

GP Practice Step-by-Step Guide (with supporting information)

GP Practice Role - *To develop and deliver annual health checks for people with learning disabilities*

Note - whilst the following steps have been developed to assist practices, some may already have procedures and protocols of a similar nature that have worked well and could also be used to support the development and delivery of annual health checks

| Phase 1 – Preparation for Health Checks | |
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| Step 1 - Identify a clinical lead for Learning Disabilities | A GP or senior nurse should be identified to lead the process of service development and delivery within the practice. This person would also be responsible to commissioners for service provision under any enhanced service or service level agreement. |
| Step 2 – Practice reps to attend a health check awareness session | Once an agreement is in place between the Primary Care Trust (PCT) and the individual GP practices to implement a system of delivering health checks for people with learning disabilities, the Community Learning Disability Team (CLDT) in partnership with the PCT public health department should run a series of short ‘health check awareness’ sessions. Someone from each GP practice should be identified as having lead responsibility and should attend and feed back information from the session to the primary care team. The purpose of the sessions is: <ul style="list-style-type: none"> to raise awareness of the importance and implications of offering health checks to patients with a learning disability and may cover such topics as consent, confidentiality, appropriate information sharing and communication plus other topics identified as potential barriers to good primary health care locally. to ensure the primary care teams are aware of their responsibilities under the new Disability Equality Duty. |
| Step 3 – Identify people with a learning disability from the practice list or LD Register and identify which are priorities for health checks. <i>Consider other LD databases held by LA (cross reference QOF disease registers)</i> | GP surgeries need to identify people with learning disabilities from the practice list and record the details on a register of people with learning disabilities. Cross-referencing the practice register with information held by the Local Authority may be a useful way of identifying individuals whom the practice will want to include on their register (although the local authority register may not be a complete list) The GP practice will need to use an agreed Read code. Those commonly used include E3, Eu7, Eu81z or 918e, but the key requirement is to come to a local agreement across the PCT to meet the existing QOF indicator and identify the target population. Details need to include their home address and circumstances and should be updated annually alongside <u>annual</u> health checks from age 18 onwards. |

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| | <p>GP practices need to identify which of their patients are priorities for annual health checks, for example those patients who are:</p> <ul style="list-style-type: none"> - individuals with severe or profound impairments - Individuals with complex associated health needs - Individuals at risk of development of health issues because they may miss out on other opportunities such as health promotion or education. - Individuals who are on the register of persons who have learning disabilities that is maintained by the social services department of the relevant Local Authority. <p>The learning disability register should link to disease registers such as asthma, diabetes, epilepsy, CHD, older people, mental health. (People with learning disabilities not identified from the practice register can be referred for a health check by other health and social care professionals, as a self-referral or by their family or paid staff).</p> |
| <p>Step 4 – GP and Practice Nurse reps to attend specific health check training</p> | <p>GP practices should undertake appropriate training, ideally involving people with learning disabilities and the Community Team for Learning Disability (CLDT) for all staff involved in the health check process – for example, practice manager, receptionists, GPs, practice nurses and possibly health visitors, district nurses and community matrons in relation to individuals with complex or continuing care health needs.</p> <p>It may be necessary to run two training sessions in each practice to ensure all staff can attend. 12 weeks needs to be allowed to ensure the training programme is in place, people with learning disabilities are involved, dates arranged and the training is delivered.</p> |
| <p>Step 5 – Contact your local Strategic Health Facilitator and named link member of the local CLDT</p> | <p>GP practices should have a named member of the CLDT to link with the practice. The named CLDT member should be available for specialist learning disability advice, support, information, resources and may assist in terms of inviting people with learning disabilities for appointments, when required. The CLDT members may also help to develop and deliver the training package in partnership with public health colleagues.</p> <p>Practices should also work closely with the local Strategic Health Facilitator to ensure health checks are delivered in the context of other services and wider support for people with learning disabilities.</p> |
| <p>Step 6 – Ensure standardised e-template is available for clinical system with agreed Read Codes</p> | <p>GP practices should have access to a standard electronic template that has been agreed across the PCT by the informatics department, which picks up the key issues and is used during the health check as a record and for monitoring purposes.</p> |
| <p>Phase 2 – Carrying Out Health Checks</p> | |
| <p>Step 7 – Invite patient for a health check (use appropriate method) and check this invite has been received</p> | <p>A letter of invitation for a health check, together with an explanation, should be sent by the GP practice to each patient identified on the learning disability register, in an appropriate format, giving an extended appointment time or choice of times, or inviting the patient with a learning disability or</p> |

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| | <p>their supporter to call to make an appointment suitable to them. It may be necessary to telephone a week later to check the person has received the invitation for a health check and understood what they need to do.</p> <p>The CLDT link person may be able to offer help such as:</p> <ul style="list-style-type: none"> - designing the letter in appropriate formats - assisting primary care colleagues with health checks for patients with learning disabilities and complex needs - home visits to engage patients and families at risk of not attending. |
| <p>Step 8 – Ensure adequate appointment time has been allocated</p> | <p>Allow 3 – 4 weeks to arrange appointment slots that suit all individual needs. People with learning disabilities may need longer appointments with the primary care team because of communication or access problems.</p> |
| <p>Step 9 – Obtain patient consent (and consider risk and 'best interests' if consent not given)</p> | <p>Before the health check can be undertaken, consent must be given by the patient with a learning disability, and issues regarding communication, capacity and confidentiality need to be explored and explained. (See Mental Capacity Act). The CLDT member may be asked to support this process. If consent is refused, this should be discussed with the patient with a learning disability, and their family carer or paid supporter if appropriate, and they should be invited to attend again at a future date.</p> <p>The risks and consequences of not pursuing a health check need to be considered by the primary care team in partnership with the patient, family and paid staff if appropriate; if required, a best interest approach should be considered.</p> |
| <p>Step 10 – Carry out health check. Capture details and outcomes of health check on e-template</p> | <p>The health check is carried out by a primary care professional, with advice and support from the named member of the CLDT if necessary. The findings are captured on the GP practice based health check electronic template IT template as a record.</p> |
| <p>Step 11 – Draw up an agreed Health Action Plan in an appropriate format (with actions, timeframes and responsibilities) and integrate this into patient's medical record</p> | <p>When the patient with a learning disability attends for a health check, they should be helped to identify a health facilitator who will work with them and support them during the process and afterwards to ensure the Health Action Plan (HAP) is implemented. The CLDT may be involved in this process.</p> <p>A HAP is drawn up, based on the outcomes from the health check, with clear actions, named individuals to undertake and support the actions, and agreed timescales for the actions. Action may include the provision of information in appropriate formats. A printed copy of the plan is given to the patient with a learning disability and any other appropriate individuals, with the agreement of the patient with a learning disability. The HAP needs to be in a format that is understandable to the individual and their needs in line with the DED.</p> <p>The primary care team need to integrate a report of the health check into the patient's lifelong medical records. Where appropriate, the patient's family and/or support workers should be involved</p> |

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| | in the provision of care for the patient. They may need some information about the patient’s health care needs in order to support them as part of the HAP. |
| Step 12 – Agree any follow up appointment or annual review date | Either an annual review date or earlier follow up appointment (based on identified need) may be agreed with the patient with a learning disability to ensure the actions identified have been undertaken. |
| Phase 3 – Following Health Checks | |
| Step 13 – Ensure patient review and recall system is in place | Annual reviews for patients with a learning disability should be incorporated within the practice recall system. Reviews should include an updated health check and review of previously agreed actions. |
| Step 14 – Follow up any specific actions (referrals to other services, management of co-morbidities) | As with other patients on the practice list, continued management of primary health care will be necessary for the individual and, where necessary, their family carer. This may also involve following up referrals to other primary care and other services. |
| Step 15 – Continue liaison with family and CDLT staff as appropriate | The primary care team should continue to be involved in the health care needs of the individual, communicating to and receiving feedback from family carers, local CLDT staff members, and other services as appropriate. |
| Step 16 – Review practice procedure for health checks | GP Practice services, protocols and procedures should be regularly reviewed at least on an annual basis or sooner if service user feedback or other service regulation suggests. Essential and on-going learning by the practice will help improve health check services for people with learning disabilities. |
| Step 17 – Attend any new or refresher training as appropriate. | Continued professional development and keeping up-to-date on latest evidence and developments are essential parts of maintaining good professional practice. |

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