# Improving Physical Health Outcomes for PWLD –

# **Enhanced Physical Health Clinic**


***Dr Inder Sawhney*** *– Consultant Psychiatrist & Clinical Director*

***Dr Mohamed Sathick*** *– Consultant Psychiatrist*

***Eresha Koralalage****-Physician Associate*

***Katy Heery*** *– Clinical Matron/Community Clinical Nursing Lead*

***Amanda Haskell*** *- HCA*

# Overview

- Background
- Setting up of the clinic
- Enhanced physical health clinic
- Next steps

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# Background

- PWLD  more comorbid disorders with a median of eleven compared with five in the general population (Kinnear D etal, 2018)
- People with ID  have higher physical health comorbidity: dysphagia, gastro-oesophageal reflux, constipation, visual impairment, hearing loss, cerebral palsy, epilepsy , CHD, hypothyroidism (Haveman et al., 2010 , Cooper et al., 2015)
- Lifestyle factors: having a sedentary lifestyle, obesity and difficulties with maintaining hygiene independently (Haveman et al., 2010)
- People with intellectual disabilities have higher rates of mental disorders than the general population & are prescribed more psychotropic medication than others (Cooper et al, 2007 & Flynn,  2012)
- Diagnostic overshadowing

# Background

- LeDeR report:
  - Discrepancy in the age of death between people with intellectual disabilities and the general population; 22 years for males and 27 years for females
  - Only 37% of people with a learning disability live beyond 65 compared to 85% in the general population
  - People with learning disabilities likely to die from an avoidable cause 2 times more frequently as people in the general population
  - Avoidabel causes of death in adults were 24% in 2018, 23% in 2019 and 24% in 2020.
  - A total of 9,110 deaths of people with learning disabilities occurring between 1st Jan 2018 and 31st December 2020 were notified to the LeDeR programme
  - Almost a quarter of adults (24%) were usually prescribed an antipsychotic medication & 28% of adults were usually prescribed an antidepressant medication

# Background

- Not having had an annual health check in the previous year, risk of dying 1.5 times greater (LeDeR )

- In the year 2019-20, 57.8% of patients with a learning disability had a Learning Disability Health Check in England.

- The NHS Long Term Plan set an ambition that by 2023/24, at least 75% of people aged 14 and over on the learning disability register receive an annual health check.

- Barriers: A survey found that 60% of people with intellectual disability or autism felt their GP did not make reasonable adjustments for them and quarter of GPs said they don't have enough time in their appointments to make reasonable adjustments


.. maybe we should try to think out of the box?
Innovation Department

# Aim

- To improve physical health outcomes in an enhanced physical health clinic for patients with intellectual disability

- Monitoring through a structured Enhanced Physical Health Clinic, working in collaboration with Primary Care and wider health and social care providers, in a step towards bridging the existing health inequalities

- Patients identified are risk stratified as on high-risk group associated with use of psychotropic medications and with physical health morbidity.

# Physical Health Clinic

- Pilot 2020: 46 patients reviewed

- **Set up the 1st enhanced physical health clinic at National level** : Physical health checks undertaken by Learning Disability Services with their expertise after making necessary reasonable adjustments, working in conjunction with Primary care, Multidisciplinary Teams and wider health systems.

- **Team** :
  - Physician Associate
  - Nursing Associate
  - HCA
  - Admin Support

# Physical Health Clinic

- **New Model of Care: Innovative, Transformational QI project:** Comprehensive physical health review undertaken by ancillary professionals (Physician Associate & Nurse Associates) within Community Learning Disability Services

- **Focus on proactive health screening and health monitoring** followed up by targeted intervention underpinned by proactive individual health facilitation and specific intervention with social prescribing

- **Comprehensive physical health monitoring toolkit** was developed informed by the findings of LeDeR

- **Comprehensive physical health monitoring toolkit** with validated and other screening tools for baseline measurements
- **Cardio metabolic monitoring and cardiovascular risks**
- blood pressure, pulse, SpO2
- height, weight, waist circumference, BMI
- cardiovascular risks (QRisk3 score), ECG

- **Biochemical monitoring with blood tests**
- **Specific psychotropic medication monitoring** (Antipsychotics, Lithium, Valproate, Stimulant medications) GASS scores

- **Screening for specific health issues**
- Screening for Bone health & risk of fractures (Q-fracture score)
- dysphagia, constipation
- lifestyle status smoking, alcohol consumption, activity levels

- Uptake **of national preventative health and public health screening programs**
- Cervical Ca, Breast Ca, Bowel Ca, Prostrate Ca, AAA screening)
- **Screening** for audiology, vision, dental
- **Screening** for annual health check uptake

# Physical Health Clinic

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- **Co-production**: Easy-read physical health action plan template, Identify the interventions is by shared decision making

- **Bespoke personalised care plan:** Developed in collaboration with the patients

- **Health action plans** are followed up by facilitating proactive support for Interventions in conjunction with wider CLDT/ ELDP

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- **Reasonable Adjustments:**

  - Longer Appointments; Multiple Appointments; Desensitise patients; Friendly environment with music

  - Reclined phlebotomy chair; Patients with capacity involved in action plan; Home visits

  - Psychoeducation provided with easy read leaflets for medications, diet and lifestyle, constipation, action plan etc

# Physical Health Clinic

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You attended a Physical Health Clinic Appointment at Lexden Hospital on .....

This appointment was to check your Physical Health and to monitor some of your medications.

**We carried out some physical health observations**

- Height
- Weight
- Waist measurement

- Blood Pressure

- Temperature

- Oxygen levels in your blood
- Pulse

- E.C.G.

- Blood tests

**We discussed your health with you and ... at your appointment**


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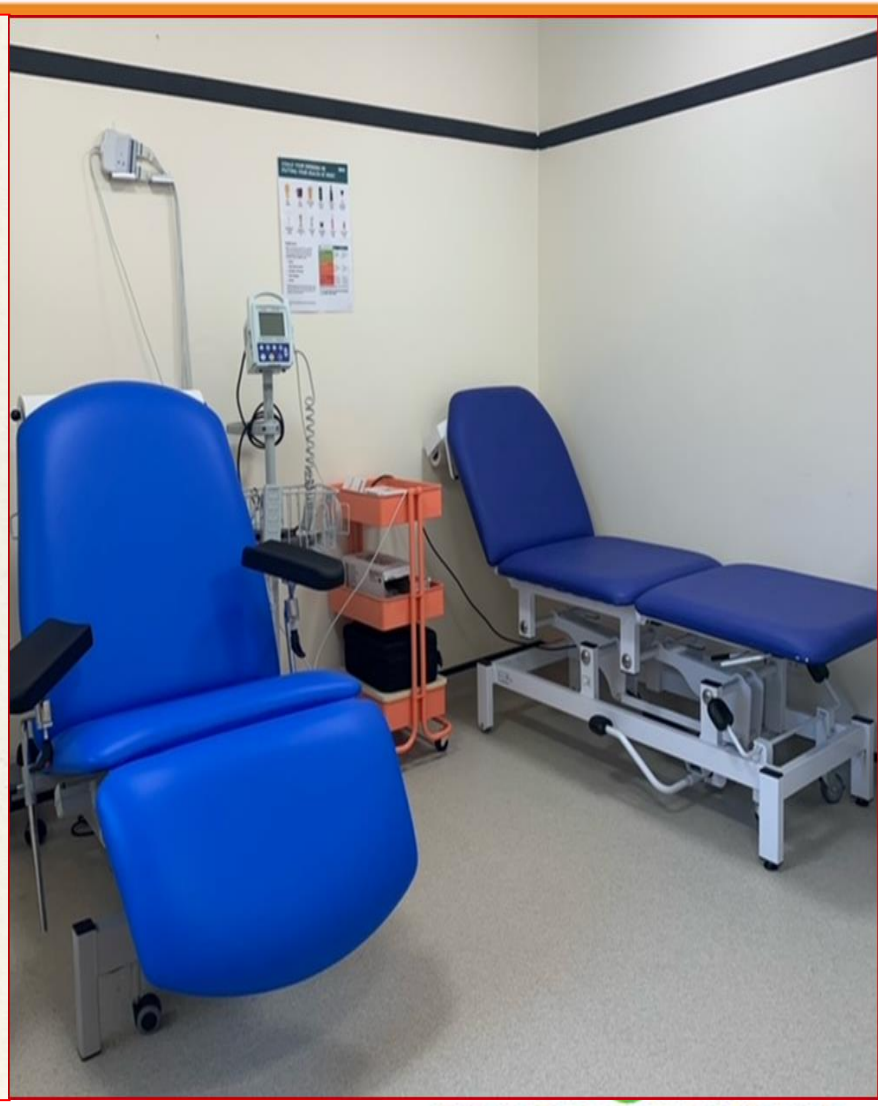
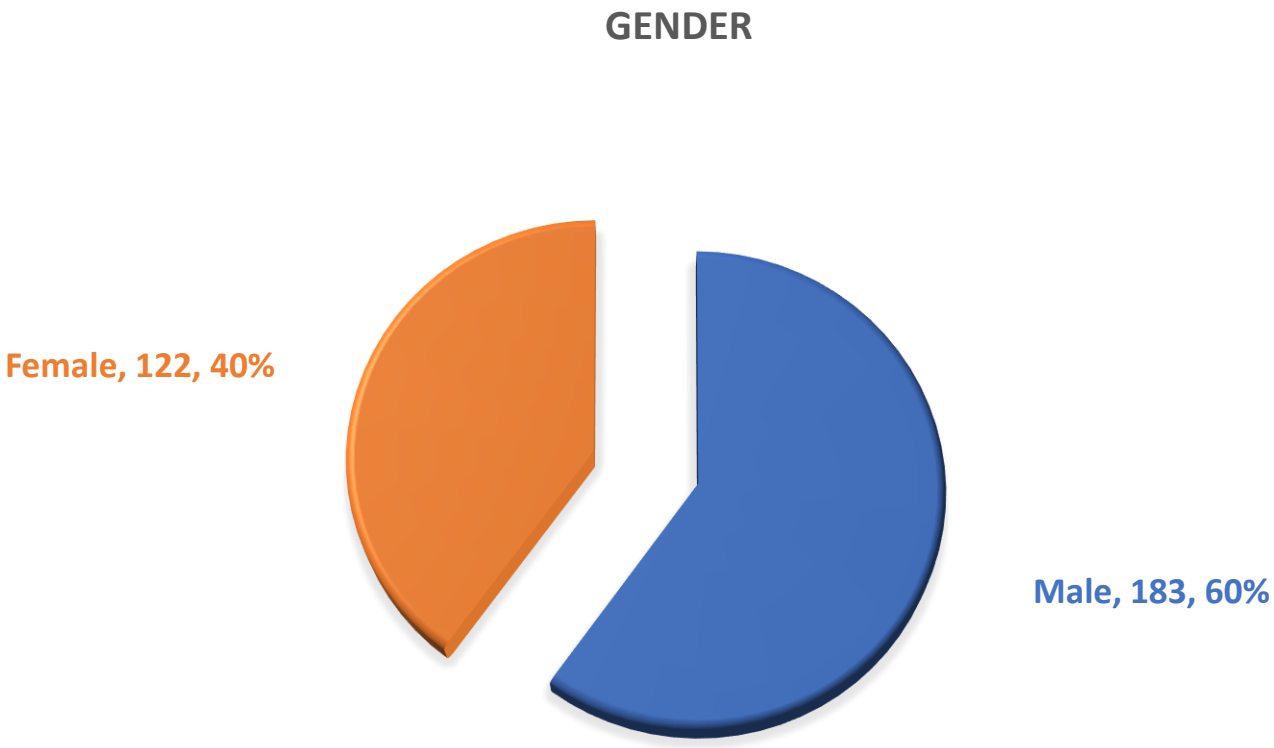
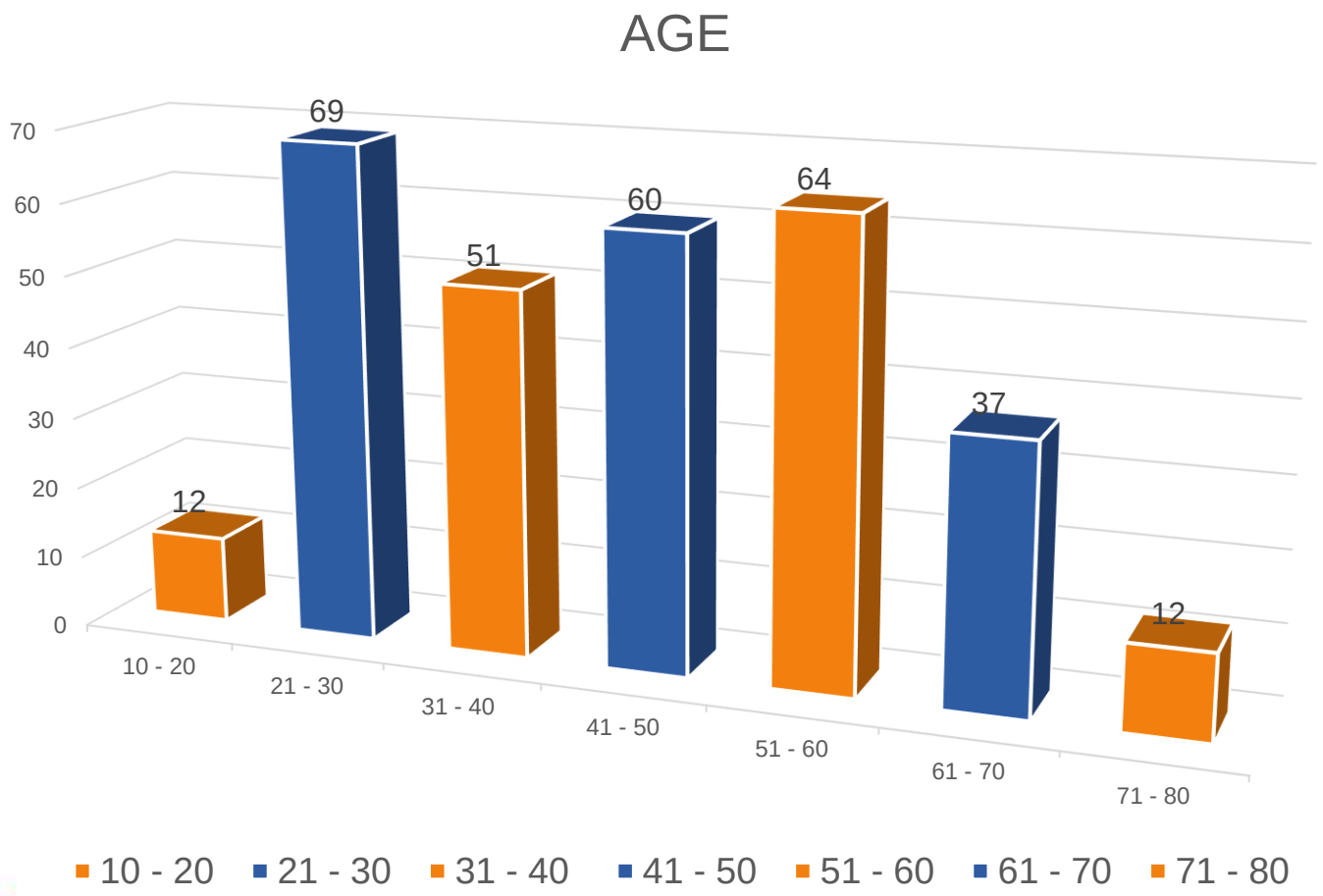


# Results: Gender

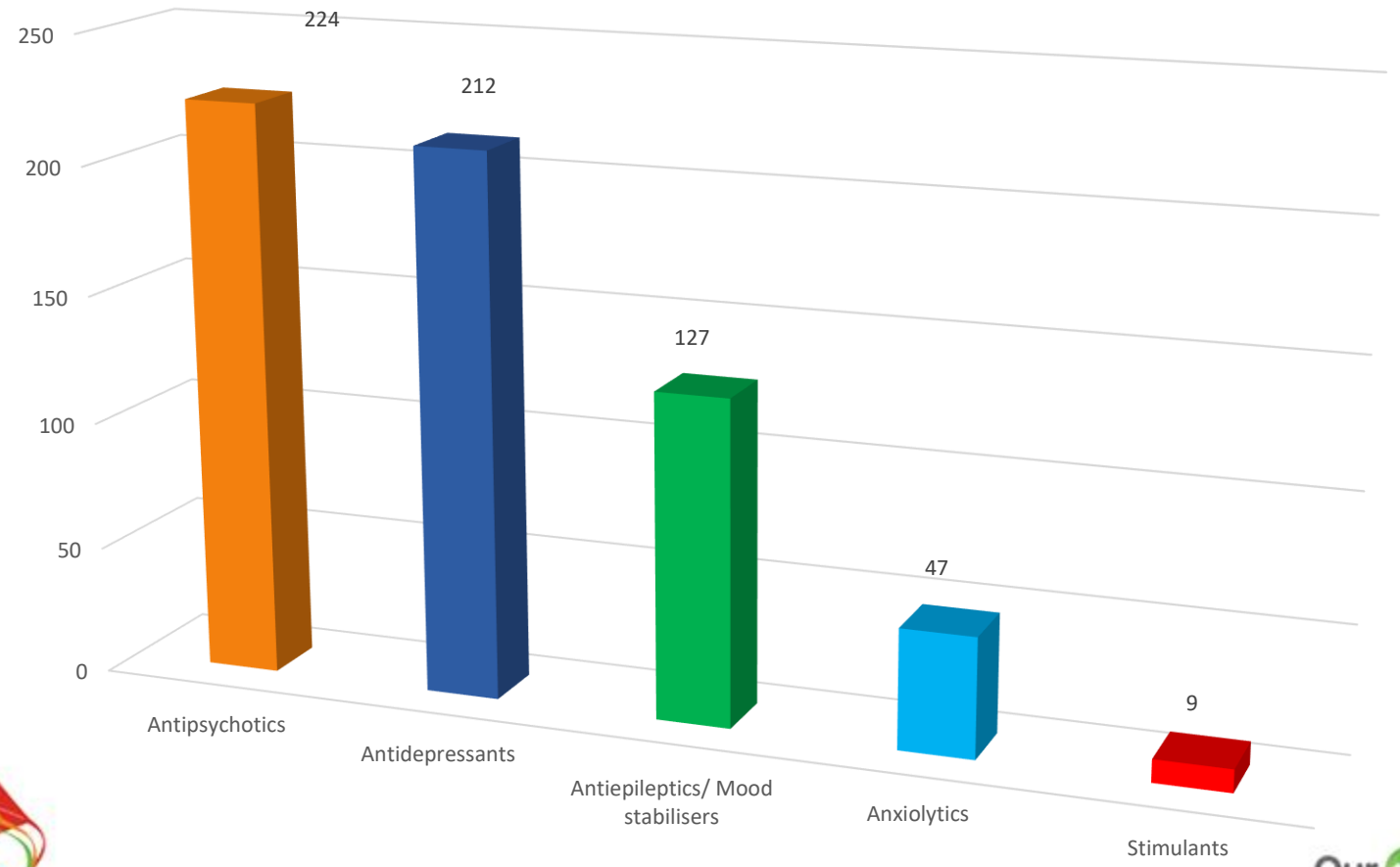



TOTAL SERVICE USERS SEEN SO FAR = 305

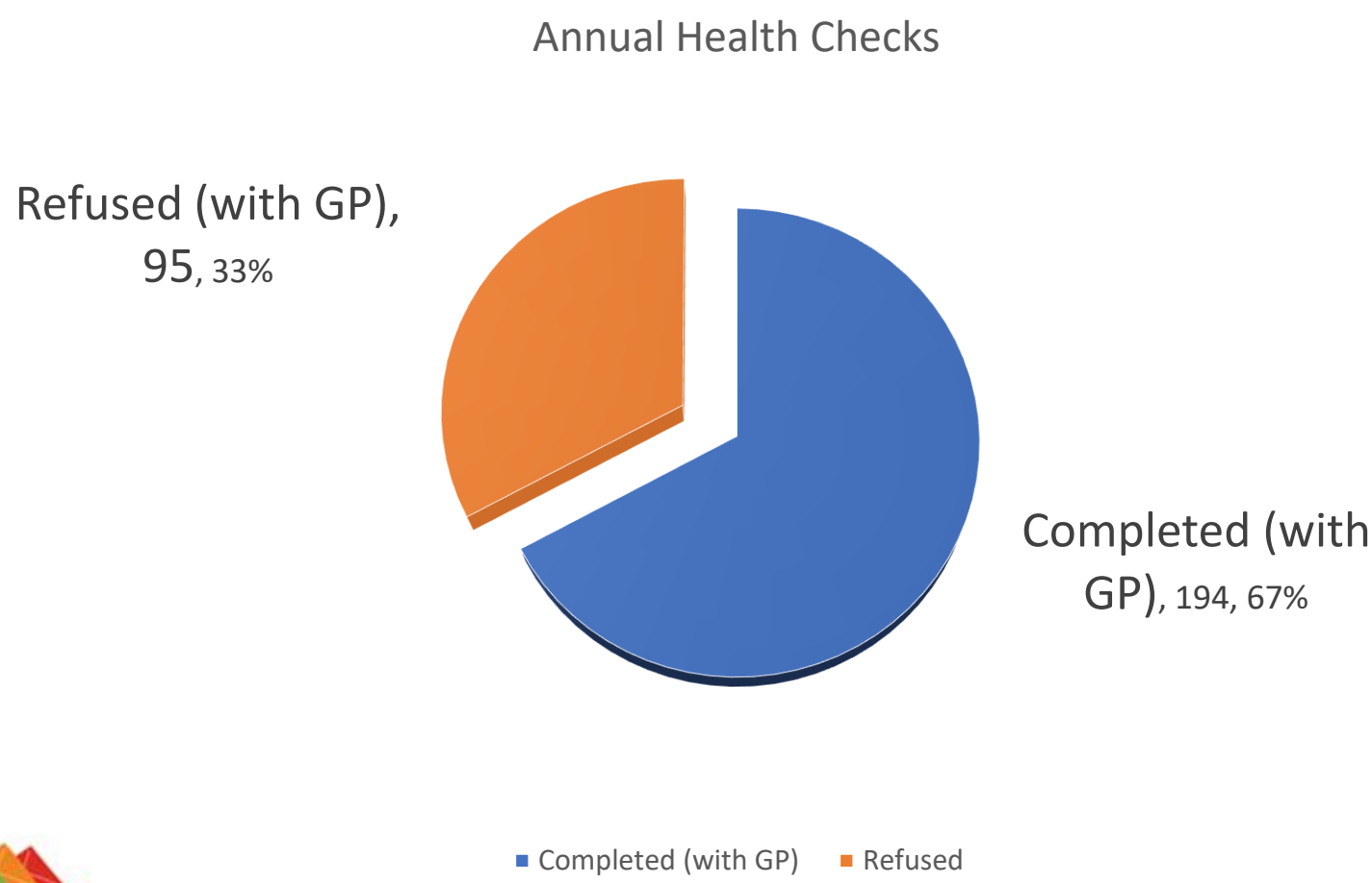
# Results: Age


AGE
70
60
50
40
30
20
10
0
69
51
60
64
37
12
12
10 - 20
21 - 30
31 - 40
41 - 50
51 - 60
61 - 70
71 - 80
10 - 20
21 - 30
31 - 40
41 - 50
51 - 60
61 - 70
71 - 80

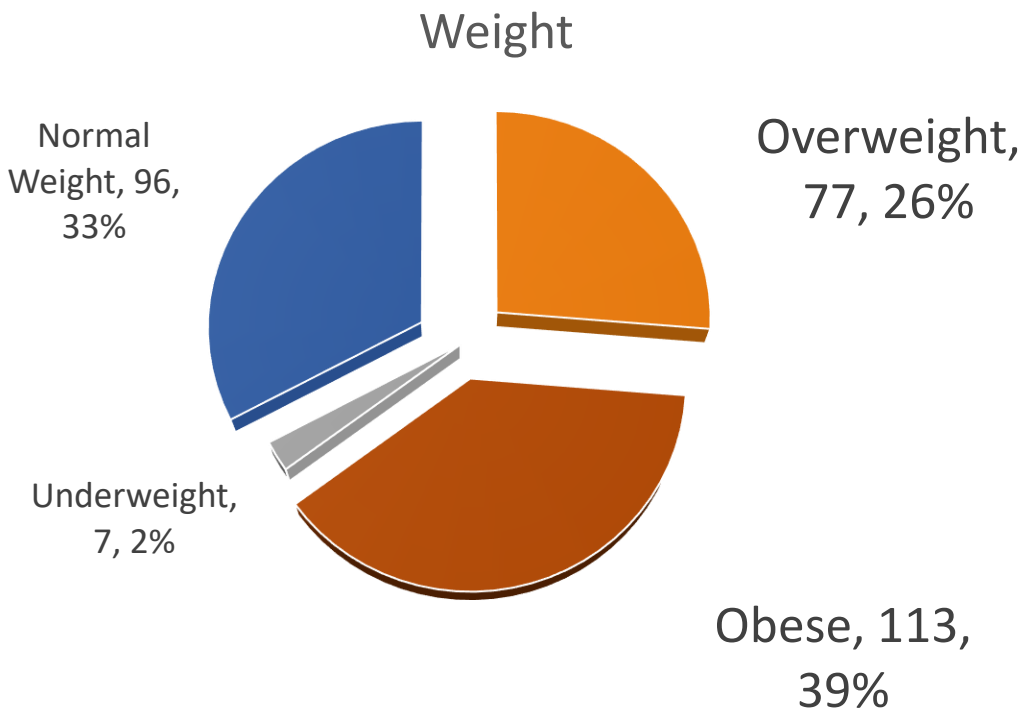
# Results: Psychotropic Medications



# Results: AHC uptake

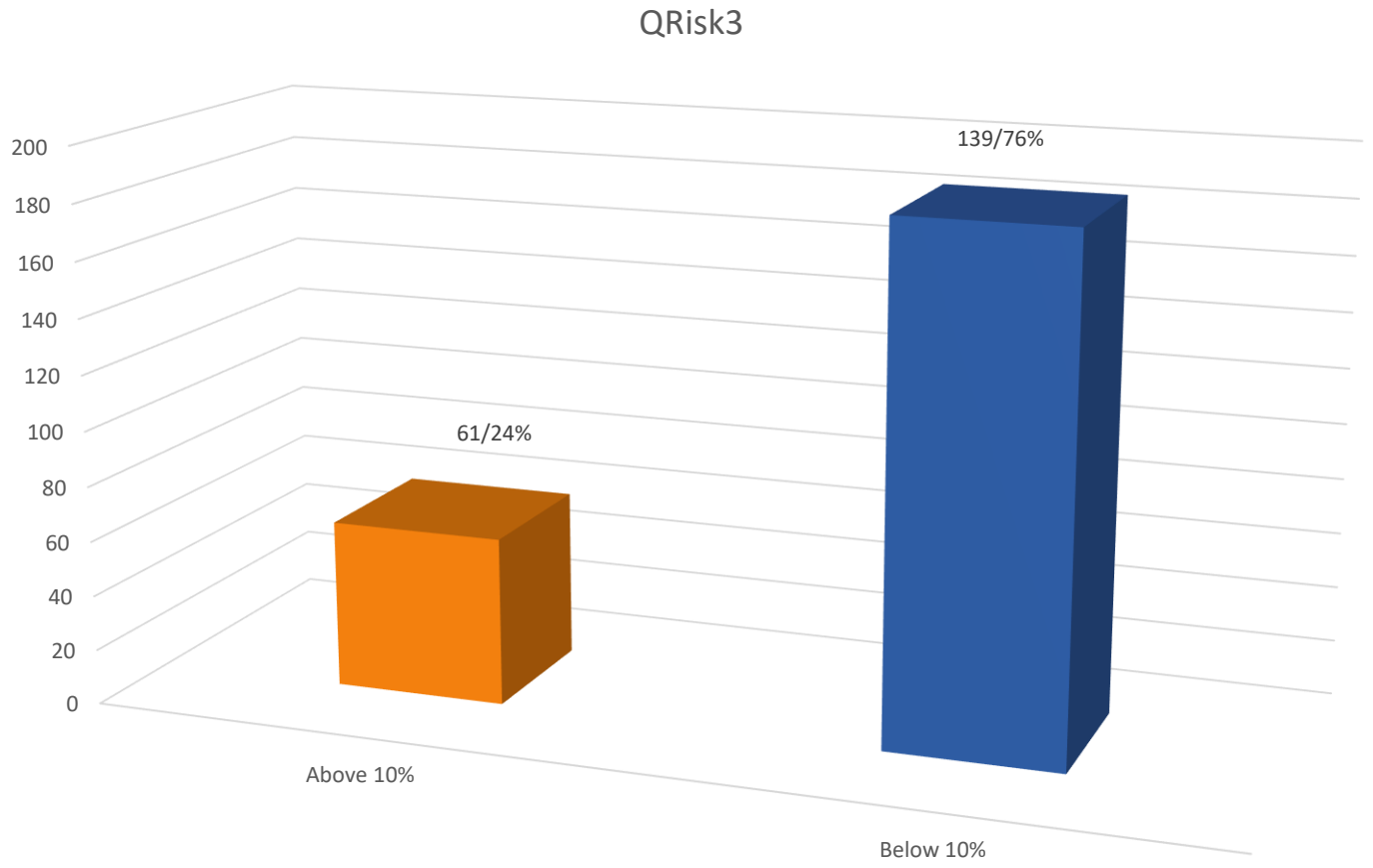


# Results: Weight



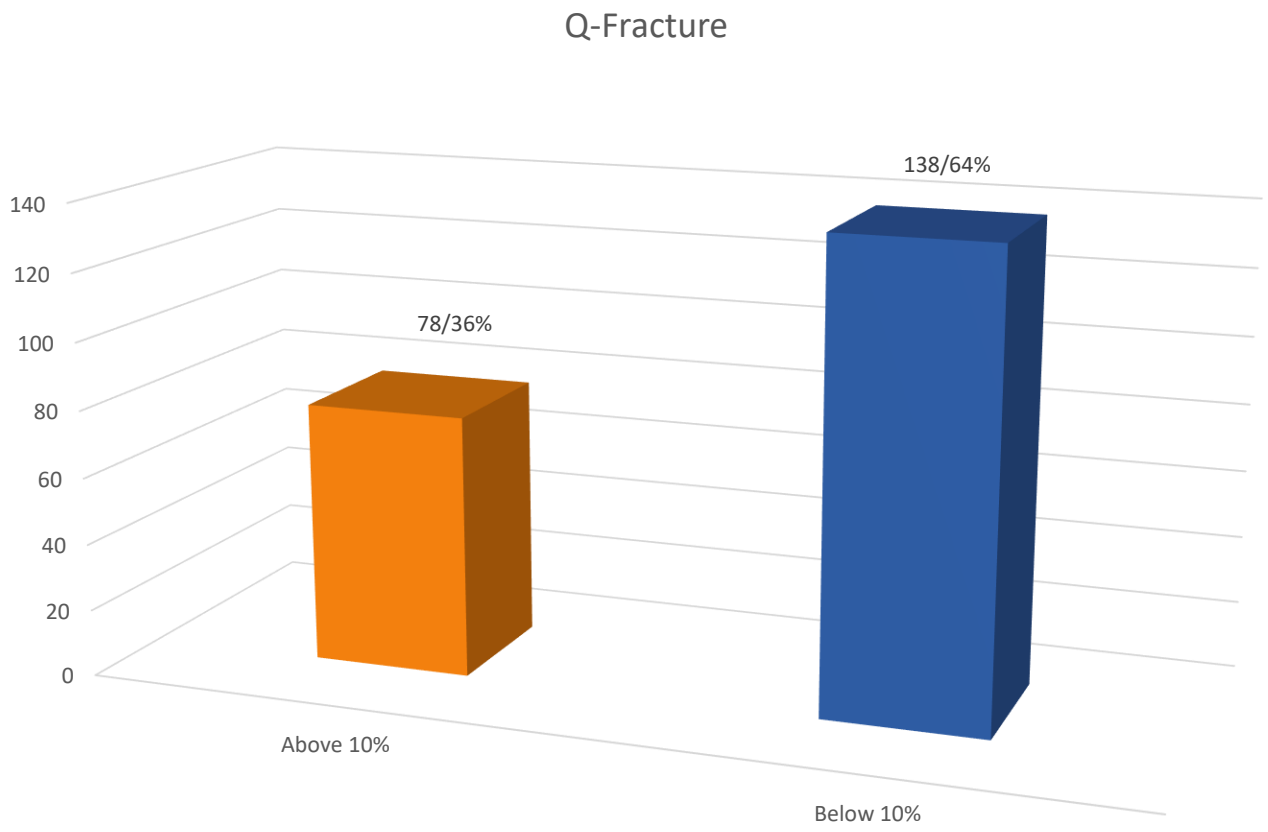

- Referred to Dietician – 10
- Adhering to Weight management plans & discharged by Dietician – 8
- Refused Dietician input – 15
- Unable to calculate BMI due to wheelchair bound - 13

# Results: QRisk3



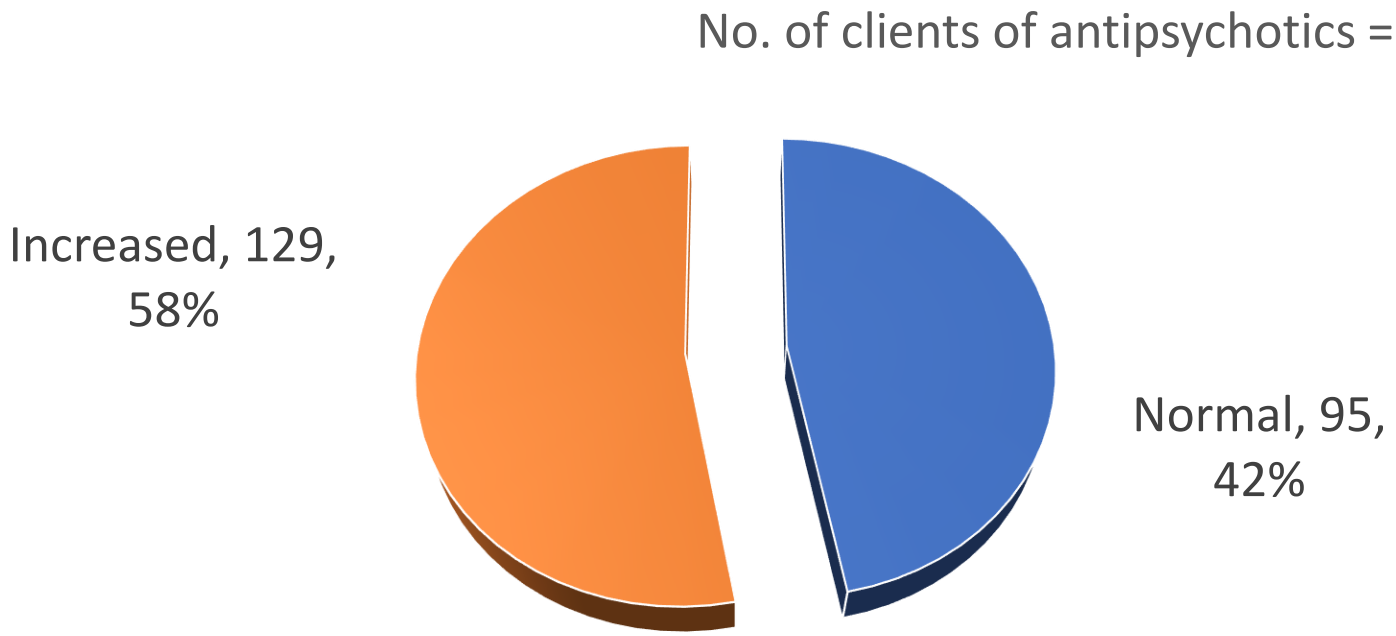

11 unable to calculate due to wheelchair bound and 45 below age

# Results: Q-Fracture



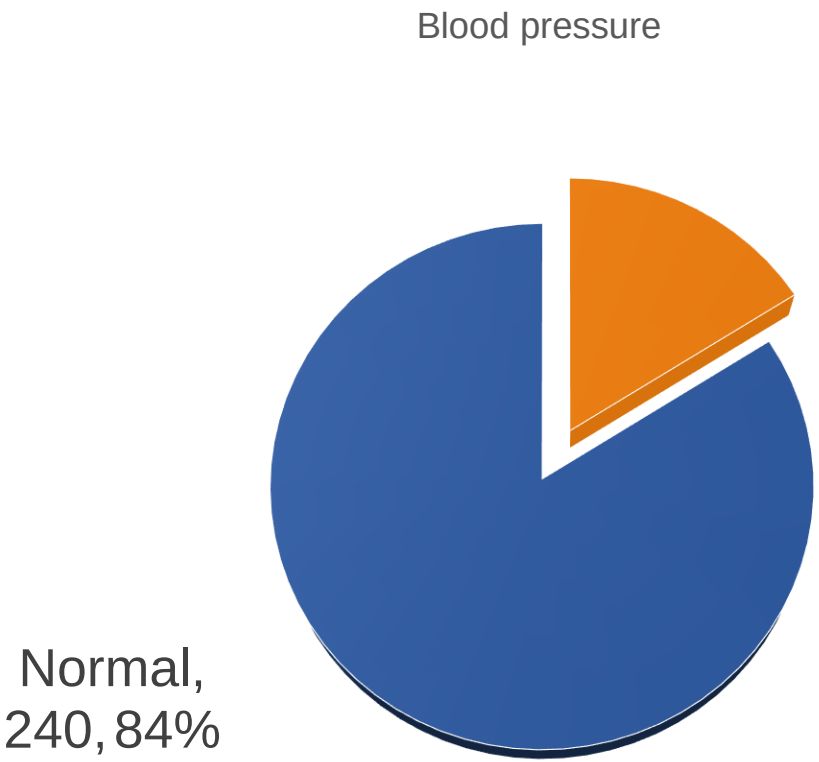

11 unable to calculate due to being wheelchair bound and 78 below age

# Results: GASS



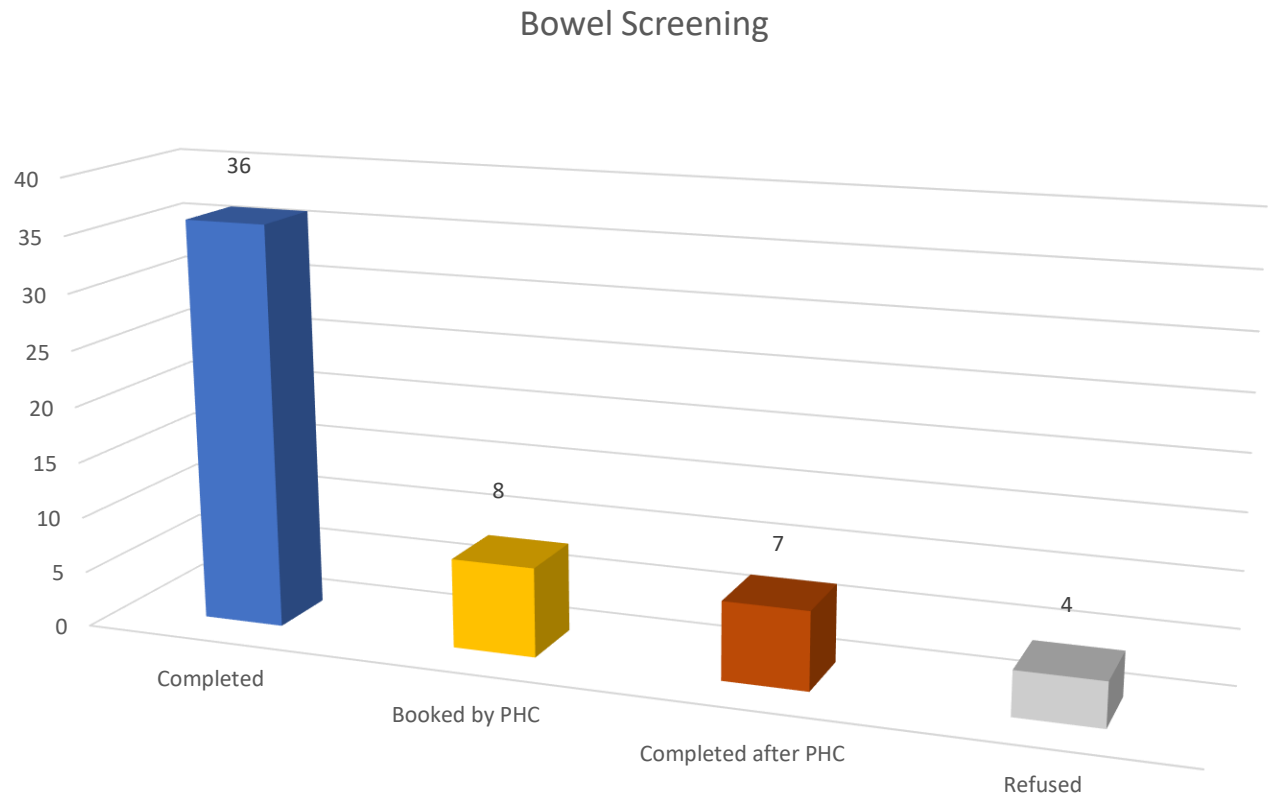

Mild to Moderate (score 0-42) = 129/224 and Severe (score >42) = nil

# Results: Blood Pressure



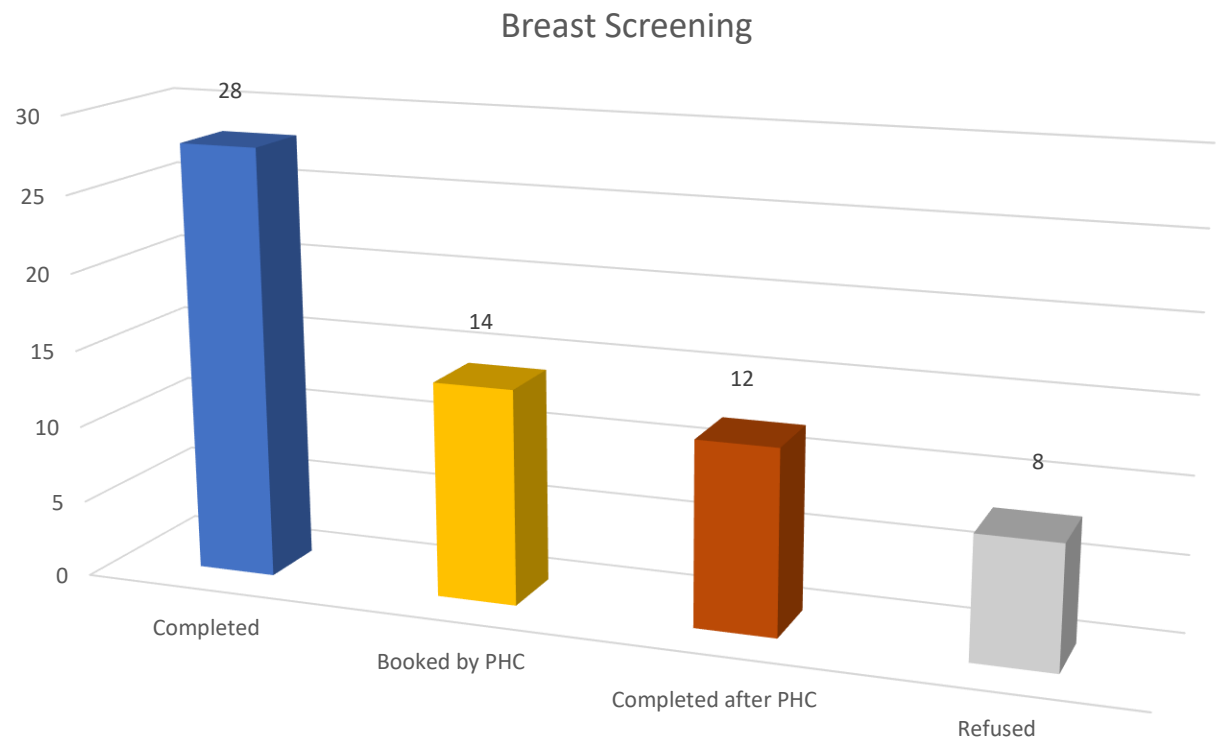

- 46 patients found with HTN
- **12 newly detected**

# Results: Bowel Screening



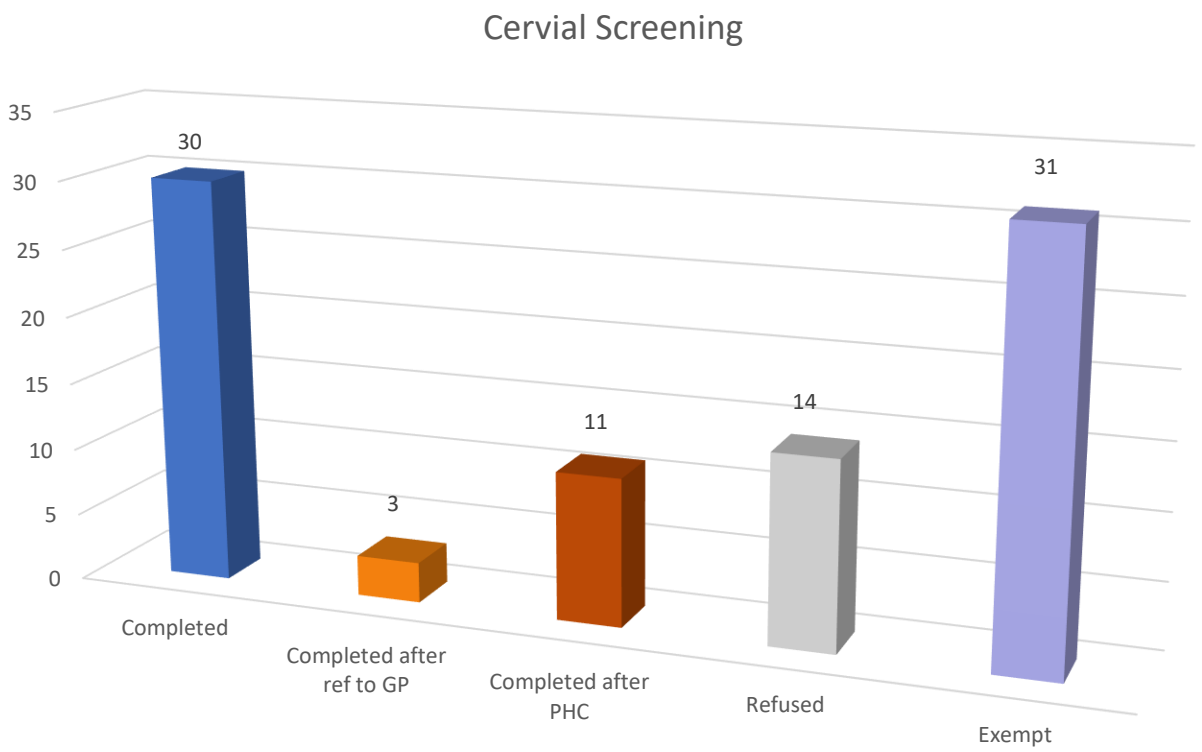

Eligible (male & female, >60 years) = 49

# Results: Breast Screening



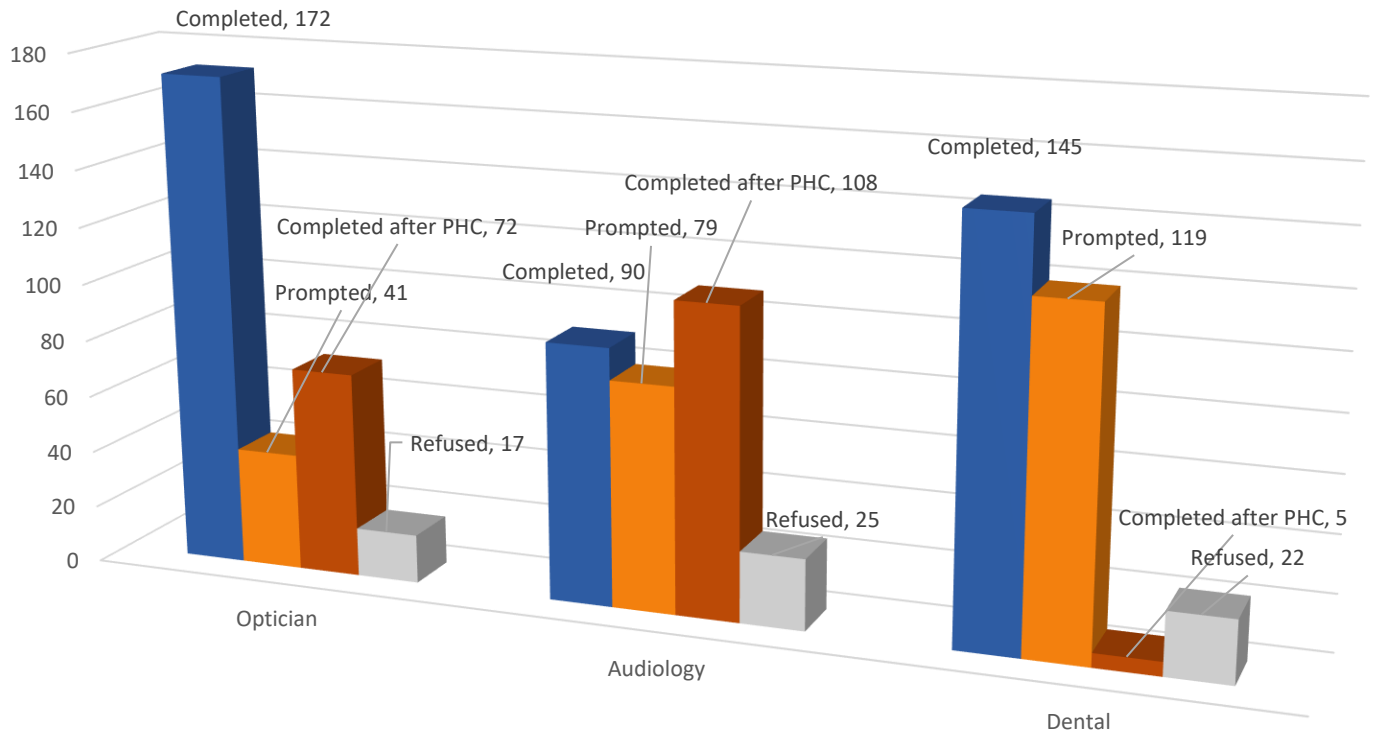

Eligible (female, 50-71 years) = 50

# Results: Cervical Screening




Eligible (female, 25-64 years) = 89

# Results: Optician, Audiology & Dental Checks



# Results: ECG & others

- ECG
  - Done in clinic: 252
  - ECG for the first time: 25 *(age ranging from 20 to 55 years old)*
  - Abnormal ECG: 19
  - 2 patients newly detected with cardiomegaly and one inpatient who had ST elevation cardiologist advised to start on Aspirin 75mg and atorvastatin 20mg.
- Other Screening
  - Constipated: 41 (on medication), 4 newly detected (referred)
  - Dysphagia: 8 newly detected and SLT referral done

# Results: Others

- Other Screening

  - Seizures – Out of 86 with history of epilepsy, 25 have symptomatic seizures needing earlier follow-up.
  - Smoking – 12 identified as heavy smokers - 3 switched over to vaping and 2 has cut down smoking after life style advice for all of them.
  - Alcohol – 30 patients has mild, 7 moderate and 1 with severe alcohol problem identified through PHC

# Results: Bloods

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- Done in clinic:130
- Done for the first time: 6

- Abnormal Blood Tests:
  - FBC – 43
  - TFT – 37
  - U&E – 52
  - LIPIDS/CHOLESTEROL – 68
  - LFT – 37
  - HBA1c –18
  - VIT D – 83 (Inadequate – 54, Deficient – 29)
  - PROLACTIN – 63

- De-sensitisation support needed: 7 (2/3 appointments)
- Refused Blood Tests: 34

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# Conclusion

- Profound health inequalities exist for PWLD
- Enhanced health Clinic:
  - Pro active screening: significant findings of unmet physical health needs
  - Reasonable adjustments & delivery of targeted interventions through health facilitation and social prescribing is improving health outcomes and bridging the existing gap in health inequalities
  - Strengthening multi-disciplinary and multi-agency working
  - Influencing wider system and health partners in making reasonable adjustments
- Personalized care planning with service users: valued by patients /carers

# Feedback questionnaires received from service users (SU) and carers

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Very kind team for nervous patient

A lot of patience with patient

Simply exemplary service

First time we have ever managed to get bloods done. Showed dignity and respect.

Excellent communications over all made the whole experience better, less stressful and comfortable as a carer its great to bring the client for a positive experience

Thorough & good understanding

Friendliness and putting patient first. Comforting.

Patient & Professional

WOW, WOW WOW, what can I say the most fantastic team of staff looking after him – just exceptional

Great service for learning disabilities

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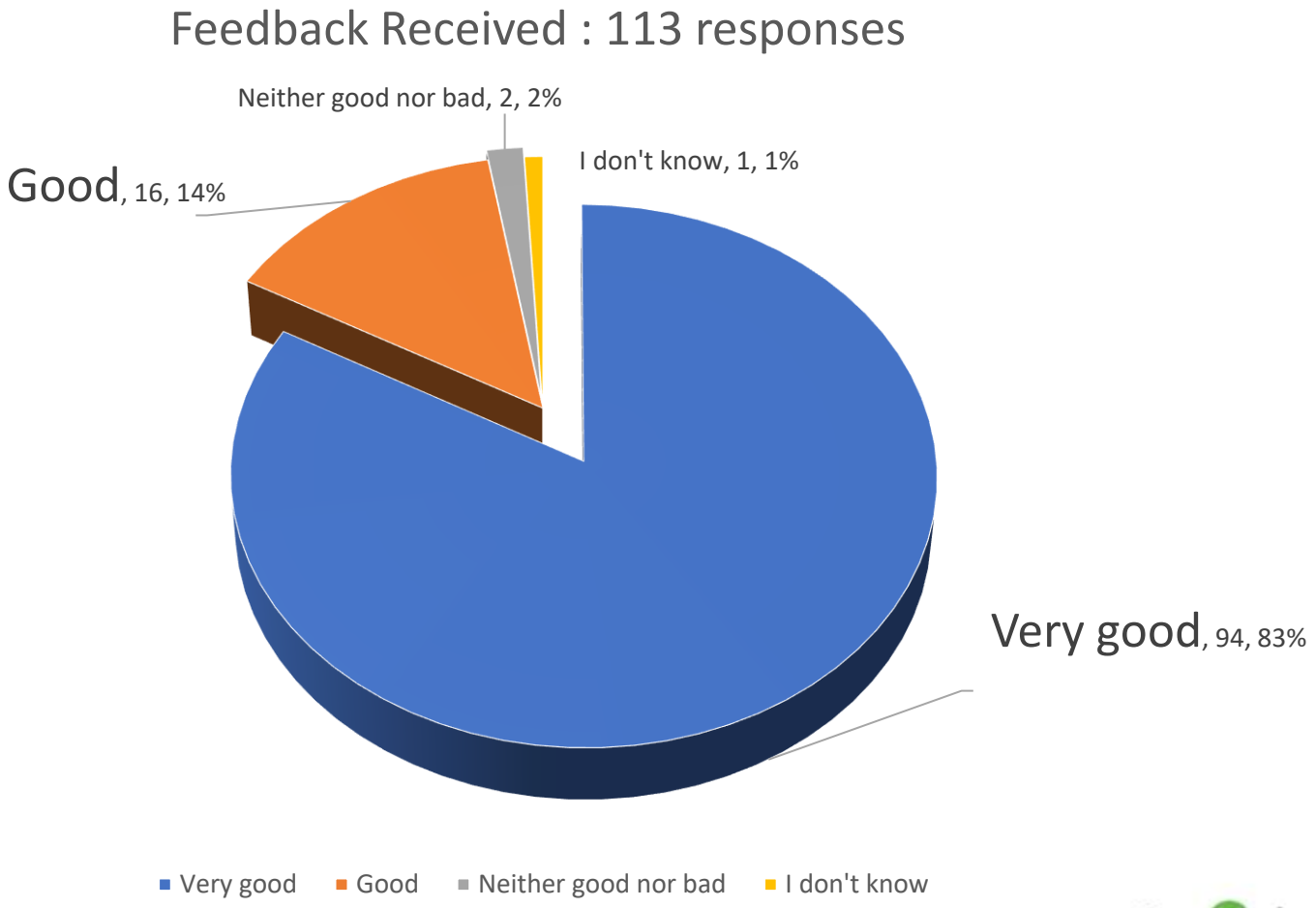
# Feedback Received



# Next steps…

- NHSE Transforming Care funded service, through the CCGs for pwLD who are RAG rated red for physical health

- Plans for expansion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