Appendix 2 - SOP for annual physical health reviews of service users with severe mental illness and patients receiving care under the care programme approach

Purpose and Objective:

There is clear evidence that people with severe mental illness experience higher rates some physical health problems and have a reduced life expectancy compared to the general population. With improvements in identification and treatment of physical health the mortality gap can be reduced.

The purpose of this SOP is to describe the approach to improving the physical health of service users receiving care from community teams in Sheffield Health and Social Care NHS Foundation Trust. The SOP is based on standards set out in the Royal College of Psychiatrists Accreditation Schemes for the teams listed in the scope.

Working with physical health services

Joint working and good communication between staff working in SHSC community teams and physical health services is essential. Most people with severe mental illness or who are receiving care under the care programme approach should have an annual physical health review conducted in primary care by GPs, practice nurses or other primary care staff. For some service users receiving care from SHSC community mental health and learning disability teams it may be more appropriate for the review to be completed by the SHSC service.

SHSC community teams have a responsibility to

1) encourage and support service users to take up the offer of an annual physical health review in primary care.
2) check that the review has happened and ensure that the details of the review are recorded in the service users SHSC care record.
3) support the service user to attend a physical health review in primary care if required.
4) complete physical health reviews for service users who do not want to or unable to attend a review in primary care if any physical observation parameters are out of normal range a NEWS2 must be completed and the observation and escalation policy must be followed.
5) share information about physical health reviews completed by SHSC staff with primary care.
6) document plans to improve physical health following reviews in primary or secondary care in the service users care plan.
7) encourage and support service users to access services to improve their physical health.

Scope:

This SOP applies to service users receiving care from the mental health recovery teams, the community enhancing recovery team, the early intervention in psychosis team and the community learning disability team. The standards have been taken from the Royal College of Psychiatrists accreditation standards.

Initial assessment

Clinical staff undertaking initial assessments should document an assessment of the service user's physical health in their initial assessment. The assessment should include details of any known physical health diagnosis, the treatment and services involved in providing the treatment. If the assessment has been documented by another SHSC team eg SPA/EWS , Home Treatment, a ward team, etc prior to the service user being taken on by your team it does not need to be repeated.

Timescale – At the time of initial assessment

Responsibility – Clinical staff member completing the assessment

Physical health reviews

Timescale – within one month of allocation of a care co-ordinator/keyworker. Repeated annually.

Responsibility – physical health reviews and associated care plan goal must be completed and documented by a clinical staff member competent to do so. The care co-ordinator/keyworker is responsible for arranging the review with an appropriate staff member if they are not competent to complete the review.

Physical health reviews must be documented in the service users' records. A care plan goal related to physical health covering arrangements for physical health reviews and any treatment or support required after the reviews must be documented in the care plan.

Step 1 – Gathering information

When undertaking a physical health review information from the following sources will be required

- Information from primary care (SHF/SMI template)
- Recent blood results
- Any other recent physical health investigations /information from other care records
- Information from the service user and/or carer

To complete a physical health review the following information is the minimum required

- Smoking status

- Alcohol consumption
- Substance use
- Diet
- Physical activity
- Weight and BMI
- Blood pressure (NEWS2 to be completed if out of normal range and observation and escalation policy to be followed)
- Blood results:
  - FBC (full blood count)
  - U&E (Urea and electrolytes)
  - LFT (Liver function test)
  - HbA1C
  - Random Glucose
  - Lipid Profile
  - Prolactin level (if likely to receive an antipsychotic for the first time)

Some service users with known physical health problems may need additional information related to their physical health to be available for the review.

If recent blood test results are not available at the time of the review, discuss with the service user preferable options for having blood tests which may include asking the GP to arrange the test, the community team completing a blood request form and the service user accessing phlebotomy services at MCC, RHH or NGH or community team staff arranging to take blood to send to the laboratory.

Step 2 – Completing the physical health review

Whether the information has been provided by primary care or has been obtained directly by SHSC it should be entered on the physical health review template. The template can be used to identify when action is required and to record action taken. The information should be discussed with the service user. Advice on actions required should be given and a care plan should be discussed and agreed with the service user and documented on the care plan.

Actions required may include advice or referral for specialist support related to smoking, alcohol or substance misuse, improving diet and increasing activity. Service users may require signposting to their GP or referral directly to a specialist service.

Physical health monitoring for service users commenced on a new antipsychotic or mood stabiliser

Timescale – at the time of prescription, monitored weekly for the first 6 weeks and repeated at 12 weeks.

Responsibility – Clinical staff.

Baseline investigations are completed before antipsychotics or mood stabilisers are prescribed. If not possible before prescription the investigations should be completed as soon as possible.

Baseline investigations are

ECG if required in the summary of product characteristics or if the service user has a personal history of cardiovascular disease.

Weight

Waist circumference

Pulse and blood pressure (NEWS2 to be completed if out of normal range and observation and escalation policy to be followed)

Glucose and lipid levels

Diet

Physical activity

Monitoring

The service user should be advised to monitor their weight weekly for the first six weeks and report weight gain to the team. At 12 weeks the baseline investigations should be repeated.