Hertfordshire Partnership
University NHS Foundation Trust

NHS

IMPROVE PHYSICAL HEALTH OUTCOMES IN AN ENHANCED CLINIC

Georgios Mousailidis (CT3 Doctor)
Hertfordshire Partnership University Trust

Aim

- To improve physical health outcomes in an enhanced physical health clinic for patients with intellectual disability open to our services.

- Provide targeted intervention including social prescribing and health facilitation.

Background

- The National Learning Disability Mortality Review Programme (LeDeR), highlighted the existing health inequalities faced by people with intellectual disabilities.

- Discrepancy in the age of death between people with intellectual disabilities and the general population; 22 years for males and 27 years for females.

Background

- People with intellectual disabilities die from an avoidable medical cause of death twice as frequently as people in the general population.

- LeDeR has recommended the need for improved health screening.

Methods

- Invite for physical health screening appointment to 80 patients.
- In total 46 patients were reviewed in the physical health clinic.
- Covid-19, shielding etc after lockdown.
- Screening tool for physical health was created according to LeDeR recommendations.

Methods

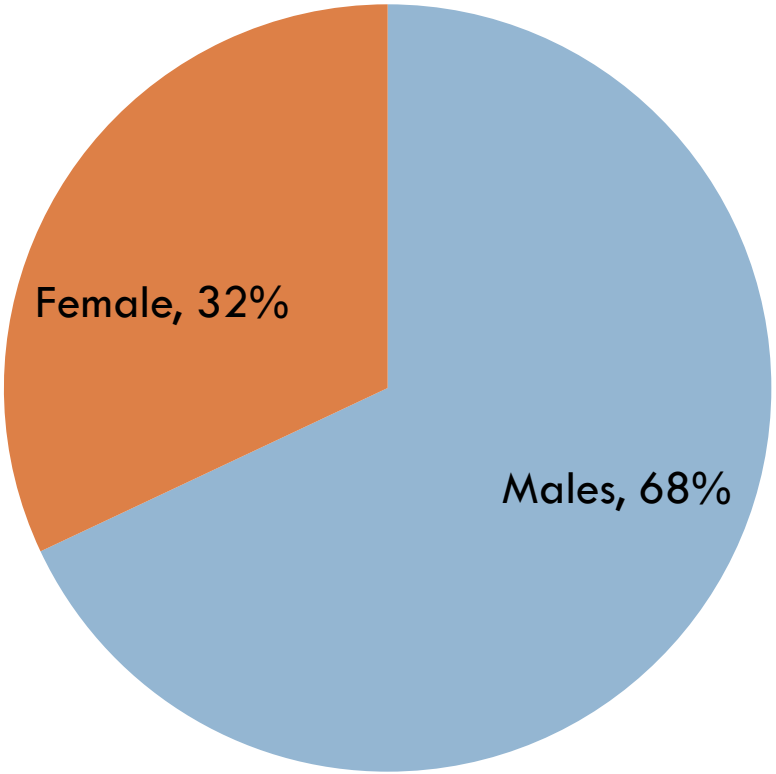
- Key physical health parameters to monitor in the clinic:

- blood pressure, pulse, SpO2
- height, weight, waist circumference, BMI
- calculate cardiovascular and fracture risks (Qrisk & Qfracture)
- lifestyle status smoking, alcohol consumption, activity levels
- uptake of national public health screening programs (cervical, breast, bowel screening)
- audiology, vision, dental screening
- dysphagia, constipation
- annual health checks,
- annual blood tests

Methods

- Structured template letter was created
- Highlight to GP the issues that need intervention; care home managers & community nurses informed
- Social prescribing was offered as a major component underpinning this pilot.
- For some clients health facilitation to access the services

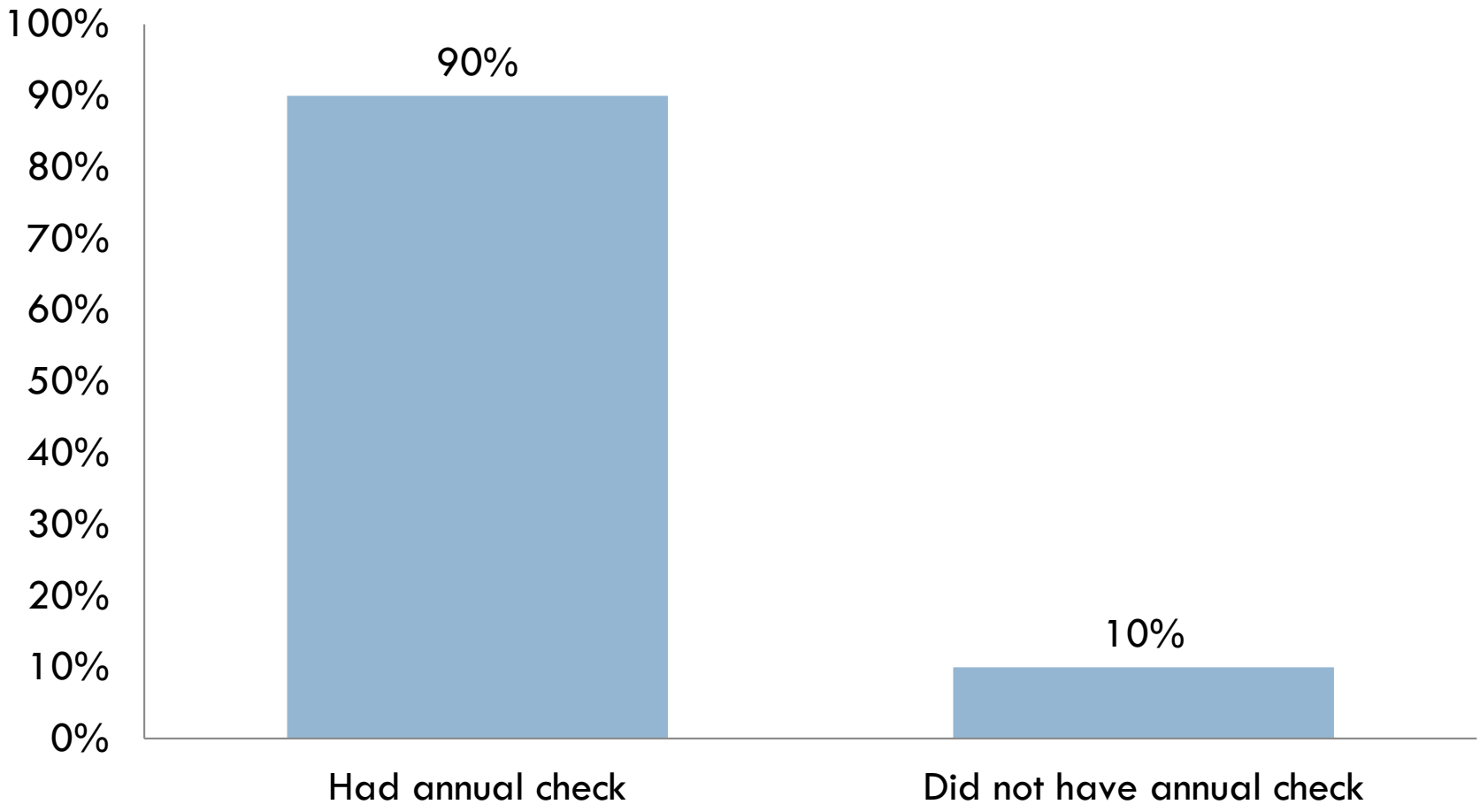
Results (Gender)



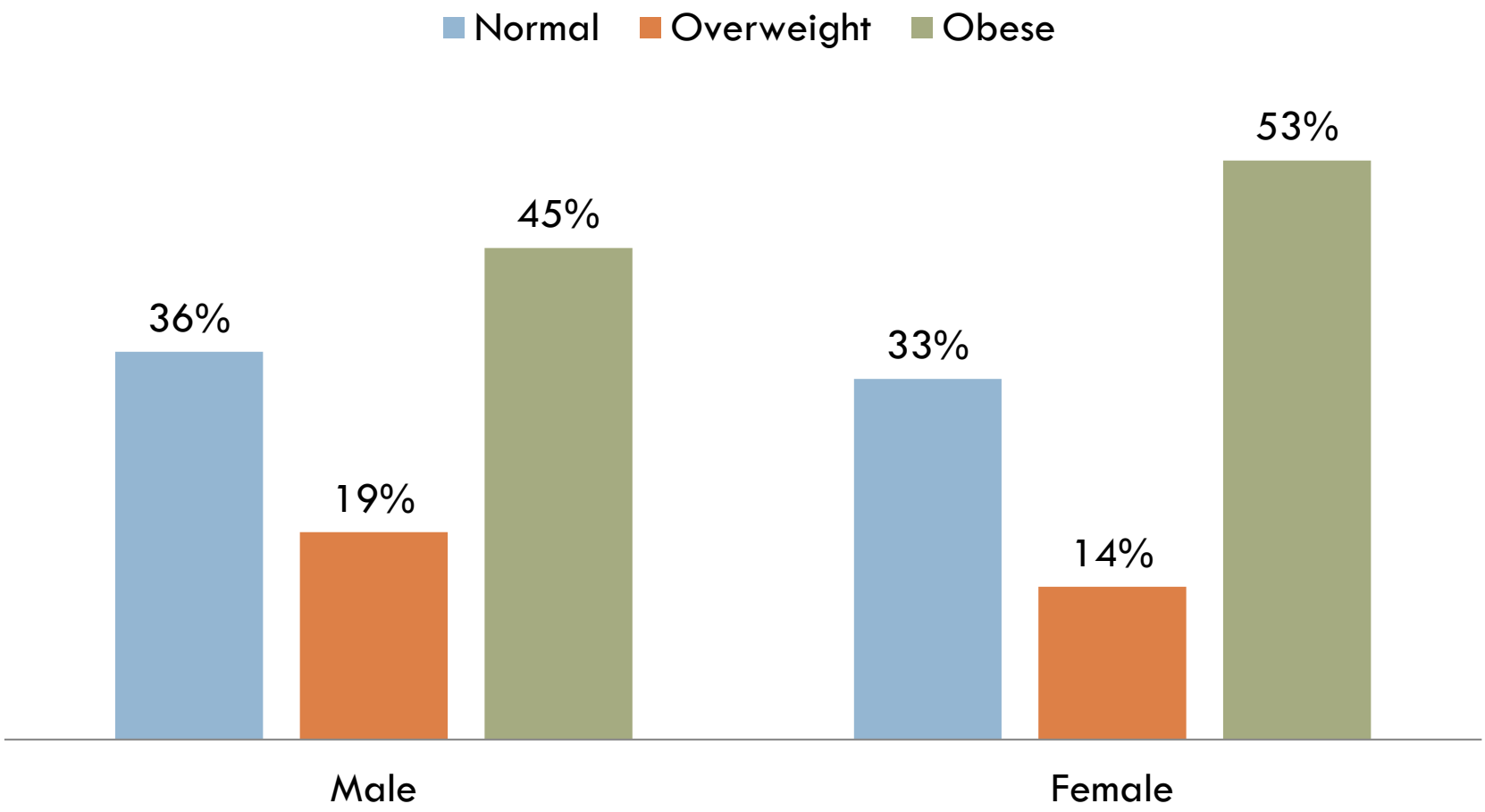
Results (mean age of service users)

- Male mean age: 39yo
- Female mean age: 42yo

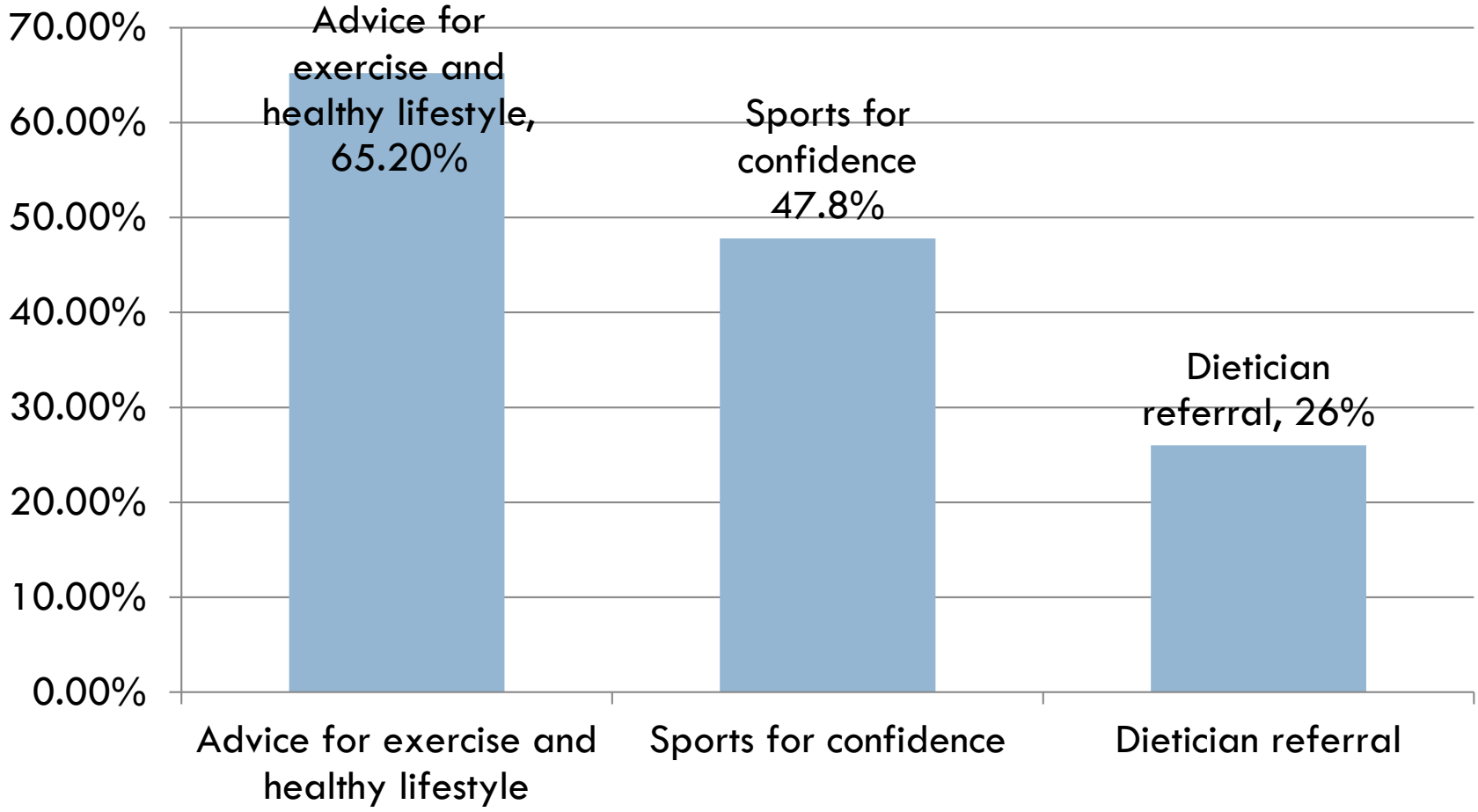
Annual health checks with GP



Body mass index (BMI)



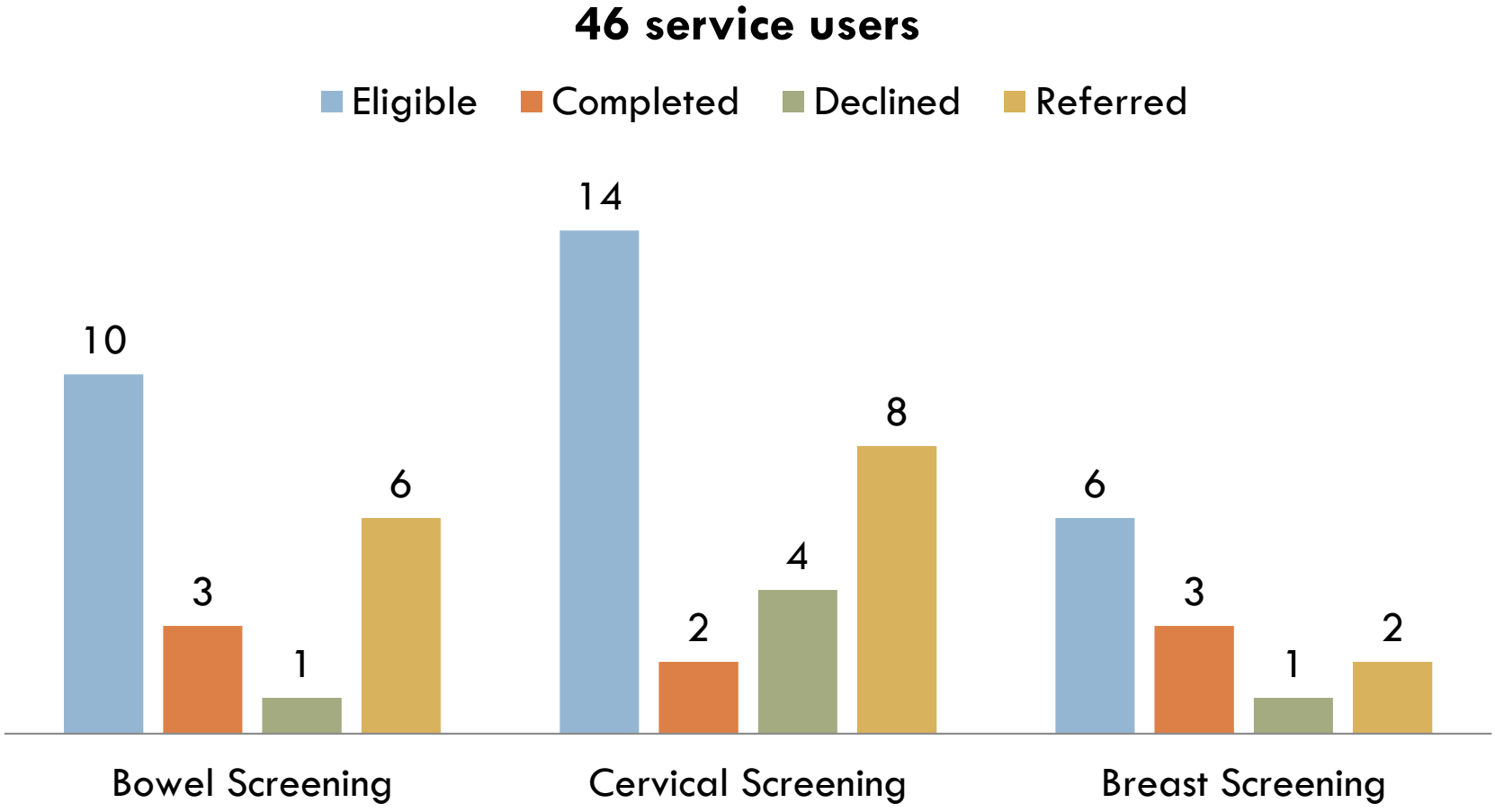
Weight management



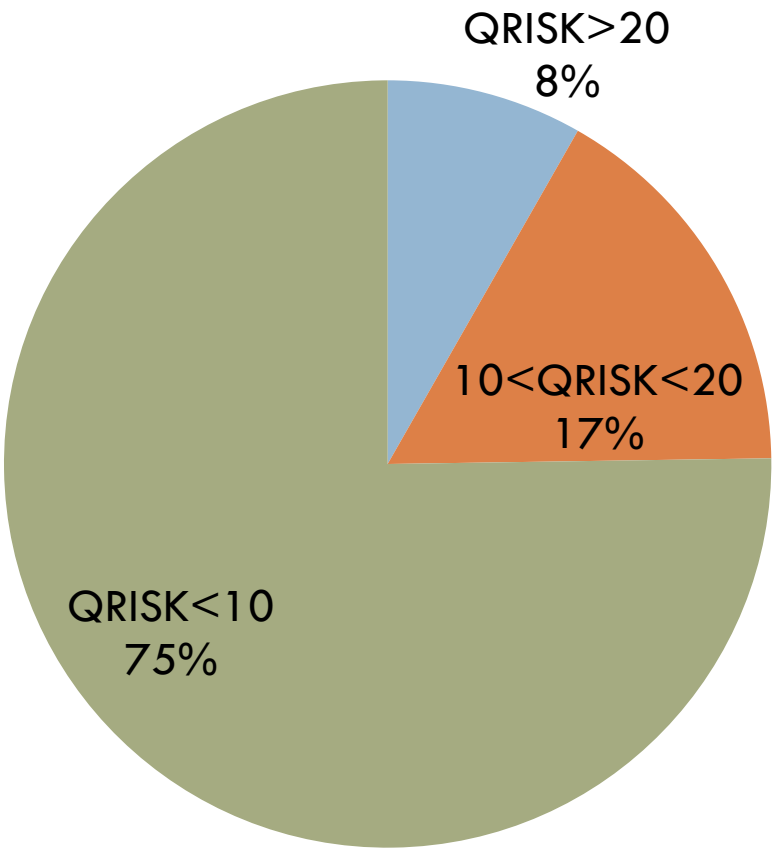
Bowel screening >55yo

Cervical screening (women 25-64yo)

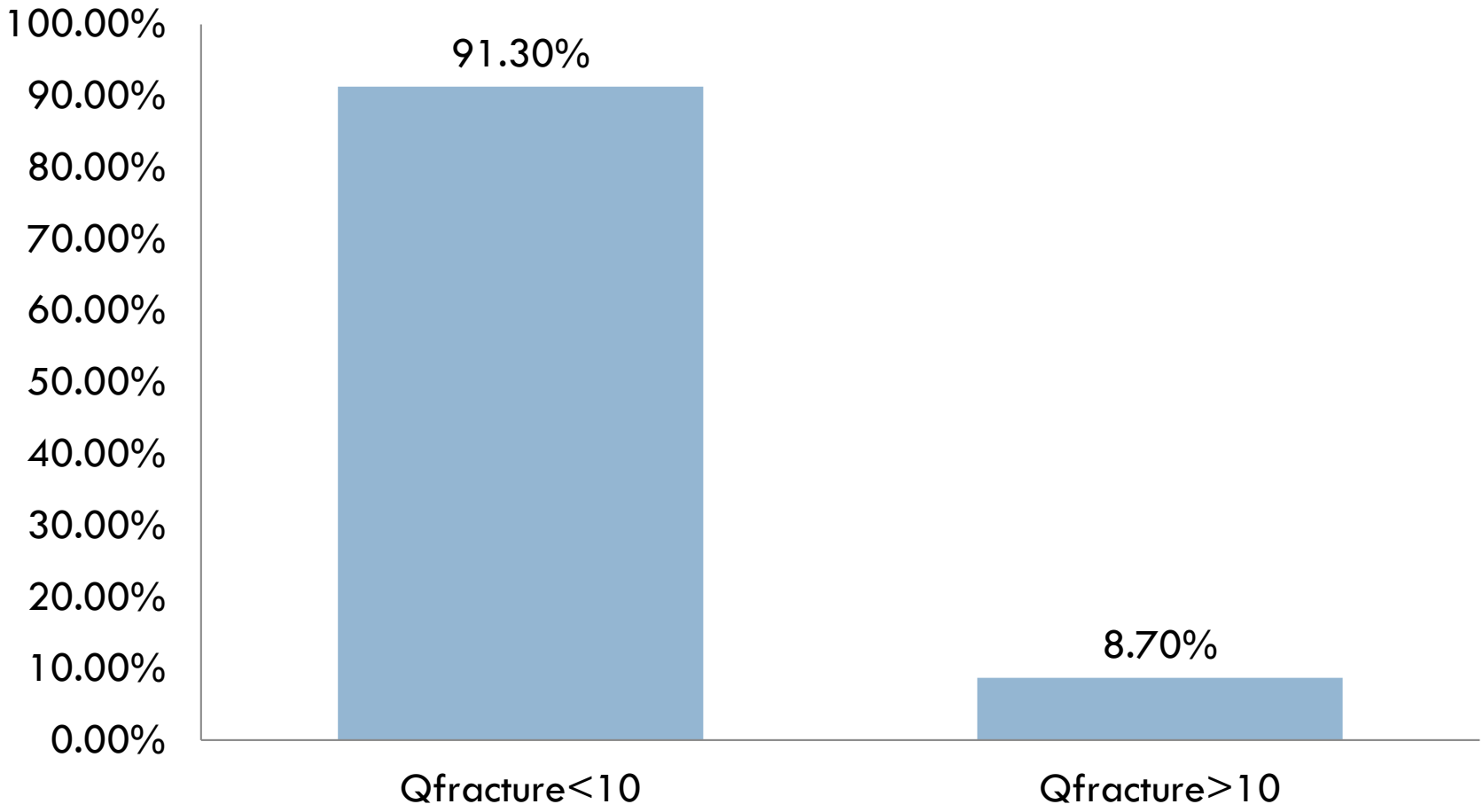
Breast screening (women 50-71yo)



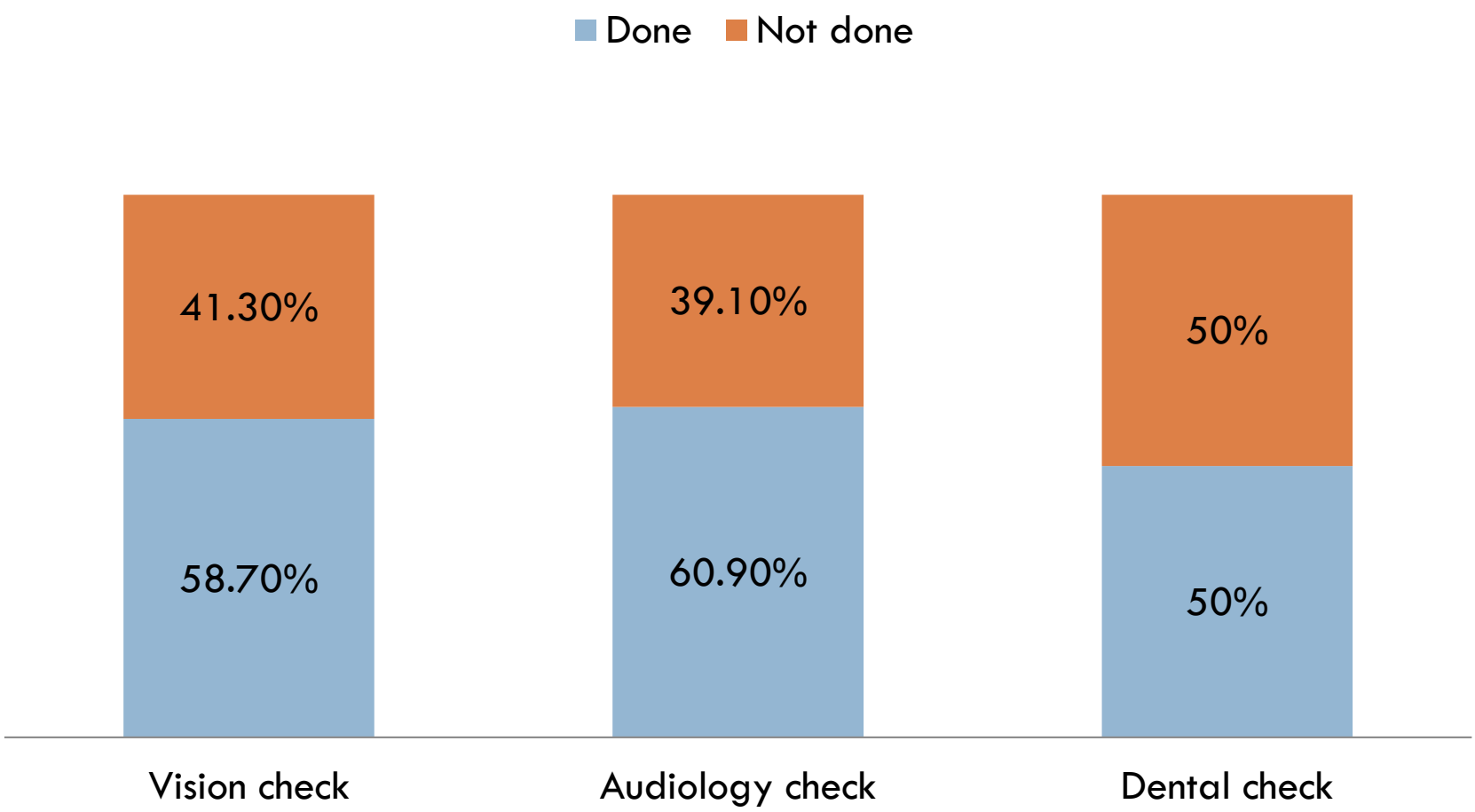
Q RISK score



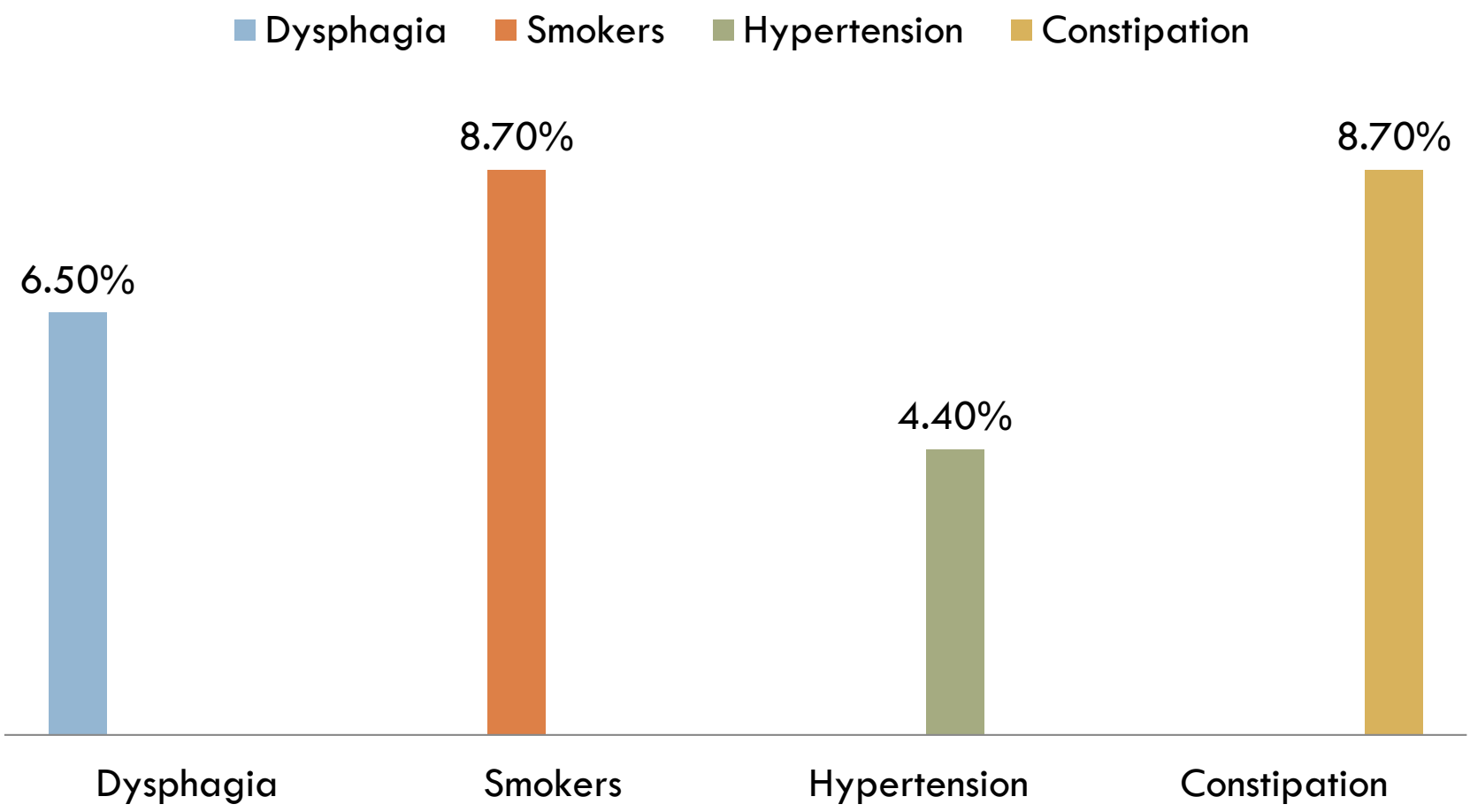
Q FRACTURE score



Optician, audiology and dental check during last year



Dysphagia, smoking, hypertension, constipation



Deranged blood tests or not having blood tests within the last year

- GP informed/blood facilitation pathway for 11 service users (24%).

Follow up (preliminary results)

- All annual health checks have now been completed
- Referrals for hypertension: all service users treated
- Constipation: 50% treated, rest ongoing
- Dietician referral: 2 commenced, rest awaiting support
- Breast screening: 1 completed
- Blood investigations were completed for 4 people

Key messages - conclusions

- Despite that clients had annual health checks done, still full health needs were unmet
- We can improve health outcomes by proactive health facilitation and social prescribing
- Work in collaboration with GP to do meaningful change
- This project was a huge step towards bridging the existing health inequalities

- Thank you