Policy:

NP 020 - Physical Health

Executive Director Lead	Executive Director of Nursing, Professions and Operations
Policy Owner	Clinical Director – Rehabilitation and Specialist Services Clinical Director – Community and Acute Services
Policy Author	Head of Nursing – Rehabilitation and Specialist Services Head of Nursing – Community and Acute Services Head of Clinical Quality Standards

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Summary of policy

The purpose of the policy is to ensure that the physical health of service users receiving care from SHSC mental health and learning disability services is assessed and that they receive monitoring and interventions as required.

Such assessments must be completed in line with this policy and the relevant Standard Operating Procedures (SOP) for each service/team. This will ensure that the assessment adheres to best practice, including good standards of recording on the electronic patient record.

The policy provides direction and guidance for the planning and implementation of high-quality physical health interventions within the organisation. It sets out the expectations of interventions that should be provided by staff employed within SHSC and those which will require advice and /or intervention from other specialist services.

Underpinning this policy is the recognition that training and equipment is required at a level which can be effectively utilised by all health care practitioners.

Target audience	All staff working in clinical and managerial roles in SHSC mental health and learning disability services

Keywords	Physical Health

Storage & Version Control

Version 7 of this policy is stored and available through the SHSC intranet/internet. This version of the policy supersedes the previous version (V6.0 May 2021). Any copies of the previous policy held separately should be destroyed and replaced with this version.

Version Control and Amendment Log

Version No.	Type of Change	Date	Description of change(s)
5.0	New policy	07/2019	Replaces the previous version (V4.0), issued in March 2013. This version was reviewed to update the policy as the date of review expired. Extension to review date approved by EDG on 26/09/2019. Second extension to review date ratified by Quality Assurance Committee on 26/10/2020.
6.0	New draft policy created	02/2021	Replaces the previous version (V5.0), issued in July 2019. New policy commissioned by Back to Good Board following the production of a revised Physical Health Strategy (CQC requirement)
6.1	Additional amends for accuracy and clarity	02/21	Further amends to develop the policy. Await the production of the SOPs before completing further changes.
6.2	Additional amends to include SOPs and alignment of policy with SOPs	02/21	SOP and Appendices for Community Health appended and policy aligned accordingly.
7	Review of policy due to expiry date		Policy reviewed for accuracy and any immediate changes required to content whilst new PH strategy drafted. New policy to be developed to support new strategy.

Contents

1. Introduction

1.1. The significant correlation between mental illness and learning disability (LD) and poor physical health is well documented (BMA Board of Science 2014).

1.2. People with a mental illness such as schizophrenia or bipolar disorder die on average 16–25 years sooner than the general population. This can be attributable to preventable physical conditions such as respiratory and cardiovascular disease and poor access to physical healthcare monitoring and assessment (Department of Health 2011).

1.3. People with a mental illness should have the same access to preventative health promotion advice and support as the general population (Department of Health 2016). Risk factors which contribute to preventable physical conditions include smoking tobacco, alcohol misuse, physical inactivity and poor diet (Naylor et al. 2012).

1.4. Smoking is the single largest cause of preventable ill health and premature death in England, and at least half of all life-long smokers will die prematurely (World Health Organisation, 2006)). The prevalence of smoking is consistently higher among people who use mental health services, and smoking is the biggest single contributor to the difference in life expectancy between people with SMI and the population as a whole (Public Health England 2018; NHS England, 2018).

1.5. Physical healthcare needs should be assessed and addressed including promotion of healthy living and steps taken to reduce any potential side effects associated with treatments (Department of Health 2015).

1.6. In general, people with an LD have poorer health and die on average 20 years younger than people without an LD. Many of the causes of poor health are avoidable. The main causes of death include doctors attributing symptoms of ill health to people's learning disability (diagnostic overshadowing), respiratory disease and epilepsy. Inpatient admission offers an invaluable opportunity to monitor and manage the physical health of people with an LD (CIPOLD 2013).

1.7. People with autism are at increased risk for a range of physical health problems, including epilepsy, diabetes and heart disease. Overall, the life expectancy of someone with autism is 16 years less than the general population. People with autism are more prone to the side effects of psychiatric drugs. Therefore, lower doses and shorter duration of treatment should be considered.

1.8. There are a number of correlations between wellbeing and physical health outcomes: improved immune system response, improved cardiovascular health and slower disease progression (Department of Health 2014).

1.9. The Royal College of Psychiatrists (2009) sets the standard for physical health monitoring for mental health and learning disability inpatients. These standards are incorporated into the Care Quality Commission Inspection Brief Guides.

1.10. SHSC is committed to the holistic care and wellbeing of patients. We believe users of mental health and learning disability services should have access to the same quality of physical healthcare as the general population. A patient's physical health is of equal importance to their mental health and must be reflected in their care package.

1.11. This policy has been written to support the SHSC's Physical Health Strategy 2020-2023 which aims to improve the mental, physical and social wellbeing of the people in our communities. Physical health and mental health are intrinsically linked and at times their complex relationship can make delivery of the appropriate physiological intervention at the right time a difficult process to safely manage.

1.12. This policy will support achievement of the following key performance indicators:

i. Presence of appropriate monitoring templates and reporting systems in the patient record.
ii. Proportion of staff in each team who have completed training as required.
iii. Proportion of people with Severe Mental Illness (SMI) receiving SHSC services who have had a cardiovascular risk review with appropriate interventions offered.
iv. Proportion of people with an LD receiving SHSC services who have had an annual physical health check.
v. Proportions of people admitted to hospital who are at risk of having falls, VTE, MRSA and malnutrition have appropriate screening and receive treatment when required.
vi. Proportion of people admitted to hospital who have their smoking status recorded and are offered appropriate interventions.
vii. Infection prevention and control data, including sepsis.
viii. Care plan and risk assessment audits.
ix. Availability and maintenance of physical health equipment

2. Scope

2.1. This policy applies to the following services/teams within SHSC – all inpatient wards, mental health recovery teams, older adults community mental health teams, adult and older adult home treatment teams, community enhancing recovery team, early intervention in psychosis team, community learning disability team and relevant specialist teams.

2.2. It applies to all staff working within SHSC services covered by the scope.

3. Purpose

3.1. The purpose of this policy is to support and improve the way the physical health needs of people of all age groups /conditions who use the SHSC mental health and learning disability services are assessed and treated.

3.2. The aims are twofold:

i. To improve physical health outcomes for service users in receipt of services from SHSC.
ii. To decrease health inequalities

3.3. This policy sets out a number of principles which should be used when writing or updating any policy, guidelines, protocol, procedures with a physical health element.

4. Definitions

Standard Operating Procedure (SOP)	A Standard Operating Procedure is a document which describes the regularly recurring operations relevant to the quality of the intervention. The purpose of a SOP is to carry out the operations correctly and always in the same manner
Comprehensive Physical Health Review	A comprehensive physical health review covers health behaviour factors such as smoking, alcohol and substance use, diet and

physical activity and biological factors such as weight/BMI, blood pressure, and blood tests including glucose and lipid levels.

5. Duties

5.1 The Board delegates responsibility to the Quality Assurance Committee to obtain assurance that this policy is being implemented across SHSC and that the key actions are progressed and completed through governance structures.

5.2 The Infection Prevention and Control and Physical Health Group is chaired by the Director of Nursing, Professions and Operations. The group is responsible for the monitoring and auditing outcomes and reports to the Quality Assurance Committee and to Trust Board, plus directly feeding into local patient safety clinical groups for improvements at an individual service level.

5.3 The Director of Nursing, Professions and Operations and the Medical Director are jointly responsible for establishing the standards for physical health promotion and monitoring within the organisation, seeking advice from relevant specialists as required.

5.4 The Medical Director is also responsible for ensuring all medical staff are aware of this policy and their role in assessing, maintaining and monitoring the physical healthcare of patients.

5.5 The Director of Nursing, Professions and Operations is also responsible for the development, review and monitoring of this policy and practice standards in physical healthcare and for the provision of appropriate training and education to support the delivery of physical healthcare.

5.6 Clinical Directors, Heads of Nursing and Heads of Service are responsible for the implementation of this policy.

5.7 Clinical Leads, Modern Matrons and Ward/Team Managers are responsible for ensuring all staff are aware of the policy, its whereabouts and their adherence to it.

5.8 All staff delivering clinical care are required to adhere to the requirements of this policy but in particular:

5.8.1. Medical Staff, Nurses, Physician's Associates, Advanced Clinical Practitioners and Nurse Associates will

i. perform physical examinations, investigations and health screening as outlined in this policy.

ii. complete all relevant documentation in relation to physical examination, investigations and health screening.

i. ensure the appropriate actions are taken for patients with an abnormal finding upon examination or investigation.

ii. identify and maintain individual competence in physical health assessment, observation and management.

iii. identify and raise awareness of research opportunities related to physical health.

5.8.2. Matrons, Team Leaders and Ward Managers will

i. be fully aware of the contents of this policy and supporting policies and guidance.

ii. be responsible for ensuring that staff read, have an awareness of and adhere to this policy and supporting policies and guidance.

iii. ensure staff undertake training required by their role to achieve and maintain level of competence in relation to physical health.

iv. Ensure that audits required to demonstrate compliance with physical health standards are robustly and consistently completed.

5.9 Managers are responsible for ensuring that any staff member required to adhere to this policy is adequately trained and assessed as competent.

5.10 Where staff are aware of any incidence of physical health needs not being adequately met, they must take action to meet the need and complete a Trust incident form.

6. Procedure

6.1. Service users who have a severe mental illness or who are receiving care from SHSC community mental health and learning disability teams will have a comprehensive annual physical health review.

6.2. Most service users will have their review in primary care. For these service users SHSC teams will check that the review has taken place, record the results of the reviews and work with the service users to agree a care plan that addresses any identified needs.

6.3. Service users who have not attended their physical health review in primary care will be encouraged and where necessary supported to attend.

6.4. Service users who are unable to access a review in primary care will be offered a comprehensive physical health review by their SHSC community team. The results of these reviews will be shared with primary care and the SHSC team will work with the service users to agree a care plan that addresses any identified needs.

6.5. Service users admitted to an SHSC ward will have physical health assessments based on national best practice standards including assessments of their smoking status, risk of venous thromboembolism and need for MRSA screening. They will also be offered a comprehensive physical health review during their admission.

6.6. SOPs to support the physical health reviews are in place for inpatient wards and community mental health and learning disability teams.

6.7. These SOPs, which are set out in the Appendices, explain in clear and unambiguous language the actions or performance expected of the relevant staff, and teams in these areas of service delivery. They describe the procedures to follow and set the standards to be met.

6.8. The SOPs address the key priorities outlined in the Physical Health Strategy, namely;

i. Implement appropriate and timely interventions

ii. Improve the clinical information we record and use

iii. Support staff to improve their awareness, knowledge and skills

iv. Collaborate and coordinate and integrate across organisations

v. The SOPs also set out staff roles and responsibilities, performance standards and any timescales that apply.

6.9. The SOPs also detail:

i. What constitutes a physical health assessment?
ii. Timescales / frequency of associated tests / actions / tasks

iii. Responsibilities and actions

6.10. The SOPs will set out clearly when responsibility for the completion of a physical health assessment rests with our partners in primary care and will explain in what circumstances the responsibility may transfer to SHSC.

Principles for physical health

6.11. Any new Trust or local policy, protocol, procedure or SOP with a physical health element or any existing document when reviewed/updated must follow these principles:

6.12.1 All policies, protocols and SOPs with a Physical Health element must be based on National Guidance to ensure that the content and timing of physical health assessments, investigations, monitoring requirements and interventions are based on best practice

6.12.2 All policies, protocols and SOPs with a Physical Health element are to be reviewed by the Physical Health Management Group and approved by the Infection Prevention and Control and Physical Health Group before approval by Trust process

Research

6.12. The Trust is committed to research and development and we know that research active organisations have better health outcomes. The Trust will actively raise awareness of research to improve physical health outcomes and staff will encourage service users to take up the opportunity to participate in research.

7. Development, Consultation and Approval

7.1 The policy has been developed to align with the Trust Strategy for Physical Health. Policy has been reviewed for accuracy and relevancy pending development of the new Physical Health Strategy (2023-2026). A new policy will be developed in 2023.

7.2 Initial consultation when policy drafted included focus groups with clinical staff and managers of community teams and inpatient wards. Future versions of this policy will include service user and care involvement.

7.3 The policy will be shared with partner organisations for comment and consultation, specifically Sheffield Physical Health Implementation Group (PHIG) and the ICS QUIT programme.

7.4 As changes to this policy are minimal, review has been undertaken by members of the senior leadership team and members of the triumvirate.

7.5 A Quality and Equality Impact Assessment has been completed in respect of this Policy.

8. Audit, Monitoring and Review

Monitoring Compliance Template						
Minimum Requirement	Process for Monitoring	Responsible Individual/ group/committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
Implementation of policy	Review of new/updated policies, procedures or SOPs with a physical health element	Physical Health Management Group (PHMG)	Monthly	Infection Prevention and Control and Physical Health Group	Physical Health Management Group (PHMG)	Infection Prevention and Control and Physical Health Group (Agenda and Minutes)
Proportion of staff in each team who have completed training as required.	Team governance reports PHMG	Clinical team governance meetings	Monthly	Infection Prevention and Control and Physical Health Group	Governance meetings	Infection Prevention and Control and Physical Health Group (Agenda and Minutes)
Proportion of people with SMI receiving SHSC services who have had a comprehensive physical health review with appropriate interventions offered.	Team governance reports and QPRs PHMG	Physical Health Management Group (PHMG)	Monthly	Infection Prevention and Control and Physical Health Group	Physical Health Management Group (PHMG)	Infection Prevention and Control and Physical Health Group (Agenda and Minutes)
Proportion of people with an LD receiving SHSC services who have had an annual physical health check	Team governance reports and QPRs PHMG	Reports to the Infection Prevention and Control and Physical Health Group	Monthly	Infection Prevention and Control and Physical Health Group	Physical Health Management Group (PHMG)	Infection Prevention and Control and Physical Health Group (Agenda and Minutes)

Proportions of people admitted to hospital who are at risk of having falls, VTE, MRSA and malnutrition have appropriate screening and receive treatment when required.	Team governance reports and QPRs PHMG	Reports to the Infection Prevention and Control and Physical Health Group	Monthly	Infection Prevention and Control, Medical Devices and Physical Health Group	Physical Health Management Group (PHMG)	Infection Prevention and Control, Medical Devices and Physical Health Group (Agenda and Minutes)
Infection prevention and control data, including sepsis	Team governance reports and QPRs	Reports to the Infection Prevention and Control and Physical Health Group	Monthly	Infection Prevention and Control and Physical Health Group	Infection Prevention and Control and Physical Health Group (Agenda and Minutes)	Infection Prevention and Control and Physical Health Group (Agenda and Minutes)
Proportion of people who have had their smoking status recorded. Proportion of people who smoke who have received smoking cessation interventions in accordance with NICE PH48 and QUIT	To be included in ward/team governance reports PHMG	Ward/Team/Service manager Ward/Team/Service Governance meeting	Monthly	QUIT Steering Group/Directorate leads Quarterly performance reviews	QUIT Steering Group/ Ward/Team/Service manager	QUIT Steering Group Directorate leads Quarterly performance reviews Infection Prevention and Control and Physical Health Group

The policy will be reviewed every year.

9. Implementation Plan

Implementation Plan Action / Task	Responsible Person	Deadline	Progress update
Upload new policy onto intranet and remove old version	Director of Corporate Governance	Within a week of approval	
Launch revised policy and new SOPs (managers' meetings, etc)	Clinical Directors and Heads of Nursing	Within one month of approval	
Make Inpatient Ward & Community Team aware of new policy	Ward / Team manager	Within one month of approval	
Implementation of SOPs for Physical Health assessment and monitoring	Clinical Directors and Heads of Nursing	Within two months of approval	
Ensure all Wards & Community Teams are aware of the requirements for SOP timescales	Ward/ Team Manager	Within two months of approval	

10. Dissemination, Storage and Archiving (Control)

Version	Date added to intranet	Date added to internet	Date of inclusion in Connect	Any other promotion/ dissemination (include dates)
5.0				The previous policy will be removed from the Trust intranet by the Director of Corporate Governance. Team managers are responsible for ensuring that it is also removed from any policy and procedure manuals or files stored in their offices and destroyed. Archiving – The Clinical Governance team will keep a paper and an electronic version of the previous policy for archive purposes. Please contact them if a copy is needed
6.0				Available trust-wide on the intranet
7.0	April 2022	April 2022	April 2022	

11. Training and Other Resource Implications

12.1 Identified training by managers should be shared with the Physical Health Team for discussion. This discussion will include:

i. Specific training requirements and rationale
ii. How many staff need training?
iii. How to meet training needs
iv. Appropriate environment and infrastructure for training
v. Links with other training/policies

12.2 Resources to help staff with physical health and wellbeing are made available on the SHSC intranet.

12.3 Staff have access to clinicalskills.net and are able to access an evidence based clinical procedures resource.

12.4 Where training needs are identified, these must be discussed with the Education, Training and Development Team and be reflected in the SHSC's Training Needs Analysis

12.5 Training administration support staff are required to book, prepare, record and monitor staff attendance on training

12. Links to Other Policies, Standards (Associated Documents)

References	
DH (2016)	Improving the physical health of people with mental health problems: Action for mental health nurses: DH, Public Health England & NHS England. London
DH (2005)	National Services Framework for Long Term Conditions: DH. London
DH (2006)	Choosing Health: Supporting the physical health needs of people with severe mental illness. DH. London
National Audit of Schizophrenia (2013)	Royal College of Psychiatrists
Schizophrenia Commission (2012)	The Abandoned Illness: A report by the Schizophrenia Commission
Wahlbeck K et al., (2011)	Outcomes of Nordic mental health systems: life expectancy of patients with mental disorders. British Medical Journal 2011 199 (6) 453-8

Policies
Development, Management and Review of Policies
NICE Guidelines
Resuscitation Policy
Infection Control Policy
Medical Devices Policy
Nicotine Management Policy
Discharge Policy
Work Equipment Policy
Medicines Management Policy

Observation and escalation Policy
Rapid Tranquillisation policy
Restraint policy
Seclusion policy
Moving and Handling
ECT (Electroconvulsive therapy)
Adult Learning Disabilities Service Dysphagia Protocol for Mental Health Referrals

13. Contact Details

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Appendix 1 – SOP for Physical Health Investigations - Older Adult Community Teams

Purpose

To ensure all patients under the care of Older Adult Community Teams receive the standard range of investigations in line with NICE Guidance.

Scope

Applies to patients admitted to the following SHSC community mental health teams: Older Adult Community Mental Health Team, Older Adult Home Treatment Teams

Procedure

1. A physical health review will be completed:
   - For new patients, unless it has been recently completed by another SHSC service or in primary care as part of the referral process.
   - For existing patients on Mood Stabilisers or Antipsychotic medication (initiation and annual), at annual review, or all other patients where there has been a significant change in physical presentation since the last review.

2. The following information will be required:
   - Information from primary care including physical health summary and up to date medication list.
   - Recent blood results.
   - Any other recent physical health investigations.

3. Ensure that you gather information about the following:
   - Smoking status
   - Alcohol consumption
   - Substance use
   - Diet
   - Physical activity
   - Weight
   - Blood pressure
   - Blood results

	Ref protocol	ACOMHS
FBC	√	X
B12 & Folate	√	X
U&E	√	X
LFT	√	X
TFT	√	X
Fasting plasma glucose/HbA1C	√	√
Lipid Profile	X	√
Calcium	√	X
Prolactin	√*	X

*Nb Prolactin level (if likely to receive an antipsychotic for the first time) felt to be unnecessary for older adults

If the information listed in 2 & 3 are not available, are more than 12 months ago, or if there has been a significant change in physical presentation then the team will be required to carry out the necessary interventions directly with the patient to obtain relevant, up to date information.

Additional investigations should be ordered if clinically indicated e.g. lithium level or thyroid function test.

Where blood results are not available, discuss with the patient preferable options for having blood tests taken which may include asking the GP to arrange the test, or for Mental Health Services to complete blood request form for the patient to access phlebotomy services at MCC, RHH or NGH.

Responsibilities

Admin staff must ensure that information is available at point of referral or prior to physical health review at request of clinician.

The lead professional is responsible for checking that all information outlined in 2 & 3 is available prior to the review and to carry out the necessary interventions where the information is not available. This may involve working in collaboration with other members of the MDT.

Results of the physical health review may be recorded in the patient care record:

- Physical Health Review Form (Annex 1)
- Antipsychotic check list (Annex 2)
- Scanned documents.
- ICE Lab reports.
- Physical health review for people prescribed Antipsychotic and/or Mood Stabiliser. (Annex 3)
- Initial Assessment/SCP Initial Assessment information.

If patients refuse examination/investigations or interventions:

- Document refusal on the physical health review form
- Develop a management plan within the patient's care plan
- Give patient information about the importance of investigations and repeatedly attempt to engage patient with the required interventions
- Monitor and record progress as part of care planning

	Intervention
Smoking	All smokers to be given Very Brief Advice and offer referral to smoking cessation worker in team if available and / or Sheffield stop smoking service.
Harmful use of alcohol	Complete alcohol screening tool and provide Very Brief Advice.

Substance use	Discuss potential adverse impact on mental and physical health and offer referral to the opiate or non-opiate service.
Diet and activity	Consider advice on: • healthy balanced diet • reducing sugar and salt intake • increasing fruit and veg • increasing activity levels/referral to SPARS https://spars.org.uk/
Weight	Consider effect of recent medication changes. Give advice on diet and activity as above.
Blood pressure	Give advice on diet and activity as above. Refer to GP if any concern.
High blood glucose levels	Advise on diet and activity as above and refer to GP.
Diabetes	Community teams have a duty to ensure that monitoring for diabetes is carried out by GP, diabetic clinic or other community team. Ask patient about diabetic review and check physical health summary from GP.
Cholesterol	Give advice on diet and activity as above. Advise to attend GP if abnormal blood results (Lipids).

- An ECG should be requested at baseline and annual review if the patient is prescribed antipsychotics and/or if required by the drug Specific Product Characteristic. Please see ECG SOP for further information.
- Do not routinely request a Brain scan unless clinically indicated e.g. evidence of neurological disease.
- Document clinical management / action plans within the physical health review form and develop a physical health goal with identified steps within the care plan.
- In the event of an acute physical health emergency, staff to ring 2222 from Trust line or 999 from outside line. For all non urgent matters, staff to consult with team medic.

Review of SOP
Review to be completed annually

Annex 1 to SOP for Physical Health Investigations - Older Adult Community Teams

Physical Health Review

For new patients to the team. To be completed within 5 days of initial assessment.

Name of patient; **Insight no;**

Date;

GP summary on insight; Y/N

GP review within the last 12 months; Y/N

Any changes in physical health over the past month; Y/N

If **yes**, please provide details; _____

Recent bloods available; Y/N

If **no**, date for bloods to be done; _____

Any sensory Impairments; Y/N

If yes, please provide details; _____

Physical observations – to be documented on NEWS2 where relevant

Observation type	**Observation Reading**	**Actions** *(if appropriate)*
Blood Pressure sitting *Electronic/Manual (please circle*		
Blood Pressure standing *Electronic/Manual (please circle)*		
Pulse Rate		
Temperature		
O2 Saturation		
Respiration Rate		
ACVPU		
Weight (kg)		

Waist Circumference (cm)		

Physical health conditions/Disabilities;

_____
_____
_____

Smoker; Y/N

If yes;
Method; _____ How many per day; _____

Offer of information for smoking cessation Y/N

/

/

If unable to complete physical health review, please explain why and arrangements made;

ANNEX 2 TO SOP for Physical Health Investigations - Older Adult Community Teams

ANTIPSYCHOTIC SIDE EFFECT CHECKLIST FOR CLIENT:

Your patient may have been prescribed one of the following antipsychotics:- Amisulpride, Aripriprazole, Olanzapine, Quetiapine, Risperidone, Haloperidol, Benperidol, Chlorpromazine. **(PLEASE CIRCLE ANTIPSYCHOTIC TO BE PRESCRIBED).** Have you, your patient or their carer noticed any of the following side effects since the antipsychotic medication was started?

	PRE-PRESCRIPTION			**1ST ASSESSMENT (IN FIRST WEEK)**			**2ND ASSESSMENT (AFTER 2ND WEEK)**		
	Date:			**Date:**			**Date:**		
	Baseline Observation:			**Baseline Observation:**			**Baseline Observation:**		
	Weight: **Waist circumference:**			**Weight:** **Waist circumference:**			**Weight:** **Waist circumference:**		
	Pulse:			**Pulse:**			**Pulse:**		
	BP (Sitting): **BP (Standing):**			**BP (Sitting):** **BP (Standing):**			**BP (Sitting):** **BP (Standing):**		
	Blood Lipids:			**Blood Lipids:**			**Blood Lipids:**		
	Yes	**No**	**Comments**	**Yes**	**No**	**Comments**	**Yes**	**No**	**Comments**
Extrapyramidal Side Effects:-									
Muscle stiffness									
Slow movements									
Leaning over to one side									
Reduced mobility									
Falls									
Restlessness									
Shakiness									
Anticholinergic Side Effects:-									
Over-wet or drooling mouth									
Dry mouth									
Constipation									
Difficulty passing water									
Blurred vision									
Dizziness									

Loss of balance on standing up									
Other Side Effects:-									
Rash									
Sensitivity to the sun									
Feeling sick									
Difficulty staying awake during the day/sedation									

Please record any of these side effects noticed in your Insight entry or weekly review. Any change of medication following completion of this checklist is to be recorded in the care records. Thank you.

ANNEX 3 TO SOP for Physical Health Investigations - Older Adult Community Teams

Physical Health Review for people prescribed Antipsychotic and/or Mood Stabiliser.
Older Adult Community Mental Health Teams.

Name:
DOB:
Insight number:

	Baseline	**Interim Review**	**3 month review**	**Annual review**
Date				
BP Sitting				
Pulse (BPM)				
Weight (KG)				
Waist Circumference (CM)		**X**	**X**	
Med Reconciliation complete?	Yes/No	Yes/No	Yes/No	Yes/No
Change to Medical history?	Comments	**X**	**X**	Comments
Lifestyle Review: • Smoking form • Alcohol screening tool • Dietary advice • Activity levels.	Comments	Comments	Comments	Comments
Side Effect Scale (GASS)	Yes/No	Yes/No	Yes/No	Yes/No
ECG completed?	Yes/No	**X**	**X**	Yes/No
Blood investigations: FBC		**X**	**X**	
B12 & Folate		**X**	**X**	**X**
U&E		**X**	**X**	
LFT		**X**	**X**	
TFT		**X**	**X**	**X**
Fasting Plasma Glucose / HbA1C		**X**	**X**	
Lipid Profile		**X**	**X**	
Calcium		**X**	**X**	**X**

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

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 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.

Appendix 3 - SOP for physical health assessments of service users receiving treatment and support from home treatment teams

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 home treatment teams in Sheffield Health and Social Care NHS Foundation Trust. The SOP is based on standards set out in the Royal College of Psychiatrists Home Treatment Accreditation Scheme.

Working with physical health services

Joint working and good communication between staff working in SHSC home treatment teams and physical health services is essential.

SHSC home treatment teams have a responsibility to

1) seek information from primary care about a service users physical health.
2) complete medicines reconciliation.
3) undertake physical health investigations and monitoring when initiating antipsychotics and mood stabilisers.
4) include physical health assessments and treatment in care plans.
5) share relevant information with primary care and other SHSC services.

Scope:

This SOP applies to service users receiving care from the home treatment teams. 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 users physical health in their initial assessment. The assessment includes but is not limited to: Details of past medical history; Current physical health medication, including side effects and compliance with medication regime; Lifestyle factors e.g., sleeping patterns, diet, smoking, exercise, sexual activity, drug and alcohol use. If the assessment has been documented by another SHSC team e.g. SPA/EWS, recovery team, a ward team, etc prior to the service user being taken on by the home treatment team it does not need to be repeated.

Timescale – At the time of initial assessment
Responsibility – Clinical staff member completing the assessment

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 if the service user is still receiving treatment and support from the home treatment team the baseline investigations should be repeated.

Actions to be taken if the service user is found to be gaining weight or developing metabolic disturbance include advice about diet and activity, referral to community services that provide support with health behaviours and signposting to the service users GP.

Appendix 4 – SOP for physical health assessments of patients admitted to SHSC wards

Purpose and Objective:

The Physical Health Policy requires a SOP for the assessment and monitoring of the physical health of Service Users. This is to ensure all people admitted to an in-patient ward receive a range of investigations. Consideration should be taken dependent where service users are in their care pathway and whether in depth physical examination is clinically indicated.

Scope:

This SOP applies to all SHSC inpatient wards.

Initial physical health assessment following admission

a. An Early Warning Score assessment will be completed as soon as possible after admission and within 4 hours. An urgent physical review will be undertaken if indicated by the National Early Warning Score (NEWS2)
b. The patients past medical history will be documented as soon as possible after admission.
c. A physical examination will be completed by a Doctor, Physician's Associate or Advanced Clinical Practitioner within 24 hours of admission. The examination completed will be based on the patient's past medical history and current presentation and will be documented in the patient record.
d. An ECG and screening tools (dysphagia, smoking form, falls assessment, MRSA screening, VTE screening) will be completed within 24 hours of admission.
e. Routine blood tests will be completed within 24 hours of admission.
    - 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)
f. Additional investigations will be requested if clinically indicated.
g. The "physical health assessment" document will be commenced within 24 hours of admission and completed within 7 days.
h. A clinical management plan will be developed to meet the patient's known physical health needs and documented in their care plan. In the event of any abnormal findings in screening and examination undertaken after admission an individualised management plan will be documented in the patient's care plan.
i. If specialist medical/surgical assessment or treatment is required the patient will be referred to the appropriate medical specialist and supported to attend any appointments. Recommended treatment will be delivered on return to the ward and documented in the care plan.
j. On discharge from the ward the discharge summary will include relevant information about physical health investigations and treatment and will be sent to the patients GP and available in the patient record for SHSC community teams to access.

Physical health monitoring for service users commenced on a new antipsychotic or mood stabiliser during an inpatient admission

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 weighed weekly for the first six weeks. At 12 weeks if the service user is still an inpatient the baseline investigations should be repeated. If the patient is discharged before 12 weeks the community team should be informed of the date the investigations should be completed.

Actions to be taken if the service user is found to be gaining weight or developing metabolic disturbance include advice about diet and activity, referral to community services that provide support with health behaviours and signposting to the service users GP.

Appendix 5 - Equality Impact Assessment Process and Record for Written Policies

Stage 1 – **Relevance** - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? This should be considered as part of the Case of Need for new policies.

NO – No further action is required – please sign and date the following statement. **I confirm that this policy does not impact on staff, patients or the public.**	***I confirm that this policy does not impact on staff, patients or the public.*** Name/Date:	**YES,** Go to **Stage 2**

Stage 2 Policy Screening and Drafting Policy - Public authorities are legally required to have 'due regard' to eliminating discrimination, advancing equal opportunity and fostering good relations in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance and Flow Chart.

Stage 3 – **Policy Revision** - Make amendments to the policy or identify any remedial action required and record any action planned in the policy implementation plan section

SCREENING RECORD	Does any aspect of this policy or potentially discriminate against this group?	Can equality of opportunity for this group be improved through this policy or changes to this policy?	Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?
Age	**No**		
Disability	**No**		
Gender Reassignment	**No**		
Pregnancy and Maternity	**No**		
Race	**No**		

Religion or Belief	**No**		
Sex	**No**		
Sexual Orientation	**No**		
Marriage or Civil Partnership	**No**		

Please delete as appropriate: - Policy Amended / Action Identified (see Implementation Plan) / no changes made.

Initial Impact Assessment Completed by: Dr J Mitchell on 8/3/21
Reviewed by Sue Barnitt, Head of Clinical Quality Standards on 16/03/22

Appendix 6 - Review/New Policy Checklist

This checklist to be used as part of the development or review of a policy and presented to the Policy Governance Group (PGG) with the revised policy.

		Tick to confirm
	Engagement	
1.	Is the Executive Lead sighted on the development/review of the policy?	
2.	Is the local Policy Champion member sighted on the development/review of the policy?	
	Development and Consultation	
3.	If the policy is a new policy, has the development of the policy been approved through the Case for Need approval process?	
4.	Is there evidence of consultation with all relevant services, partners and other relevant bodies?	
5.	Has the policy been discussed and agreed by the local governance groups?	
6.	Have any relevant recommendations from Internal Audit or other relevant bodies been taken into account in preparing the policy?	
	Template Compliance	
7.	Has the version control/storage section been updated?	
8.	Is the policy title clear and unambiguous?	
9.	Is the policy in Arial font 12?	
10.	Have page numbers been inserted?	
11.	Has the policy been quality checked for spelling errors, links, accuracy?	
	Policy Content	
12.	Is the purpose of the policy clear?	
13.	Does the policy comply with requirements of the CQC or other relevant bodies? (where appropriate)	
14.	Does the policy reflect changes as a result of lessons identified from incidents, complaints, near misses, etc.?	
15.	Where appropriate, does the policy contain a list of definitions of terms used?	
16.	Does the policy include any references to other associated policies and key documents?	
17.	Has the EIA Form been completed (Appendix 1)?	
	Dissemination, Implementation, Review and Audit Compliance	
18.	Does the dissemination plan identify how the policy will be implemented?	
19.	Does the dissemination plan include the necessary training/support to ensure compliance?	
20.	Is there a plan to i. review ii. audit compliance with the document?	
21.	Is the review date identified, and is it appropriate and justifiable?	