We thank Russell and House for raising an important issue which we lacked space to discuss in our paper1. While we noted “practices may not identify all ID individuals, especially those with mild ID”, it was not our intention to underestimate this difficult task.

Adults with ID not known to primary care in England, have been described as a “hidden majority”, due to administrative health systems failing to detect a large proportion of mild and moderate ID2. Large discrepancies have been seen between the administrative prevalence of mild or moderate ID identified in school age *children* compared with *adults* from primary care registers (the “transition cliff”2), and Public Health England have estimated that 2.17% of the English adult population may have ID3.

A meta-analysis estimated global ID prevalence at 1.0%4, falling to 0.5% when only adults were considered. Our study of adults in England estimated a prevalence of 0.54%1, similar to a recent Scottish study (0.56%)5. Prevalence rates in adults calculated using QOF registers have stabilised around 0.5%6, so a true prevalence of 2.0%, implies 3/4 patients with ID are not on QOF registers. In our data, only 8% of practices had a prevalence >1.0%, so while ID coding is highly variable across practices, any potential under-recording of ID must be consistent across them.

In our data, among those with severity recorded, about 1-in-4 adults were classified as severe/profound, compared with 1-in-5 estimated known to schools in 20133. Assuming all severe/profound patients have been identified, and the under-recording is only of mild/moderate ID, then 2% prevalence would result in only 7% (1-in-15) of our patients having severe/profound ID, much lower than 1-in-5.

Finally the implications for any under-recording in our study would be that our comparisons with the general population are exaggerated, as we assume that ID patients with chronic co-morbidities are more likely to be known to primary care, presumably having their ID recorded as a result. However, our central message of improving continuity of care and offering longer appointment times is not changed. Nor should it detract from efforts to better collect and identify ID among adults7.

Word count: 350

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