East London NHS
NHS Foundation Trust

PHYSICAL HEALTHCARE POLICY

This policy relates to people accessing community and secondary care Mental Health Services.

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Services	Applicable
Trustwide	X
Mental Health and LD	
Community Health Services	

	Date	Author	Status	Comment
10.0	22.06.2010	Physical Health Lead	Draft	(a) Rationalisation of addendums/ Relevant areas now hyperlinked (b) QoF outcomes updated (c) Formatting changes for clarity
10.1	18.11.2010	Physical Health Lead	Draft	Ratified by physical health group
10.2	October 2011	Physical Health Lead	Final	Ratified by physical health group and quality committee
10.3	July 2014	Physical Health Lead	Final	CQUIN Compliance
10.4	09/2015	Physical Health Lead	Final	Cardio metabolic risk assessment and intervention added
13	January 2017	Associate Medical Director – Primary Care		Requirements to use RiO forms added
14	29th March 2020	DDIPC and Trust Lead Physical Health	Final	Updated in line with population health and Pan London Physical Health Standards and lessons learnt re Serious Incidents actions
14.1	4-2-2021	DDIPC and Trust Lead Physical Health	Final	Updated: News 2 Rio, Vital signs . Glasgow antipsychotic side effect rating scale (gass). DSN Admission screening checklist. Vit D. Fluid balance

Version Control Summary

CONTENTS

EXECUTIVE SUMMARY

1. The gap in health inequalities between people with serious mental illness (SMI) and the general population is stark. People living with SMI can experience a reduction of 15 – 20 years in life expectancy, compared to the general public. The reasons for this are complex and multifactorial but increased behavioural risk factors and inequalities in access to preventative health and wellbeing services play a part. (appendix 10) This policy aims to help address the physical health of patients with SMI; and ensure their physical health and wellbeing is supported and improved as part of their in-patient and community mental health care support.

2. 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.

3. East London NHS Foundation Trust also manages community services in Newham, Tower Hamlets and Bedford. This consists of 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 (Community Health Nurses yearly) also provides a source of physical health advice and expertise to the mental health directorates.

4. 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, 2014). 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. However, in Bedford this service has been commissioned to be delivered by ELFT.

5. 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, physical activity and diet (NICE, 2014). appendix 8

6. 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.

7. Assessments and management should be undertaken in consideration of the -service user's physical and mental health needs and in discussion with them. Once identified, physical healthcare needs should be included within the individual's care plan and Care Programme
   Approach (CPA), (DoH 1995). Any action taken should 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).

8. 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

The NHS Long Term Plan (LTP) sets out specific ambitions for the NHS, through local planning and national programmes to take a 'more concerted and systematic approach to reducing health inequalities'. ELFT Strategy focusses on population health which is a public health approach to recognising the many factors that impact and influence health across the lifespan. **Figure** 1. We know that the social and economic environment in which we are born, grow up, live, work and age, as well as the decisions we make for ourselves and our families collectively have a bigger impact on our health than healthcare alone (appendix 10) These conditions are not fixed, but are amenable to change through interventions which address:

- risk and protective factors such as smoking, diet and physical activity;
- through addressing unwarranted variation in access, experience and outcomes from treatment and care in conditions such as cancer, mental health, cardio-vascular disease (CVD), respiratory disease and diabetes
- the wider determinants of health including the gap in health access and outcomes experienced between the least and most deprived populations, and other population groups such as inclusion health and protected characteristic groups most likely to experience health inequalities, and as a key enabler, this will include levelling-up access to high quality primary and community care.

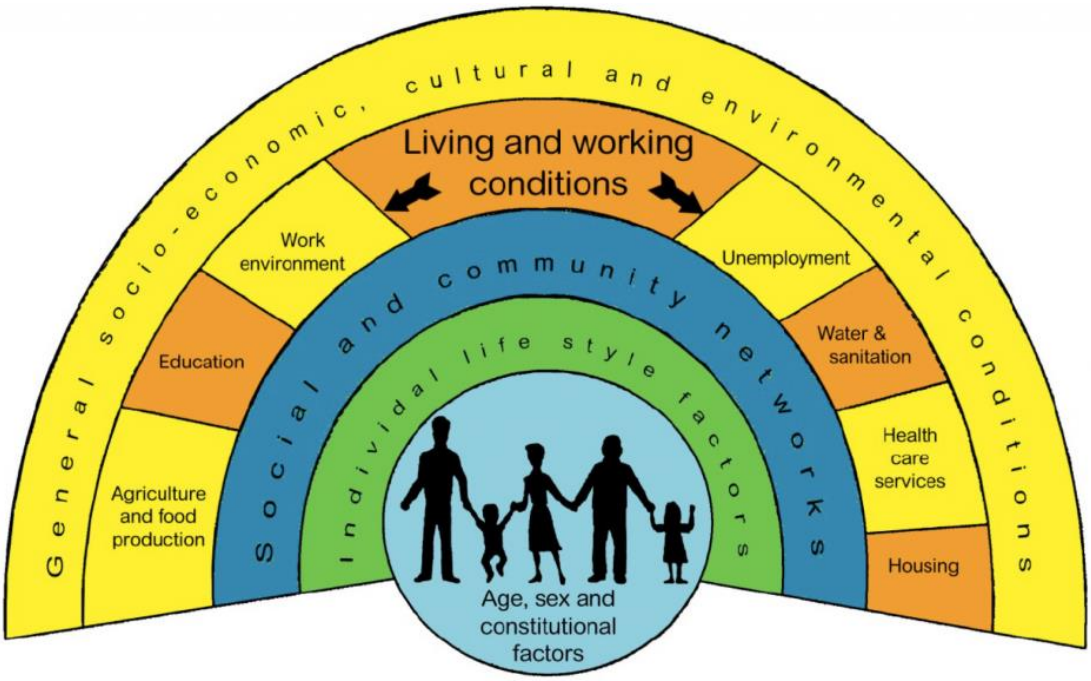

Figure 1 The wider determinants of health. Ref Dahlgren and Whitehead

The Kings Fund, Nuffield Institute and the Faculty of Public Health all emphasise that mental health and physical health should be treated with 'parity of esteem' and it is cost effective to treat both taking an integrated approach.
Poor management of physical ill health among people with severe mental health conditions accounts for much of the premature death rate seen in this population.

1.2 Public Health England (PHE) have started to develop a 'menu of evidence-based interventions for addressing health inequalities which will continue in line with the 10-year plan. The Menu provides a catalogue of interventions that local healthcare systems and commissioners, working with partners across the system, can draw on to take effective action at neighborhood, place and system-level to reduce health inequalities. https://www.england.nhs.uk/ltphimenu/
One of those inequalities' is that 'Life Expectancy' for adults with psychosis or schizophrenia is between 15 and 20 years less than for people in the general population. This may be because people with psychosis or schizophrenia often have physical health problems, including cardiovascular and metabolic disorders, such as type 2 diabetes, that can be exacerbated by the use of antipsychotics.
Estimates suggest there would be up to 12,000 fewer deaths from cardiovascular disease (CVD) each year if people with SMI had the same outcomes as the general population. The reduction in CVD related mortality in the general population is attributed primarily to improvements in diagnosis and treatment. However, considerable progress and commitment will be required to make a significant impact on patient outcomes in Mental Health.

There are several approaches required to reduce this inequality which involves operating at all levels using a public health approach. As well as recognising the broader public health challenges, Physical Health involves measuring, monitoring, screening, interventions prevention and promotion Lester (UK 2014). It involves engaging people in a personalised approach to make decisions about what matters to them backed up by an evidence based approach in line with Nice standards and guidelines (Health Foundation 2014).

1.3 It is also important that clinical staff have access to appropriate evidence based recommendations regarding how best to monitor and manage physical health problems, and particularly risk factors for cardiovascular and metabolic disorders, in people with mental illnesses. Alongside the recommendations of the Five year forward View (2015) the DOH (2016) has published *Improving the physical health of people with Mental Illness, actions for Mental Health nurses.* 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. Assessment tools have been developed to promote a consistent approach to help identify specific physical health risks.

2. Rationale

Life expectancy is reduced by 15-20 years in people with schizophrenia than for people in the general population. Physical illness, and particularly CVD, is the main contributor to this. A significant proportion of people with schizophrenia develop diabetes and/or have other risk factors for CVD (especially smoking, overweight/obesity and alcohol misuse. These factors are associated with increased CVD and consequent increased mortality. Being overweight is an important risk factor for diabetes and CVD in people with schizophrenia. Factors driving weight gain and the risk of diabetes and include: the effects of some antipsychotic treatment which can result in profound weight increase in the first few weeks of treatment; reduced physical activity levels and diets high in sugar and saturated fats. Comprehensively assessing physical health will enable health and social care practitioners to offer physical health interventions if necessary.

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.

The General GMS 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. It is the duty of each service users care co-ordinator to support the service user to register with a local GP and to support the engagement with primary care service; including screening and health promotion services accordingly, depending on clinical need.

3.2 The physical health needs of adults of all ages and young people with mental illness are integral to the individual wellbeing 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 and inequalities in access to services are addressed. Children and adolescence are not in scope for this policy. Please also refer to separate policies relating to Eating Disorders Clinical Guideline Physical Health Management.

4. Trust Policies:

4.1 The policy should be read in conjunction with:

- Smoke Free Policy (2019)
- Manual Handling Policy
- 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
- Venous Thromboembolism; Reducing the Risk (2019)

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. This is supported by the Trust Physical Health leads

6. Aims & Objectives

6.1 To improve the detection, assessment, treatment and ongoing management of the physical healthcare needs and wellbeing of service users accessing community and secondary Mental Health-inpatient care.

6.2 Objectives in-patient mental health services

6.2.1 To ensure that all service users accessing in-patient mental health services have a baseline physical assessment carried out within 24 hours of admission and/or transfer to another ward 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.
To work with the service user on what matters to them in improving their health and wellbeing.

6.3 Objectives for Mental Health 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 as well as health promotion and screening 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 and address inequalities and barriers in access to these services.

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. Practitioners talk to service users about the physical health assessment, the reasons why it is being done and address any questions and concerns in a sensitive manner.

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 6- 24 hours of admission including NEWS 2 on admission and transfers and consideration of sepsis as per (appendix 5). This should be recorded on the updated New 2 on the Rio electronic patient record.

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. There needs to be documentation of observed Physical Health parameters and daily review by MDT and escalating to the on call doctor if in high risk group or concerned.

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

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

7.5 Physiological monitoring of women who are pregnant and require acute assessment should use the Modified Early Obstetric Warning Signs (MEOWS) scoring and not the National Early Warning Score (NEWS2), which has not been validated in pregnancy. There is no nationally standardised MEOWS chart; therefore, all women should have their observations recorded on the locally agreed MEOWS chart.

The RCP has produced an Acute Care Toolkit on Managing acute medical problems in pregnancy which you may find helpful and referral to obstetrics in-patients team as appropriate. https://www.rcplondon.ac.uk/guidelines-policy/acute-care-toolkit-15-managing-acute-medical-problems-pregnancy

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 6-24 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)
- 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
- VTE assessment.
- Infections screening. (Appendix 11)
- Immunisation

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.and Vitamin D levels and prescribe as required and appropriate.

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 where there are issues of concern there should be a referral to a dietician
- Urinalysis – (multisite) (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)
- Side -effect assessment for antipsychotics using the Glasgow Antipsychotic Side Effect Scale. (GASS) (See appendix 10)
- Smoking status
- Pregnancy test if indicated
- Hydration should be monitored
- Infections prevention and control
- Alcohol assessment
- VTE risk assessment.

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 (2020).A falls assessment should be carried out within 24 hours.

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 using the policy risk assessment tool.

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

As a guide, fluid balance status should be monitored and recorded on patients who present with signs of:

a. Refusing food / fluid
b. Dehydration/ restricted fluid intake
c. Vomiting and/or diarrhoea
d. Known or suspected renal impairment
e. Excessive fluid intake

Fluid balance monitoring requires documentation of the amount of fluid taken in orally/ s well as the volume of fluid excreted, on the fluid balance chart. It is accepted that measurement of fluid balance may be difficult in mental health.
Offering fluids hourly recording refusals. Recording whether service user has been seen to use the toilet are some of the measures that can be taken.
Speak with patient service user and the family. Engage them in keeping a record.
Record also bowel movements and any vomiting episodes or excessive sweating
,
Patients /service users who are refusing oral intake and are considered to be high risk should be on enhanced observation or 1:1.

Clients on a fluid balance chart should have their Fluid balance calculated at least once every 24 hours. When assessing fluid balance take account of fluid loss through respirations, sweating, secretions and any patients with input less than or more than 2 litres or with reduced output should be reported to the nurse in charge in the first instance, as well as electronically.

7.16 If service users' baseline observations are outside the normal range or the service user's 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 by nurses and doctors should be undertaken in consideration of in-service user service users' physical and mental health needs.

7.19 National Early Warning Score (NEWS 2) Monitoring.
https://www.rcplondon.ac.uk/projects/outputs/national-early-warning-score-news-2

7.20 ***Lifestyle Assessment and Interventions***

7.21 The Ward Manager and Nursing team are 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.

Lifestyle interventions should support service users to develop healthier 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 **Appendix**
Smoking cessation support, please see Trust policy.
Alcohol assessment and referral as appropriate.

7.23 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 The Glasgow Antipsychotic Side Effect Scale (GASS) should be used to assess and monitor side-effects of antipsychotic medications. This should be completed when initiating an antipsychotic, when switching to a new antipsychotic, increasing or decreasing dose or prescribing a medication to relieve the side effects. Once the patient is stable on their medication and any side effects have been addressed and managed, then the tool should be used once every 6 months as an ongoing monitoring and be based on clinical needs.
The original tool did not assess for constipation, which is a major omission. This has been added at number 20 for ELFT. Should a copy of the tool be used that does not include constipation, the nursing staff must assess for this and document on the tool.

7.28 *Responding to Physical Health Monitoring; Other*

7.28.1 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.

7.29 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. 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 to ensure Physical Health needs are met.

7.33 If clinically indicated in-service users should be offered access to smoking cessation therapy in line with the Trusts smoking cessation policy, 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; which they have been involved in developing and identifies what matters to them around their physical health and wellbeing. This is documented and 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. Links to community health and wellbeing organisations.

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 team as below.

7.42 Comprehensive physical health assessments should focus on physical health problems by monitoring the following:

- Assessment of side effects for people prescribed antipsychotic medication, using The Glasgow Antipsychotic Side Effect Scale (GASS). This should be completed when initiating an antipsychotic, when switching to a new antipsychotic, increasing or decreasing dose or prescribing a medication to relieve the side effects. Once the patient is stable on their medication and any side effects have been addressed and managed, then the tool should be used once every 6 months as an ongoing monitoring and be based on clinical needs.
  The original tool did not assess for constipation, which is a major omission. This has been added at number 20 for ELFT. Should a copy of the tool be used that does not include constipation, the nursing staff must assess for this and document on the tool.

- weight (plotted on a chart) – regularly for the first 6 weeks, then at 12 weeks, at 1 year and then annually
- waist circumference annually (plotted on a chart)
- pulse and blood pressure at 12 weeks, at 1 year and then annually
- fasting blood glucose, HbA_{1c} and blood lipid levels at 12 weeks, at 1 year and then annually. overall physical health.

7.43 Patients who smoke should be offered help to stop smoking, even if previous attempts have been unsuccessful. Be aware of the potential significant impact of reducing cigarette smoking on the metabolism of other drugs, particularly clozapine and olanzapine

7.41 Health Promotion and Education

All service users will have their smoking, weight, dietary, exercise, drug and alcohol, debt and housing employment and loneliness 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, employment status, loneliness 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 or community health promotion activities (e.g. exercise on prescription, walking for health; loneliness clubs 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).

Community smoking cessation services should be accessed to support any attempts at quitting made by the service users, Barriers to access or inequalities in access to these services for people experiencing mental health issues should be addressed with service providers and commissioners.

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.

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. Trust staff will support service users to register at a GP surgery of their choice using

https://www.nhs.uk/using-the-nhs/nhs-services/gps/how-to-register-with-a-gp-practice/

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. All effort should be taken to discuss the benefits of the physical health check with the service user and how they can be involved in the decision making around this.

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 News 2 observations, weight 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 user's 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 user's 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, HIV (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.

9.2.1.2 The Glasgow Antipsychotic Side Effect Scale (GASS) should be used to assess and monitor side-effects of antipsychotic medications. This should be completed when initiating an antipsychotic, when switching to a new antipsychotic, increasing or decreasing dose or prescribing a medication to relieve the side effects. Once the patient is stable on their medication and any side effects have been addressed and managed, then the tool should be used once every 6 months as an ongoing monitoring.

The original tool did not assess for constipation, which is a major omission. This has been added at number 20 for ELFT. Should a copy of the tool be used that does not include constipation, the nursing staff must assess for this and document on the tool.

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, Smoking status and alcohol consumption. These records will be audited monthly by the nursing team. At Elft there is also a focus on high BMI, HbA1c, lipids and Q Risk.

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. 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 (Water low/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-patient's 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 The Glasgow Antipsychotic Side Effect Scale (GASS) should be used to assess and monitor side-effects of antipsychotic medications. This should be completed when initiating an antipsychotic, when switching to a new antipsychotic, increasing or decreasing dose or prescribing a medication to relieve the side effects. Once the

patient is stable on their medication and any side effects have been addressed and managed, then the tool should be used once every 6 months as an ongoing monitoring and be based on clinical needs.
The original tool did not assess for constipation, which is a major omission. This has been added at number 20 for ELFT. Should a copy of the tool be used that does not include constipation, the nursing staff must assess for this and document on the tool.

10.2.3 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. 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, Alcohol services and screening services for Breast, Bowel and Cervical screen as per National policy.

11.3.2 Interventions to improve quality of diet and nutrition

11.3.3 Promoting increased physical activity if important for all patients and will also benefit those that are overweight.
11.3.4 Monitoring the effects of antipsychotic medication on a patient's physical health any tools used 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.

12. Monitoring

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

- Trust wide clinical records audit
- 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)

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The Management of Diabetes in adults and children with mental disorders in inpatient settings (Joint British Diabetes Societies – Inpatient Care/RCPsych 2017))

Appendix 1

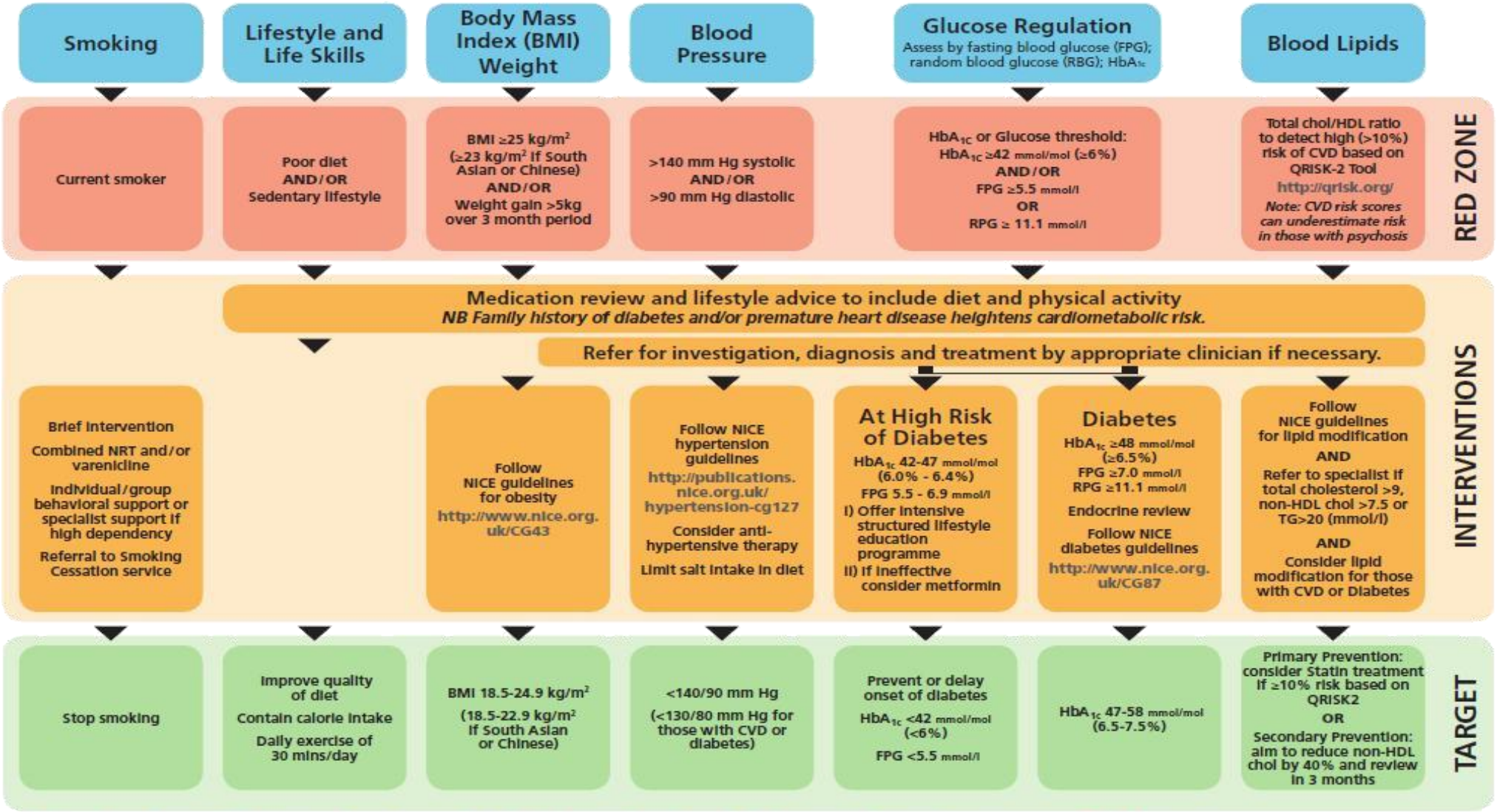
Appendix 1: Lester Tool UK Adaptation 2014

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]	■		■	■
	■	■	■	■
ence	■			■
	■		■	■
	■		■	■
	■		■	■

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 functior
- 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 benefit 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 v 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.

Appendix 2 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 **Physical assessment of patients when they are admitted to a service, including timeframes** How appropriate follow-up of physical symptoms takes place **Ongoing assessment of physical needs for all patients, including timeframes** How the organisation assesses the competency of all staff involved in the physical assessment and examination of patients	Lead Nurse	Inpatient standards audit Monthly audit	quarterly	The Lead nurse will receive the audit report	The lead Nurse will formulate action points and timescales for each Directorate where there is evidence of non-compliance within two weeks of each audit	The local Quality Committee will receive and discuss the report and monitor the action plan for the preceding quarter

Appendix 3

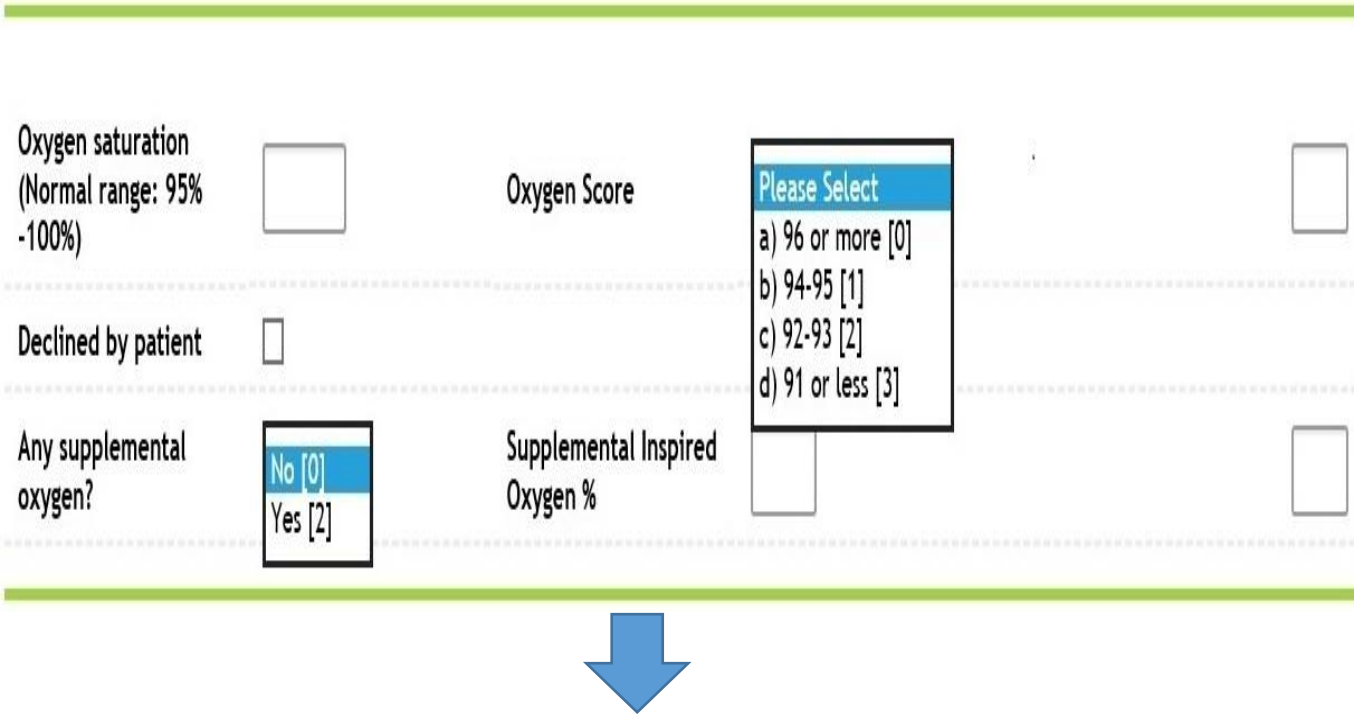
Changes to the RiO Observations and Measurements form to make it NEWS2 Compatible

The Observations and Measurements form in RiO will shortly be updated in line with the NEWS2 standards. The form will remain in the same place and be accessed in the same way and staff will see the changes when completing a new form. The changes are largely self-explanatory and staff should follow the instructions on the form. The two key changes are illustrated below with before and after screenshots.

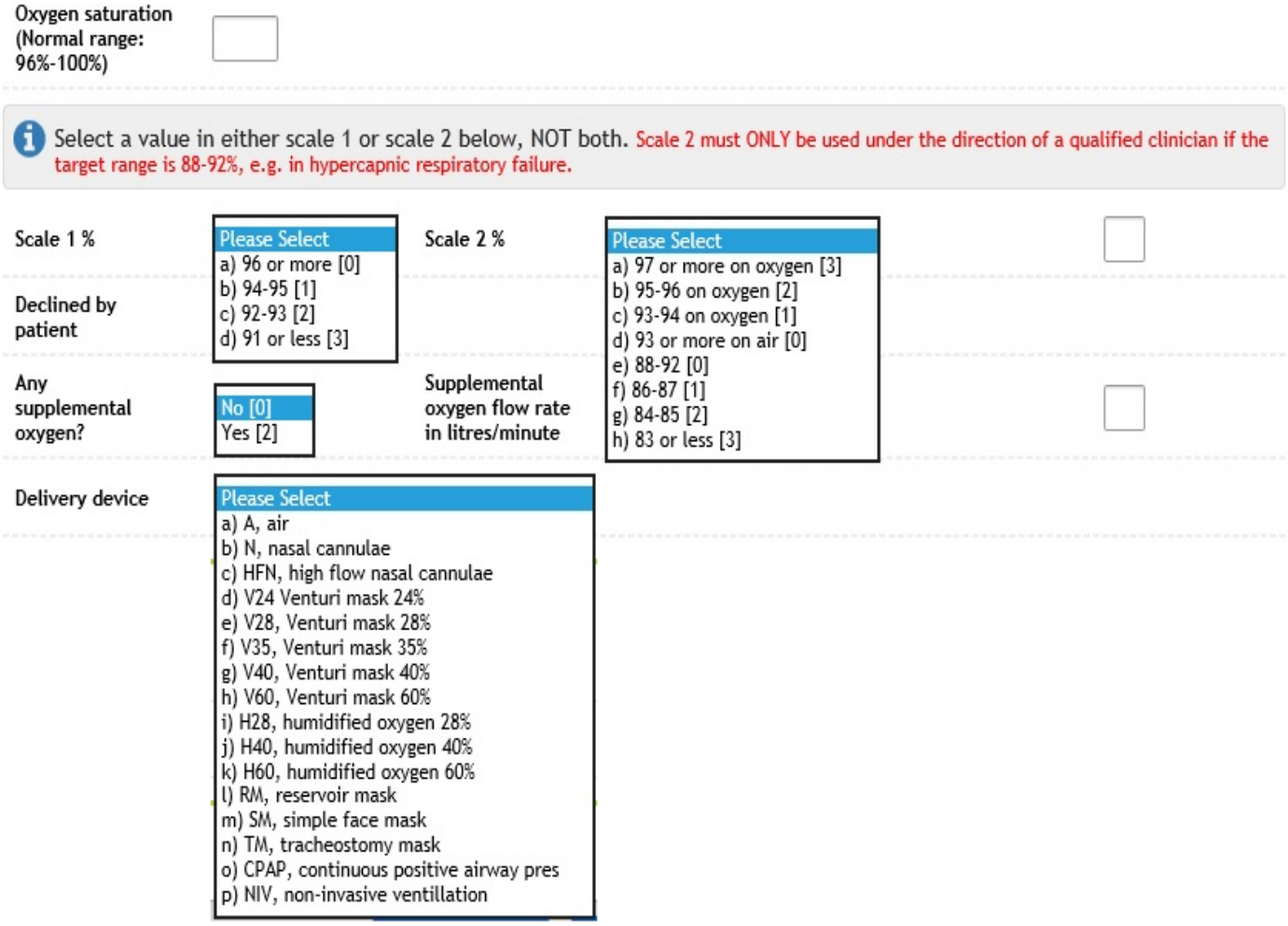
Change to oxygen saturation recording

A second oxygen scale has been added which should be used under specific circumstances, such as hypercapnic respiratory failure, where the target saturations are lower.

Old form



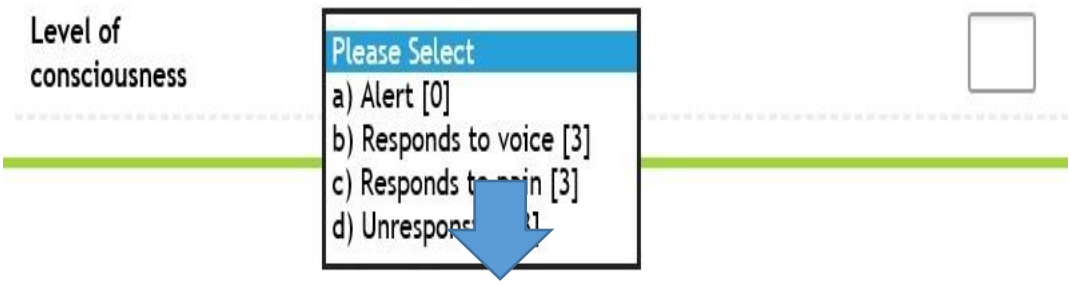
New form

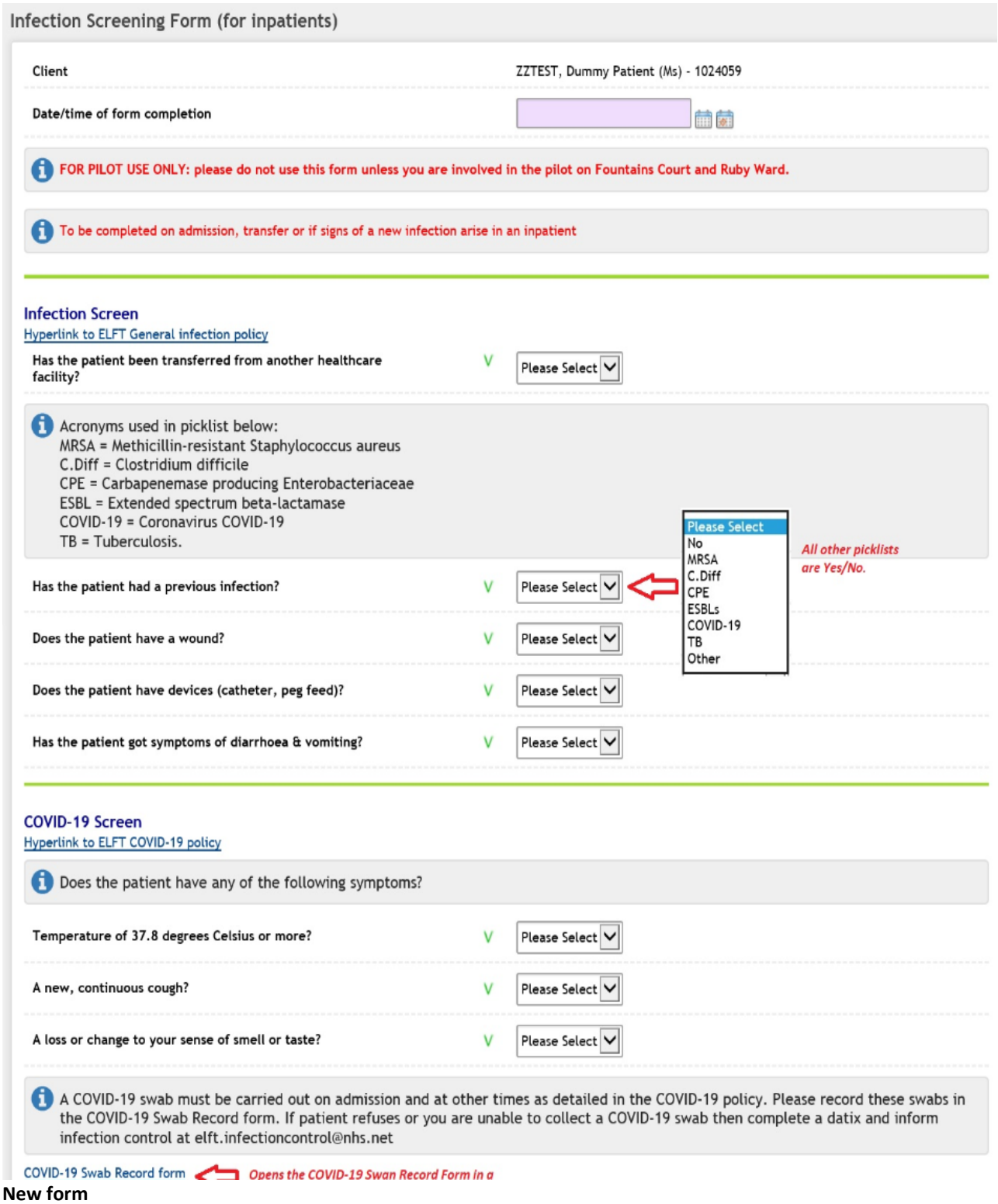


Changes to level of consciousness recording

An additional item “Confusion” has been added to the Level of consciousness picklist.

Old form




Infection Screening Form (for inpatients)
Client
ZZTEST, Dummy Patient (Ms) - 1024059
Date/time of form completion
FOR PILOT USE ONLY: please do not use this form unless you are involved in the pilot on Fountains Court and Ruby Ward.
To be completed on admission, transfer or if signs of a new infection arise in an inpatient
Infection Screen
Hyperlink to ELFT General infection policy
Has the patient been transferred from another healthcare facility?
Please Select
Acronyms used in picklist below:
MRSA = Methicillin-resistant Staphylococcus aureus
C.Diff = Clostridium difficile
CPE = Carbapenemase producing Enterobacteriaceae
ESBL = Extended spectrum beta-lactamase
COVID-19 = Coronavirus COVID-19
TB = Tuberculosis.
Has the patient had a previous infection?
Please Select
No
MRSA
C.Diff
CPE
ESBLs
COVID-19
TB
Other
All other picklists are Yes/No.
Does the patient have a wound?
Does the patient have devices (catheter, peg feed)?
Has the patient got symptoms of diarrhoea & vomiting?
COVID-19 Screen
Hyperlink to ELFT COVID-19 policy
Does the patient have any of the following symptoms?
Temperature of 37.8 degrees Celsius or more?
A new, continuous cough?
A loss or change to your sense of smell or taste?
A COVID-19 swab must be carried out on admission and at other times as detailed in the COVID-19 policy. Please record these swabs in the COVID-19 Swab Record form. If patient refuses or you are unable to collect a COVID-19 swab then complete a datix and inform infection control at elft.infectioncontrol@nhs.net
COVID-19 Swab Record form
Opens the COVID-19 Swan Record Form in a

New form

Appendix 4 News 2 (National Early warning Score)

East London NHS
NHS Foundation Trust

Patient Physical Health Dossier for Inpatient Mental Healthcare

The purpose of the Patient Physical Health Dossier is to record, recognise and respond to the patient's physical condition.
All physical observations that are taken should be recorded directly onto this chart and any physical observations outside the individual patient's baseline normal range, should be reported to the nurse in charge.
Before using the N.E.W.S. chart for the first time, staff should complete the on-line learning programme.

Patient Physical Health Admission Information			
Patient's Name			
NHS Number		Ward Name	
Date of Birth		Consultant	
Allergies			

Observation Planning					
Standard Normal Range for Each Physical Health Observation					
BP Systolic	111 – 219 mmHg	Temperature	36.1 – 38° C	Blood Montioring	4 – 7 mmols
Pulse	51-90 beats per minute	Respiration	12 – 20 breaths per minute	O² Saturation	96 – 100% on air

Frequency of Observations		Alert Threshold*		Date set		Initials	

*Each patient may have a different baseline normal range. Enter any change of parameter e.g. If a raised pulse is noted, then a doctor or senior nurse should set a new escalation level. Patients with respiratory long term conditions may lower saturations levels. The Doctor will advise the expectation levels

SBAR Communication to Effectively Escalate Concerns

Guidance Notes

1. Situation, Background, Assessment, Recommendation' known as an 'SBAR' is a communications tool that is used to help frame conversations.
2. SBAR aims to help clinicians make escalation communication clear and assertive as to how quickly the patient needs to be seen.
3. Always use SBAR as a model to shape your escalation communication to ensure that you are giving **sufficient and relevant information** for the healthcare professional to make a judgement.
4. If used appropriately N.E.Ws 2 can be a very powerful tool, just by reciting a high N.E.W.S. 2. score, it signifies the urgency of the situation. Be aware of the escalation process when response is not available.
5. SBAR is used:
   a) To reduce the barrier to effective communication across different disciplines and levels of staff.
   b) To create a shared mental model around all patient handoffs and situations requiring escalation, or critical exchange of information (hand overs)
   c) To provide a memory prompt; easy to remember and encourages prior preparation for communication
   d) To reduce the incidence of missed communications
6. Document all SBAR actions taken in the patients clinical record.

S	Situation	Identify yourself the site/service you are calling from Identify the patient by name and the reason for your report Describe your concern Firstly, describe the specific situation about which you are calling, including the patient's name, GP, patient location, resuscitation status, and vital signs.
B	Background	Give the patient's reason for admission (or presentation on referral in community care setting) Explain significant medical history **Overview of the patient's background: admitting diagnosis, date of admission, prior procedures, current medications**, allergies, pertinent laboratory results and other relevant diagnostic results
A	Assessment	Vital signs **N.E.W.S. Score Clinical impressions, concerns**
R	Recommendation	Explain what you need - be specific about request and time frame Make suggestions Clarify expectations Finally, what is your recommendation? That is, what would you like to happen by the end of the conversation with the clinician? Any order that is given on the phone needs to be repeated back to ensure accuracy. **Readback:-** Making sure you have been understood Following any communication using SBAR, it is important that the receiver of the information reads back a summary of the information to ensure accuracy and clarity. This should also be documented in the patients' health records.

National Early Warning Score (N.E.W.S. 2)

Chart 1: The NEWS scoring system

Physiological parameter	Score 3	2	1	0	1	2	3
Respiration rate (per minute)	≤8		9–11	12–20		21–24	≥25
SpO_2 Scale 1 (%)	≤91	92–93	94–95	≥96			
SpO_2 Scale 2 (%)	≤83	84–85	86–87	88–92 ≥93 on air	93–94 on oxygen	95–96 on oxygen	≥97 on oxygen
Air or oxygen?		Oxygen		Air			
Systolic blood pressure (mmHg)	≤90	91–100	101–110	111–219			≥220
Pulse (per minute)	≤40		41–50	51–90	91–110	111–130	≥131
Consciousness				Alert			CVPU
Temperature (°C)	≤35.0		35.1–36.0	36.1–38.0	38.1–39.0	≥39.1	

Chart 2: NEWS thresholds and triggers

NEW score	Clinical risk	Response
Aggregate score 0–4	Low	Ward-based response
Red score Score of 3 in any individual parameter	Low–medium	Urgent ward-based response*
Aggregate score 5–6	Medium	Key threshold for urgent response*
Aggregate score 7 or more	High	Urgent or emergency response**

* Response by a clinician or team with competence in the assessment and treatment of acutely ill patients and in recognising when the escalation of care to a critical care team is appropriate.

**The response team must also include staff with critical care skills, including airway management.

NEWS key	FULL NAME	
0 1 2 3	DATE OF BIRTH	DATE OF ADMISSION

ndix 4

Parameter	Range	Score	Range
	DATE		DATE
	TIME		TIME
A+B **Respirations** Breaths/min	≥25	3	≥25
	21–24	2	21–24
	18–20		18–20
	15–17		15–17
	12–14		12–14
	9–11	1	9–11
	≤8	3	≤8
A+B **SpO_2 Scale 1** Oxygen saturation (%)	≥96		≥96
	94–95	1	94–95
	92–93	2	92–93
	≤91	3	≤91
SpO_2 Scale 2† Oxygen saturation (%) Use Scale 2 if target range is 88–92%, eg in hypercapnic respiratory failure	≥97 on O_2	3	≥97 on O_2
	95–96 on O_2	2	95–96 on O_2
	93–94 on O_2	1	93–94 on O_2
	≥93 on air		≥93 on air
	88–92		88–92
†ONLY use Scale 2 under the direction of a qualified clinician	86–87	1	86–87
	84–85	2	84–85
	≤83%	3	≤83%
Air or oxygen?	A=Air		A=Air
	O_2 L/min	2	O_2 L/min
	Device		Device
C **Blood pressure** mmHg Score uses systolic BP only	≥220	3	≥220
	201–219		201–219
	181–200		181–200
	161–180		161–180
	141–160		141–160
	121–140		121–140
	111–120		111–120
	101–110	1	101–110
	91–100	2	91–100
	81–90	3	81–90
	71–80		71–80
	61–70		61–70
	51–60		51–60
	≤50		≤50
C **Pulse** Beats/min	≥131	3	≥131
	121–130	2	121–130
	111–120		111–120
	101–110	1	101–110
	91–100		91–100
	81–90		81–90
	71–80		71–80
	61–70		61–70
	51–60		51–60
	41–50	1	41–50
	31–40	3	31–40
	≤30		≤30
D **Consciousness** Score for NEW onset of confusion (no score if chronic)	Alert		Alert
	Confusion	3	Confusion
	V		V
	P		P
	U		U
E **Temperature** °C	≥39.1°	2	≥39.1°
	38.1–39.0°	1	38.1–39.0°
	37.1–38.0°		37.1–38.0°
	36.1–37.0°		36.1–37.0°
	35.1–36.0°	1	35.1–36.0°
	≤35.0°	3	≤35.0°
NEWS TOTAL			TOTAL
	Monitoring frequency		Monitoring
	Escalation of care Y/N		Escalation
	Initials		Initials

Appendix 5 Sepsis

Sepsis is a common and potentially life-threatening condition triggered by an infection.
In sepsis, the body's immune system goes into overdrive, setting off a series of reactions including widespread inflammation, swelling and blood clotting. This can lead to a significant decrease in blood pressure, which can mean the blood supply to vital organs such as the brain, heart and kidneys is reduced.
Septicaemia (blood poisoning) refers to invasion of bacteria into the bloodstream and this occurs as part of sepsis. Bacterial infections are by far the most common cause of Sepsis. If not treated quickly, sepsis can eventually become more severe, leading to shock and death.
Each year in the UK, it is estimated that more than 100,000 people are admitted to hospital with sepsis and around 37,000 people will die as a result of the condition.70% of cases arise in the community.

Risk factors
Patients most at risk of sepsis include those who are very young or very old, those with long term invasive devices e.g. urinary catheters and intravenous drug users. Those following recent surgery or who have wounds or are dehydrated are at risk. Patients on long term clozapine medication and cancer treatments are at an increased risk of acquiring sepsis.

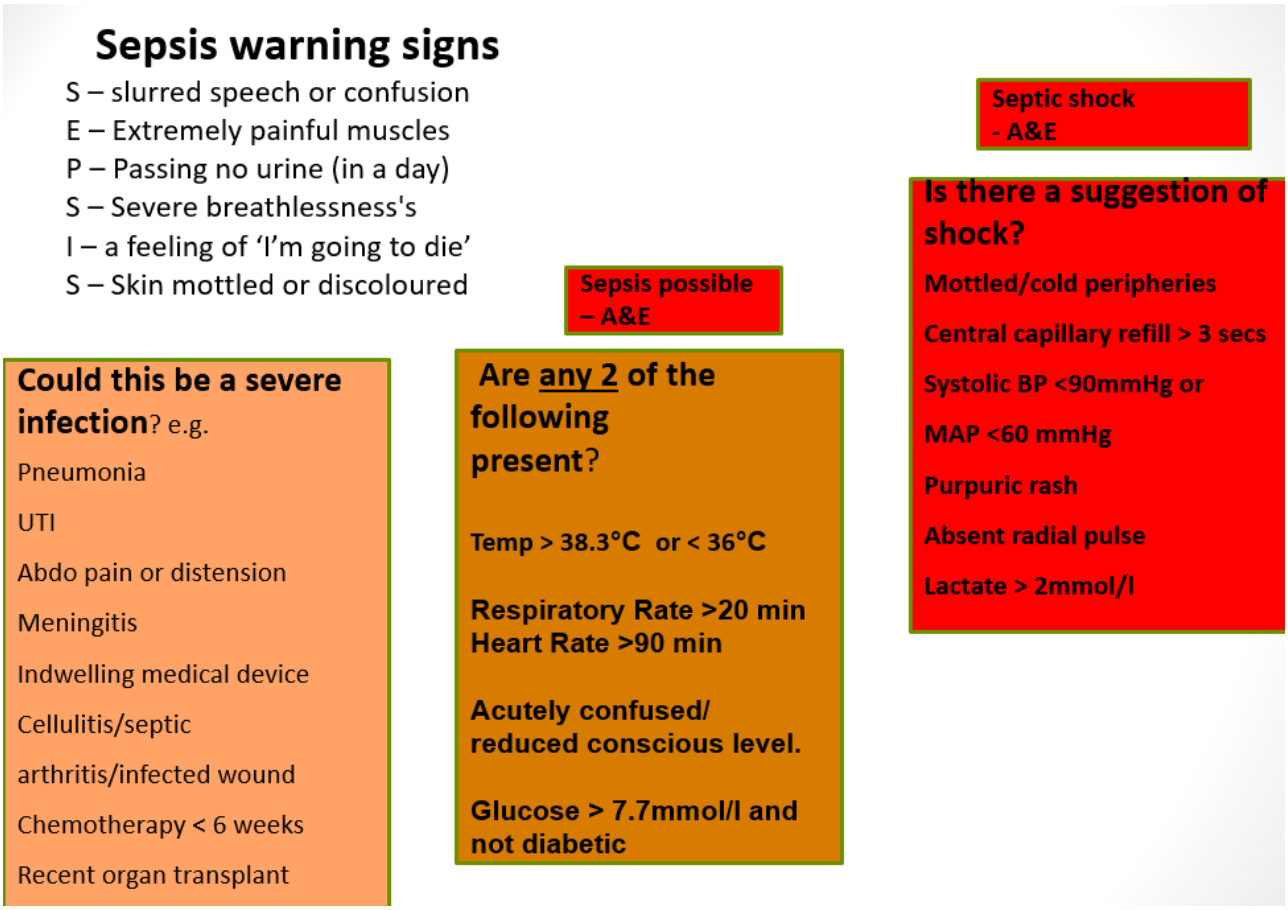
Signs and symptoms of sepsis

Identifying sepsis early is key to survival. Nurses play a vital role in identifying sepsis during routine observations. **Figure 1 b**elow
Early symptoms of sepsis usually develop quickly and can include:

- a high temperature (fever)
- chills and shivering
- a fast heartbeat
- fast breathing

Symptoms of severe sepsis or septic shock may include: Low blood pressure, feeling dizzy or faint, confusion or disorientation, nausea, vomiting diarrhoea and clammy and pale or mottled skin.
S = Severe shortness of breath
E = Extremely cold hands or feet
P = Palpitations or racing heart
S = Slurred speech
I = "I've never felt so bad"
S = Shivering uncontrollably

Sepsis Management
If sepsis is detected early and has not yet affected vital organs, it may be possible to treat the infection with oral antibiotics. Most people who have sepsis detected at this stage will make a full recovery. However, for initial treatment follow advice below.
Escalation of high Early Warning system scores to medical staff to reduce the risk of deterioration
If sepsis is suspected:
Call (9)999(in-patient and community teams) Be sure the ambulance has been called
Assess and treat using the ABCDE approach to managing a deteriorating patient
Give high-flow oxygen 15L
Gain IV access, give fluids
Check urine output
Once identified and transferred to an acute trust, the patient will require IV antibiotics within one hour.



Training at Elft on the Trust Intranet.

COVID-19: Recognition of the Physically Deteriorating Patient (with a focus on respiratory failure and sepsis)>>

Dates for virtual training using Zoom

Sepsis Training slides >>
The Deteriorating Patient slides >>

This training is required for all East London NHS Foundation Trust patient facing nursing and therapy staff (inpatients and community).
The above slides reinforce learning for staff after attending the webinars rolled out across the Trust.

Appendix 6 Physical Health Nice guidance

People with psychosis or schizophrenia, especially those taking antipsychotics, should be offered a combined healthy eating and physical activity programme by their mental healthcare provider. If a person has rapid or excessive weight gain, abnormal lipid levels or problems with blood glucose management, offer interventions in line with relevant NICE guidance (see the NICE guidance on obesity, cardiovascular disease: risk assessment and reduction, including lipid modification and preventing type 2 diabetes

Interventions should be offered in line with NICE guidelines on lipid modification, preventing type 2 diabetes, obesity, hypertension, prevention of cardiovascular disease and physical activity. [Adapted from Psychosis and schizophrenia in adults (NICE guideline CG178) recommendations 1.1.3.2, 1.5.3.2 and 1.5.3.3]

Psychosis in adults: prevention and management

Clinical guideline [CG178] Published date: February 2014

https://www.nice.org.uk/guidance/cg178/chapter/1-Recommendations#care-across-all-phases

NICE (2015) Clinical Guidelines for Psychosis and Schizophrenia in adults (CG178)

NICE (2015) Quality Standards for Psychosis and Schizophrenia (QS80)

NICE (2016) Guideline Multi-morbidity (NG56)

NICE (2016) Obesity: Identification, assessment and management

NICE (2018) Guidelines Venous Thromboembolism in over 16s (NG89) All NICE products on physical activity including guidance, NICE pathways and quality standards can be found here.

Appendix 7

Prevention and Physical Health Promotion.

The role of physical activity for preventing and managing illness is included within many National Institute for Health and Care Excellence (NICE) guidelines, and the promotion of physical activity helps to support their implementation.

Wider role and benefits of physical activity

In addition to supporting good physical and mental health and functioning, regular physical activity also contributes to a range of wider social, environmental and economic benefits for individuals, communities and wider society. Wider benefits come primarily from physical activities undertaken in a community setting. such as walking, cycling, active recreation, sport and play. They include:

- improved learning and attainment
- increasing productivity in the workplace
- managing stress
- self-efficacy
- improved sleep
- the development of social skills
- better social interaction

The relevance and importance of these benefits vary according to life stage and other factors.

Appendix 8

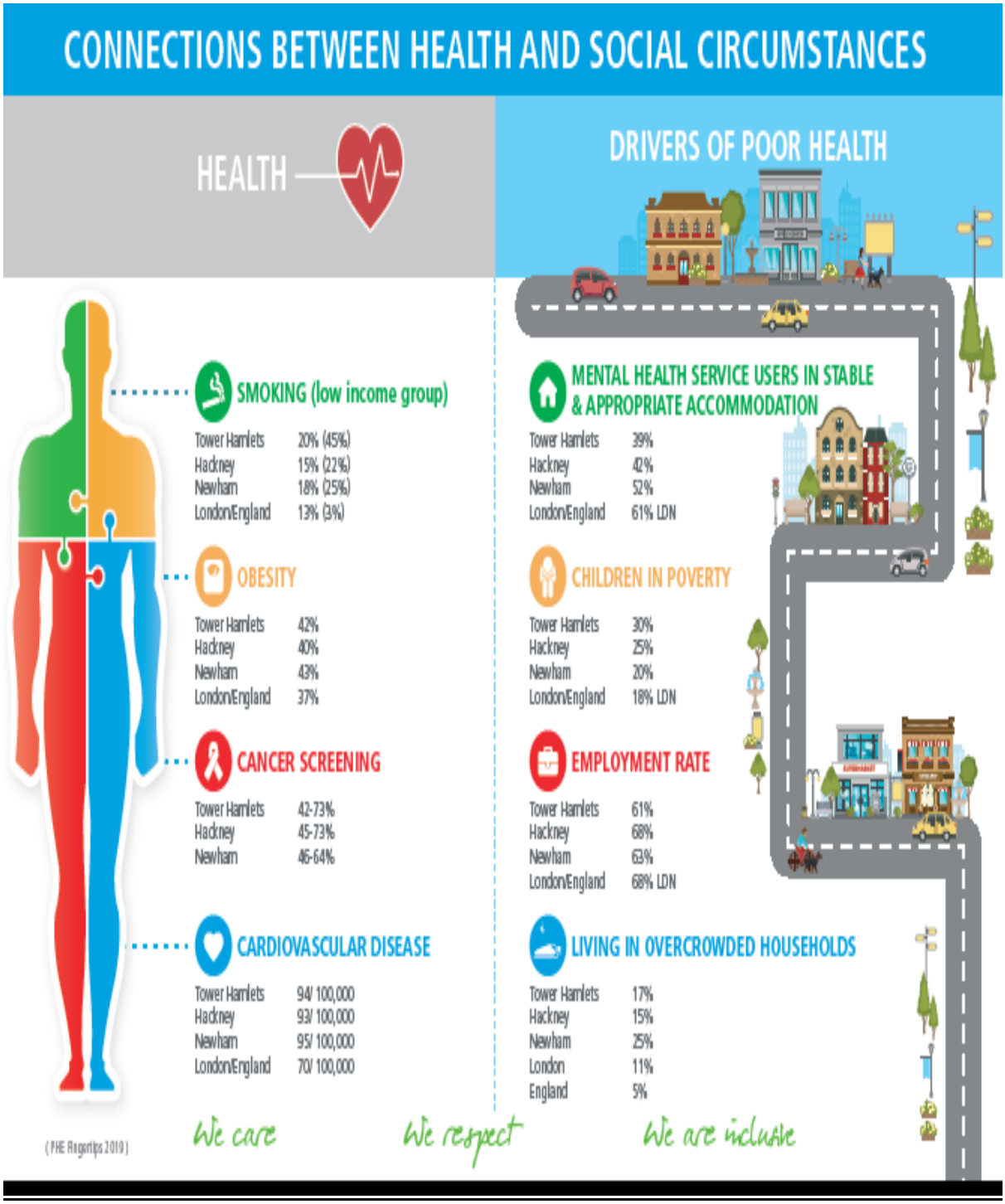
Benefits of sport and physical Activity .

https://www.nice.org.uk/news/article/employers-encouraged-to-help-their-staff-become-active-in-fight-against-obesity

Sport England's Sport Outcomes Evidence Review sets out how sport and physical activity can contribute to the government's Sporting Future strategy outcomes. One of the outcomes is social and community development, which is described as being about "helping to build stronger communities by bringing people together, often from different backgrounds, to make them feel better about where they live, improve community links and cohesion, and build social capital."

Appendix 9

Connections between Health and Social Circumstances.



The places we live in have a profound impact on our health and wellbeing. Kings Fund 2019

Appendix 10

Glasgow antipsychotic side effect rating scale (gass)

NAME: _____ AGE: _____ SEX: M / F Please list current medication and total daily doses below:_____
_____
_____

This questionnaire is about how you have been recently. It is being used to determine if you are suffering from excessive side effects from your antipsychotic medication.
Please place a tick in the column which best indicates the degree to which you have experienced the following side effects. Tick the **end** box if you found that the side effect distressed you.

*Over the **past week:***	*Never*	*Once*	*A few times*	*Everyday*	*Tick this box if distressing*
1. I felt sleepy during the day					
2. I felt drugged or like a zombie					
3. I felt dizzy when I stood up and/or have fainted					
1. I have felt my heart beating irregularly or unusually fast					
4. My muscles have been tense or jerky					
5. My hands or arms have been shaky					
6. My legs have felt restless and/or I couldn't sit still					
2. **I** have been drooling					
7. My movements or walking have been slower than usual					
1. I have had, or people have noticed uncontrollable movements of my face or body					
2. My vision has been blurry					
3. My mouth has been dry					
4. I have had difficulty passing urine					
5. I have felt like I am going to be sick or have vomited					
6. I have wet the bed					
7. I have been very thirsty and/or passing urine frequently					
8. The areas around my nipples have been sore and swollen					
9. I have noticed fluid coming from my nipples					
10. I have had problems enjoying sex					
20. I have been constipated					
21 **Men only**: I have had problems getting an erection					
22 **Woman Only** I have noticed a change to my periods					

Tick yes or no for the following questions about the last three months	No	yes	Tick this box if distressing.
23 .**Men and Woman:** I have been gaining weight			

Appendix 11

DSN Admission screening checklist

Name of patient: …… Date and time of assessment: ……

This checklist should be used by DSNs for all referrals for admission. It is important every admission is thoroughly screened to avoid omissions, minimise risk to service users and others and to ensure that rights of service users are protected and respected at all times especially out of hours.

1	Does the patient have a GP on RIO or National spine?	
2	What is their Address?	
3	New to the service? Are they registered on RIO?	
4	Is patient's RIO registration comprehensive: DOB, marital status, employment status, ethnicity, next of kin, GP, full address?	
5	If the patient is known to service, check CMHT and documentation on RIO?	
5	For informal patient, has a full capacity assessment been completed and documented on RIO stating outcome?	
6	Is handover comprehensive from other medical facility, psychiatric liaison before patient is transferred to the ward? (GO THROUGH 7)	
7	**Medical clearance:** / **Y/N** • If patient presented via A&E drunk, have alcohol levels been checked and recorded • following an overdose or physical health concerns: Are there blood test and urinalysis results, ECG completed? • Has the patient had a previous infection ie MRSA, COVID, • Is a device in situ, ie catheter, stoma, peg feed • Diarrhoea or vomiting • Does the patient have a temperature on or above 37.8 • A new or continuous cough • Loss or change of smell or taste • Can this patient mobilise independently? if not this patient may need specialist equipment • Does this patient have a wound that needs wound dressings? if so this patient may need specialist bed, equipment and wound care dressings • BMI 30 and above. This patient will need a bariatric bed and equipment put in place before admissions.	
8	Has a full risk assessment been completed, documented and handed over to DSN and shared with admitting ward?	
9	If brought under section 136 (if out of hours follow specific protocol): - has time of arrival been documented on 136 paperwork? - Joint DSN and Police risk assessment completed? - AMHP contacted on arrival of police with 136 patient - Rights of patient under 136 explained and leaflet given - Physical health assessment completed? Body Mapping where appropriate?	
10	RIO entries /documentation commenced?	

DSN initials and signature:

Please see local separate Patient Admission /Transfer Checklist for Forensics