# Ethnic minority groups and non-English speaking patients

- Identifying
- Interpreters - how long do we provide the service?
- Consent
- Monitoring patients + results letters
- Who should translate?
- Religious events

## Solutions

- Apps on patient phone
- 'Are you happy with your family/friend interpreting?'
- Balance the risk
- Patients objecting to drops during Ramadan
- Results letters sent in English, even when invite sent in 1st Language
- find local community groups who can be the link between DESP and the minority patients?

# LEARNING DIFFICULTIES

① IDENTIFY COHORT - PRIOR TO APPT

② IDENTIFY RESOURCES (LOCALLY) / COUNCIL - ALLIED TRUSTS

③ ADVOCATE

④ PEOPLE ARRIVING WITHOUT SUPPORT LETTERS

⑤ COMMICATIONS / APPT

⑥ CONSENT

⑦ MANAGEMENT POLICY (SCREENER TRAINING)

# LEARNING DISABILITIES
## - SOLUTIONS

① Identify cohort + Resarces
- Request from GP's - those patients w/ diabetes code
- " " Council and an LD code

② - Collaborate w/ community LD team for specific needs to support access
- Have easy read or other tools available @ all screening clinics

③ Advocate
- 'Best interests clinic' for those w/ dementia or LD
- Identify a carer - educate the carer of importance of screening

④ People arriving w/ asr support
- having the right tools - easy read / e-charts
- ask Practice Nurse for support if possible

⑥ - Mental Capacity assessment tools for consent.

⑤ Communication
- easy read info leaflets / letters / web page / picture cards
- videos.
- tailor to level of disabilities

⑦ Mgmt Policy

- SOP's drafted w/ comm LD collaboration (expert support)
- Provider policy re: mental capacity and consent
- As the patient able to consent, but refuses on the day (incr suitable for exclusion?).

Other

service user feedback / focus groups
w/ LD community support groups / sessions

## ③ GYPSY / TRAVELLER COMMUNITY

### OBSTACLES

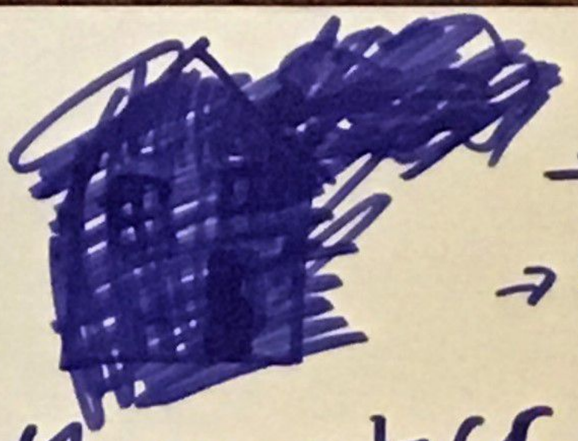
- Identify them
- Are they registered w/ a GP?
- Are they transient - how long do they remain in the catchment?
- How prepared are liaison teams to work collaboratively? (Local Authority / Police / GP)
- Education, are they able to read?
- Trust, do the community trust outsiders
  - how do you gain their trust?
- If identified - where do letters get sent if residing in a temp/mobile site?
  - Is the screening software able to separate the cohort for invitation?

# GYPSY / TRAVELLER COMMUNITY

- Engaging with local authority / CCGs who will have a named person who works with travelling communities / to gain trust
- Input to health information leaflets tailored to travelling communities
- Links with DSN teams.
- Easy to read literature
- Mobile screening service delivery model
- Results to GP if registered & can pick up from practice
- Use of technology to email results etc (IG issues)
- ?easier identification of cohort within software

1) Identification of Cohort
2) Confirmation of Diabetic Status
3) Communication - Correspondance
4) Screening location - Access
5) Secondary Complications - ie Mental Health, Addiction
6) Diabetes care - likely to be poor
7) Secondary care? - HES attendance?

# Homeless solutions:



→ Identify deprived areas
→ Results → ask how they'd like.

→ Incentive to screen.

* → If come for other appts get those staff to ask if screenings done + do it on a drop in clinic. Get pharmacists to provide
↳ Educating staff (one stop → quick healthcheck

→ Identify via specialist surgeries (clock tower) → discuss with them options
→ Small no.s. Tailor made.
→ Work with homeless support groups /charities/ Respect festival.

→ Regular audit or Equity audit
→ Drop in sessions. / Mobile units
→ one key member.
→ Educating pt → knowing they can claim back travel.
→ One stop shop → all diabetes / OCT / Eye care
→ Send to A+E or work with eye units to get in quick / flexible appt.

→ Use mobile / c/o / email rather than address
→ Free phone / online booking

GP2DRS

+

SOFTWARE LIMITATION

? FIXED APPT

(VS INVITE)

ACCESSIBLITY

SPECIAL ARRANGEMENTS
DURING APPT

IG ISSUES / GDPR

# Patients in Prison / secure units

Access: DESP "getting into" the prison
- Named contact.
- keep camera in clinic - Minimise equipment - security checks

Security & administration/communication
- using same staff - consistency

Infomed consent
- Training
- Validate SD

Transient population- remand prisons
- Validation
- Drop in patients

Lack of NHS numbers
- on non live software.
- Temporary Patient ID
- use alternative ways of verifying ID

List validation
- Validate before attending
- good communication with Prison Admin

Onward referral process
- Understanding referral Process intend or extend?

Staff safety
- Adequate training for staff
- risk assessments

Resources to screen regularly
- capacity planning - Screen every 3 months.

Lack of access to education resources

Commissioner engagement (Health + Justice / SITs)
- Yes!
- Liaising with other Screening programmes

# Students

→ Turn up late/cancel last min.
→ Screened at home not at uni.
→ ↑ DNA/DNR rate.
→ Sometimes missed at home + university or screened twice (cost)
→ Fixed or open appointment?
→ Awareness they need to be screened
→ Turn up to GP for appt + no longer reg there.
→ Where to screen → at GP or University.
→ When? holidays/Exam time
→ Where send results
→ keeping address/mobile up to date.
→ Do we dilate?
→ Building good relation with uni.
→ cost of a room there.

# Forces.

→ Go abroad to train. ↗ have to send back to UK to treat.
→ Transient.
→ Where to screen/Drop in?
→ How do we raise awareness with them.
→ How do you follow up a referral.
→ How do you contact patient if there is a problem.
→ How to provide good relationship with forces
→ How identify cohort

↓

- Contact known nurse in forces as lead to ensure screening completed in timely manner
- Prioritise grading + referrals.

student union
- Welfare team (contact) for fresher's week + health week
- Out of hours clinic (weekend, eve)
- Contact care team (GP, diabetologist)
- Type 1 charity - uni buddies → patient champions
- Social media chats
- Posters on forums
- Social media adverts