seekers and their dependents
- individuals receiving support from the Home Office. This is under section 95 of the Immigration and Asylum Act 1999.
- those whose application for asylum was rejected, but they are supported by the Home Office under section 4(2) of the Immigration and Asylum Act 1999
- children looked after by a local authority
- victims, and suspected victims, of modern slavery or human trafficking, (determined by the UK Human Trafficking Centre or the Home Office) and their dependents provided they are lawfully present in the UK
- those receiving compulsory treatment under a court order, or who are liable to be detained in an NHS hospital or deprived of their liberty
- prisoners and immigration detainees.

Asylum seekers, refugees and migrants face many of the same health problems as the UK population. However, they may:

- have poor awareness of the NHS and fear barriers to accessing treatment
- come from countries of origin with poor healthcare
- suffer health impacts (mental and physical) after leaving their country and being detained in the UK
- have experienced war, conflict or torture
- be separated from family, have poor housing and be socially isolated.
- Some refugees, asylum seekers and migrants incorrectly believe they are not entitled to free treatment.

Doctors of the World – Safe Surgeries

This initiative supports any GP surgery to become a Safe Surgery. A Safe Surgery commits to taking steps to tackle the barriers faced by migrants in accessing healthcare. The three ELFT East London GP Practices are signed up as Safe Surgeries.

A declaration as a Safe Surgery means ensuring that lack of ID or proof of address, immigration status or language are not barriers to patient registration.

The Safe Surgeries initiative offers:

- Resources to support Practice staff
- Network events for learning and collaborative working
- Training for Clinical and Non-Clinical staff
- Safe Surgeries toolkit

<https://www.doctorsoftheworld.org.uk/what-we-stand-for/supporting-medics/safe-surgeries-initiative/>

Bedfordshire Refugee & Asylum Seeker Support

<https://www.brassbedford.org.uk/>

01234 211381

Refugee Council

<https://www.refugeecouncil.org.uk/>

13. Age Disputes in Refugee/Asylum Seekers

Age disputes can arise when a young person arrives in the country unaccompanied and is ascribed 'adult status' by the official meeting them as they appear, in their opinion, to be over 18 years old. This should lead to a person under 18 being placed in a hotel which houses families with children, however it can be the case they are placed in hotels that may be unsuitable for their needs.

Accommodation providers should notify Local Authority safeguarding teams and health services that a person claiming to be a child has been housed with lone adults, but this might not always happen.

If a member of staff becomes aware that a hotel resident is in dispute about their age they must:

- Check that the local safeguarding team is aware and, if not, raise a MASH referral or inform the GP Outreach team who can raise a referral if needed
- Ensure that the hotel is aware
- Notify the Home Office safeguarding team and the Ready Homes safeguarding team

ELFT Outreach and Newham Transitional Practice can, with the GP's consent, register unaccompanied minors as patients. Greenhouse Practice and Health E1 cannot register under 18s as patients, therefore registrations with local GP practices need to be facilitated.

14. Homeless Patients

Homeless people experience much worse health than the general population and die much earlier. This is due in part to tri-morbidity – having a physical health, mental health and substance misuse issue at the same time. These issues are both a cause and consequence of homelessness.

Homeless people are twice as likely to have a physical health condition or mental health diagnosis as the general population (Homeless Link, 2015), with men dying on average 30.2 years earlier and women dying 37.5 years earlier (ONS, 2020). More than two in five homeless people (41%) use drugs or are in recovery, one in four has an alcohol problem (27%) and nearly four in five smoke (78%) (Homeless Link, 2015).

Many homeless people find it difficult to get the right healthcare, leading to unnecessarily high financial (as well as human) costs. Homeless people in England are 4 x more likely to be treated in A&E and admitted to hospital.

There is a significant overlap between the offender, substance misusing and homeless populations. Two-thirds of people using homeless services also being in touch with the criminal justice system and/or in drug treatment (Bramley et al, 2016)

Homeless people are more likely to have a brain injury or have specific cognitive needs than the general population, but they receive insufficient recognition or support for these needs. Homeless people the UK are far more likely to have a learning disability (5.6%-39%) than the general population (2.5%-3%), (Stone et al., 2019).

Early research suggests 12% of people experiencing homelessness may show strong signs of autism, compared to 1.1% of the general population. (Churchard et al., 2017). Older homeless people are more likely to have memory problems than older people generally, and probably more so than younger homeless people (Manthorpe et al. 2019). More than half of the homeless population report a traumatic brain injury (TBI) and nearly a quarter report a moderate-to-severe TBI (Stubbs, Thornton, Sevick et al., 2019).

GP practices have a responsibility to register people who:

- are homeless
- sleeping rough
- sofa surfing
- have no fixed abode
- are legitimately unable to provide documentation living of within their catchment area.

Homeless patients are entitled to register with a GP using a temporary address. This may be a friend's address or a day centre. They can also use the practice address to register. Practices should try to have a way to contact the patient (for example with test results). Some areas have special services for homeless patients. Practices may refer homeless patients into these in line with local arrangements if:

- it is in the patient's best interests,
- the patient agrees.

When caring for patients who are homeless or are at risk of becoming homeless, you should consider:

- introducing double appointments
- keeping prescriptions as short a duration as possible
- ensuring clear boundaries for consultations are in place
- giving fast access to a named GP
- waiving any charges for housing letters or medical reports
- health and well being
- mental health, depression & learning disabilities.
- language barriers
- dental care
- housing and benefits

15. Roma Community

The Roma are the largest ethnic minority in Europe and health outcomes for the Roma community are very poor compared to other ethnic groups. The Roma community can have challenges in accessing or registering for healthcare services for a number of reasons and barriers to accessing health care include:

- direct discrimination
- economic disadvantage
- differences in cultural interpretations
- language
- digital literacy
- health literacy
- lack of knowledge of healthcare systems
- lack of trust in health professionals
- lack of identification

It is important to be sensitive to the wider context of your Roma patients' experience of accessing health services and to understand that a wide array of interconnected factors likely influence their health seeking behaviours.

Language and interpreters

Most Roma speak a dialect of Romanes as their first language, and many later learn the language of their countries of origin. There are many dialects of Romanes, and although some are mutually intelligible, others are so different as to essentially constitute different languages. It is important to pay close attention to which language a Roma individual speaks and to ensure that communications are carried out in this language in as many cases as possible. Direct and clear communication is highly valued in Roma culture; it is very important to explicitly state what you are trying to accomplish through your work and what you intend the outcomes to be, to make and maintain eye contact, and to avoid referring too frequently to notes or looking at a computer screen.

It is best to ask which language your service user is most comfortable using before requesting interpreter services. Assessments of children would be best facilitated by interpreters and carried

out in the first language of the child. Roma community organisations may also be able to recommend Roma people who speak fluent English.

When using a non-Roma interpreter, it may be helpful to brief the interpreter on key issues in Roma health communication (i.e. the taboo subjects and the importance of simple language) and explain the need for jargon-free language and, if necessary, outline strategies for explaining relevant health concepts.

Culture, Traditions and Taboos

When working with the Roma, it is important to remember that there are many cultural taboos that may influence their health-related behaviours and use of services. As a general rule, a good way to show respect is to directly ask Roma service users what they expect from you.

Some of the most significant health taboos involve public discussion of sexual and mental health issues.

Mental health

Mental health is considered a greater taboo than any other health problem, and for this reason it is very rarely discussed amongst the Roma. When talking about mental health Roma might talk about being sad, feeling down and having a specific problem in their life and some might describe mental health issues as 'problems with the head' or 'being crazy' rather than recognising and naming mental health conditions. There is strong belief that mental health problems can be passed on genetically. This can jeopardise the prospect of marriage for the sufferer, as well as other family members, making mental health one of the most hidden and shameful issues in the community. Even when Roma do use mental health services, they are often afraid to disclose full details of their condition to mental health professionals (e.g. hearing voices) due to fear that it would lead to sectioning and forcible treatment in a mental health institution. Ensure that Roma service users understand that all mental health information will be kept confidential and only passed on to third parties if the user agrees or if it has impact on others. Professional jargon should be avoided when communicating.

Gender

In traditional Roma culture, there are clear gender divisions in terms of responsibility within the family and appropriate social conduct. Gender-related issues may arise in a health context when health problems are associated with sexual health, or even simply the lower half of the body. In these cases, Roma patients may be unwilling to discuss symptoms with a health professional of the other gender, thus increasing the likelihood of misdiagnosis. It is generally advisable to make sure that any consultations involving the middle and lower regions of the body only take place between Roma individuals, health professionals and interpreters of the same gender.

Age

The Roma have a set of cultural rules related to age that may not be initially apparent to outsiders. When hosting any discussion of health issues, it is important to make sure that there is no more than a 10-year age difference between those attending, this includes when using family members to interpret, otherwise it may not be possible to discuss issues related to sexual health and certain areas of the body. In such cases it may be advisable to find a different interpreter or attempt to communicate directly with the person in need of care

Elderly Roma are most commonly supported and looked after by their families but taboos around gender are particularly important in health context. For instance, a mother can look after her husband or son but not after her father in law or her father.

Cancer, Terminal Illness and End of Life Care

Most Roma avoid discussing serious illness, especially cancer and dying. There is no clear consensus about diagnosis disclosure as, the same as the wider population, some Roma prefer to know full diagnosis in order to prepare themselves for the end of life where others prefer that terminal diagnosis is not disclosed to the person in question, in order to protect them from distress and enable them to remain hopeful about their recovery.

There is a general lack of awareness and misconception relating to cancer. Many Roma people believe that cancer can “get angry” if touched (through biopsy, surgery, radio therapy or chemotherapy etc.).

Most Roma prefer spending their last days of life at home, with their families. Immediate and extended family members will visit the dying person on a daily basis. Some of the family members stay with the dying person throughout day and night. Very important dying rituals take place during this time which enables the dying person to ‘depart calmly.’

Drug addiction and substance misuse

There is very little published information about drug use within the Roma community, and drug misuse within the Roma community remains a taboo subject, which contributes to general lack of knowledge about drugs, their effect on individuals and their families and drug services available.

Domestic violence

Although a 2008 European Commission report suggests that domestic violence is considered an acceptable practice within Roma society, evidence from Roma community members reveals it to be a taboo topic which can cause victims to feel as though they are unable to discuss family problems outside. When domestic violence victims are in a vulnerable position with regard to immigration or employment status, they may fear that seeking out help will alert authorities to their situation. If you are working with a Roma individual who you suspect may be a victim of domestic violence, it is important to offer clear descriptions of what services are available, what actions can be taken and to offer assurance that support services for domestic violence victims will not make them more vulnerable.

Roma Support Group

<https://www.romasupportgroup.org.uk/>

07949 089778

Luton Roma Trust

<https://lutonromatrust.org.uk/>

01582 510709

16. Translation Services

Clinical care should always be provided in such a way as to ensure that service users and their carers or significant others can:

- Communicate accurate information to clinicians and practitioners so that symptoms and their meanings can be understood, correctly diagnosed and the best available treatment offered
- Understand the health issues facing them, the treatment options available and the steps required to recover or maintain well-being
- Express themselves fully and freely as appropriate to the context within which they receive care
- Have access to qualified interpreters in response to identified needs

- Have access to translated information about the care being provided by the Trust
- Be reassured that the provision of interpreting and other language services is the responsibility of the Trust and not the service user, carers, or their family
- Staff are responsible for implementing the policy effectively and for bringing any issues which may affect implementation to their managers. They also need to recognise that a language need exists.

Staff responsibilities:

- Inform service users and carers that an interpreter can be arranged at no cost to them
- Assess which language is being spoken and make provision for language need by liaising with the service user or carer, where appropriate
- Arrange interpreting or translating services as soon as the need becomes apparent
- Liaise with the interpreting service to arrange for an interpreter
- Define or explain complex terminology or acronyms
- Accurately document within the service user's clinical records, the language and dialect used and any hearing or visual impairment or additional needs identified

Local Translating services are commissioned by the CCG and each Practice has access to book translation services. Additionally, translation can be arranged using peer-to-peer services. Practices should also consider utilising staff knowledge of additional languages, where staff are fluent in the language.

Patients' family members, children or carers should NEVER be used to translate clinical sessions unless the patient presents in a medical crisis and information is required immediately.

The Primary Care Handbook holds full details of current translating services and instructions for booking a translator.

17. Review

This policy will be subject to review every three years, or, in light of any changes to national standards or Trust policy.