Public Health England

The Uptake of Health Checks for Adults with Learning Disabilities

2008/9 to 2012/13

About Public Health England

We work with national and local government, industry and the NHS to protect and improve the nation's health and support healthier choices. We address inequalities by focusing on removing barriers to good health.

We were established on 1 April 2013 to bring together public health specialists from more than 70 organisations into a single public health service.

The Learning Disabilities Team, IHaL, was set up on the recommendation of a public inquiry into access to healthcare for people with learning disabilities. This followed a report in to the deaths of six individuals described in the Mencap report *Death by Indifference*.(Mencap, 2007; Michael, 2008)

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Easyread Summary

What we did

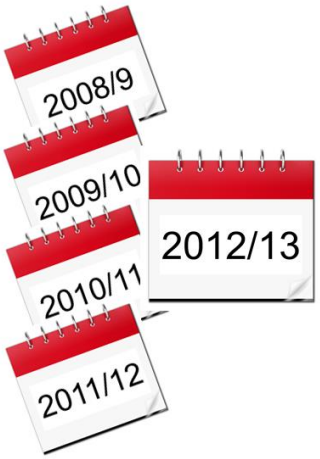
In England the NHS asks family doctors (GPs) to offer a health check every year to adults with learning disabilities.

hscic Health & Social Care Information Centre

The NHS Health and Social Care Information Centre collects information about this.

How many people?	
Should have a check? ☐	Did have a check? ☐

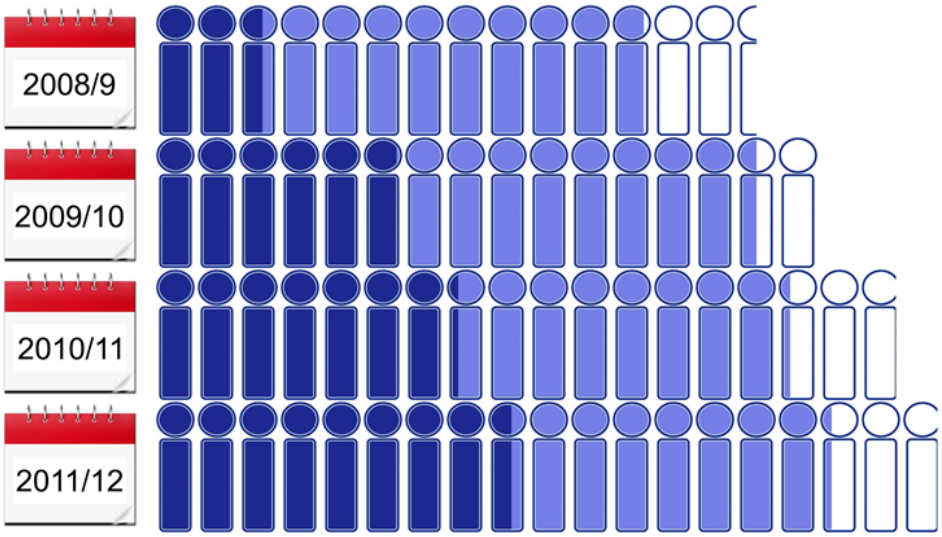
They collect two numbers from every local area (called Primary Care Trusts or PCTs) These are the number of people who had a Learning Disability health check and the number who could have had one, who are called ‘Eligible’.



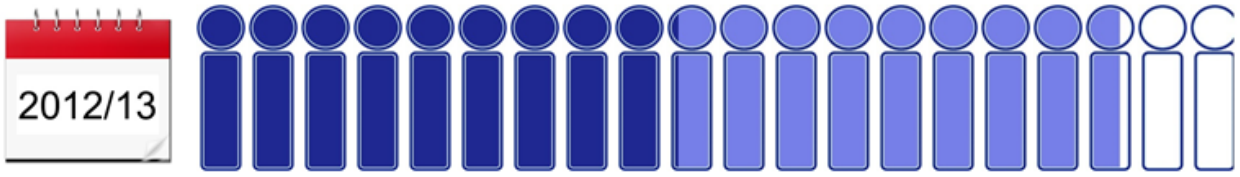
This report compares the numbers this year to the last four years.

What we found

Previous years

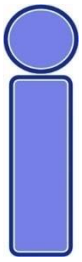


This year



92,329

People with learning disabilities had a health check.
This was 7.2% more than last year.



PCTs reported that

177,389

people could have had a check. This was 8.8% more than last year. It means that

85,060

who could have had a check, didn't.

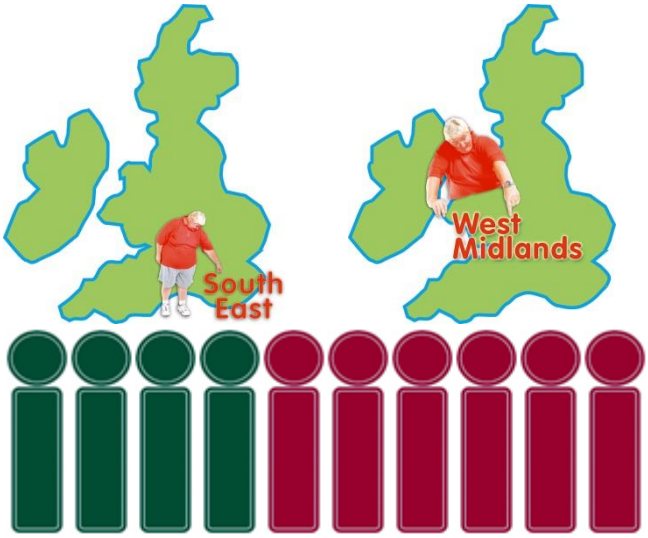
21,488

People with learning disabilities known to GPs were not eligible for a check because they are not known to social services

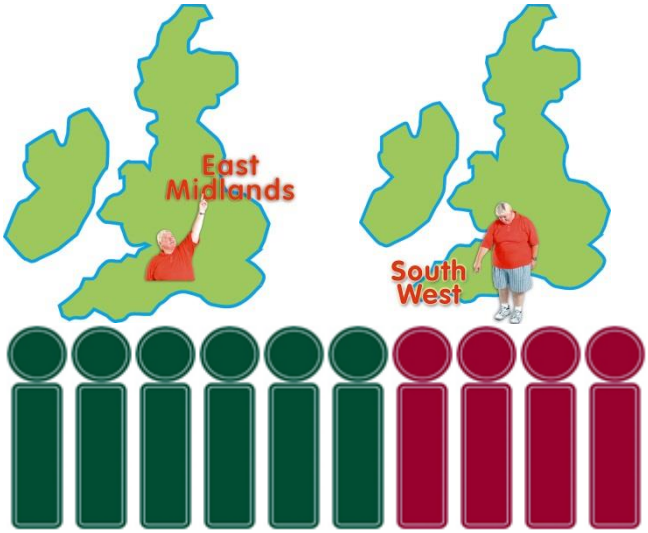
Variation

Nationally, just over half the people who could have had a check, did. This was almost the same as last year.

Some parts of the country did better than others.



In the South East Coast and West Midlands Strategic Health Authority areas only 4 out of every 10 people who could have had a check did.



In the East Midlands and the South West more than 6 out of every 10 did.

Local areas PCTs varied a lot.

Some were very good

←7 PCTs
managed checks for 8 out of every 10

Some PCTs were poor

←6 PCTs
only managed checks for 2 out of every 10 people

Most PCTs where a lot of people had health checks last year also did well this year

Most PCTs which only covered a small number of people last year also did badly this year

Background

- People with learning disabilities have significantly poorer health than their non-disabled peers. In part this is because they have more difficulty in identifying important symptoms and getting access to appropriate care (Disability Rights Commission, 2006; Emerson, Baines, Allerton, & Welch, 2011; Mencap, 2007, 2012; Michael, 2008).

- A robust body of evidence suggests that providing health checks for people with learning disabilities in primary care settings is effective in identifying previously unrecognised morbidity, including morbidity associated with life-threatening illnesses.(Robertson, Roberts, Emerson, Turner, & Greig, 2011)

- Following a Formal Investigation, in 2006 the Disability Rights Commission recommended the introduction of annual health checks for people with learning disabilities in primary health care services in England as a reasonable adjustment to address the health inequalities they faced. The Department of Health responded with a commitment to introduce 'regular, comprehensive health checks for people with learning disabilities'. This was based on their conclusion that these were 'the best way to improve the health of people with learning disabilities'.(Department of Health, 2007)

- The introduction of annual health checks for adults with learning disabilities in England (as part of a Directed Enhanced Service [DES]) was also recommended by the 2008 Independent Inquiry into Access to Healthcare for People with Learning Disabilities.(Michael, 2008) In September 2008 the NHS and the British Medical Association announced plans for a DES to deliver annual health checks. This programme is distinct from the five-yearly NHS Health check for all adults aged 40 to 74 focussed on the prevention of heart disease, stroke, diabetes, kidney disease and certain types of dementia.

- In February 2009 directions were published by the Department of Health requiring Primary Care Trusts (PCTs) to offer GP practices in their area the opportunity to provide health checks for adults with learning disabilities as part of a Directed Enhanced Service. The DES was originally agreed for two years (2008-9 and 2009-10); it has been subsequently extended, most recently until March 2014.(NHS Employers, 2012; NHS England, 2013)

- We have produced three annual reports on the progress in implementing health checks, first in the summer of 2010.(Emerson & Glover, 2010;Emerson, Copeland, & Glover, 2011; Glover, Emerson, & Evison, 2012). This fourth report

extends the period to include 2012/13. It will be the last in the present form. Whilst the programme of checks is continuing, the mechanics of monitoring has changed from April 2013.

Management and Data Collection

Data on health checks for adults with learning disabilities were collected from former PCTs by the Health and Social Care Information Centre using the Omnibus system. Detailed instructions in relation to the data to be collected were published on the NHS Information Centre website and are reproduced at Annex 1.

The DES guidance indicates that the initial PCT task of identifying the list of patients eligible for health checks is more than simply a statistical task for the purposes of this return. It is a key element of the DES process involving liaison between PCTs, local authorities and GPs to ensure familiarity with a group of patients for whom particular consideration is required. The initial DES task for PCTs is that they:

> 'should work with their LA (or LAs where practices' registered patients are resident in more than one authority area) to produce a register of patients who are known to social services primarily because of their learning disabilities, determine which practice they are registered with and share this with their constituent practices.'(NHS Employers, 2012)

In response, practices were supposed to integrate this information with data about patients already on the practice's learning disability register to establish a health check learning disabilities register.

Information was collected from PCTs on two questions:

> (1) the number of people with learning disabilities receiving a health check; and
> (2) the number of people with learning disabilities eligible for a check.

Practices were required to submit reports of numbers of people who had received checks (Question 1) to PCTs within 28 days of the end of March 2013 as the basis for payment.

The DES specified details of the checks required. These included that they should be undertaken by an appropriately trained provider and based on a protocol that included the following:

- a review of physical and mental health with referral through the usual practice routes if health problems are identified including:
  - health promotion
  - chronic illness and systems enquiry
  - physical examination
  - epilepsy
  - dysphagia
  - behaviour and mental health

– specific syndrome check
- a check on the accuracy of prescribed medications
- a review of coordination arrangements with secondary care
- a review of transition arrangements where appropriate.

Question two asked how many people in the PCT area were eligible for a check. From the guidance cited above, it appears that PCTs were expected to have a full listing of those eligible from the initial liaison process, normally mediated by learning disability nurses. The guidance did not state explicitly whether, in answering this question, PCTs should include eligible people registered with GP practices who had decided not to participate in the scheme. However it has done in earlier years, and there is no good reason why these should be excluded. In a few cases PCTs reported that they had not included these people.

A complexity arises in administering the scheme where people are placed by local authorities in residential care settings located outside their boundaries and in PCT areas with which they do not share territory. These are expected to be registered with GPs in the receiving PCT. In earlier years it has been made clear that their eligibility for a check is expected to be known as a result of the sending local authority notifying the receiving local authority and PCT.

Returns for 2012/13 were sent in on behalf of all 151 former PCTs. As last year, PCTs were given the opportunity to revise figures for the previous year. This year 5 PCTs did. Except where otherwise indicated, all 2011/12 figures quoted in this report are the revised figures.

As additional background information we also used the numbers of adults in each PCT identified as having a learning disability in the current Quality and Outcomes Framework (QOF) data.(NHS Information Centre, 2012) Because of publication timetables these always lag one year behind the health check data, hence this year we are comparing health checks from 2012/13 with QOF numbers from 2011/12

Maps of PCT values for the coverage, coverage in relation to QOF numbers and ratios of eligible numbers to QOF numbers (all described in the next section) were produces using ARC-GIS. Geographic distributions were tested for spatial autocorrelation using Moran's I test, calculated by the Geoda software. This calculates the probability of the observed level of spatial correlation for variables by comparison with a large number of random reassignments. The largest number offered (1000) was used meaning that the programme was able to test for probabilities down to, but not lower than, p=0.001.

Findings

Headlines and trend data

Table 1 shows the headline results. 92,329 people received a health check in 2012/13, an increase of 6,195 (7.2%) on the 2011/12 figure. The number identified as eligible was 177,389, an increase of 14,398 (8.8%). As the number identified as eligible rose by a greater proportion than the number receiving checks, the coverage, (defined as the number receiving checks as a percentage of the number identified as eligible), fell slightly. From 52.8% in 2011/12, this dropped to 52.0%, a fall of 1.5%.

Table 1. Numbers receiving health checks, reported eligible, and coverage of health checks, 2008/9 to 2012/13.

	2008/9	2009/10	2010/11 (revised)	2011/12 (revised)	2012/13
Number of people who received a health check (% change in number)	27,011	58,919 (+118.1%)	73,068 (+24.0%)	86,134 (+17.9%)	92,329 (+7.2%)
Number identified as eligible for a health check (% change in number)	118,230	145,130 (+22.8%)	153,021 (+5.4%)	162,991 (+6.5%)	177,389 (+8.8%)
Percentage of eligible people receiving a health check (% change in number)	23%	40.6% (+77.7%)	47.8% (+17.6%)	52.8% (+10.7%)	52.0% (-1.5%)

Revised figures

This year only five PCTs submitted revisions to the figures for the previous year; one revised the number of checks, one the number eligible and three revised both numbers. In most cases these had a relatively small effect. The upward revision of the number eligible in Haringey lowered the estimate of coverage for 2011/12 from 73% to 56%. Other changes all had the effect of increasing reported coverage (by 7% in Salford and Mid Essex, by 4% in Sefton and by 1% in Cambridgeshire).

Table 2 Numbers receiving health checks, reported eligible, and coverage of health checks, 2008/9 to 2012/13 by strategic health authority. Proportional changes from year to year shown in brackets.

	2008/9	2009/10	2010/11 (revised)	2011/12 (revised)	2012/13
Number of people receiving a health check (% change in number)					
North East	1,186	2,625 (+121.3%)	3,768 (+43.5%)	4,830 (+28.2%)	5,438 (+12.6%)
North West	3,287	8,193 (+149.3%)	9,837 (+20.1%)	11,976 (+21.7%)	13,926 (+16.3%)
Yorkshire & Humber	2,177	5,809 (+166.8%)	7,707 (+32.7%)	9,310 (+20.8%)	9,678 (+4.0%)
East Midlands	3,781	5,496 (+45.4%)	7,314 (+33.1%)	8,606 (+17.7%)	9,688 (+12.6%)
West Midlands	3,569	6,062 (+69.9%)	6,515 (+7.5%)	8,191 (+25.7%)	8,375 (+2.2%)
East of England	1,331	6,028 (+352.9%)	8,216 (+36.3%)	9,512 (+15.8%)	10,108 (+6.3%)
London	3,884	7,129 (+83.5%)	9,314 (+30.6%)	9,806 (+5.3%)	9,328 (-4.9%)
South East Coast	1,047	4,236 (+304.6%)	5,094 (+20.3%)	5,789 (+13.6%)	6,075 (+4.9%)
South Central	1,812	3,390 (+87.1%)	3,850 (+13.6%)	4,594 (+19.3%)	5,178 (+12.7%)
South West	4,937	9,951 (+101.6%)	11,453 (+15.1%)	13,520 (+18.0%)	14,535 (+7.5%)
England	27,011	58,919 (+118.1%)	73,068 (+24.0%)	86,134 (+17.9%)	92,329 (+7.2%)
Number identified as eligible for a health check (% change in number)					
North East	7,851	6,816 (-13.2%)	10,007 (+46.8%)	11,140 (+11.3%)	11,989 (+7.6%)
North West	16,065	18,868 (+17.4%)	20,885 (+10.7%)	22,092 (+5.8%)	25,605 (+15.9%)
Yorkshire & Humber	8,619	14,839 (+72.2%)	15,107 (+1.8%)	16,636 (+10.1%)	16,147 (-2.9%)
East Midlands	10,351	11,883 (+14.8%)	12,942 (+8.9%)	12,886 (-0.4%)	15,751 (+22.2%)
West Midlands	12,908	15,893 (+23.1%)	16,480 (+3.7%)	17,911 (+8.7%)	20,437 (+14.1%)
East of England	11,802	15,721 (+33.2%)	15,832 (+0.7%)	17,191 (+8.6%)	17,738 (+3.2%)
London	19,150	19,442 (+1.5%)	20,433 (+5.1%)	19,610 (-4.0%)	20,500 (+4.5%)
South East Coast	4,952	14,038 (+183.5%)	13,620 (-3.0%)	14,249 (+4.6%)	15,162 (+6.4%)
South Central	9,938	9,654 (-2.9%)	10,469 (+8.4%)	11,557 (+10.4%)	11,686 (+1.1%)
South West	16,594	17,976 (+8.3%)	17,246 (-4.1%)	19,719 (+14.3%)	22,374 (+13.5%)
England	118,230	145,130 (+22.8%)	153,021 (+5.4%)	162,991 (+6.5%)	177,389 (+8.8%)
Percentage of eligible people receiving a health check (% change in number)					
North East	15%	38.5% (+154.9%)	37.7% (-2.2%)	43.4% (+15.1%)	45.4% (+4.6%)
North West	20%	43.4% (+112.2%)	47.1% (+8.5%)	54.2% (+15.1%)	54.4% (+0.3%)
Yorkshire & Humber	25%	39.1% (+55.0%)	51.0% (+30.3%)	56.0% (+9.7%)	59.9% (+7.1%)
East Midlands	37%	46.3% (+26.6%)	56.5% (+22.2%)	66.8% (+18.2%)	61.5% (-7.9%)
West Midlands	28%	38.1% (+38.0%)	39.5% (+3.6%)	45.7% (+15.7%)	41.0% (-10.4%)
East of England	11%	38.3% (+240.0%)	51.9% (+35.3%)	55.3% (+6.6%)	57.0% (+3.0%)
London	20%	36.7% (+80.8%)	45.6% (+24.3%)	50.0% (+9.7%)	45.5% (-9.0%)
South East Coast	21%	30.2% (+42.7%)	37.4% (+23.9%)	40.6% (+8.6%)	40.1% (-1.4%)
South Central	18%	35.1% (+92.6%)	36.8% (+4.7%)	39.8% (+8.1%)	44.3% (+11.5%)
South West	30%	55.4% (+86.1%)	66.4% (+20.0%)	68.6% (+3.2%)	65.0% (-5.2%)
England	23%	40.6% (+77.7%)	47.8% (+17.6%)	52.8% (+10.7%)	52.0% (-1.5%)

Figure 1 - Numbers of people who had DES health checks by SHA

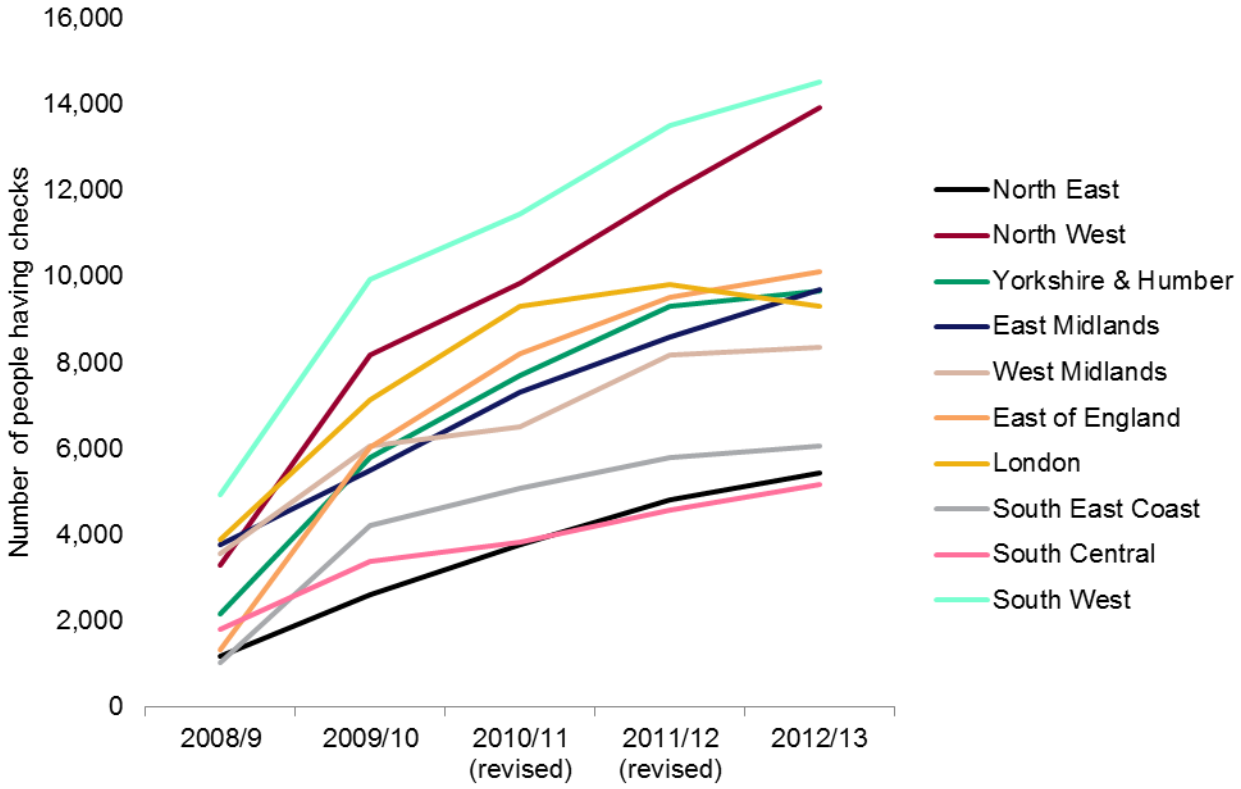


Figure 2 Numbers of people identified as eligible for DES health checks by SHA

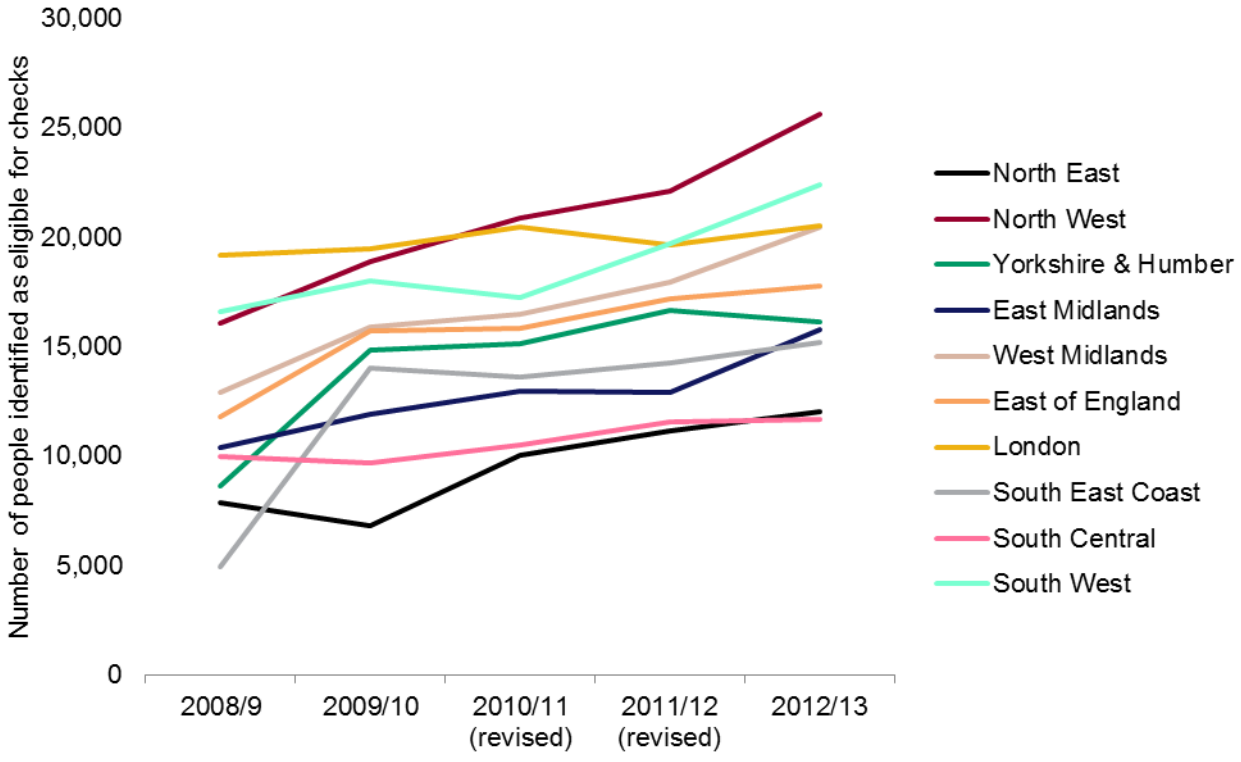
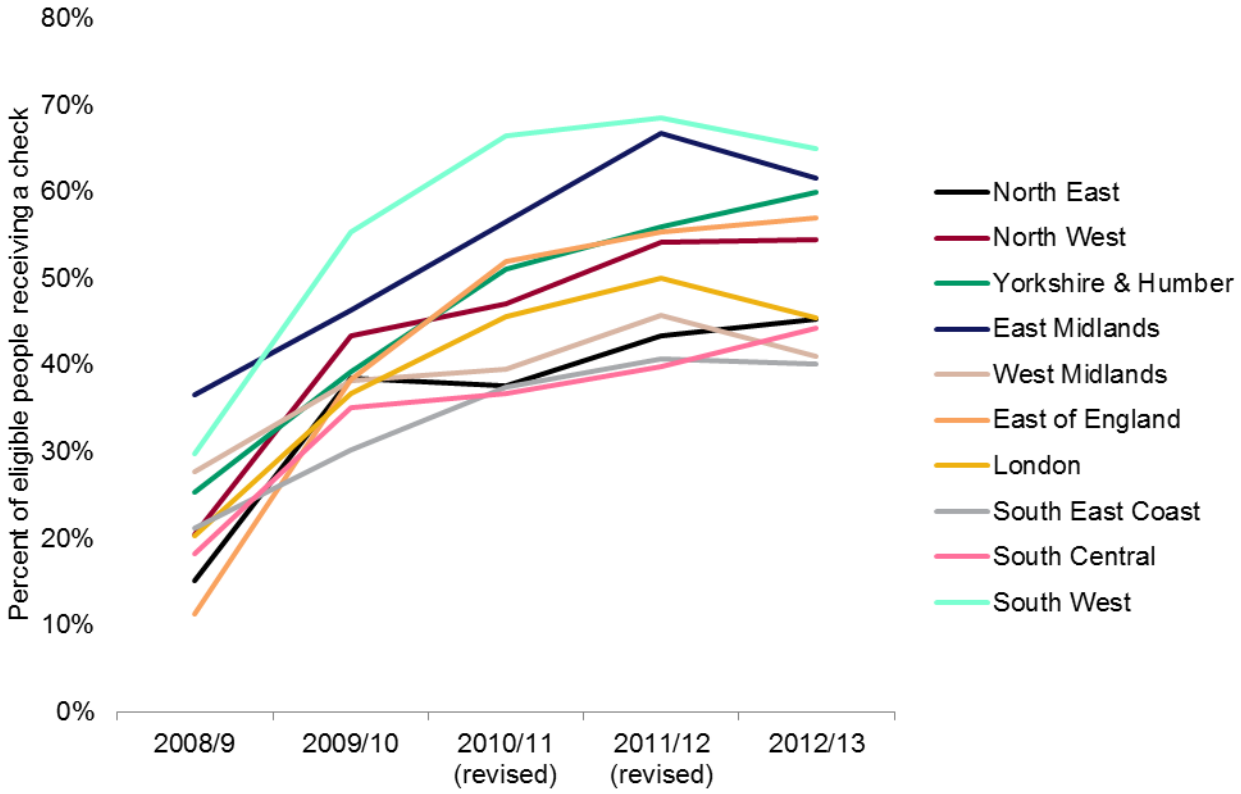


Table 2 looks at variations in performance around the country at the level of Strategic Health Authorities. The lowest section of the table shows that coverage at this level ranged from 40% in the South East Coast and 41% in the West Midlands Strategic Health Authorities to 62% in the East Midlands and 65% in the South West. However in many ways the trends in each area are more illuminating.

Figures 1 and 2 show the trends in the underlying numbers. The number of health checks performed continued to rise in most Strategic Health Authorities. The exception was London where numbers fell (down 4.9%). Numbers in London had risen the previous year but by much less than in the rest of the country. Very modest growth was seen in the West Midlands (up 2.2%), Yorkshire and Humber (up 4.0%) and the South East Coast (up 4.9%), however all of these had shown substantial increases in numbers the previous year. Numbers identified as eligible for checks rose in all areas except Yorkshire and Humber where they fell slightly (down 2.9%). However the overall 8.8% rise is not a good reflection of the overall pattern; there were sharp rises in the North West (up 15.9%), East and West Midlands (up 22.2% and 14.1%) and South West (up 13.5%), but much more modest change elsewhere.

Figure 3 shows the trends in coverage (defined as the percentage of eligible people receiving a check. There is a clearer separation between the better performing areas (South West, East Midlands, Yorkshire and Humber, East of England and North West) and the weaker areas (London, North East, South Central, West Midlands and South East Coast), a pattern that has remained unchanged for three years now. London initially occupied an intermediate position, but has now fallen back to the position of the weaker group.

Figure 3 - Coverage - (% of eligible receiving a check)



At PCT level

Figure 4 shows PCT level coverage. At the extremes, fourteen PCTs achieved higher than 75% coverage, up from twelve last year. Eleven PCTs achieved less than 25% coverage, down from thirteen last year.

Most Strategic Health Authorities include PCTs showing a substantial range of performance. The South West and the East Midlands show the most consistent performance, with no PCT falling below 47% or 43% coverage respectively. Seven out of the ten Strategic Health Authorities have at least one PCT falling below 25% coverage; London and the West Midlands each have three.

Statistically the coverage scores for PCTs are highly correlated from year to year. Spearman's coefficient of rank correlation comparing 2011/12 with 2012/13 is 0.70, comparing 2010/11 with 2012/13 it is 0.57 ($p<0.0001$ in both cases). Figure 5 gives an impression of the consistency of performance of individual PCTs over time. In this analysis, PCTs are given a score of one (lowest) to five (highest) for each of the last four years according to the fifth (quintile) of the ranking of PCTs for coverage into which they fell. These scores are summed giving a possible range from four to twenty. Five PCTs have never scored outside the bottom fifth, a further six have only managed this once.

To a large extent PCTs performing poorly last year or the year before have continued to perform poorly, whilst those performing well in the past have continued to perform well. Of the thirty PCTs with the lowest coverage scores in 2011/12 (the bottom fifth), twenty six were still in the bottom two fifths in 2012/13 – seventeen still in the bottom fifth. Of the thirty in the bottom fifth in 2010/11, twenty five were still in the bottom two fifths – thirteen in the bottom fifth. At the other end of the scale, out of the top thirty one in 2011/12, twenty six were still in the top two fifths, with twenty one still in the top fifth. Of the top thirty one in 2010/11, twenty three were still in the top two fifths, with fourteen still in the top fifth.

Figure 4 - Coverage at PCT level

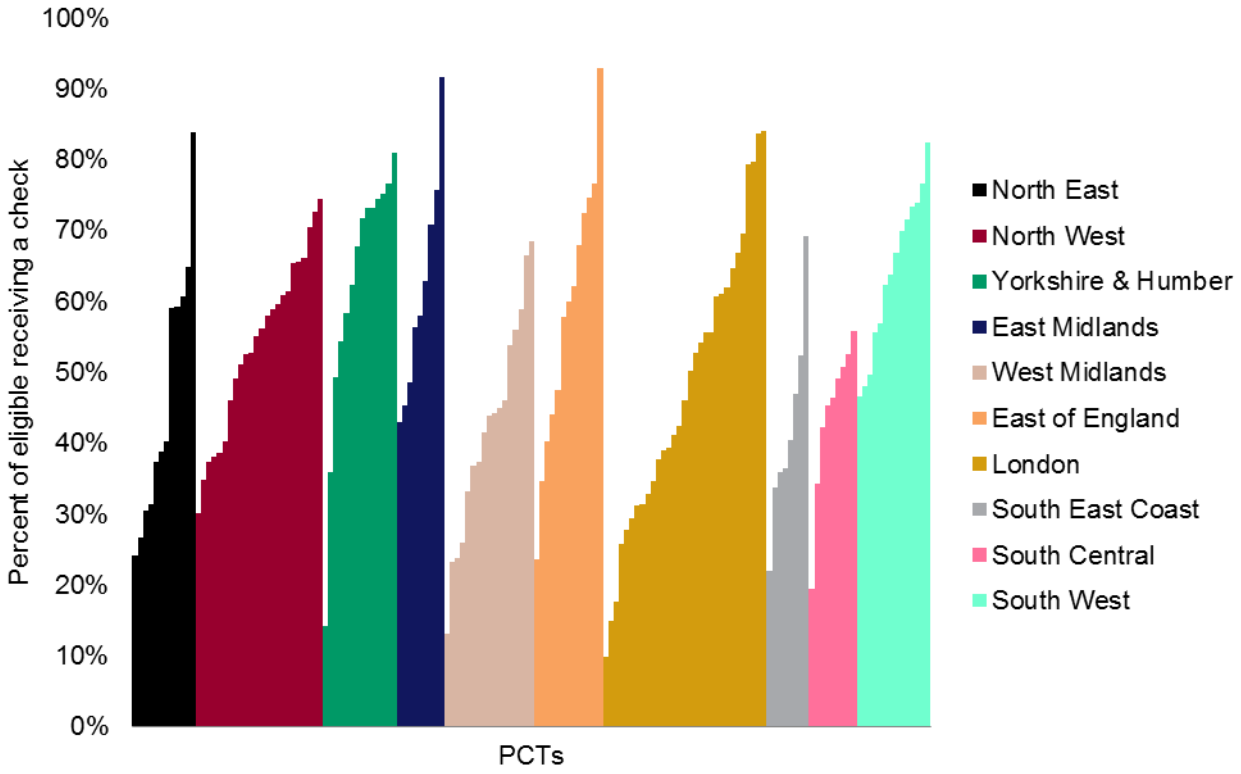


Figure 5 - Coverage - position over last five years

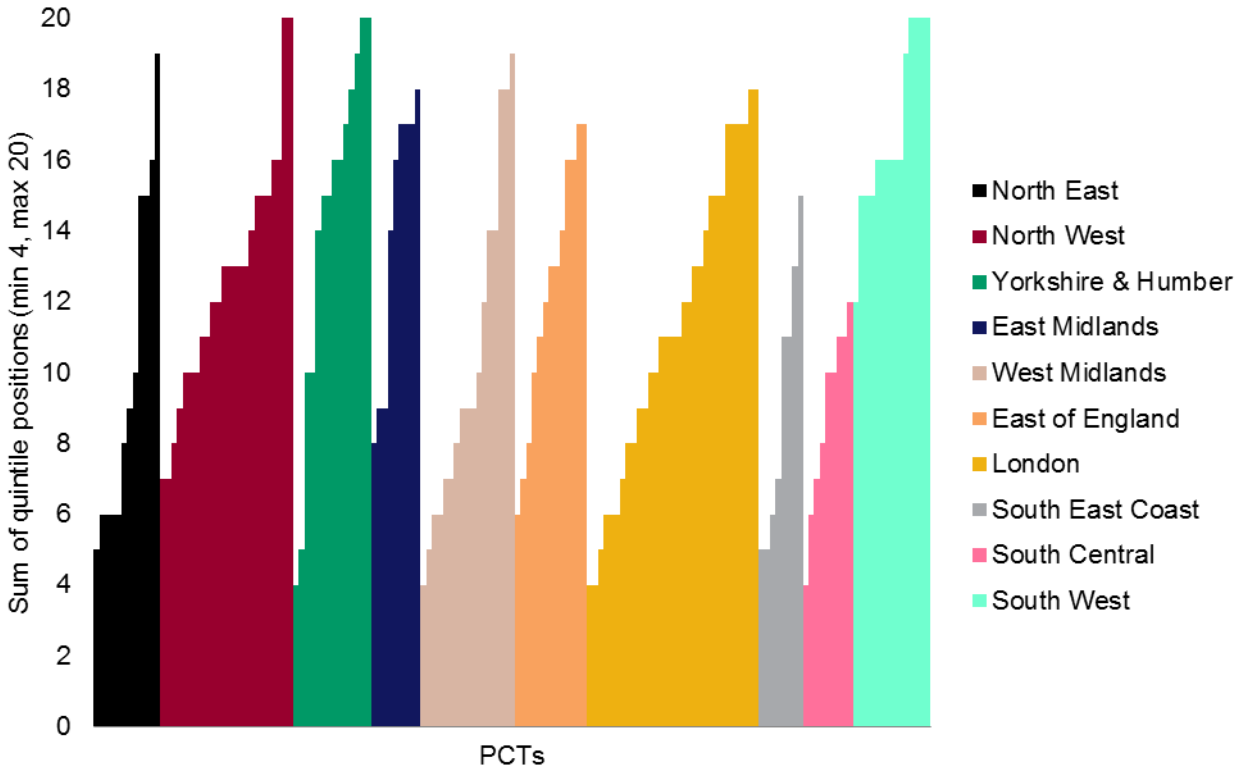
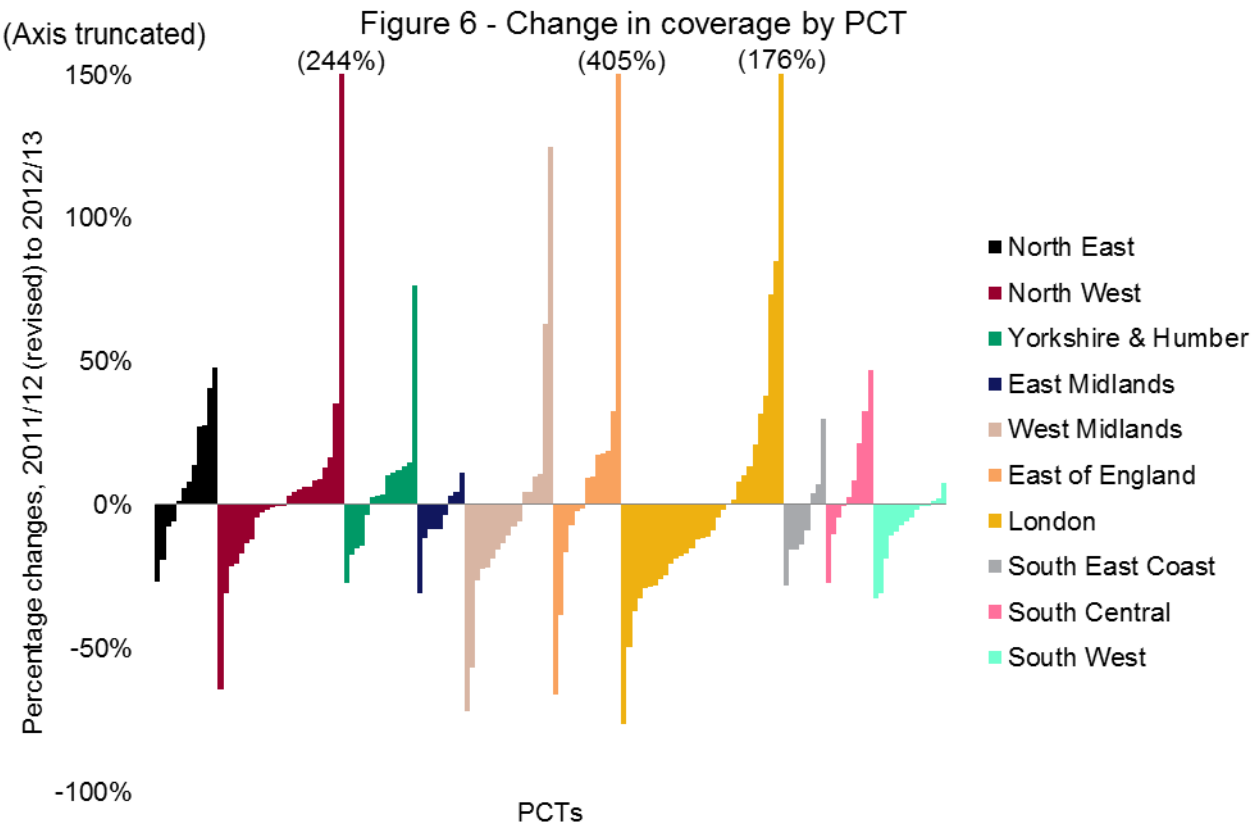


Figure 6 shows the movement in individual PCTs' coverage from 2011/12 to 2012/13. In all cases where a PCT's coverage increased by a high proportion, it was from a very low figure in 2011/12. This shows how difficult it has been to sustain high coverage. In the best performing Strategic Health Authority, almost 80% of PCTs reported a fall in coverage. In four others, more than 60% of PCTs reported falls. Only in two, North East and South Central, did a majority of PCTs report increased coverage.



Health checks and learning disability registers

In previous reports we have identified a small number of PCTs that have reported surprisingly low numbers of individuals as eligible for health checks. This is important partly because it gives a misleadingly optimistic estimate of the extent of coverage of the programme, but more importantly because it raises the question of whether there is a large number of people with learning disabilities being effectively excluded from it in those areas.

One obvious and simple cause for this is uncertainty on the part of staff submitting the data about how they are supposed to know the number eligible. Comments returned with the data indicate that frequently this is taken from the returns of participating practices, along with the numbers of checks completed. Where substantial numbers of practices do not participate in the scheme, this gives a significantly incomplete figure.

In our report on the 2010/11 figures we identified eight PCTs reporting eligible numbers representing less than half the average rate of learning disabilities in their Strategic Health Authority. In 2011/12 three of these remained in the same position. This year two of the original eight are still reporting notably low eligible numbers by this measure.

However it seems that a more satisfactory approach to getting around the problem of erratic reporting of eligible numbers may be to undertake parallel analyses of the numbers of checks performed but in comparison to the numbers reported as having learning disabilities by their GP in QOF registers. QOF register numbers have stabilised in the last two years. Inter-decile ranges for the annual change in register numbers in PCTs were +1.2% to +10.7% for 2010/11 to 2011/12 and +1.5% to +8.8% for 2010/11 to 2011/12. By contrast the inter-decile range for annual changes in the numbers reported as eligible for health checks, which should track fairly closely in parallel to the numbers on GP registers, were -15.4% to +30.3% for 2010/11 to 2011/12 and -8.6% to +32.4% for 2010/11 to 2011/12.

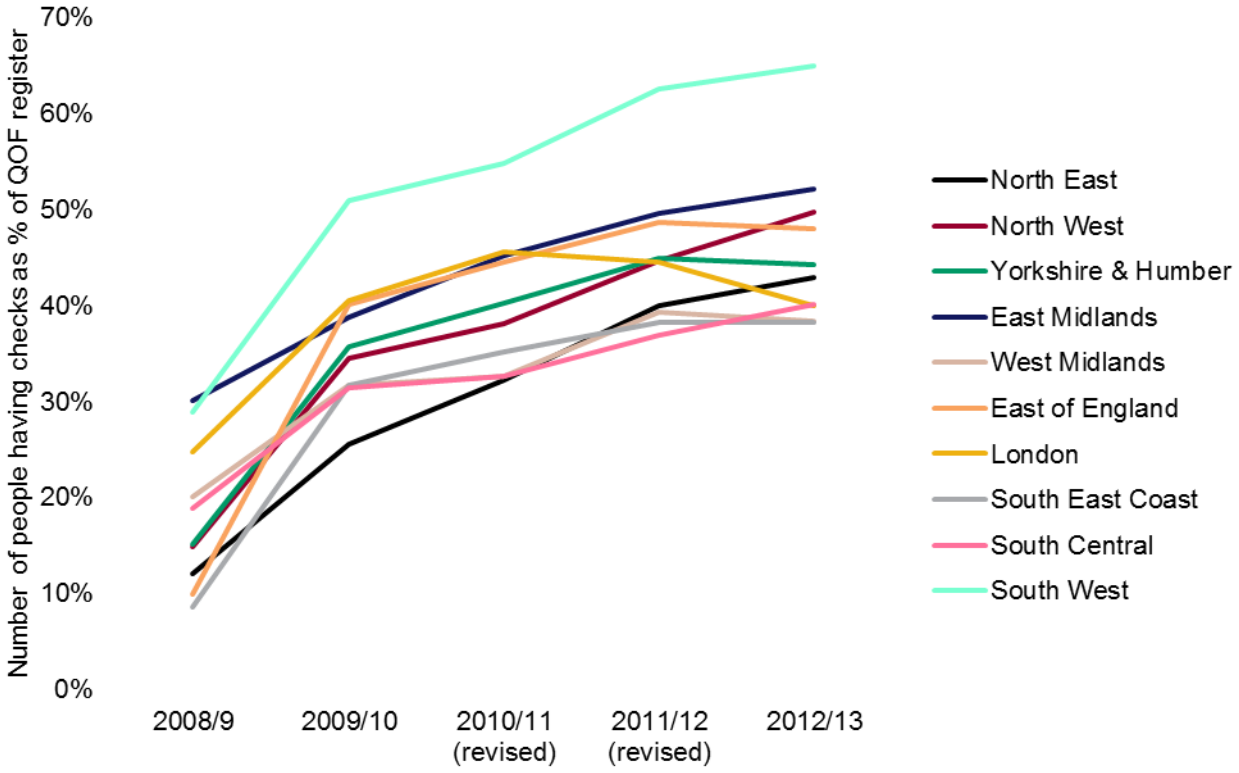
Table 3 shows an analysis of the numbers of checks using this approach. Overall coverage rose to 45.6% of numbers known to GPs by 2011/12 and remained almost steady in 2012/13, rising by 1.8% to 46.4% in 2012/13.

Table 3. Numbers receiving health checks reported as a proportion of those known on GP learning disability (LD) registers, 2008/9 to 2012/13.

	2008/9	2009/10	2010/11 (revised)	2011/12 (revised)	2012/13
Number of people who received a health check (% change in number)	27,011	58,919 (+118.1%)	73,068 (+24.0%)	86,134 (+17.9%)	92,329 (+7.2%)
Number of adults on GPs QOF LD registers (% change in number)	144,909	160,165 (+10.5%)	179,064 (+11.8%)	188,819 (+5.4%)	198,877 (+5.3%)
Coverage of adults known to GPs (% change in number)	18.6%	36.8% (+97.4%)	40.8% (+10.9%)	45.6% (+11.8%)	46.4% (+1.8%)

Analysed this way, Strategic Health Authority level returns (figure 7) show much more stable trends. Most show steady progress, albeit with varying degrees of success. The South West is clearly and consistently the most successful. The figures for the East of England, West Midlands and Yorkshire and the Humber, however, show an interruption in this progress in the most recent year. London shows a sharp down turn, from 44.3% to 39.8% coverage over the last two years.

Figure 7 - Coverage by QOF - (% of GP register receiving a check)



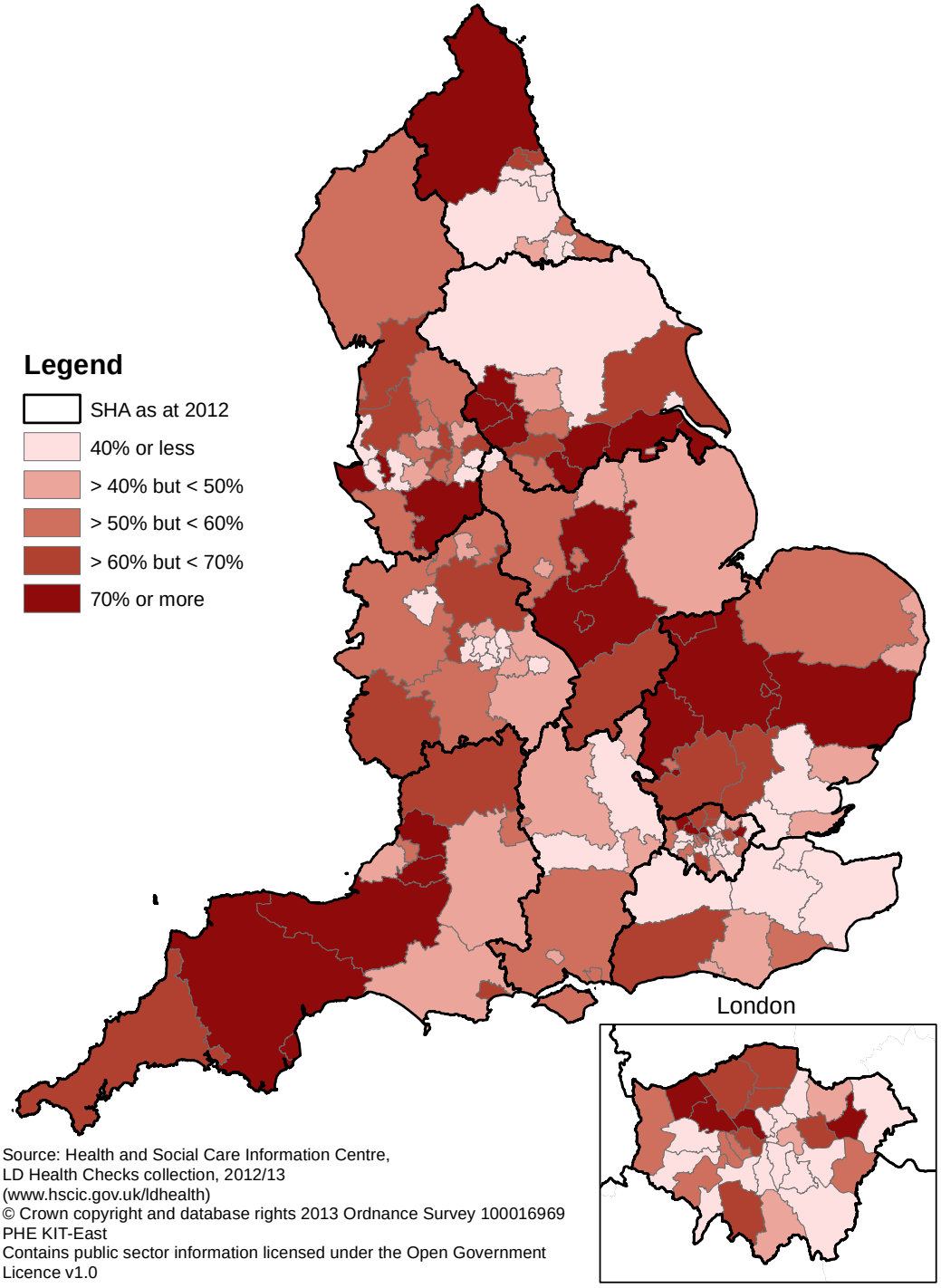
Variations around the country

On the following pages we show three aspects of the data as maps. For each there is a pair of maps showing first the situation in the most recent year (2012/13), then the previous year (2011/12). Each map shows the country divided roughly into fifths on performance with shadings reflecting these. However in order to make each pair comparable we have kept the grade boundaries consistent from year to year so there are not exactly equal numbers of areas in each group each year.

The first pair (figures 8 and 9 – the red maps) shows the pattern of coverage of people identified as eligible. The second pair (figures 10 and 11 - the green maps) shows the number of checks done as a proportion or patients known on GP QOF learning disability registers. The final pair (figures 12 and 13 - the blue maps) shows the number identified as eligible expressed as a proportion of the number known to GPs in the area.

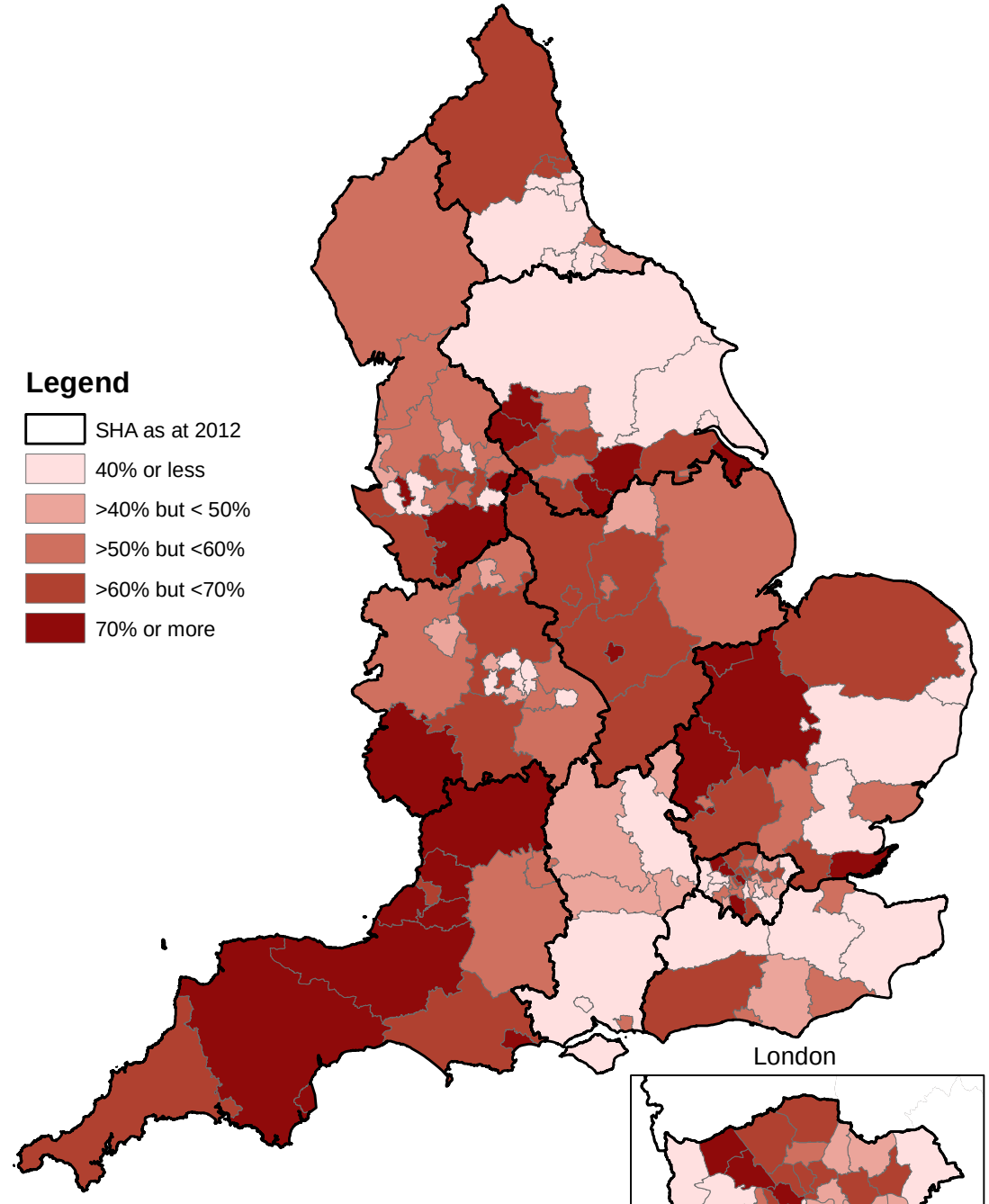
In all cases the maps show a considerable amount of clustering - PCTs' performance tends to be similar to that of their neighbours. The statistical likelihood of the degree of clustering observed occurring in a random assignment of the observed set of values was tested by calculating Moran's I. For all four of the coverage maps (figures 8 to 11) Moran's I was highly significantly above the theoretical expected value of -0.0067 (Coverage: 2011/12 I=+0.270, 2012/13 I=+0.246, Coverage in relation to QOF numbers: 2011/12 I=+0.212, 2012/13 I=+0.185, in all cases $p<=0.001$). The maps of the ratios of reported eligible numbers to numbers of people with learning disabilities reported as known to GPs in QOF data also showed significant clustering; (2011/12 I=+0.157, $p=0.002$; 2012/13 I=+0.114, $p=0.019$). To some extent and on some occasions clustering followed Strategic Health Authority boundaries, but the maps show many exceptions to this generalisation. In some cases, individual PCTs show striking improvements from the first to the second year.

Figure 8. Coverage of eligible people 2012/13. Number of people receiving a health check as a percentage of number identified as eligible by primary care trust; strategic health authority (SHA) boundaries shown.



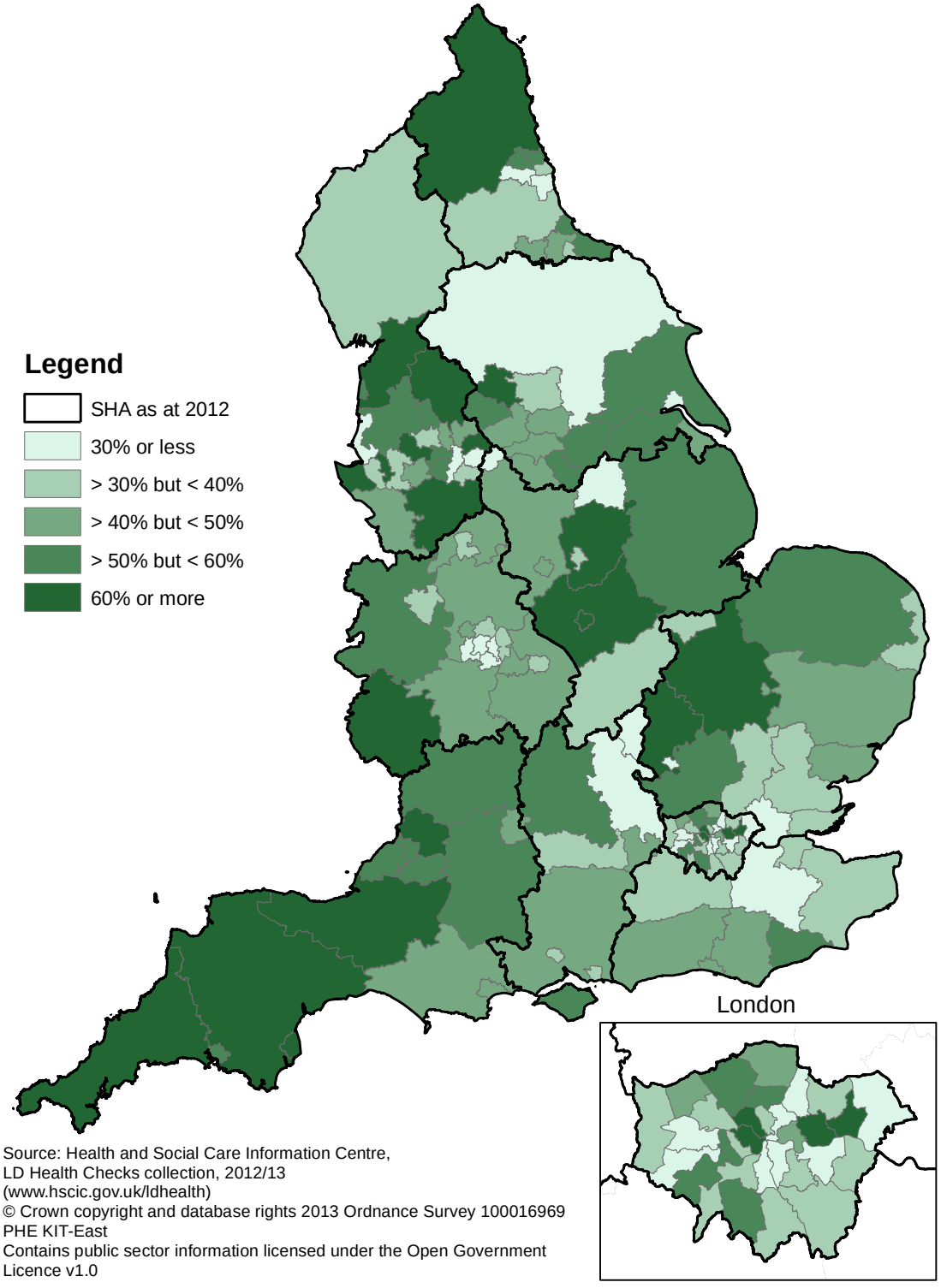
Source: Health and Social Care Information Centre,
LD Health Checks collection, 2012/13
(www.hscic.gov.uk/ldhealth)

Figure 9. Coverage of eligible people 2011/12. Number of people receiving a health check as a percentage of number identified as eligible by primary care trust; strategic health authority (SHA) boundaries shown.



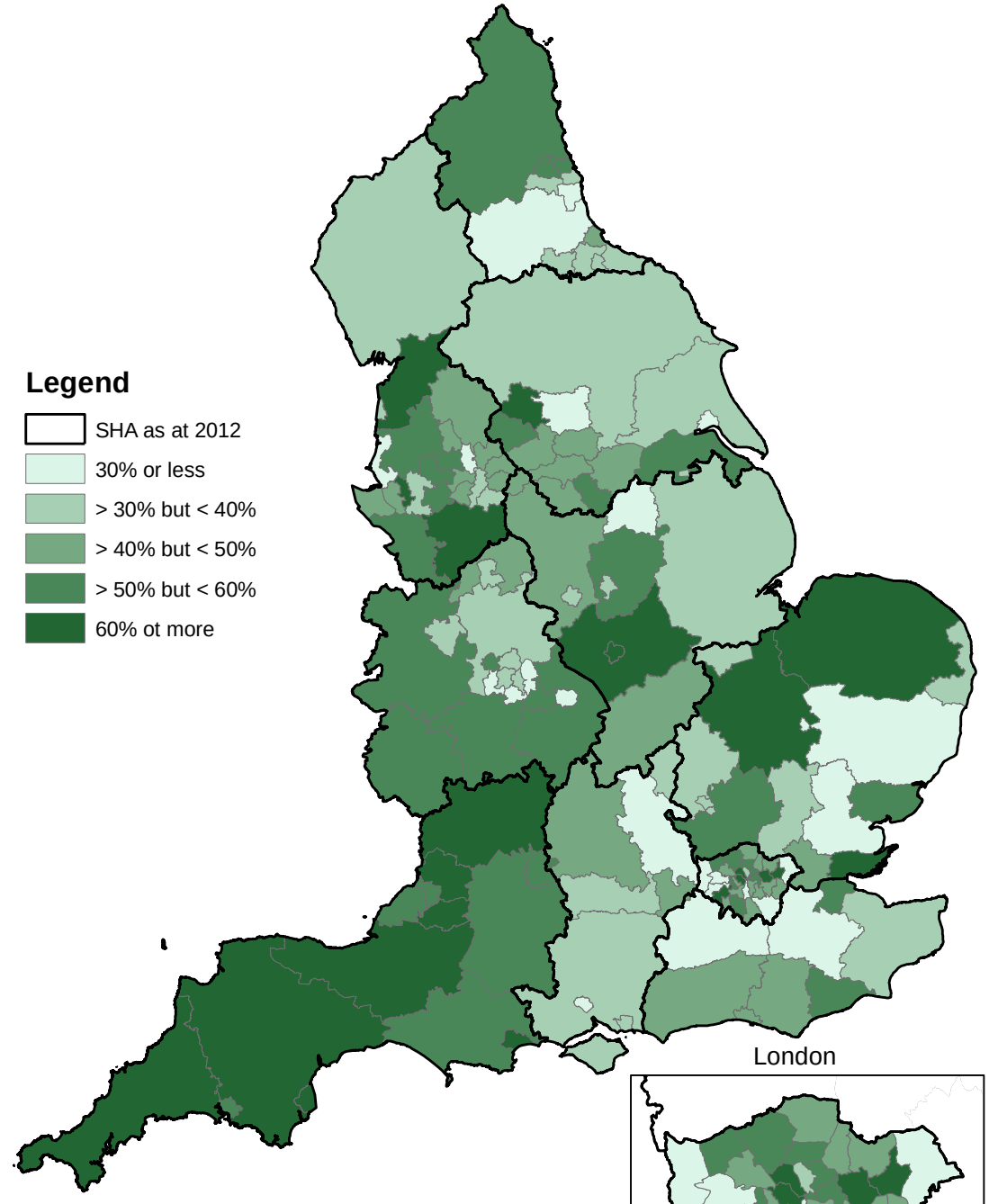
Source: Health and Social Care Information Centre,
LD Health Checks collection, 2012/13
(www.hscic.gov.uk/ldhealth)

Figure 10. Coverage in relation to numbers of people on QOF registers 2012/13. Number of people receiving a health check as a percentage of number known to GPs by primary care trust; strategic health authority (SHA) boundaries shown.



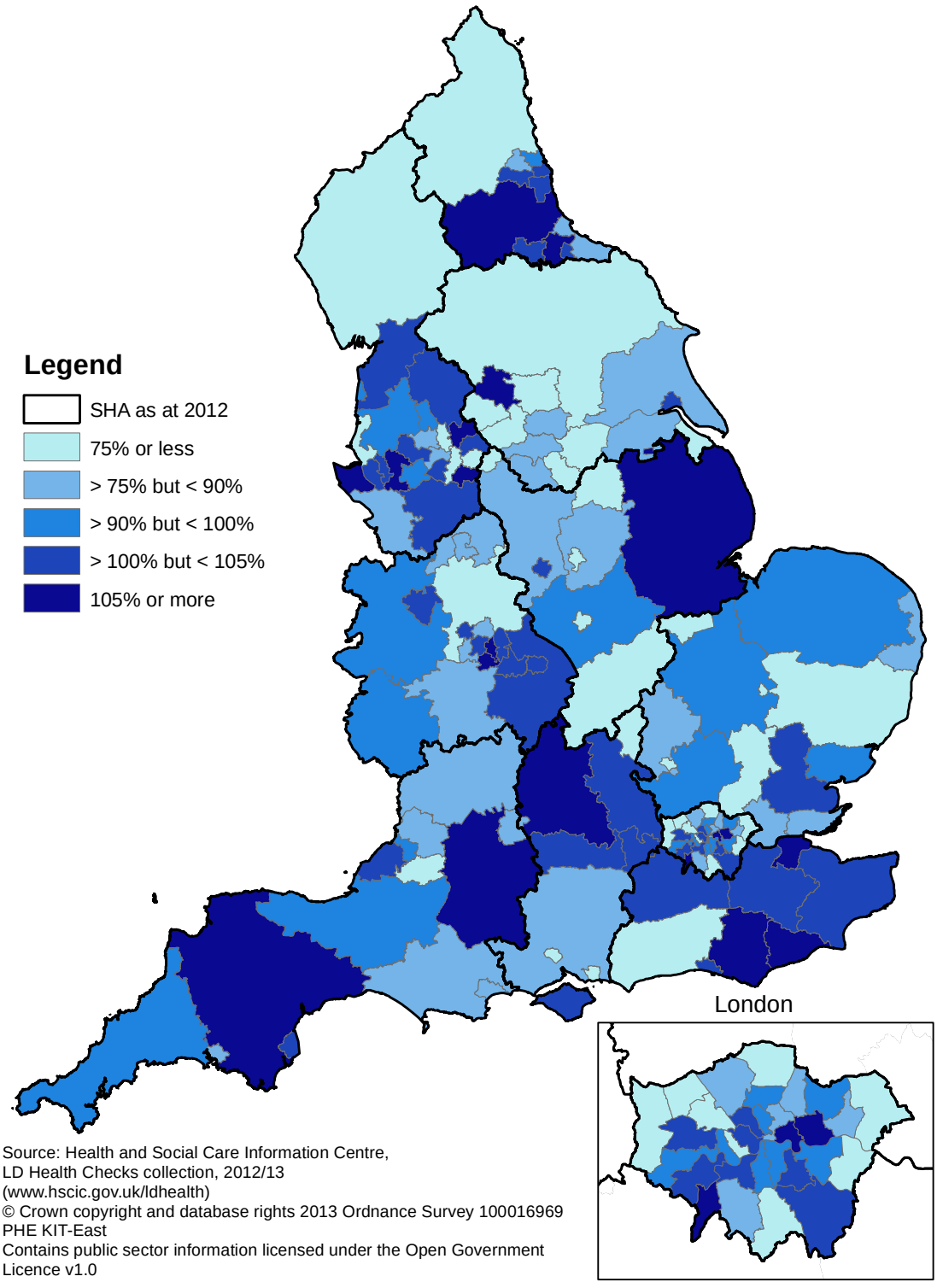
Source: Health and Social Care Information Centre,
LD Health Checks collection, 2012/13
(www.hscic.gov.uk/ldhealth)

Figure 11. Coverage in relation to numbers of people on QOF registers 2011/12. Number of people receiving a health check as a percentage of number known to GPs by primary care trust; strategic health authority (SHA) boundaries shown.



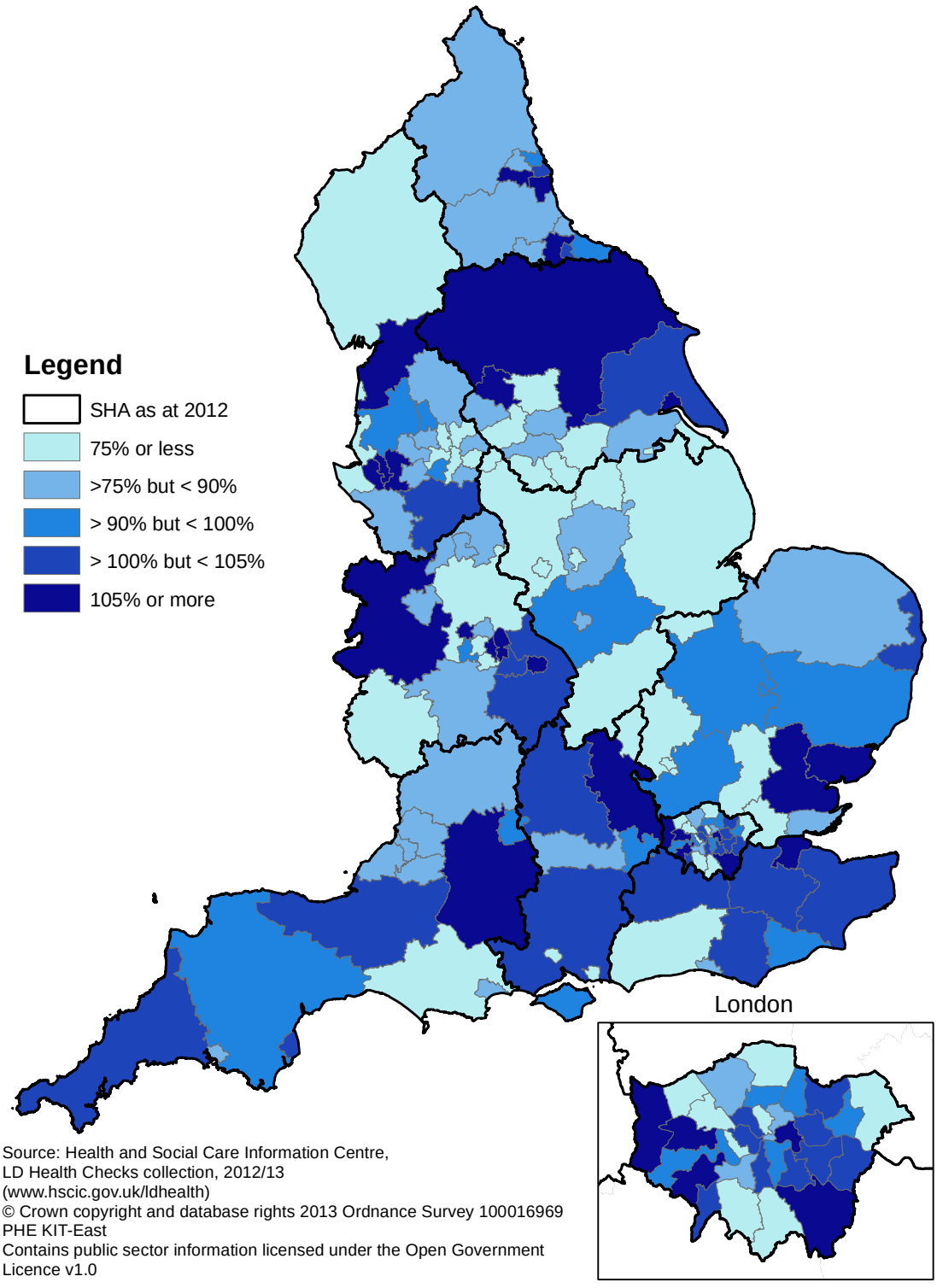
Source: Health and Social Care Information Centre,
LD Health Checks collection, 2012/13
(www.hscic.gov.uk/ldhealth)

Figure 12. Number of people identified as eligible as percentage of number known to GPs recorded in QOF registers 2012/13 by primary care trust; strategic health authority (SHA) boundaries shown.



Source: Health and Social Care Information Centre,
LD Health Checks collection, 2012/13
(www.hscic.gov.uk/ldhealth)

Figure 13. Number of people identified as eligible as percentage of number known to GPs recorded in QOF registers 2011/12 by primary care trust; strategic health authority (SHA) boundaries shown.



Source: Health and Social Care Information Centre,
LD Health Checks collection, 2012/13
(www.hscic.gov.uk/ldhealth)

Discussion

This is the Observatory's fourth annual report on this topic. Over the five years reported, overall there has been considerable progress. However the rate of improvement has slowed considerably. In part this may be due to the disruptions of the re-organisation. These may have had an impact both on the management of the health checks and on the collection of information about them.

There may be other factors impeding further improvement in the coverage of health checks which are emerging as the system matures. We have no evidence at present about the proportion of eligible patients who firmly do not want to have checks, or whose carers do not want this. (Where the latter is the case, we do not know if decisions to avoid checks are subject to 'Best Interests' protocols including an independent advocate for the patient.) By now GPs inclined to participate will mostly have come into the process. The minority who have remained outside thus far have presumably done so out of a positive choice. They may not be persuaded by the evidence of the efficacy of checks, or they may consider that whilst checks are useful, the rewards for taking up the DES are not worth the additional administrative and training burden involved. This may be a particular concern for practices with a comparatively small number of eligible patients. As the system has matured, able GPs, implementing it rigorously may have begun to find that after the first two or three health checks for any individual, new findings become less common and they consider it possible that checks in alternate years may suffice.

These questions cannot be explored with the data as collected to date. They require practice-level analyses, preferably linking the experience of patients from year to year. The new approach to monitoring the system announced earlier this year should provide this.(NHS England, 2013) NHS England envisages a quarterly extract of data about progress in undertaking the year's checks, taken directly from practice information systems. This will inevitably, at least initially, exist at practice level, although as announced to date, not at patient level. In the first instance the question of whether there is a substantial group of patients specifically resistant to participation will be a research one, one on which the big anonymised GP practice data systems could shed some light at relatively little cost.

However the findings do underline the observation made first in our report on the figures for last year, that PCTs that were doing well by three years ago have largely continued to do well whilst most of those with very low coverage rates then have stayed in this position.(Glover et al., 2012) Understanding why this is the case and tackling this source of geographical inequity seems likely to require action targeted specifically at areas currently performing poorly.

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Acknowledgements

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Annex 1. Guidance relating to the data collection.

The guidance on the following pages is reproduced from the website of the Information Centre for Health and Social Care. It is reproduced here as these documents are likely to be superceded.

Guidance Notes for the Annual Health Checks for People with Learning Disabilities return

Why the collection?

People with learning disabilities tend to have poorer health than the general population, yet are more likely to have poorer access to healthcare. This has been highlighted in a number of inquiries, reports and policies.

Formal Inquiries, reports:	Underpinning Policies:
• 'Healthcare for All' (2008) – the report of Sir Jonathan Michael's independent inquiry	• Valuing People Now (2008)
• Closing the Gap (2006) - a report from the Disability Rights Commission	• NHS Next Stage Review (2008)
• Six Lives (2009) - a report by the Parliamentary and Health Service Ombudsman and Local Government Ombudsman	• Our Health Our Care Our Say (2006)
• Six Lives (2010) - a progress report from DH.	

One aspect of improving healthcare for people with learning disabilities is to provide annual health checks. The Department and the BMA agreed a Directed Enhanced Service (DES), introduced in 2008/09, in order to provide health checks in general practice for people with learning disabilities known to local authorities. The new indicator monitors the proportion of people in this group who receive annual health checks.

If the local PCT is commissioning a Local Enhanced Scheme that meets the requirement of the DES, with regards to the content of the annual health check and the training component, then annual health checks provided under this scheme can be provided.

The Data collection table

First denominator: Number of people with learning disability receiving a health check

The only health check that should be counted is one that meets the requirement of the DES specification. Namely:

- The health check is undertaken by a provider who can demonstrate that they had appropriate training, which meets the standard outlined in the DES specification.

- The health check is based on a local protocol that includes the following.

  - a review of physical and mental health with referral through the usual practice routes if health problems are identified:
  - health promotion
  - a systems enquiry and review of chronic illness
  - a physical examination
  - a review of epilepsy
  - a review of behaviour and mental health
  - a syndrome specific check

- a check on the accuracy of prescribed medications
- a review of co-ordination arrangements with secondary care
- a review of transition arrangements where appropriate

Second denominator: Number of people with learning disabilities

This should be based on a list or register of people who are known to social services primarily because of their learning disability.

The clinical Guidance for the DES specifies that it is the number of "Learning disabled clients known to Councils with Adult Social Services Responsibilities: those clients who are assessed or reviewed in the financial year and who have received a service, as well as those who are assessed and/or reviewed but who have not received a service. In addition, include learning disabled clients who should be reviewed by the CASSR in a financial year but are not."

Support documentation:

See hyperlinks on Omnibus Guidance

Validations

Please note: if both Q1 and Q2 are zero please submit a nil return using the 'Nil Return' button found at the top-right of the online collection form.

Q1 - Number of people with LD receiving health checks

1. If the figure entered is zero please provide a reason for this in the breach box that will appear below the question on the online form.

Q2 - Number of people with LD

1. The figure entered should be greater than or equal to Q1.

2. If the figure entered is zero please provide a reason for this in the breach box that will appear below the question on the online form.