Adult Learning Disability Service Improves Access to Primary Healthcare

People with learning disabilities statistically have poorer health than other people and find it hard to access and navigate local health services.

If you have a learning disability you are 58 times more likely to die before the age of 50; and are 4 times more likely to die from a preventable cause of death than the rest of the population.

Bridgewater’s Adult Learning Disability Service, Primary Care Access Team is a key service across the borough which supports Primary Care Services to successfully manage the health needs of adults with a learning disability.

Following concerns raised by General Practice the Primary Care Access Team developed the “Did Not Attend (DNA) pathway” as it was becoming increasingly evident that learning disability patients:

- do not routinely attend for annual health checks
- do not reply to practice correspondence
- cannot be easily contacted by Practice staff

The “DNA pathway” was developed by the team to ensure that people with learning disabilities have equal access to healthcare and takes referrals from General Practice staff for patients who have not attended an appointment or responded to practice correspondence.

The Primary Care Access Team visits adults with a learning disability at home to assess if the patients are making an informed choice in not accessing healthcare. Additionally, they identify any barriers relating to a person’s learning disability that may be preventing them from getting the healthcare they need.

The Primary Care Access Team subsequently provides personalised interventions to address any identified barriers to enable the patient to get access to the healthcare they need.

Summary of Outcomes and Insight

- 40% patients referred via this pathway have either had or plan to have a health check following assessment and intervention from Primary Care Access Team

Barriers identified from initial assessments with Primary Care Access Team included:

- Patients had a poor understanding about their own health needs
- Patients did not understand the importance of health checks
- Patients did not understand the letters they received from healthcare providers
- Patients were scared and anxious about accessing healthcare
- Patients did not have adequate social care support to enable them to access healthcare.
Steven’s Story

Steven 50 has a learning disability and lives alone; he was not in receipt of any social care provision. Steven had failed to respond to all correspondence from his general practice and he never contacted them for any treatment or support. The Practice Nurse was concerned for Steven as he has a diagnosis of diabetes and had not had a check-up at the surgery for more than three years. Steven was missing out on his diabetes check-ups and the learning disability annual health check. The Practice Nurse used the “Did not attend” pathway and referred Steven to the Bridgewater Primary Care Access Team. A Learning Disability nurse visited Steven at home to undertake an initial assessment and establish if he was making an informed choice to neglect his health needs. The assessment process identified that there were barriers relating to Steven’s learning disability that were preventing him from accessing healthcare.

Steven had moved home and his new flat was far away from his surgery. Steven did not know that he could register with a doctor’s nearer to his new home. Steven’s mobility had become impaired and he reported falls. Steven had sought advice from his family and was using an old elbow crutch they loaned to him. He did not recognise that he needed the cause of the falling investigating. Steven had poor circulation and pain from vascular disease that was being exacerbated by extreme cold temperatures in his home. He was also not following a diabetic diet. Steven’s income was not covering basic heating and eating costs, he did not know his benefit entitlements. Steven does not read and did not understand health related letters that he received. As a consequence Steven was no longer engaged with any health care providers.

The Learning Disability nurse referred Steven for a social care assessment. He was then helped to register with a doctor that was near to his home. Steven had a learning disability annual health check and a diabetes review. Onward referrals were made to the falls service and occupational therapy. The Primary Care Access Team then ensured that he re-engaged with the healthcare providers that could manage his needs. The learning disability service helped Steven to have a better understanding of his health needs and how to manage these. This including helping Steven develop new skills plus identifying where ongoing support would be needed.

A key part of the intervention with Steven was ensuring that healthcare providers were aware of their obligations under the Equality Act 2010. Services needed to make reasonable adjustments in order for Steven to access their service. The reasonable adjustments included sending easy read/pictorial letters, reminding of appointments and wherever possible ensuring that clinic visits were at venues that were close to his home. Services worked together and in partnership to ensure that Steven got equal access to healthcare.

Today thanks to the DNA pathway Steven has a better understanding of how to manage his health needs. He has the social care support he needs and is now in a position to make informed choices about how he wants to manage his health needs.

“I don’t know what would have happened to me without you lot.”

“I wouldn’t be here. I would have been in a box.”