Appendix A: Health Improvement Team for Learning Disabilities End of Year Report 2024-2025

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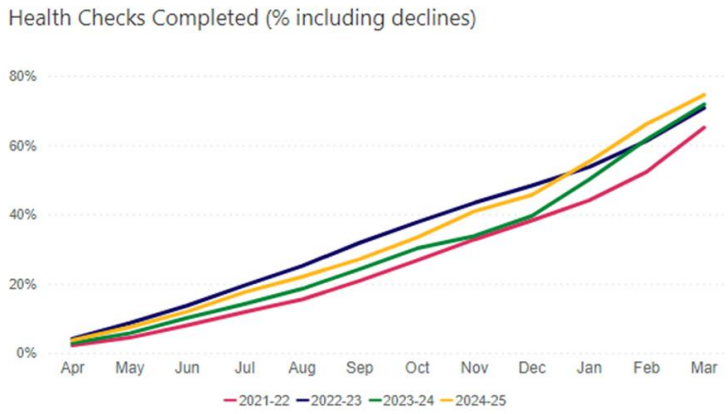
1. Executive Summary

The Health Improvement Team for Learning Disabilities is an integral part of delivering change that LeDeR promotes, to reduce health inequalities and improve the quality of care experienced by people with a learning disability. This is done by increasing the uptake and awareness of ill health prevention measures including, but not limited to, cancer screening, vaccinations and the learning disability annual health check. The teams hard work and dedication has been recognised over the year with our Health Improvement Nurse winning the NHS England East of England Learning Disability Nurse of the Year at the East of England Learning Disability Nursing Celebration. While our Health Improvement Facilitator was also nominated for NHS England East of England Learning Disability Support Worker of the Year at the same event. The team was also nominated for the Norfolk and Waveney ICB Staff Recognition Award for 'going above and beyond'.

2. Primary Care Support

2.1 Annual Health Checks

This year, Norfolk and Waveney delivered more Learning Disability Annual Health Checks than in any of the past 3 years (see below image). The attendance at annual health checks has continued to increase since the commencement of the health improvement team in 2021. Using both automatically extracted and manually submitted practice data, Norfolk & Waveney GPs have delivered 76.8% of annual health checks to patients in Norfolk & Waveney.



2.2 Learning Disability Registers

The team has trialled some support on case finders with some practices. Case finders are searches that can be completed on GP systems to identify codes on the patient record that could indicate someone has a learning disability. The team reviewed records of 710 patients, sending feedback to practices on 66 of these patients, with the suggestion that 21 of these patients were added to the learning disability register and that others may need some further exploration with the patient as a possibility to add. This work took a significant amount of resource and is best completed by practice staff, so the team share this useful tool with surgeries for their consideration. The team have had multiple requests on learning disability register eligibility, but this is not currently collected in data sets, this will be reviewed to capture in the future.

2.3 Learning Disability Leads Meeting

The team continue to run a network meeting for people identified in their practice as a learning disability lead/champion. These roles include GPs, nurses, practice managers and administrative staff. Colleagues from the local Community Learning Disability Teams are invited to attend to promote networking. The meeting is hosted monthly on MS Teams, with speakers based on recent learning, including from LeDeR reviews. Over the last year topics have included safeguarding, learning from the LeDeR annual report and end-of-life care. Services such as Vision Norfolk, Change Grow Live (CGL) and Talking Therapies have attended to share how they support people with a learning disability and improve referrals and collaborative working. There are 181 members on the MS Teams channel, which provides updates on learning disability care and details of events and webinars. The sessions are recorded and made available for staff that can't attend live.

2.4 Training

The team delivered multiple training sessions either face to face or online via MS Teams, some delivered in conjunction with the Community Learning Disability Teams. The sessions were delivered on a locality basis, which allowed for local areas to meet with their local community learning disability nurses. Other sessions the team were invited to include the Norfolk and Waveney Learning Opportunities and Cancer Champions for Primary Care. The delivery of training on MS Teams has allowed more surgeries to be reached and improved the team's capacity. The sessions were recorded and remain on the repository for primary care to be signposted to if people request further sessions. Please see below for number of attendees at these sessions:

Training	Attendees
Admin Training	80
Learning Disability Awareness - West	25

Learning Disability Awareness - South	11
Learning Disability Awareness - North	16
Learning Disability Awareness - Norwich	22

2.4.1 Feedback from Training Sessions:

After the online sessions the facilitators collected feedback. All participants that completed the feedback said that the session was delivered clearly and that they had an improved understanding of local learning disability services and support. When asked to rate the sessions on how useful they were from 1-5 (with 1 being not very useful and 5 being very useful) the facilitators received an average score of 4.5 and none of the participants scored under 3. One question asked if there were any changes staff would make to their practices after the session and some feedback included:

- *"Will do a more enhanced assessment"*
- *"Will use pre health check questionnaire as had not been aware of it"*
- *"Look at limiting time in waiting room or alternative spaces"*
- *"Feel more confident about inviting patients in and can reassure them now I know what will happen at an appointment"*

3. Patient Outreach

The team changed processes this year, asking practices to make three invitation attempts before requesting support with engaging in the annual health check. The team provide outreach support for 93 patients who had not had their annual health check in the last 12-18 months, and they supported 43 (54%) who were eligible to have their annual health check. Some required support with transport and/or asked for the team to attend the appointment with them. The team have completed over 67 home visits to patients and multiple contact attempts have been made via various methods, including but not limited to phone, text and email. In some cases, despite multiple contact attempts and home visits, the team have not been able to contact patients, these have either been referred onto the police for welfare checks, safeguarding or a plan has been made with their GP practice, such as adding alerts to their records.

Some of the reasons that were observed for patients not attending their annual health checks are anxiety, not being aware of the annual health checks, reasonable adjustments not recorded or implemented, poor understanding or use of mental capacity act or lack of support to attend. The team have worked with practices to consider home visits for some patients where required due to anxiety. Some patients did not have a learning disability, and we advised practices to remove them from the learning disability

register, therefore supporting practices to save resources in offering annual health checks to people who did not have a learning disability. Some patients chose to decline the annual health check, the team ensured they had access to accessible information to make an informed choice. Some patients agreed to book their appointments but did not attend and declined further support from our team. Many of the referrals are complex and require support from additional teams, such as colleagues in the learning disability community teams, social care and safeguarding. Some patient support has carried over into 25/26 to continue with engagement.

Case Study

Nick (pseudonym) is in his 50s and had never had an annual health check and had not collected his medication in recent months. The team were contacted by his GP practice as they were unable to contact him, he did not have a phone and was not responding to letters. The team visited him at home and observed some swelling to his legs, the team contacted his GP who offered a same day appointment where treatment was offered for leg swelling and medication restarted. The team later supported him to attend his annual health check which also included a discussion with care co-ordinator at the surgery for some signposting for social support that was required, including social prescriber appointment booking.

3.1 Events

The team attended 20 events across Norfolk and Waveney to hold stands and raise awareness of the learning disability annual health check, screening programmes and other health promotion and illness prevention information. This includes two during Learning Disability Awareness Week in June 2024, with colleagues across the ICB. Regular stands are held at PositivTEA and Making Sense of SEND. Most events were well attended, the feedback from discussions were that people had not heard about the annual health checks previously and were going to contact their GP surgeries, asking for reasonable adjustments as required. There are a high number of queries related to support for people with autism and requesting details on when an autism annual health check will become available.

3.2 School Promotion

NHS England requested an increased focus on engagement with the 14-17 year cohort for the 24/25 financial year and therefore the team visited 9 local special education schools with the highest percentage of young people with a learning disability, joined by colleagues in the community learning disability and CAMHS teams and oral health (Happy Smiles and Community Dental Services). The team worked closely with colleagues in the ICB Health Inequalities Team to utilise the Wellness on Wheels (WOW) bus. The children and young people can visit the WOW bus, which has a clinical room environment, look at and practice using

some medical equipment and share their health experiences. An information pack was sent home to parents and carers including information about the annual health checks and local services. The teachers fed back that it was helpful to have these discussions and would like to see this on a regular basis. This work could be reflected in this year's data which shows an increase in attendance at annual health checks in the 14-17 cohort and an increase of young people being appropriately added to their GPs learning disability register.

4. Care Homes and Supported Living Engagement

The team have worked closely with Norfolk County Council Learning Disabilities Commissioning Team to complete joint visits to residential and care homes to promote learning disability annual health checks. The Quality Improvement Officer reported the following about the joint visits:

"These collaborative visits have had a significant impact, including:

- *Demonstrating a unified, collaborative approach to providers, rather than appearing as isolated professionals.*
- *Enhancing providers' understanding of Annual Health Checks, empowering them to confidently challenge GPs who do not complete Gold Standard reviews.*
- *Offering additional training, which has deepened providers' knowledge of health provision, and the expectation is to directly improve the quality of care delivered to the individuals they support.*
- *Providing a valuable opportunity for providers to ask questions and seek clarification on Annual Health Checks.*

- *The team provided content to support the development of the Provider Handbook"*

The team have conducted 29 visits to homes that are flagged as "providers of concern" or have Care Quality Commission (CQC) ratings of Requires Improvement. 83% of these visits included a 45-minute training session to managers about what to expect during an annual health check and advice on accessing screening programmes. This provided staff with an understanding of why annual health checks are important and what a good quality annual health check should include, meaning staff can advocate for residents during their appointments to assist with improving quality of provision. The training outlines what to expect in a health action plan and staff have reported an increased confidence to ask for one and implement it after an annual health check. Overwhelmingly, the feedback from care homes is that they don't receive a health action plan at the end of the annual health check, despite the data showing that 78% of people received a health action plan. Some care homes have invited the team back to provide an enhanced training session to other members of care staff in their organisations. During these sessions staff have reported barriers they face to accessing healthcare for their residents and advice has been given about how to challenge this. Some challenges expressed have included:

- Lack of information from GP surgery as of what to expect when going for appointment therefore staff cannot prepare residents, and it has meant that patients miss blood tests as they were not prepared before going.
- Residents being recorded as having an annual health check during a care home visit, despite the person not being seen by the GP during the visit.
- Communication with practices and not having appropriate recorded reasonable adjustments and information sharing so staff cannot make appointments when residents are non-verbal or unable to speak on the telephone.
- Capacity and best interests not being completed around accessing screening programmes

Some homes have requested additional resources and support discussions around accessing bowel screening for their residents. At one home they had tried alternative ways of engaging the residents to complete bowel screening, the health improvement team looked back at their annual health checks and there was no documented discussion around bowel screening. The health improvement nurse discussed this with the surgery and planned with them to ensure this was part of their next annual health check and to complete capacity assessment and best interest discussion where applicable.

Feedback received from an assistant manager of a care home:

At the time of the visit, the home had concerns around their GP surgery and felt the doctors did not value the staff knowledge about residents. They were also having problems booking in residents to have their annual reviews. Residents whose review had

been completed were very quick, with minimal questions being asked, it was normal for several resident's reviews to be completed within an hour. In some instances, the GP would only spend 5 minutes with some residents.

Part of the support provided by the ICB was to inform the home what an annual health review should entail and how long it should be. Easy read booklets about annual health reviews and health screening were given to the home to make residents more aware of their health needs.

As a result of the training, the staff are aware that annual health reviews should take an hour for each resident. They also have written guidance around what questions and tests are completed at the review which has provided them with confidence to challenge if annual reviews are not being completed to Gold Standard level.

The training has given the staff the confidence to know when reviews are not being completed to Gold Standard and they will push back and request further input from the GP surgery.

5. Quality Improvement & Partnership Working

5.1 Partnership Working

The team continue to attend regular network meetings including but not limited to: Local Safeguarding Adults Partnership, National Health Facilitators Network and Norwich Asylum Seeker and Refugee Forum. Additionally, the team attend working group meetings and liaise closely with colleagues in the ICB to drive improvements in the annual health check delivery. The Health Improvement Nurse regularly attends the LeDeR – Learning into Action Groups, allowing for learning to be shared to primary care and community care staff via the learning disability leads meeting and within other communications with practices and providers. The team sometimes are allocated specific actions from reviews to support individual practices. The team have good partnership working and collaboration with the LeDeR team to provide improved outcomes for patients.

5.2 Reasonable Adjustments

The team have been promoting reasonable adjustments and suggesting practices begin using the SNOMED codes to capture these in training and communication with practices as per guidance for promoting the agenda for the digital flag implementation.

5.3 Cancer Care & Screening

The team have collaborated with the ICB cancer team in developing a charter and developing a pathway for cancer care and screening for people with learning disabilities. An action for the team was to promote that when people attend for their annual

health check, they are asked about screening programmes. Local data shows us that there has been an increase in the number of people being given advice about cancer screening.

Advice on…	22/23	23/24	24/25
Bowel screening	19	157	1433
Breast screening	8	58	695
Cervical screening	8	67	799

5.4 Pre Health-Check Questionnaire

The team has worked with colleagues in Suffolk & North East Essex ICB to review and adapt their pre health check questionnaire. This was further reviewed this with local advocates at Opening Doors and adapted following learning from LeDeR. It was launched as a hard copy and as an editable digital version.

5.5 NHS (40+) Health Check Promotion

The team have been part of improving cardiovascular health, working closely with colleagues in Norfolk County Council. To achieve this, they have been promoting the 40+ NHs health check to parents and carers to reduce cardiovascular disease burden and improve parent/carer health. At all the events and training sessions attended, information was shared about the 40-74 NHS health check to support paid carers, colleague and parent-carers to look after their own health and support the wider cardiovascular prevention work.

5.6 New Learning Disability Annual Health Check Business Intelligence (BI) Dashboard

The team has supported the ICB BI team to create a dashboard using clinical system data from Norfolk and Waveney practices who have opted into a local data sharing agreement. This new dashboard allows commissioners and the health improvement team to target support where the data shows that a practice has a high number of patients who have never had a health check, or where there are gaps in reporting on key elements of an annual health check.

While this information is anonymous, it is now possible for practices to request the reports showing the number of patients who haven't had an annual health check in the past three years is provided for them directly with patient details so that they can follow up with patients. This has been trailed successfully with two Norwich practices and is now being used with West Norwich Primary Care Network.

An example of this data being used where there is an improvement is an increase in practices discussing vaccinations with patients during the annual health check. See table below:

Vaccine	22/23	23/24	24/25
Flu	26	217	2002
Pneumococcal	1	17	370
Hepatitis B	4	47	391

6. Forward Planning for 2025/2026

Building on the progress made in 2024/25, the ICB has identified several priorities to further strengthen delivery of Learning Disability Annual Health Checks in the coming year, which will be supported by the Learning Disabilities Health Improvement Team.

1. **Sustain and enhance support to General Practice** to ensure consistent, high-quality delivery of Learning Disability Health Checks.
2. **Introduce routine feedback mechanisms** to capture and act upon patient experience.
3. **Focus on younger cohorts**, particularly 14–17-year-olds, to drive early engagement.
4. **Target those who have never had a check**, ensuring equitable access for all on GP Learning Disability list register.
5. **Leverage the new BI Dashboard** to identify gaps, monitor progress, and provide tailored support to practices.
6. **Increase reasonable adjustment digital flag recording**, to ensure equity of access to health appointments
7. **Enhance delivery of awareness sessions for care providers**, ensuring they are aware of what to expect from an annual health check.
8. **Reaching 75% target for attendance**, via awareness raising, event attendance to people with learning disabilities and their carers.