East London NHS
NHS Foundation Trust

# PHYSICAL HEALTHCARE POLICY

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| 13 | January 2017 | Associate Medical Director – Primary Care | | Requirements to use RiO forms added |

## EXECUTIVE SUMMARY

1. Secondary Specialist Services for Mental Health are required to work closely with Primary Care Services to ensure that those with a serious and enduring mental illness have their physical health monitored and managed effectively.

2. East London Foundation Trust also manages community services in Newham – the Community Health Newham directorate (CHN). This consists of over 30 nursing, therapy and primary care medical services. Each service carries out initial and follow-up assessments of their patients in line with professional and good practice requirements. CHN also provides a source of physical health advice and expertise to the mental health directorates.

3. Secondary care mental health services should undertake a regular and full assessment of the mental and physical health of the service user, addressing all issues relevant to the individual's quality of life and well being (NICE, 2002). For community service users accepted by psychiatric services, the annual health check should be arranged in collaboration with the service user's General Practitioner as this is an annual requirement for General Practitioners under the Quality Outcome Framework (QoF 2006-7) (www.nhsemployers.org)

4. Physical healthcare checks should pay particular attention to endocrine disorders, such as diabetes and hyperprolactinaemia, cardiovascular risk factors such as, blood pressure and lipids, respiratory disease and obesity, side effects of medication and lifestyle factors such as smoking and diet (NICE, 2002).

5. Cardio metabolic risk factors once identified should have appropriate actions taken to manage the condition or reduce risks. The Lester tool (appendix 1) should be used as guide to identify risk factors and provide intervention.

6. Assessments and management should be undertaken in consideration of inservice user service user's physical and mental health needs. Once identified, physical healthcare needs should be included within the individual's care plan and Care Programme Approach (CPA), (DoH 1995) and Single Assessment Process (SAP) documents (DoH, 2001). Any action taken will also be recorded within the care plan and RIO and a copy of this should always be sent to the individual's General Practitioner (GP).

7. Where there is an emergency or life – threatening situation involving a service user, local emergency response procedures should be followed including contacting 999 services where indicated.

## 1. Introduction

1.1 Mental and physical health are inextricably linked and we need to apply a 'whole person' approach to integrate rather than separate them

1.2 This policy and guidance is intended to assist practitioners to assess for physical healthcare needs, identify cardio metabolic risk factors and take appropriate action to improve the long term health outcomes including the ongoing monitoring of service users. This policy should be used in conjunction with other trust policies.

1.3.1 Assessment tools have been developed to promote a consistent approach to help identify specific physical health risks

## 2. Rationale

2.1 It is estimated that 17.5 million adults in Great Britain may be living with a chronic illness and the incidence is highest among the most disadvantaged groups, such as those who are unemployed and those with a mental illness (DoH, 2005).

2.2 The National Service Framework (NSF) for mental health makes explicit recommendations about the physical healthcare of people with a serious and enduring mental illness (NSF, DoH 1999).

2.3 Secondary specialist services for mental health are required to work closely with primary care services to ensure that those with a serious and enduring mental illness have their physical health monitored and managed effectively.

2.4 The General nGMS Standard Contract (July 2006) - variations incorporating the new Directed Enhanced Services : Department of Health - Health care. Medical Services contract (Revisions 2006/07) states that general practice teams are responsible for the management of chronic diseases. These currently include coronary heart disease, heart failure, hypertension, atrial fibrillation stroke, transient ischaemic attacks, , diabetes mellitus, chronic obstructive pulmonary disease, epilepsy, hypothyroidism, cancer, palliative care, mental health & depression, asthma, dementia, chronic kidney disease, learning disabilities, smoking and obesity. In addition the following women's services are included: cervical screening, maternity services and contraception (Revisions to GMS contract 2009)

As these are national benchmark targets to be met by all General Practices all community service users should be encouraged and enabled to register with General Practitioners so that they can benefit from this range of services. It is the duty of each service users care co-ordinator to support the service user to register with a local GP and to engage with primary care services accordingly, depending on clinical need.

2.5 The written care plan for individuals on an enhanced level of Care Programme Approach (CPA) should include arrangements for physical healthcare; how and what will be provided DoH 2008.

## 3. Scope of the Policy

3.1 This policy pertains to all services and directorates across the East London NHS Foundation Trust (ELFT) to ensure that the organisation is working towards the same

objective in planning and delivering health care. It is the responsibility of all doctors, nurses and other mental health workers to take necessary actions to improve physical healthcare outcome and experiences for service users.

3.2 The physical health needs of adults of all ages nd young people with mental illness are integral to the individual well being and overall holistic package of care. In the case of children and adolescents it is generally assumed that parents or carers take full responsibility for meeting their physical health care needs. The mental health professional's responsibility is to work closely with parents in assisting identification of these needs and ensuring that appropriate services are accessed.

3.3 Within Community Health Newham directorate initial and follow-up assessments are undertaken in line with the professional and good practice requirements of the service.

## 4. Trust Policies:

4.1 The policy should be read in conjunction with:

- Smoke Free Policy (2017)
- Manual Handling Policy (2002)
- Guidelines for the Management of Antipsychotic-induced Hyperprolactinaemia
- Guidelines for High Dose Antipsychotic Medication
- Tissue Viability Policy
- Clozapine Clinic Policy
- Rapid Tranquilisation Policy
- TB Policy
- Resuscitation Policy
- Community Health Newham clinical policies and procedures
- Vital Signs Policy (2016)
- Venous Thromboembolism; Reducing the Risk (2013)

## 5. Duties

5.1 The Medical Director and the Director of Nursing are responsible for overseeing the policy being put into practice. Operationally it is the responsibility of the Clinical Directors, Medical Staff, Lead Nurses and Community Service Managers. The framework for delivery will be the CPA and in-service user care plans

## 6. Aims & Objectives

6.1 To improve the detection, assessment, treatment and ongoing management of the physical healthcare needs of service users.

### 6.2 *Objectives for In-service user Services*

6.2.1 To ensure that all inservice user service users have a baseline physical assessment carried out within 24 hours of admission and this is recorded in the service user records. To improve the prevention, detection, assessment, treatment and management of diabetes and other disorders in service users taking antipsychotic medication.

6.2.2 To improve service users access to disease prevention programmes.

6.2.3 To improve service users access to screening programmes.

6.2.4 To ensure General Practitioners are informed of changes and follow up care upon the discharge of service users into the community.

### 6.3 *Objectives for Community Services*

6.3.1 To ensure the primary care team are involved in the identification and management of the physical healthcare needs of service users with severe and enduring mental illness.

6.3.2 To facilitate access of service users with a mental illness into primary care and specialist health care services.

6.3.3 To improve the prevention, detection, assessment, treatment and management of cardio metabolic risk factors and conditions and other disorders in service users taking antipsychotic medication.

6.3.4 To improve service users access to disease prevention programmes and screening programmes

6.3.5 To assist General Practices to maintain an up to date register of people suffering from long term mental health conditions (Revisions to GMS contract 2009)

6.3.6 To support General Practices and the service user to complete the annual health check in line with current Quality Outcome Framework (QoF) recommendations

## 7. Physical Assessment, Examination & Ongoing Physical Health Care Monitoring

7.1 Issues of sensitivity, gender, ethnicity and preference should be considered by clinical staff carrying out a physical examination.

### 7.2 *Baseline Physical Assessment for Inpatient service users:*

7.2.1 All service users admitted to in-service user services must receive an initial physical health assessment within 24 hours of admission.

7.3 If the service user refuses, or is too distressed to cooperate with having observations completed within the agreed timeframe, there must be documentation of such refusal and this must be reviewed continually until fully completed. The situation should be reviewed in the next ward round.

7.4 The physical examination and assessment at the point of admission to hospital should be sufficient standard to pick up significant abnormalities in order that they can be appropriately managed. The GMC document entitled ‘Good Medical Practice’ considers good clinical care to include:

(i) An adequate assessment of the patient’s condition and, if necessary, an appropriate examination
(ii) Investigations where necessary
(iii) Suitable and prompt action where necessary

(iv) Referral to another practitioner, where necessary

7.5 Rio inline physical health forms must be used for all physical health assessments, so that information is documented in the service user's health record.

7.6 ***Admitting doctors' responsibilities:***

7.6.1 An in-depth, history, assessment and examination of an individual's physical and mental health, must be carried out by a doctor and recorded in the notes.

7.6.2 The physical health assessment within the first 24 hours should include the following information, entered onto the Rio Inline Physical Health Forms:

- General condition of service user
- Blood pressure & temperature, pulse and respiration (TPR/BP)
- Cardiovascular system (ECG where relevant)
- Respiratory system
- Abdomen
- Baseline bloods done or requested, including HDL –LDL and HbA1c
- ECG, done or requested
- Allergies
- Medications
- Sexual Health
- Underlying medical conditions
- Past medical history

7.7 Physical Investigations should include baseline bloods to exclude any co-occurring medical conditions that may present with psychiatric symptoms. These include blood tests; measuring TSH to exclude hypo- or hyperthyroidism, basic electrolytes, serum calcium and liver enzymes, and a full blood count, metabolic risk predictors of ischemic heart disease – HDL, LDL and diabetes predictor HbA1c .

7.8 People receiving antipsychotic medication require measurement of plasma glucose and lipid levels to detect a medication-induced metabolic syndrome, and an electrocardiogram to detect iatrogenic cardiac arrhythmias

7.9 The investigation of dementia could include measurement of serum vitamin B-12 levels, serology to exclude syphilis or HIV infection, EEG, and a CT scan or MRI scan.

7.10 ***Admitting nurse responsibilities:***

7.10.1 A physical health assessment with smoking status should be carried out by the nurse.

7.10.2 The assessment should include the following and be documented in the Rio Observations and Measurements Inline Form:

- Height, weight & waist circumferences
- BMI (weight for height in children) (MUST tool to be completed if concerns noted). In inpatient CAMH use of electronic weight/height charts are to be used issues of concerned result in referral to dietician
- Urinalysis – (multistix) (sub-Rio Form: Urinalysis)
- Blood glucose test (BM) if glucose present in urine or known diabetic.
- Baseline observations (TPR and BP if not completed by the admitting doctor)
- Smoking status
- Pregnancy test if indicated

- Hydration should be monitored

7.11 If there are any concerns about the service users' mobility on admission a full moving and handling assessment must be completed in line with the ELFT Manual Handling Policy (2008).

7.12 If there are any concerns about the service users' skin integrity on admission a tissue viability assessment must be completed.

7.13 All service users should have nutritional screening on admission .If there are any concerns about the nutritional status of the service user, the MUST (Malnutrition Universal Screening Tool) should be completed.

7.14 All service users should have their risk of Venous Thromboembolism assessed at admission and if at risk treatment commenced in line with the policy Venous Thromboembolism; reducing the Risk.

7.15 Admission assessments should include monitoring of food and fluid input and output and appropriate management plan in place where concerns noted

7.16 If service users' baseline observations are outside the normal range or the service users physical presentation causes immediate concern, the doctor and nurse in charge should implement a management plan. This plan may include referral to a clinical specialist in the local acute Trust.
NB. If the doctor records the TPR and BP on admission, the nurse does not need to repeat it unless indicated. However, the nurse is responsible for the continued recording of baseline observations if clinically indicated (Baseline Observation Schedule).

7.17 In-patient service user Physical Health Care Monitoring Based on assessment on admission

7.18 Ongoing risk assessments and management should be undertaken in consideration of in-service user service users' physical and mental health needs.

7.19 National Early Warning Score (NEWS) Monitoring See Vital Signs Policy

**7.20** ***Lifestyle Assessment and Interventions***

7.21 The Ward Manager is responsible for ensuring that service users lifestyle is assessed, with appropriate interventions then put in place, as soon as possible and within 1 week of the service user being admitted to the ward. This assessment is not expected within 24 hours, as it is recognised that the period immediately following admission will generally not be the best time for service users to have a positive discussion about lifestyle factors.

7.22 The assessment should cover the areas in the Lifestyle Assessment Rio Form; exercise, diet, smoking status, drug and alcohol, debt and housing and 5 ways to wellbeing

7.23 Lifestyle interventions should support service users to develop more healthy behaviours whilst they are on our wards including;
- Nutritional counselling: reduce take-away and "junk" food, reduce energy intake to prevent weight gain, avoid soft and caffeinated drinks and juices, and increase fibre

intake.

- Physical activity: structured education-lifestyle intervention. Advise physical activity such as a minimum of 150 minutes of 'moderate-intensity' physical activity per week (http://bit.ly/Oe7DeS). For example suggest 30 minutes of physical activity on 5 days a week
- Smoking cessation support

7.24 Specific lifestyle interventions should be discussed in a collaborative, supportive and encouraging way, taking into account the person's preferences. Interventions should be tailored to the needs of the person and reflect their recovery goals.

7.25 Lester Tool Monitoring standards should be followed for all service users on psychotropic medication. The full Lester Tool is included in Appendix 1, however its key requirements are:

**Monitoring: How often and what to do**

Applies to patients prescribed antipsychotics and mood stabilizers.

| | Baseline | Weekly first 6 weeks | 12 weeks | Annually |
|---|---|---|---|---|
| Personal/FHx | ■ | | | ■ |
| Lifestyle Review[1] | ■ | | ■ | ■ |
| Weight | ■ | ■ | ■ | ■ |
| Waist circumference | ■ | | | ■ |
| BP | ■ | | ■ | ■ |
| FPG/$HbA_{1c}$ | ■ | | ■ | ■ |
| Lipid Profile[2] | ■ | | ■ | ■ |

[1]Smoking, diet, and physical activity [2]If fasting lipid profile cannot be obtained, a non-fasting sample is satisfactory

Monitoring table derived from consensus guidelines 2004, j clin. psych 65:2. APA/ADA consensus conference of 2004 published jointly in Diabetes Care and Journal of Clinical Psychiatry with permission from the Ontario Metabolic Task Force.

7.26 Lester Tool Intervention Framework; responding to physical health monitoring. For any high risk service users in the "Red Zone", according to the Lester Tool (2014) (see Appendix 1), Lifestyle interventions should be put in place and referrals made to appropriate specialists to improve the person's physical health. The full Lester Guidance is available in Appendix 1 and should be reviewed and followed by all ward teams.

**7.27 *Responding to Physical Health Monitoring; Other***

7.27.1 When there is a change noted in a service user's physical health presentation, consideration should be given to completing a baseline physical assessment examination and advice sought accordingly. Where indicated, investigations must be ordered. Rio inline physical health forms should be used so that this information is documented in the service user's health record.

7.28 If abnormal results are obtained a management plan relating to the prescribing of the psychotropic medication should be formulated and a decision as to the need to refer to the General Practitioner or secondary care physical health services, made.

7.29 There are specific physical health considerations and standards for service users

prescribed high dose psychotropic medication. These are described in section 9 High Dose anti-Psychotic Policy.

7.30 Service users who have a physical ill health problem identified will have this recorded in their care plan. There should be clear and early liaison documented with the primary health care service (GP) where appropriate. This should be considered during regular CPA meetings by the care team, service user, carers and other professionals (specialist secondary or primary care professionals) and reviewed as clinically indicated.

7.31 Where clinically indicated, a referral should be made to an appropriate clinical specialist. If an assessment is to take place outside of the Trust, sufficient clinical information to allow the service user to be adequately assessed/cared for, including up to date risk assessment and care plan should accompany the service user at all times.

7.32 When the mental health service user is detained under a section of the Mental Health Act, refer to the Trust's Mental Health Act Hospital Managers Policy and Procedures; agreement between local acute trusts.

7.33 If clinically indicated in-service users should be offered access to smoking cessation therapy, appropriate immunisation schedules and flu and pneumococcal vaccination

7.34 All service users who have admissions >6 months will be offered appropriate and gender specific health screening in conjunction with the National Screening Programme.

7.35 All service users identified with a long term condition should have a clear management plan documented which includes regular review by their GP or specialist review where appropriate. Arrangements will be made for service users to attend appointments outside of the Trust.

7.36 If information is not available from the GP it should be recorded and efforts made by the team to mitigate, i.e. carry out the check locally.

7.37 The processes for ensuring appropriate follow up of physical health symptoms will be via the pre discharge planning meeting and final CPA plan of care. All service users discharged will have a summary of their physical health needs included in the discharge letter and sent to their GP or appropriate primary health care team.

***7.38 Discharge***

7.39 Information about physical health assessment, monitoring, interventions and signposting, should be communicated to the service users' GP at discharge. Recording in Rio forms will also enable the Trust's community staff, including care coordinators, to effectively support the person's physical health following discharge.

**7.40 Physical Health Assessment and Monitoring for Service Users in the Community**

7.41 For any high risk service users in the "Red Zone", according to the Lester Tool (2014) (see Appendix 1), Lifestyle interventions should be put in place and referrals made to appropriate specialists to improve the person's physical health. The full Lester Guidance is available in Appendix 1 and should be reviewed and followed by all community teams.

**7.41 Health Promotion and Education**

All service users will have their smoking, weight, dietary, exercise, drug and alcohol, debt and housing and 5 ways to wellbeing status recorded in their records.

7.42 Where indicated (in accordance with the Lester Tool) appropriate interventions including smoking cessation advice, exercise etc. will be offered and documented.

7.43 All care coordinated users will be given access to written information on healthy eating; smoking cessation, drug and alcohol, debt and housing and exercise programmes at CMHT premises and this information will be available verbally from their care co-ordinators. Health Promotion information should be available in all areas and used appropriately.

7.44 Care co-ordinators should encourage service users to engage with primary care health promotion activities (e.g. exercise on prescription, walking for health etc) where appropriate.

7.45 Health promotion groups offered to service users by CMHT's should embrace the principles of Self Care and Self Support (DoH 2005 www.dh.gov.uk/SelfCare) the care taken by individuals towards their own health and well-being to promote empowerment, personalised choice so leading to improved health, quality of life and service user satisfaction.

7.46 The multidisciplinary team are responsible for educating service users about their medicines. This includes giving information about the effects of medicines as well as their side effects and how to manage them. for the physical effects of psychotropic medicines. Written information leaflets about medicines are available in different languages on the intranet under Information Leaflets / Medicines.

7.47 Foot care is essential for those with diabetes due to the increased risk of ulceration. Those with type 2 diabetes should have a foot check at least annually (NICE, 2004).

**7.48 Community Physical Healthcare for Service Users on CPA**

7.48.1 Current mental health indicators set out in Quality and Outcome Frameworks (QoF) state that all general practices should maintain a register of those service users with a severe mental illness (SMI) and provide an annual physical health check to service users on that register. A review of a service users' physical health will include, as a minimum, the following:

- issues relating to alcohol and drug use
- smoking status and blood pressure (including history suggestive of arrhythmias)
- cholesterol checks when clinically indicated
- Body Mass Index BMI
- an assessment of the risk of diabetes from antipsychotic medication
- cervical screening where appropriate
- Service users on lithium to have lithium level every six months and thyroid function tests every fifteen months (GP QOF standards).

**7.49 Service Users Registered With General Practitioners**

7.49.1 When a service user is accepted for care under the Care Programme Approach (CPA), their care co-ordinator will verify the details of their General Practitioner and, in line with ELFT Information Sharing Policy, will obtain a summary of their physical

healthcare needs within 28 days of initial contact.

7.49.2 If the service user is already included on the general practice mental health disease register, the care co-ordinator will identify the date of the next scheduled annual General Practice health check, include this in their CPA documentation and support the service user to attend.

7.50 The Care Co-ordinator should verify with their GP practice if the service user has attended their annual health check after fourteen days of this date.

7.51 If the service user has not attended they should be supported to make a new appointment and supported to attend.

7.52 In the event that the service user is not yet included in the general practice SMI register, the practice should be informed in writing of the service users acceptance by psychiatric services and their diagnosis and proposed treatment plan, so that their annual health check can be arranged in consultation with the general practice.

7.53 Once the annual health check is completed, any actions arising in relation to health needs must be included in the service users' CPA plan and the service user encouraged to engage with these by their care co-ordinator and CMHT.

7.54 Records of Physical Health Checks should be recorded in the CPA in the Physical Health section

7.55 Information about assessments, monitoring, interventions and signposting, should be communicated to the service users' GP following CPA review.

7.56 **Service Users not registered with General Practitioners**

7.56.1 Where service users accepted for care under the CPA are not registered with a general practitioner, their Care Co-ordinator will take responsibility for offering support and encouragement to facilitate engagement with primary care health services.

7.56.2 In the event that attempts to persuade the service user to register with a General Practitioner are unsuccessful, the care co-ordinator should arrange an alternative means of completing a medical, in consultation with the service user's responsible community consultant psychiatrist and CMHT.

7.56.3 Efforts to engage the service user with primary care health services should continue as this is the optimum arrangement for supporting and promoting good health and well-being.

**7.57 Service Users Who Refuse to Attend Annual General Practice Checks**

7.57.1 In the event of the service user refusing to attend their General Practice the care co-ordinator should attempt to arrange an alternative means of completing a physical health check, in consultation with the service user's responsible community consultant psychiatrist and CMHT and their General Practitioner.

7.57.2 In the event of the service user refusing all physical interventions, this should be recorded in their records and the service user encouraged to sign that they are aware of the increased risk to their health and well-being. The service user's

decision to refuse their annual medical should be reviewed with them at regular intervals and the discussion documented in the case notes.

## 8. Clozapine Clinics

8.1 All Clozapine service users will have their physical health monitored according to the Trust Clozapine clinic policy. This will include baseline blood pressure, pulse, weight and temperature along with baseline blood test for full blood count, U&E, HbA1c, Random Glucose, LTF and cholesterol.

## 9. Physical Health Standards for Forensics wards and Long Stay

9.1 ***On admission***

A base line physical health assessment must be completed within 24 - 72 hours of admission. From this assessment any specific condition identified must be referred to an appropriate primary care service for screening; and/ or been referred for appropriate treatment. This referral must also be completed within 72 hours of admission. The assessment and referral letters will be recorded/ filed in the service users current clinical notes.

9.1.2 The clinical team must establish whether a patient is registered with a GP and if not, support patients to access a GP. During admission all GP contact will be through the in-house GP provision. A community GP must be identified for discharge to the community. A letter will be sent to all identifiable GP's within 5 days of admission.

9.1.3 In-patients must have documented medicines reconciliation within their care plan within 72 hours of admission. The reconciliation discussion will be filed in the service users current clinical notes.

9.1.4 All Service Users are to be offered Hepatitis B vaccinations. The discussion and outcome of this will be recorded in the service user's current clinical notes.

9.1.5 All current and former substance misusing patients should be assessed and, where possible, treated and/ or vaccinated for blood borne viruses. All current or previous injectors are to be offered Hepatitis C testing (and subsequent treatment). The discussion and outcome of this will be recorded in the service user's current clinical notes.

9.1.6 The requirements documented above will be audited by the service quarterly with an expected target of 100%.

9.2 ***During Admission***

All patients must receive an annual health check. This is completed through the in-house GP provision. The assessment and outcome are recorded within the GP files with a copy forwarded for the Service Users MDT clinical notes. This will be audited quarterly by the service.

9.2.1 When a patient has a change in prescribed medication or there is a change noted in their physical health presentation, consideration should be given to completing a baseline physical assessment examination and advice sought accordingly. Where indicated, investigations must be ordered. These must be documented in the patient's health record.

9.2.2 All patients will have their physical baseline observations monitored monthly. These

checks will consist of Temperature; Weight (kg); BMI; Waist (cm); Urinalysis; BP; Pulse and Respirations. These records will be audited monthly by the nursing team.

9.2.3 Requirements for monitoring physical health observations outside of the parameters set above will be outlined in individual service user care plans. These care plans will be reviewed fortnightly by the MDT and monitored monthly through line management supervision.

## 10.0 Physical Health Standards for Mental Health Care of Older People admission and continuing care wards

10.1 ***On admission***

A base line physical health assessment should be completed within 24 hours of admission. Including assessment of skin (Waterlow/Braden) Nutrition (MUST) and falls risk (FRASE). Refusals to be clearly documented and attempts made to complete daily. From this assessment any specific condition identified and be referred to an appropriate primary care service for screening; and/ or be referred for appropriate treatment. This referral will also be completed within 72 hours of admission. The assessment and referral letters will be recorded and filed in the patients MDT clinical notes.

10.1.1 The clinical team should establish whether a patient is registered with a GP and if not, support patients to access a GP. During admission GP provision will be available through the in-house GP provision with the exception of Continuing Care wards (in Newham and Hackney) patients are registered with a GP who visits regularly. A community GP should be identified for discharge to the community. The patients GP will be informed of admission GP's within 5 days of admission.

10.1.2 Within in-patients admission wards all patients will have documented medicines reconciliation within their care plan within 72 hours of admission. The reconciliation discussion will be filed in the patients current MDT clinical notes.

10.2 ***During Admission***

Where the patient has not received an annual health check in the community the MDT should encourage the patient to have an annual health check, through the in-house GP provision, local GP provision or through the ward Doctor. The assessment and outcome should be recorded within the GP files with a copy forwarded for the patients MDT clinical notes.

10.2.1 When a patient has a change in prescribed medication or there is a change noted in their physical health presentation, consideration should be given to completing a baseline physical assessment examination and advice sought accordingly. Where indicated, investigations should be ordered. These will be documented in the patient's current MDT clinical records.

10.2.2 On the admission wards, all patients will have their physical baseline observations monitored weekly. on the continuing care ward, all patients will have their physical baseline observations monitored monthly or as prescribed.. On all wards the patient may have their observation recorded more regularly if their presentation or condition indicates or the MDT decide it is required. These checks will consist of Temperature; Weight (kg); BMI; Waist circumference (cm); Urinalysis (unless the patient is incontinent); BP; Pulse and Respirations.

10.3 Requirements for monitoring physical health observations outside of the parameters

set above will be outlined in individual patients care plans. These care plans will be reviewed fortnightly by the MDT and monitored monthly through line management supervision.

11.0 **Improving Health Outcomes**
The Lester UK Adaptation of the positive cardio metabolic health resource.

11.1 The Lester tool was introduced in June 2015 to help health professionals improve the physical health of people with serious mental illnesses.

11.2 The Lester Tool co-produced by NHS Improving Quality, NHS England, Public Health England and the National Audit of Schizophrenia . The tool guides health professionals through the assessment of a person's smoking history, lifestyle, body mass index, blood pressure, glucose regulation and blood lipids. It also sets out appropriate interventions and targets to improve that person's physical health.

11.3 Appropriate interventions help improve the physical health of people with mental illness in particular,

11.3.1 Referring people who smoke to stop smoking services

11.3.2 Interventions to improve quality of diet and nutrition

11.3.3 Promoting increased physical activity if a patient is overweight
11.3.4 Monitoring the effects of antipsychotic medication on a patient's physical health

11.4 Use of the tool and appropriate interventions should be clearly documented in the notes. Where interventions are required these should be added to the service users care plan and reviewed in ward round and CPA. - See more at: http://www.nhsiq.nhs.uk/news-events/news/new-tool-to-improve-physical-health-of-people-with-serious-mental-illness.aspx#sthash.bt6gJPaK.dpuf.

12.0 **Monitoring**

12.1 The implementation of the policy will be monitored by the Quality Committee via the following process:

- Trust wide clinical records audit
- Annual Count Me In Survey
- Comparison of current service users known to CMHT on enhanced CPA with shared care registers held by CMHT'S to identify % that have had an annual health check by their GP.
- Royal College of Psychiatry AIMS process.
- Yearly community physical health audit
- Yearly tissue viability audit (MHCOP)
- http://rcpsych.ac.uk/quality/nationalclinicalaudits/schizophrenia/nationalschizophreniaaudit/nasresources.aspx#LesterResour

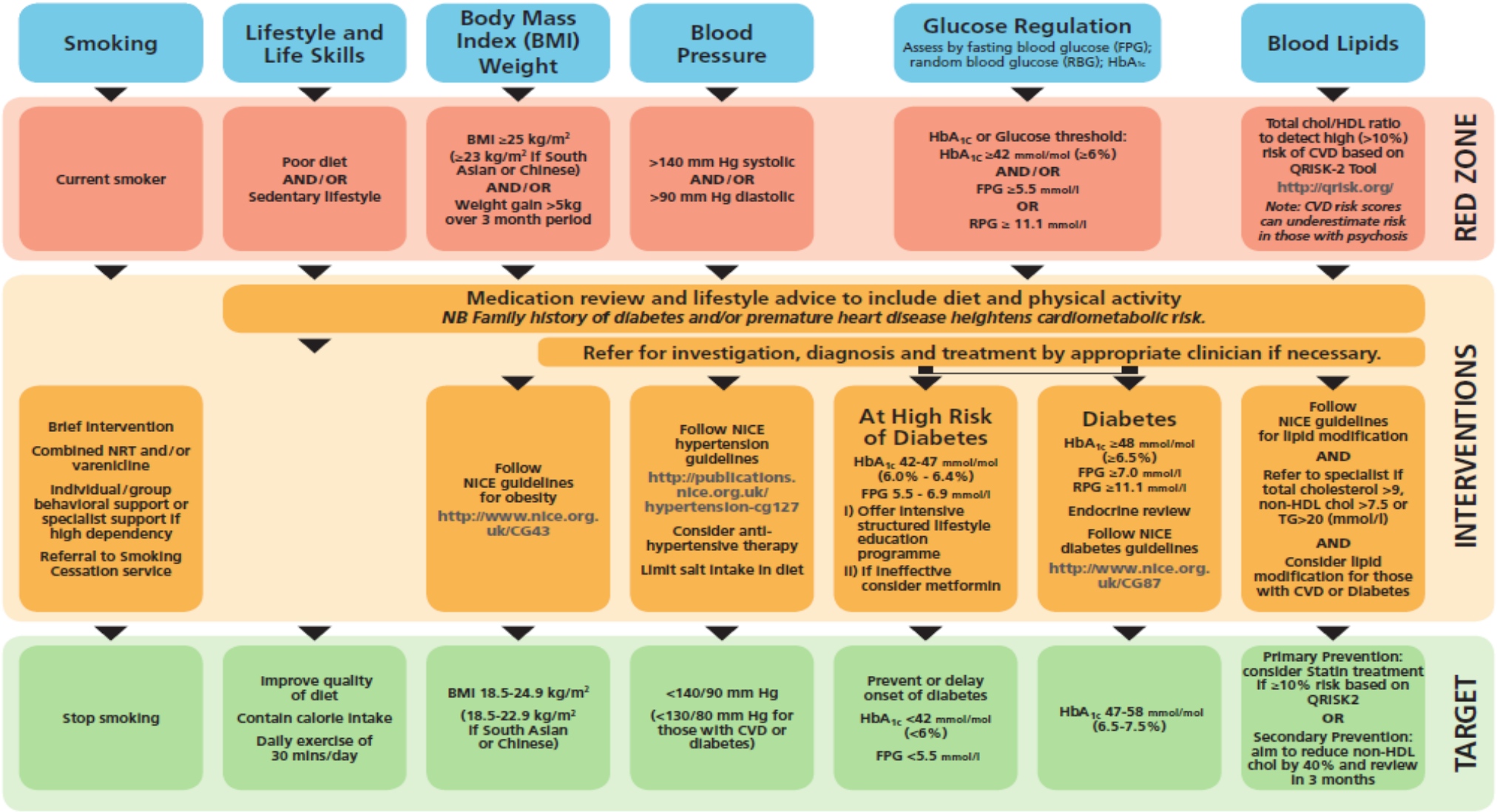

Appendix 1: Lester Tool UK Adaptation 2014

http://rcpsych.ac.uk/quality/nationalclinicalaudits/schizophrenia/nationalschizophreniaaudit/nasresources.aspx#LesterResource

Lester UK Adaptation | 2014 update

# Positive Cardiometabolic Health Resource

An **intervention framework** for people experiencing **psychosis** and **schizophrenia**




FPG = Fasting Plasma Glucose | RPG = Random Plasma Glucose | BMI = Body Mass Index | Total Chol = Total Cholesterol | HDL = High Density Lipoprotein | TRIG = Triglycerides

## d examination following initiation of antipsychotic medication

nally supervised by the psychiatrist. As a minimum review those prescribed a new aseline and at least once after 3 months.

assessed weekly in the first six weeks of taking a new antipsychotic, as rapid early redict severe weight gain in the longer term.

/s should take place annually unless an abnormality of physical health emerges. In these action should be taken and/or the situation should be reviewed at least every 3 months.

tory of substantial weight gain (e.g. 5kg), especially where this has been rapid (e.g. Also review smoking, exercise and diet. Ask about family history (diabetes, obesity, CVD yrs male relatives and <65 yrs female relatives) and gestational diabetes. Note ethnicity. Weight, BMI, BP, pulse.

Fasting estimates of plasma glucose (FPG), HbA1c, and lipids (total cholesterol, non-rides). If fasting samples are impractical then non-fasting samples are satisfactory for its except for triglycerides.

story of CVD, family history of CVD; where examination reveals irregular pulse (If al fibrillation, follow NICE recommendations http://guidance.nice.org.uk/CG36); certain antipsychotics (See SPC) or other drugs known to cause ECG abnormalities tricyclic anti-depressants, anti-arrhythmics – see British National Formulary for further

**Disease*:** Screen those with co-existing diabetes, hypertension, CVD, family history disease, structural renal disease (e.g. renal stones) routinely:

unction: a) urea & electrolytes
b) estimated glomerular filtration rate (eGFR)
a) for proteinuria (dip-stick),
b) albumin creatinine ratio (laboratory analysis)

nic kidney disease additionally increases risk of CVD:
te NICE guidelines on chronic kidney disease.

## : How often and what to do

s prescribed antipsychotics and mood stabilizers.

| | Baseline | Weekly first 6 weeks | 12 weeks | Annually |
|---|---|---|---|---|
| | ■ | | | ■ |
| [1] | ■ | | ■ | ■ |
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physical activity [2]If fasting lipid profile cannot be obtained, a non-fasting sample is satisfactory
erived from consensus guidelines 2004, J clin. psych 65:2. APA/ADA consensus conference
ointly in Diabetes Care and Journal of Clinical Psychiatry with permission from the Ontario e.

## Specific lifestyle and pharmacological interventions

Specific lifestyle interventions should be discussed in a collaborative, supportive and encourag taking into account the person's preferences:

- **Nutritional counselling:** reduce take-away and "junk" food, reduce energy intake to weight gain, avoid soft and caffeinated drinks and juices, and increase fibre intake.
- **Physical activity:** structured education-lifestyle intervention. **Advise physical activity a minimum of 150 minutes of 'moderate-intensity' physical activity per week (http Oe7DeS).** For example suggest 30 minutes of physical activity on 5 days a week.

**If the patient has not successfully reached their targets after 3 months, consider specific pharmacological interventions:**

**Anti-hypertensive therapy:** Normally GP supervised. Follow NICE recommendations http://publications.nice.org.uk/hypertension-cg127.

**Lipid lowering therapy:** Normally GP supervised. (If total cholesterol >9, non-HDL chol > (mmol/l), refer to metabolic specialist.) Follow NICE recommendations http://www.nice.org.uk/nicemedia/pdf/CG67NICEguideline.pdf.

**Treatment of diabetes:** Normally GP supervised. Follow NICE recommendations http://www.nice.org.uk/CG87.

**Treatment of those at high risk of diabetes:** FPG 5.5-6.9 mmol/l; $HbA_{1c}$ 42-47 mmol/m *Follow NICE guideline PH 38 Preventing type 2 diabetes: risk identification and interventions f individuals at high risk (recommendation 19)* – **http://guidance.nice.org.uk/PH38.**

- Where intensive lifestyle intervention has failed **consider a metformin trial** (normally be G
- Please be advised that **off-label** use requires documented informed consent as described guidelines, **http://www.gmc-uk.org/guidance/ethical_guidance/14327.asp.** These GMC guidelines are recommended by the MPS and MDU, and the use of metformin has been agreed as a relevant example by the Defence Unions.
- Adhere to British National Formulary guidance on safe use (in particular ensure renal function
- Start with a low dose e.g 500mg once daily and build up, as tolerated, to 1500–2000mg dai

**Review of antipsychotic and mood stabiliser medication:**

Discussions about medication should involve the patient, the general practitioner and the psy Should be a priority if there is:

- Rapid weight gain (e.g. 5kg <3 months) following antipsychotic initiation.
- Rapid development (<3 months) of abnormal lipids, BP, or glucose.

The psychiatrist should consider whether the antipsychotic drug regimen has played a causati abnormalities and, if so, whether an alternative regimen could be expected to offer less adver

- As a first step prescribed dosages should follow BNF recommendations; rationalise any poly
- Changing antipsychotic medication requires careful clinical judgment to weigh any benefits risk of relapse of the psychosis.
- An effective trial of medication is considered to be the patient taking the medication, at ar dosage, for a period of 4-6 weeks.
- If clinical judgment and patient preference support continuing with the same treatment, th appropriate further monitoring and clinical considerations are carried out regularly.

It is advised that all side effects to antipsychotic medication are regularly monitored, especially w commencing a new antipsychotic medication **(GASS questionnaire http://mentalhealthpart resource/glasgow-antipsychotic-side-effect-scale/)**, and that any side effects, as well as the continuing, changing or stopping medication is clearly recorded and communicated with the pa

The Psychiatrist should maintain responsibility for monitoring the patient's physical health and the psychotic medication for at least the first 12 months or until the person's condition has stabilised, wh Thereafter, the responsibility for this monitoring may be transferred to primary care under shared car

Discuss any non-prescribed therapies the patient wishes to use (including complementary ther patient, and carer if appropriate. Discuss the safety and efficacy of the therapies, and possible with the therapeutic effects of prescribed medication and psychological treatments.

**Monitoring**

| NHSLA Standard | Name | Element to be monitored | Lead | Tool | Frequency | Reporting Arrangements | Actions on recommendations and leads | Change in practice and lessons to be shared |
|---|---|---|---|---|---|---|---|---|
| Physical Healthcare Policy | | | | | | | | |
| 6.4 | Physical Assessment & Examination of Patients | Duties<br>**Physical assessment of patients when they are admitted to a service, including timeframes**<br>How appropriate follow-up of physical symptoms takes place<br>**Ongoing assessment of physical needs for all patients, including timeframes**<br>How the organisation assesses the competency of all staff involved in the physical assessment and examination of patients | Deputy Director of Nursing | Inpatient standards audit<br>Monthly audit | quarterly | The Deputy Director of Nursing will receive the audit report | The Deputy Director of Nursing will formulate action points and timescales for each Directorate where there is evidence of non-compliance within two weeks of each audit | The Safety Sub Committee will receive and discuss the report and monitor the action plan for the preceding quarter |

**Appendix 2**

**RiO form guidance document**

Physical Health
Forms Guidance v4.p

**References:**


Department of Health. (1999). 'National Service Framework for Mental Health London: DoH

Department of Health. (2000). 'National Service Framework for Older People.' London: DoH

Department of Health. (2005). 'Self Care and Self Support.' London: DoH

Department of Health. (2005). 'Choosing Better Oral Health: An Oral Health Plan for England' London: DoH

NHS Employers and BMA. (2006) 'Quality and Outcomes Framework: General Medical Services Contract (Revisions 2006/7). London: NHS Employers & BMA

National Institute of Clinical Excellence. (2004) 'NICE Guidance: Type 2 Diabetes: Prevention and management of foot problems'. London: NICE

Royal College of Psychiatry (2006). 'Accreditation for Acute Inservice user Mental Health Services'. London: RCPsych


Websites:
www.dh.gov.uk/SelfCare
service userreporting@mhra.gsi.gov.uk
www.yellowcard.gov.uk
www.nhsemployers.