Letter head and contact details for GP practice

Date

To whoever it may concern,

Re:

DOB:

NHS number:

**Essential information for use of GP records in relation to asylum claims**

**Use of GP records in asylum claims:**

We are aware that GP records are increasingly being used in asylum claims instead of medico-legal reports and formal letters.

When using GP records in asylum claims, as evidence of past heath and healthcare, it is important to consider their nature and limitations. The purpose of a GP record is to record health and health interventions and for clinicians and others to communicate with one another. In recent years, the GP record has become complex with entries from multiple GP services, primary care team members (not just clinicians) and other services. They are not written with a view to the record being used as evidence in medico-legal situations. It is important to be aware of the following points, which may vary across different GP practices:

* 1. **Attendance.** Not all patients make use of their GP service. This can be for many reasons including lack of awareness about health and what can be offered, lack of assertiveness trying to get appointments, fearfulness and lack of trust. Some clinicians are confident in managing trauma and ask about it and facilitate regular follow-up. Other clinicians are not. Workload pressures in General Practice are severe and have a bearing on availability of support. The fact a patient is not regularly attending their GP practice does not necessarily mean that they are not having problems with their health.
  2. **Disclosure.** A significant proportion of patients do not disclose details of any past abuse (such as torture, trafficking or domestic violence), unless asked directly about it. Even when clinicians do ask, some patients may still take months to disclose full details. Some will never disclose everything that has happened to them. Sometimes patients even deny that anything adverse has happened because they are not comfortable, at that point in time, with a disclosure.
  3. **Quality of interpreting.** The quality of interpreters used by the NHS cannot be guaranteed. Most interpreting work is now provided via contracts with telephone interpreting services. Regrettably some consultations have to be conducted without interpreters. As a consequence, information available may be limited, and/or errors may be introduced.
  4. **Accuracy.** Whilst every effort is taken to ensure accuracy, GP records can nevertheless be inaccurate. Records may contain unclear abbreviations. There may be typing errors. Misunderstandings and interpreting mistakes are not uncommon. Patients do not get any opportunity to correct factual errors.
  5. **Mental health care.** GP practices and individual clinicians vary in their interest and skills around mental health, the amount of mental health prescribing they are happy with, and referrals made. Not many GPs have training in trauma and asylum related issues. In many areas it is also very difficult to get access to counselling and therapy for people seeking asylum because of a lack of resources in mental health services. Patients are often treated by default with medications for sleep and depression/anxiety. If they are prescribed medications without engagement and follow up, the individual may often just stop taking them and stop seeking help. The absence of appointments about, medications and referrals for mental health need is not always because there is no mental health need. Non-adherence to medication prescribed, in the absence of other support, does not indicate that a person is free of mental health difficulties.
  6. **GP records and suicide risk.** GP suicide risk assessments are usually made in the moment. They relate to acute suicidal ideation, rather than the level of chronic background risk which relates to life experience, social circumstances, and personality style. There can be sudden changes in risk level in response to changes in a person’s circumstances. Presence or absence of acute suicidal ideation at a particular point in time is only one component of overall suicide risk assessment and cannot be taken as a measure of risk at a different point in time.
  7. **Examinations of injuries and scars relating to ill-treatment.** If there have been any examinations made in general practice these are not likely to be comprehensive. Many GPs will be unaware of the significance of physical injuries in asylum claims.
  8. **Gaps in GP records.** There are many reasons why there may be gaps in a GP record or an apparent delay in registration. There are many possibilities including a patient choosing not to register, difficulty registering, lack of awareness of services or fears about registering. It is not rare for some patients to have more than one NHS number and set of records due to mistakes with the spelling of names and other personal details. If this comes to light the records can be merged as one, but there will be circumstances when it does not come to light and results in a gap in the record.

Yours faithfully

Name of service or GP[[1]](#footnote-1)

1. This template has been created by TortureID as part of a bank of resources for NHS clinicians who are working with people who are seeking asylum. [www.tortureid.org](http://www.tortureid.org). It has been created by Dr Jo Miller who is a GP working with people seeking asylum. They are suggestions, drawn from practical GP experience, about how to respond to common requests.  They are not 'official' templates with the endorsement of any organisations. The asylum environment is fast changing, and materials are likely to need updating regularly. Each template needs to be read through, agreed and adapted to the needs of the service planning to use them. [↑](#footnote-ref-1)