

**Support pack for GP practices**

**Re-starting annual learning disability health checks**

1. **Rationale**

It is important to re-start the annual health checks for patients with learning disabilities. This patient group has lower levels of health literacy and self-advocacy skills, which is likely to put these patients at greater risk of unintended consequences from the necessary safety measures in place to deal with the covid-19 pandemic.

This information pack is designed to support you re-start this service. It is not prescriptive, it is a guide and toolkit with some suggestions for ways forward. We recognise that all practices are different and that you are working in several different ways right now.

1. **Risk Assessment**

Broadly, patients can be placed in low, moderate and high-risk groups. These should take into consideration the following:

* Likelihood of deterioration of existing conditions or a missed diagnosis of a new condition based on residency: patients in non-residential settings or with little to no social or health care package should be placed in the high-risk group. These patients are less likely to be shielding, so will generally have fewer problems attending a face-to-face review.
* Likelihood of deterioration based on clinical history: patients with 2+ co-morbidities should be prioritised as high-risk. Clinical judgement will be required dependant on stability of condition, potential polypharmacy problems, lack of compliance with treatment plans and the specific morbidities in the patient record. Those at greatest risk should be called first. In most instances, these patients will require a face-to-face review to enable physical examination. The deciding factor will be the judgement of potential harm vs potential benefit.

Patients in lower risk groups can be assessed using the remote pack and then brought to the practice for a face-to-face consultation by exception, where deemed clinically necessary. Consideration can also be given to online consultations where this is manageable for the patient and where physical examination is not core to assessment.

There are some specific morbidities of particular concern in this group due to prevalence and / or poorer outcomes than the general population. They should therefore be specifically included in reviewing co-morbidities for this patient group, rather than relying solely on the chronic disease registers associated with QOF and any specific syndromes diagnosed.

**Epilepsy:** prevalence is x20 higher and PHE have identified that poorly controlled epilepsy is one of the most common reasons for avoidable hospital admissions. Managing epilepsy well will reduce SUDEP <https://sudep.org/>

**Respiratory disease:** the main cause of death for people with learning disabilities.

**Dysphagia:** nearly 10% of patients in this cohort have dysphagia. People with learning disabilities often die from choking, chest infections and malnutrition. Please see the following for reasonable adjustment guidance. <https://www.gov.uk/government/publications/dysphagia-and-people-with-learning-disabilities/dysphagia-in-people-with-learning-difficulties-reasonable-adjustments-guidance>

**Constipation:** constipation is common in this group and incidents of bowel cancer much higher. Please see <https://www.england.nhs.uk/publication/constipation-learning-disability-resources/> for information for patients and healthcare professionals

**Diabetes**: there is a higher prevalence and earlier onset of type 2 diabetes in this group. Diabetes is harder to manage for people with learning disabilities, and they therefore require more checks and screening.

**Mental health problems:** these are more common and communication problems make it harder to diagnose and manage. Please also note STOMP <https://www.england.nhs.uk/learning-disabilities/improving-health/stomp/>

**Dementia:** diagnosis is aided by regular monitoring and it helps to have continuity of care so that a person’s capabilities can be witnessed over time. People with Down’s Syndrome are likely to get dementia earlier and therefore cognitive baseline assessments should be done from about the age of 30.

**Physical deterioration:** with the closure of day services and other specialised enablement services, patients with learning disabilities are at particular risk of physical deterioration including pressure problems, increased falls and general decreased fitness and mobility problems. Patients coded as frail or with a history of falls should be prioritised.

**Risk assessment outcome examples - low, moderate and high risk categories**

* Peter is a 41-year-old man. He lives on his own and has an extensive social care package. He is generally fit and well but has epilepsy. He manages his medication and whilst not fit-free, he is considered stable.

Peter is in the low category. He would receive the pre-check questions to complete with a carer and then have a remote review (unless a clinical concern was flagged up in the pre-check questions or during remote review which warrants physical examination).

* Jay is a 27-year-old woman. She lives in a care home with 24/7 support. She has dysphagia.

Jay is in the moderate group. A pre-check questionnaire should be sent to the home for completion. A remote review will take place unless anything is flagged by the pre-check questions.

* Alex is a 57-year-old man. He has type 2 diabetes, anxiety and a history of constipation. He usually manages his conditions well and enjoys his independence. His care package has been stepped down in the last few years to support his growing independence.

Alex is in the high priority group. The pre-health checks should still be done, but it is important that Alex comes for a face-to-face review.

1. **Model of Care**

The processes in place to manage the pandemic are important. However, it may be appropriate to make reasonable adjustments to these measures for patients with a learning disability or autism. This can include allowing a person with learning disabilities or autism to bring an advocate or carer to a face-to-face appointment, even if patients are generally not permitted to do so as part of social distancing or infection control measures. It is also important to ensure virtual reviews are fully supported with a carer or advocate in attendance who knows the patient (and therefore understands their baseline condition) where required.

We therefore recommend a stepped approach to reviews based on the risk assessment above.

* Patients at greatest risk be reviewed first.
* Patients who can safely be assessed remotely should be. Please refer to the supporting information.
* Patients who present a clinical risk at initial review or on completion of health check should be invited to the surgery or offered a video consultation if that medium can be managed by the patient / carer. Video consultation should only be used where physical examination is not core to assessment and where communication skills are good enough to support this method.
* Patients who present a high clinical risk should be invited to the practice for a face-to-face review. Where these patients are shielding or a have a high risk of Covid-19 infection, consideration should be given to on-line consultation and a clinical decision made on the balance of risk and benefit.

Reviews should all be conducted in line with the Directed Enhanced Service specification for Learning Disability Annual Health Checks. The only aspect of the DES which is not expected to be delivered is the physical examination and only where this would prevent an unacceptable risk and is deemed appropriate for virtual review according to the guidance in this document.

If your practice is working as a group or sharing space it is reasonable to invite patients to a practice that is not their usual one. It is important that this is very clear for patients and that you ensure they have the necessary information to undertake a journey which may be unfamiliar. Patients attending an unfamiliar setting should be invited to bring someone with them for support.

Please note that templates for Emis and System One are attached. You don’t need to use any of the attached pre-check health questions if you have your own in place already.

Please note that the expectation is that all AHCs go back to face-to-face appointments once services are being ‘unlocked’ from the pandemic response.

1. **Funding**

All payments will be made against the usual CQRS submissions according to the terms in the Directed Enhanced Service.

**Annual health check model of care flow chart**

Risk assess patients to prioritise reviews and decide on review format

Send out easy read letter and pre-check health questions to patient and carer

Annual health check is due

Invite patient for a remote or face-to-face review. Consider reasonable adjustments including allowing the patient to attend with a carer or advocate

Receive pre-check health questions and assure the chosen review format is still correct (change from remote to face-to-face if flags are raised)

Complete face-to-face review

Complete remote review. No flags raised

Complete remote review. Flags are raised

Flags raised:

Put in place appropriate measures, investigations etc. in line with severity and risk.

Record review in clinical record and make payment submission

No flags raised:

Record review in clinical record and make payment submission

Record review in clinical record and make payment submission

Make appointment to have a face-to-face review with the patient and follow the face-to-face flowchart boxes

1. **Further support, information and links**

**Attached documents:**

* Checklist for patients and carers for annual health checks (you can continue with other agreed local models)
* GP letter
* DES directions 2020
* EMIS health check questions
* System One health check questions

**Links:**

* Please also note that the MindED LD and physical health module for tier 2 staff and carers is now published and available to be shared: <https://www.minded.org.uk/Component/Details/638978>
* NHS England GP contract information with links to Directed Enhanced Services [**https://www.england.nhs.uk/gp/investment/gp-contract/**](https://www.england.nhs.uk/gp/investment/gp-contract/)
* NHS England Improving identification of people with LD – clinical coding included [**https://www.england.nhs.uk/wp-content/uploads/2019/10/improving-identification-of-people-with-a-learning-disability-guidance-for-general-practice.pdf**](https://www.england.nhs.uk/wp-content/uploads/2019/10/improving-identification-of-people-with-a-learning-disability-guidance-for-general-practice.pdf)
* Mencap – patient information about annual health checks (NOT updated for pandemic times) [**https://www.mencap.org.uk/advice-and-support/health/dont-miss-out/dont-miss-out-annual-health-checks**](https://www.mencap.org.uk/advice-and-support/health/dont-miss-out/dont-miss-out-annual-health-checks)
* NHS Digital guidance with links to payment information and clinical coding [**https://digital.nhs.uk/services/general-practice-gp-collections/service-information/learning-disabilities-health-check-scheme#2020-21**](https://digital.nhs.uk/services/general-practice-gp-collections/service-information/learning-disabilities-health-check-scheme#2020-21)
* NHS England Mortality Review: [**https://www.england.nhs.uk/publication/leder-action-from-learning/**](https://www.england.nhs.uk/publication/leder-action-from-learning/)
* Directed Enhanced Service for Annual Health Checks for Patients with Learning Disabilities and supporting documents <https://digital.nhs.uk/services/general-practice-gp-collections/service-information/learning-disabilities-health-check-scheme>

**If you have any questions, please email the team** **england.learningdisabilityandautism-sw@nhs.net**