

IMPROVE PHYSICAL HEALTH OUTCOMES IN AN ENHANCED CLINIC

I. SAWHNEY¹, G. MOUSAILIDIS¹, M. SATHICK¹, K. SCHRODER¹, E. STANLEY¹, K. HEERY¹

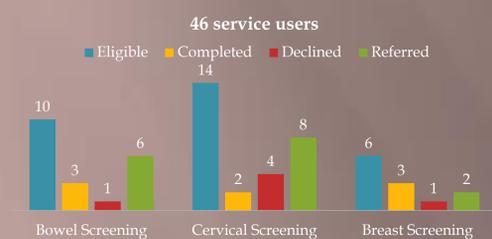
1. HERTFORDSHIRE PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Aim and background

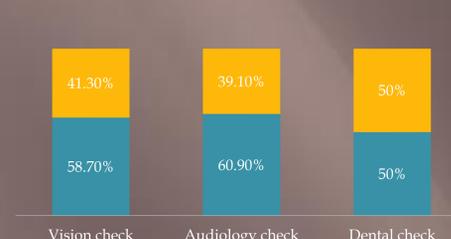
To improve physical health outcomes in an enhanced physical health clinic for patients with Intellectual Disability open to our services. There is significant evidence to indicate that people with Intellectual Disability are at greater risk of poor physical health and reduced life expectancy compared to the general population. People with Intellectual Disability experience significant health inequalities, which contribute to discrepancy in the age of death between people with Intellectual Disability and the general population; 22 years earlier for males and 27 years earlier for females. It is well established that people with Intellectual Disabilities die from an avoidable and preventable medical cause of death twice as frequently as people in the general population. LeDeR (National Learning Disability Mortality Review Programme) has emphasised on disjointed service provision between multiagency and on poor quality of care received by those adults with Intellectual Disabilities who have died and has recommended the need for improved health screening, working in conjunction with other health services in reducing the preventable causes of death.

Methods

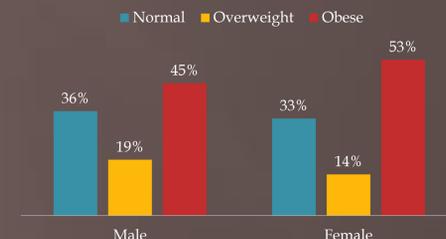
A series of key physical health parameters to monitor in the clinic were identified from LeDeR (National Learning Disability Mortality Review Programme) and QNLD (Quality Network for Community Learning Disability) standards, and screening tool for physical health was devised to include blood pressure, pulse, weight, waist circumference, screening for cardiovascular and fracture risks, smoking status, activity levels, uptake of national public health screening programmes (cervical, breast, bowel screening), audiology, vision, dental, annual health checks, dysphagia, constipation and blood tests. We sent an invite for physical health screening appointment to 80 patients who were open to Intellectual Disability services. In total 46 patients were reviewed in the physical health pilot immediately after Covid lockdown was eased off.



Graph 1. Cancer screening uptake



Graph 2. Vision, audiology and dental annual checks



Graphs 3. Service users BMI

Results

For patients where health problems were identified, they were offered individual health facilitation support to enable them to access the requisite services. Most had their annual health checks with GP completed 41/46. GP referrals were made for those who needed annual health checks (5/46), hypertension (2/46), constipation (4/46) smoking cessation (4/46). Patients who were eligible and not had the cancer screening were also referred to GP for the same; Bowel 6/10, Breast 2/6, Cervical 8/14 (graph 1). Similarly, those who were identified not having health checks completed in the last year (vision 27/46, audiology 28/46 and dental 23/46) were referred to appropriate services. (graph 2). 20/31 males and 10/15 females were found to have increased BMI (graph 3). Social prescribing was offered as a major component underpinning this pilot and we made specific interventions for patients to facilitate healthy lifestyle choices including promoting exercise in 21/46 patients and diet modification with referral to specialist dietician for 22/46. 4 service users were identified with dysphagia and were referred to SaLT. Calculated standardized Q-risk scores >20 in 4/46 and Q-fracture scores >10 in 4/46.

Conclusions

Following our recommendations from enhanced clinic, all annual health checks were completed. Referrals to GP and specialist services were offered via multiagency health care co-ordination work with proactive support from individual health facilitation, and referrals for hypertension 2/2 (treated); constipation 2/4 (treated), 1/4 (ongoing); dietician (2/22 intervention commenced, 18/22 awaiting support), SaLT (1/4 intervention commenced, 2/4 awaiting support), breast screening (1/4 completed, 1/4 awaiting support). Blood investigations were completed in 4/11 and other 6/11 were referred to blood facilitation pathways and are awaiting support. Social prescribing to improve their lifestyle with exercise promotion through referrals to sports in confidence (19/46) and smoking cessation (1/4 successful, 2/4 awaiting support) were taken up. This co-ordinated approach from enhanced health clinic has shown as a step towards bridging the existing health inequalities in intellectual disability population, in spite of annual health checks.

Literature

1. Learning Disability Mortality Review (LeDeR) Programme: Action from Learning, available at <https://www.england.nhs.uk/publication/leder-action-from-learning/> (accessed 25/09/20)
2. Quality Network for Community Learning Disability Service, RCPsych October 2019.
3. Hollins Sheila, Tuffrey-Wijne Irene. (2013) Meeting the needs of patients with learning disabilities *BMJ*, 346 :f3421
4. Cooper, S.A., McLean, G., Guthrie, B., McConnachie, A., Mercer, S., Sullivan, F., & Morrison, J. (2015). Multiple physical and mental health comorbidity in adults with intellectual disabilities: Population-based cross-sectional analysis. *BMC Family Practice*, 16, 110