Physical Healthcare Policy

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

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Services	Applicable
Trust wide	X
Mental Health and LD (Learning Disabilities)	X
Community Health Services	

Version Control Summary

Version	Date	Author	Status	Comment
10.0	22 June 2010	Physical Health Lead	Draft	Rationalisation of addendums/ Relevant areas now hyperlinked QoF outcomes updated (c) Formatting changes for clarity
10.1	18 November 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	September 2015	Physical Health Lead	Final	Cardio metabolic risk assessment and intervention added
13	January 2017	Associate Medical		Requirements to use RiO
		Director – Primary Care		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 February 2021	DDIPC and Trust Lead Physical Health	Final	Updated: News 2 Rio, Vital signs. Glasgow antipsychotic side effect rating scale (gass). DSN (Duty Senior Registered Nurse) Admission screening checklist. Vit D. Fluid balance
14.2	21August 2023	DDIPC and Trust Lead Physical Health	Minor review	News 2. Lester review re SANSI (St Andrews Nutrition Screening Instrument) tool and inclusive of LD adults. 6.10 In cases where there has been a significant concern raised about the physical health of a service user be reviewed by the consultant psychiatrist within 24 hours.
14.3	July 2025	DDIPC and Trust Physical Health Lead / Physical Health Lead Nurse at Forensics	Major review	Significant updates to all sections. Communication between Teams on transfers, Physical Health Assessment flow charts, areas of duplication with other policies removed. Replaced word observation with Vital Signs to include non-contact as required

Contents

1. Executive Summary

East London Foundation Trust (ELFT) aims to ensure that all service users receive the best possible care at the right time and in the most suitable health care environment. This includes ensuring that physical health needs are met appropriately.

ELFT has strategic aims to improve population health, improve patient experience of care, improve staff experience and improve value. Improving physical health for our service users is a key part of this strategy.

This policy describes approaches that are taken within ELFT to ensure that anyone using mental health services in the Trust has support in managing their physical health and wellbeing needs as part of their inpatient and/or community mental health care and treatment.

The policy will be rolled out as part of a comprehensive physical health package including physical health training for mental health in Inpatient Wards, physical health RiO Forms & regular training as stated in the policy.

2. Introduction

Physical Health in Mental Health is a priority for ELFT as part of our commitment to improving care and population health. This is in line with NHSE's expectations to address the 15–20 years gap in life expectancy for people with Severe Mental Illness compared to the general population. We also know that people living with learning disabilities and or autism experience significant health inequalities, and face premature mortality, often due to preventable causes.

Clinical staff should have access to appropriate evidence-based recommendations regarding how best to monitor and manage physical health problems in people with mental illness, particularly risk factors for cardiovascular and metabolic disorders. This policy integrates this evidence-based guidance for the Trust, supporting staff, service users and carers in terms of understanding the best way to support physical health as part of mental health service provision.

3. Scope

The policy is relevant to staff, service users and carers within ELFT's adult inpatient and community mental health services.

4. Tools Used to Assess Physical Health

This policy refers to a number of tools. These have been adopted to ensure appropriate recording of key information relating to physical health in a way that can gauge progress over time:

NEWS2

ELFT expects staff within mental health settings to use the National Early Warning Score (NEWS2) tool, as recommended by NHSE.

https://www.rcp.ac.uk/improving-care/resources/national-early-warning-score-news-2/
https://vimeo.com/402507826

Staff should be confident in and understand the use of NEWS2 to record the service user's vital signs, how the early warning system works, and when to escalate swiftly to a senior clinician when needed. Staff are expected to upload physical health measurements at point of care and ensure safe and timely interventions as required.

An electronic version of NEWS2 is accessible on RiO. Any use of hard copy NEWS2 forms should be uploaded onto RiO after completion.

NEWS2 should be used as an aid to clinical assessment. It is not a substitute for clinical judgment or from the need to escalate concerns if needed. Concerns about a service user's clinical condition should prompt a clinical review, irrespective of the NEWS2 score.

MEWS

NEWS2 as an early warning tool is not designed for use with service users who are pregnant, because the physiological response to acute illness can be modified in pregnancy and post-partum.

The Maternity Early Warning Score (MEWS) tool can be used from day one of pregnancy. The Scottish safety programme recommends using MEWS up to six weeks after giving birth. Although NEWS2 can be used up to about week 18 of pregnancy, it should not be used after this time or for up to six weeks after giving birth.

If staff are unclear about the use of MEWS, or other aspects of the management of pregnant service users, advice should be sought from the medical team and, if appropriate, from perinatal services.

As for NEWS2, MEWS should be used as an aid to clinical assessment. It is not a substitute for clinical judgment or from the need to escalate concerns if needed. Concerns about a service user's clinical condition should prompt a clinical review, irrespective of the MEWS score.

Vital Signs

This policy uses the term vital signs throughout, rather than observations, to avoid any confusion with mental health supportive observations.

A set of vital signs would normally include measuring temperature, pulse, blood pressure, and respiratory rate. Oxygen saturation would usually also be taken at the same time. Additional vital signs include blood sugar level and hydration status. Other vital signs include: weight, height and body mass index. The presence or absence of pain is also sometimes described as a vital sign, and staff should certainly always take pain into consideration when assessing physical health.

Taking vital signs should also always go hand in hand with considering the service user's overall physical presentation and, where possible, considering any information from carers, friends and family.

Although staff are encouraged to be confident in taking a manual pulse or measuring blood pressure using a sphygmomanometer and stethoscope, the use of electronic vital signs monitors is standard in all inpatient areas in the Trust, and their use is perfectly acceptable. The Trust's Medical Devices Policy sets out expectations for maintenance and calibration of these monitors.

This policy adopts the use of the terms 'contact' and 'non-contact' vital signs. It is not acceptable for no vital signs monitoring to take place due to a service user's non-cooperation. Non-contact vital signs can still be recorded.

Contact Vital Signs

These rely on the consent and cooperation of the service user. Temperature, pulse, blood pressure, oxygen saturation, height and weight are considered contact vital signs.

Non-contact Vital Signs

Non-contact vital signs do not rely on the consent or cooperation of the service user. Respiration rate, level of consciousness using ACVPU (**A**lert, **C**onfusion (new), **V**oice, **P**ain, **U**nresponsive) and hydration status are considered non-contact vital signs. A set of non-contact vital signs should be taken even when service users are non-cooperative with contact vital signs.

ECG

Electrocardiograms (ECGs) support the identification of baseline cardiac arrhythmias, acute cardiac problems and potential iatrogenic changes. QT intervals are crucial measurements in ECGs as abnormalities can indicate potential heart problems e.g. interval changes with antipsychotic medication.
Guidance for the use of ECGs with psychotropic medications can be found in the relevant policy, e.g. Standards for physical health monitoring of patients on antipsychotic treatment.

SBARD

SBARD is a communication tool used to facilitate clear concise information sharing. It stands for **S**ituation, **B**ackground, **A**ssessment, **R**ecommendation, **D**ecision.

Clinical staff are encouraged to use SBARD when reporting or escalating a physical health or other concern. The agreed course of action or decision taken following discussion about a significant concern should always be documented in the service user's notes.

Qrisk 3 Tool

This tool uses an algorithm to calculate a person's risk of developing a heart attack or stroke over the next ten years. It represents the average risk for people with the same risk factors as those entered for that person.

Lester Tool

The Lester 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. Appropriate interventions help improve the physical health of people with mental illness in particular. See Appendix 3.

Nutrition Screening

St Andrews Nutrition Screening Instrument (**SANSI**) is a nutrition screening tool validated for use in mental health and learning disabilities settings. This tool can be used to screen patients aged 12 and above. Nutrition screening identifies service user at nutrition risk, prompts intervention, care planning and monitoring, and fulfils good healthcare governance.
The Malnutrition Universal Screening Tool (**MUST**) is an acute-based tool, that can be used in addition to SANSI. MUST provide a structured evaluation of undernutrition specifically; it can only be used for those aged 18 and above. Please refer to Section 7.

5. Roles and Responsibilities

Role	Responsibility
Chief Medical Officer/Medical Directors/Chief Registered Nurse	• Oversee the implementation of the Physical Health policy into practice, monitor, identify any risk and report to the Board. • Ensure that the Clinical Directors, Medical Staff, Borough Leads, Registered Nurses, and Community Mental Health Service Managers are aware of this policy. • Ensure that clinical staff are aware of their role in assessing, implementing, monitoring and reviewing the physical health of service users.
Directorate Leadership Teams (Clinical Director, Service Director, Borough/Service Lead Nurse & Borough Lead Occupational Therapist)	• Ensure the implementation and monitoring of this policy within their own service areas. Have overview of physical health within the directorate for reporting, assurance, improvements, and governance. • Ensuring compliance with the Care Quality Commission standards. • Working with those commissioning services to support physical healthcare needs and priorities.
Director of Patient Safety & Patient Safety Teams	• Identifying the priorities, themes, physical healthcare risks that arise from Serious Incidents, National Confidential Inquiries, Health Quality Improvement Partnership and Healthcare Safety Investigation Branch and work with both clinical, operational, and corporate directorates to develop systems to minimise potential harm to service users. • Reviewing physical healthcare incidents, making recommendations to improve patient experiences across the organisation and recommending actions to reduce risk of future incidents.
Medical staff, Physical Health Leads, Directorate Leadership Teams	• Developing strategies and guidance arising from NICE and other national/ professional guidance related to physical healthcare. • Working with the Learning and Development department to develop competency requirements for clinical and non-clinical staff to ensure high quality care of people with physical health conditions. • Appointing Physical Health Leads. • Lead specific work streams relevant to prevention. • Support physical health services which provide complex clinical management for service users
Physical Health Leads, Registered Nurses, Borough/Service Lead Nurses & Borough Lead Occupational Therapist	• To monitor compliance pertaining to physical health, identifying trends, and leading where necessary. • Contribution to Trustwide committees relating to physical health and linking relevant topics back to an appropriate governance mechanism within directorates. • Facilitate physical health competency assessments. • Ensuring clinical areas are well stocked with medical supplies, equipment & consumable items required for the care of patients with physical health needs.

	• Provide protected time to teams for complex case reviews and have oversight of physical health in their identified specialist areas. • Linking with Subject Matter Experts for specialist advice and disseminate to all staff. • Facilitating teaching & education on the Trust physical health course and supporting competency assessments. • Provide support to teams who are caring for patients with Long-Term Conditions for example; Diabetes & Cardiovascular Disease Management.
Nursing, Matrons & Ward Managers, New & Advanced Roles	• Provide safe skill mix within teams to meet the physical health needs of Service Users. • Ensure Registered Nurses/Registered Associate Nurses attend Physical Health training, complete their competencies and are compliant with their mandatory training. • Staff appraisals and personal development plans reflect their training and support needs on physical health and health promotion. • Supervision includes a review of the physical health needs of Service Users. • Staff are competent in undertaking and recording Physical Health Assessments. • Clinical rooms are stocked with approved medical devices and clinical consumables. • All equipment is available to meet the specific assessed needs of Service Users. • A risk assessment has been completed, and the environment is safe to provide care for Service Users with physical health care. • Staff competencies have been assessed, and they have the skill and knowledge when admitting a Service Users who is physical unwell. • Escalate to a Senior Manager and/or medical staff any concerns. • Undertake local audits against the standards in this policy addressing any deficits and reporting concerns. • Services have a range of physical health and well-being promotion materials displayed; these include, but are not limited to, materials relating to alcohol and drug use, exercise/physical therapy, stop smoking services, cancer screening, and healthy eating. • All staff know how to refer to specialist services where these are available e.g. Tissue Viability Nurse, Dietitians, Speech & Language Therapist & Physiotherapy, and Podiatry.
Allied Health Professionals	• Comprise 14 autonomous professionals regulated by the health and care Professions Council (HCPC). AHPs provide assessment and treatment supporting diagnosis, recovery, rehabilitation, self-management and prevention across health care settings. • Contribute to strategic planning in relation to physical health as appropriate**.**

All clinical staff	• Provide high quality clinical care in relation to physical health, commensurate to role and seniority. • To undertake required training and remain up to date with knowledge relevant to role. • To undertake or support with physical health interventions and assessments, commensurate with role, seeking advice if needed. • To provide leadership around physical health within MDTs. • To work collaboratively with service users to promote physical health and support with individualised approaches to delivering care.
Non-clinical Staff	• Escalate to the Registered Nurse changes to baseline vital signs, NEWS2 score and any deterioration in Service User's condition and if they report that they are feeling physically unwell. • To summon help using the Trust 2222 system and to call the emergency services using 999 if they witness or see a Service user is physically unwell or experiencing medical emergency. • Ensure investigation results, reports from both primary care and secondary care services are available and accessible to clinical staff.
Pharmacy	• Be fully aware of the contents of this policy and other policies, guidance and procedures. • Undertake the appropriate training required to perform the role and maintain a level of competence in relation to physical health, associated prescribing and monitoring. • Maintain appropriate knowledge base in relation to physical health, associated national guidelines and/or best practice relevant to the professional discipline. • Support the prescribing, dispensing and availability of necessary medication and equipment to facilitate the physical health needs of Service Users. • Provide medicines reconciliation within inpatient settings. • Support Medical and Registered Nursing Staff in terms of providing guidance, information and advice regarding drugs/medications that may be prescribed and/or administered. • Support Medical Staff, Physical Health Leads, Registered Nurses, Allied Health Professionals and Non-Registered Staff to implement this policy. • Be a point for advice and knowledge for staff on specific medication relating to physical health monitoring requirements, for example Lithium and Clozapine.

Community Secondary Care Teams	• Undertake annual Physical Health Assessments and follow-up care for service users with SMI, who are under the care of mental health teams for less than 12 months and/or whose condition has not yet stabilised. This would include service users who find it hard to engage with primary care for physical health checks for any reason). Learning Disability Team should encourage uptake of the Learning Disability Annual Health Check provided by primary care. • To encourage service users to be fully engaged with physical health services and provide reasonable adjustments to support engagement with the Physical Health Assessment. • Undertake proactive follow up on the results of all assessments. • Provide proactive outreach, drawing on resources from peer support and voluntary sector organisations for those struggling to attend appointments or engaging with activities to improve overall health and wellbeing. • Identify opportunities to support, assist and/or advocate for service users to engage with their local primary, public health services and with their local secondary care services, for example, if English is not their first language, if they cannot read and/or write, (identify relevant follow-up interventions were indicated by the Physical Health Assessment).
Learning & Development	• To upload compliance on Physical Health training and maintain a record in line with staff's training needs analysis.
Service Users, Family, Friends & Carers	• Support with development and implementation of the Physical Health Policy. • To provide healthcare professionals with relevant information relating to a service user's physical health. • Access to clear information on general Physical Health Assessments carried out. • Access to healthy lifestyle advice, health promotion and updates on physical health including transfers to physical health care settings. • To contribute to improvement and learning related to physical health.

6. Standards for Inpatient Services

6.1 Guiding Principles

- All service users accessing inpatient Mental Health Services to have a baseline physical health examination and assessment carried out as soon as it is reasonable. This should include:
  - A nursing assessment of physical health, to be completed within 2-4 hours of admission
  - A medical assessment of physical health, to be completed within 12–24 hours of admission, or sooner if there are concerns about the physical health of the service user.

- If service user refuses contact vital signs monitoring, a set of non-contact vital signs should be completed, with contact vital signs being re-offered on a regular basis.

- The Registered Nurse is responsible and accountable for managing the nursing care of service users on the ward, from admission to discharge. Registered Nursing Associates can plan and deliver care but cannot manage care. Care interventions, such as physical health monitoring can be delegated to other members of the nursing team, including unregistered nursing staff, but the Registered Nurse remains in charge of nursing care and must ensure that they receive a handover upon completion of any delegated tasks, to respond and act as needed.

- Nursing and medical staff should be able to recognise and act on the signs of physical health deterioration, including using NEWS2/MEWS. They should escalate concerns with appropriate urgency, using SBARD as a handover tool if appropriate.

- Any staff member should initiate an emergency CPR response if needed and appropriate. The Trust's resuscitation policy, Do Not Attempt Cardiopulmonary Resuscitation Decisions (DNACRD) Policy and local resuscitation protocols are relevant here.

- Policies for the use of antipsychotics should be referred to for guidance of physical health aspects of these medications.

- When transfers of care take place, whether to acute hospitals or the community, this should take account of physical health needs and communication to other professionals, service users and carers (if appropriate) should be thorough and effective.

- Access to disease prevention programmes should be facilitated, including NHS Population Screening.

- Access to interventions and activities should consider any physical or cognitive needs, including those related to dementia.

- General Practitioners should be informed of any changes and communication of responsibility for follow-up after discharge should be clearly communicated.
- Please see Appendix 9 for list of related Policies to the above available on ELFT Intranet.

6.2 Physical Health Assessment and Examinations

On admission to the wards:

- Referral documentation will be reviewed. Information about past medical history will be obtained, including from other electronic systems, if necessary, e.g. EMIS, RiO, HIE (Health Information Exchange), System one etc.

Relevant assessments will be undertaken and a personalised care plan recorded in the service user's RiO record using Dialog+. Section 6.4 provides an in-depth review summarising the responsibilities of the admitting nurse and doctor, with relevant timeframes. If the assessment and examination cannot be completed within the timescale, a clear plan showing when it will be undertaken should be documented in the service user's electronic care record.

- Section 6.4 provides a summary of the roles of the admitting registered nurse and doctor, with relevant timeframes. If the assessment and examination cannot be completed within the

timescale, a clear plan showing when it will be undertaken should be documented in the service user's electronic care record.

6.3 Health Equalities

At ELFT, we are strategically implementing the Patient and Care Race Equality Framework (PCREF) across our services. Our PCREF approach addresses race, ethnicity, and intersectionality, encompassing the Equality Act's nine protected characteristics, lifestyles, neurodiversity, and special educational needs. Applicable to all mental health pathways, we recognise the disparities that minority communities face and prioritise coproduction and implementation through partnerships with local statutory services and community organisations.

We acknowledge that many patients in minority groups have had negative experiences accessing healthcare and continue to do so. The advice contained here is not intended to be exhaustive.

- Staff must complete training as directed by the Trust to address health inequalities.
- Staff must respect and use the patient's preferred pronouns and chosen name throughout the patient's care.
- Treatment approaches should be tailored to the individual needs of each patient, ensuring culturally sensitive and person-centred care.
- Staff should actively listen to and validate patients' experiences, acknowledging past healthcare disparities and striving to build trust.
- Ensure communication is accessible, using interpreters, easy-read formats, or other adjustments as needed.
- Challenge and address any discrimination, bias, or assumptions in clinical decision-making and patient interactions.
- Staff should consider seeking specialist guidance where needed for example specialist LD services.

NHS England also encourages the adoption of Make Every Contact Count (MECC), enabling the delivery of consistent and concise health and wellbeing information and encouraging conversations about health at scale across organisations and populations. MECC Vital 5 is a public health initiative that focuses on five key areas crucial for improving health and reducing health inequalities: healthy weight, healthy blood pressure, safe drinking, stop smoking, and healthy mind. These areas are interconnected and address the leading causes of poor health and health inequalities

6.4 Mental Health Inpatients – Physical Health Monitoring

Mental Health Inpatient Physical Health Monitoring			
*****All Patients MUST be offered a chaperone during investigations and examinations.**			
Admission	**Task**	**Documentation**	**Notes**
Nursing	Blood Pressure, Respiratory Rate, Oxygen Saturation, Capillary Blood Glucose, Height, Weight and Body Mass Index.	RIO: Observations and measurements. View News Chart.	Nursing staff to escalate in line with NEWS 2 recommendation or concerning physical health issues or evidence of substance withdrawal to medical staff. Refer section 7.1 for options of nutrition screening tools.
	Urinalysis, Urine Drug Screen, Pregnancy Test (female patients aged < 55yrs).	RIO: Urine test forms.	
	Waterloo Score and Body Map if clinically indicated. (See Pressure Ulcer Prevention and Management Policy).	RIO: Progress Notes.	
	Physical health screening form: Tobacco Use, Diet, Physical Exercise, Alcohol Use, Recreational Drug Use, 5 Ways to Mental Wellbeing, nutrition risk screening and Signposting for support with debt or housing. Infection Screening Form. Commence CIWA if indicated. **Has the patient had an infection i.e.** MRSA (Methicillin Resistant Staphylococcus Aureus) C.diff (Clostridium difficile), CPE (Carbapenemase producing Enterobacteriaceae), COVID, TB (Tuberculosis)?	RIO: Physical health screening form RIO: Infection Screening Form (for inpatients) RIO: SANSI form Please complete infection-screening form on RIO.	
Medical	VTE assessment; completed within 24 hours of admission to inpatient services. (VTE risk assessment requires review if there is a change in mobility or identified risk factors)	RIO: Risk assessment for Venous Thromboembolism	Consider any escalation or referrals required for example cardiology, endocrinologist or diabetic specialist.
	Electrocardiogram (ECG). Bloods: U&Es (including estimated GFR), FBC, Blood Lipids, Glucose, Prolactin, LFTs, TFTs, Cholesterol, HbA1C. *Blood Borne virus screen: HIV, Hep B and C, Syphilis. *Patient consent required.	RIO: Investigation Form.	
	Following medication Reconciliation, a decision will be made to continue, stop, or amend previously prescribed medication. If indicated, commence the Glasgow Antipsychotic Side-Effect Scale. Update Allergy status	EPMA and RIO	

	Patient physical Examination. Cardiovascular, Respiratory Examination, Abdomen, Nervous system, Reflexes. If clinically indicated: breast, gentile exam. Complete: Women's physical health form.	RIO: Medical Physical Health Assessment. RIO: Women's Physical Health Form.	
1 Week	**Task**	**Documentation**	**Notes**
Medical and Nursing staff	Nursing and Medical staff to audit and ensure compliance with assigned tasks, re-attempt any task missed and document refusal. Medical team to review physical health parameters	Assigned RIO form and Progress notes	Nursing and medical team to reattempt missed tasks frequently and documented refusal or issues
Throughout Admission	**Task**	**Documentation**	**Notes**
Nursing	Unless clinically indicated Physical observations should be undertaken weekly, Blood Pressure, Respiratory Rate, Oxygen Saturation, Capillary Blood Glucose, Height, Weight and Body Mass Index. Update any changes to the patient's health on the relevant RIO form.	RIO: Observations and measurements. View News Chart. RIO: Investigation Form. RIO: Urine test forms. RIO: Life Assessment Form.	Nursing staff to escalate in line with NEWS 2 recommendation or concerning physical health issues or evidence of substance withdrawal to medical staff.
Medical	Review policy to ensure compliance with relevant commencement and monitoring requirements for medication. Lithium: ELFT Policy: Protocol for the safe use of lithium. Sodium Valproate: ELFT Policy: Management and Review in all patients. Antipsychotics: ELFT: Policy: Standards for physical health monitoring of patients on antipsychotic treatment ELFT Policy: The Use of High-Dose Antipsychotic Therapy. Clozapine: ELFT Policy: Clozapine Policy.	RIO: Psychotropic Medication Monitoring. RIO: Progress Notes RIO: Clozapine Prescription Form.	
Discharge	**Task**	**Documentation**	**Notes**
Nursing	Discharge checklist and TTA checklist.	RIO: Progress notes.	
Medical	Order TTA medication. Complete the Hospital Discharge form.	RIO: Progress notes. RIO: Hospital Discharge Form.	

6.5 Other Clinical Screening & Tests On Admission

As well as the above responsibilities, staff should consider whether any further screening/tests below would be of benefit, such as:

- **Dementia**: The investigation of dementia should include measurement of serum vitamin B12 levels, serology to exclude syphilis or HIV (Human Immunodeficiency Virus) infection, EEG, and a CT or MRI scan.

- **Delirium**: New onset of confusion is a sign of potential for clinical deterioration in patients/service users, especially those in whom sepsis is suspected or confirmed. This is considered of such importance, that new confusion results in a score of 3 on the NEWS2 tool identifying that the patient should be assessed as a matter of urgency. Please see deterioration patient policy for further information.

- **Sepsis**: Consideration of sepsis in a deteriorating patient. Please see Sepsis Policy (when available).

- **Qrisk3**: See section 4. Consider medication as required & appropriate.

- **Alcohol**: The Alcohol Use Disorders Tool is a brief alcohol screening tool that is available on RiO, which can help identify service users who are hazardous drinkers or intoxicated with alcohol. This should be used as required. Refer to ELFT's policy on inpatient alcohol detoxification.

- **Smoking**: Check and record status and refer to the stop smoking service if relevant. Stopping smoking can impact on plasma levels of some medications, so dosing may need to be reviewed.

- **Urinalysis/Pregnancy Test**.

- **Pain/Distress Score Assessment** - e.g. the Visual Analogue Scale.

- **Falls Assessment**: if the service user is considered at risk of falls. See RiO Form.

- **Clinical Frailty Scale** (for Mental Health Services for Older People).

- **Dysphagia Assessment**: if there are any concerns eating, drinking, and/or swallowing. A referral is required for specialist Speech and Language Therapist in swallowing.

- **Fluid Intake/Output Record Chart**: if there are concerns on hydration status of the service user, fluid restriction of overconsumption, or concerns regarding urine output.

- **Food Record Chart**: If nutrition screening indicates medium or high nutrition risk (SANSI). Please see RiO Form.

- **Patient Stool Record Chart**: if the service user is constipated or at risk of constipation or has loose stools or diarrhoea. A stools assessment is available on RiO.

- **Wound Assessment and Management Chart**: if the service user has a wound/pressure ulcer, contact the Tissue Viability Service.

- **Positional Change Chart**: can the service user reposition independently and/or are they at risk of developing a pressure ulcer?

- **Sleep**: If the service user has difficulties sleeping consider if their sleeping pattern should be monitored.

6.6 Lifestyle Assessment and Interventions

Admitting nurse must complete lifestyle assessment within 24 hours of admission and ensure appropriate interventions. The assessment should be completed on RIO Physical health screening form.

If it is recognised that the period during admission is not the best time for the service users to have a positive discussion about lifestyle factors, then admitting nurse should add to lifestyle review to list of outstanding actions for follow up within 7 days. Thereafter, ward managers and nursing teams are responsible to assess service users' lifestyle annually and follow up on actions. This includes discussing exercise, nutrition, hydration, smoking status, drug and alcohol. Staff should use every interaction as an opportunity to promote positive health behaviour change.

Lifestyle interventions should support service users to develop healthier behaviours, including:

- **Nutritional counselling:** If there are **no** nutritional concerns, encourage general UK government healthy eating advice (The Eatwell Guide), and consumption of non-caffeinated, no added sugar or sweeteners, non-alcoholic fluids. Access First-line nutrition advice on the ELFT intranet, and complete food record charts if indicated.

- **Physical activity**: Advise physical activity, such as a minimum of 150 minutes of moderate intensity physical activity per week, e.g. suggest 30 minutes of physical activity on 5 days a week.

- **Smoking cessation support**: please see Trust policy.

- **Alcohol and Drugs:** assessment and referral as appropriate.

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

Lester Tool (see Appendix 3 monitoring standards should be followed for service users taking psychotropic medication (antipsychotic and mood stabilizer)

6.7 Additional Considerations

Documentation: All findings should be documented on the RiO record. This should include where service users have declined to cooperate with assessments. Documented plans should be clear and include reference to how they have been communicated and arrangements made for following up any outstanding areas.

Communication: Reasonable adjustments should be provided to support service users with the physical health examination and assessment process, and to help service users to understand the information, recommendations and/or advice that is given to them. Staff should also be aware of the language/communication needs of the individual and consider whether there is a need for an interpreter.

Review of Results: All results from investigations must be reviewed in a timely manner by an appropriately qualified clinician. It is the responsibility of the clinician completing the overall physical health examination and assessment to ensure that all relevant assessments and/or investigations are tasked and completed. If there are any concerns, these should be escalated to a member of staff who is competent to make further decisions about any further tests or treatment changes needed.

Diagnostic overshadowing: This is the misattribution of symptoms of a service user's illness to an already diagnosed comorbidity. For example, physical health symptoms in a person with Learning Disability may be misattributed to mental health/behavioural problems or as being inherent to the person's learning disabilities.

Medication: It is essential that when service users are admitted to hospital, an up-to-date and accurate medication list is obtained detailing all medicines prescribed for any mental health and/or physical health related conditions. Please refer to the Trust's Procedure for Medicines Reconciliation for further information. Medicines must be re-reconciled and documented in all medical correspondence, including any updates and transfers.

Staff should provide information to service users and carers to ensure that they are aware of the therapeutic indication, dose, frequency, potential side effects, cautions and/or contraindications of any prescribed medication. This should be provided in easy read and/or a translatable format for service users/carers if needed.

Many medications have specific Trust policies available guiding their use, including clozapine, antipsychotics, lithium, valproate, insulin and others. These should be referred to as needed, especially where a drug can pose high risks.

Referral: Medical staff are encouraged to seek advice from colleagues within ELFT or from specialist services via established care pathways and referral routes. If the service user presents with any infection control issues—such as influenza, COVID-19, MRSA, C. difficile, tuberculosis, or diarrhoea and vomiting—the Infection Control Team must be alerted promptly.

6.8 Ongoing Inpatient Physical Health Monitoring

- As a minimum vital signs monitoring, including weight, should take place weekly. The medical team may prescribe vital signs monitoring to take place daily or more often. When vital signs monitoring and NEWS2 completion are delegated to unregistered staff, the Registered Nurse must ensure unregistered staff is competent in completing vital signs and have completed NEWS2 training on ELA. The registered nurse must prompt a handover of vital signs & NEWS 2 immediately after it is completed and follow up with appropriate actions.

- Issues of sensitivity, gender, ethnicity, and preference should be considered by clinical staff carrying out a physical examination. A chaperone should always be offered where appropriate. It is important that all groups within the patient population have access to appropriate, timely, high-quality healthcare.

- If service user refuses contact vital signs or is too distressed to cooperate with contact vital signs monitoring, this must be documented in RiO and a Physical Health Assessment should still take place based on all the data available. Non-contact vital signs must still be carried out. Staff should revisit or reoffer contact vital signs monitoring at appropriate intervals.

- Non-contact vital signs should always be carried out, including when patient is asleep, sedated, immobile, or refusing. Non-contact vital signs should be monitored for all service users being cared for in seclusion.

- When the service user is asleep, contact vital signs may be suspended if there are no concerns, and non-contact vital signs completed until the service user wakes up. Where there are concerns, contact vital signs should still be completed.

- All attempts to perform vital signs monitoring should be documented on the patient's electronic care record and on the NEWS2 chart

- Referrals to and appointments with specialists outside of ELFT may be needed. 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 should be provided. This may include an up-to-date risk assessment and care plan if relevant.

- Service users with a long-term condition should have a clear management plan, which they have been involved in developing and which identifies what matters to them around their physical health and wellbeing. There should be clear and early liaison documented with the

GP where appropriate and possible. If information is not available from the GP this should be recorded and efforts made by the team to mitigate.

- Pre-discharge planning meetings should include matters related to physical health and follow-up arrangements. A summary of physical health needs should be included in discharge documentation and sent to their GP or appropriate primary health care teams.

- For service users who have admissions lasting longer than six months, the service should ensure that they are offered or signposted for health screening in line with the National Screening Programme.

- Any service user who has been an inpatient for 12 months (or longer) must be offered an annual physical health review inclusive of a comprehensive physical health assessment and referral to GP for examination as required and appropriate. Findings and ensuing plans must be fully documented on RiO.

6.9 Service Users Declining To Accept Physical Health Assessments and Interventions

If a service user does not consent to a physical health examination and/or assessment (either in part or in full), an alternative date or time should be offered to complete the process. The service user's decision must be documented on the electronic care record and their decision discussed/reviewed by the MDT at the earliest opportunity. Each attempt to complete a physical health examination and assessment with the service user must be recorded on the electronic care record.

If the service user continues to decline a physical health examination and/or assessment, this should be reviewed by the senior medical doctor responsible for the person's care. The review should be documented on the electronic care record and a plan formulated.

Where required, reasonable adjustments must be provided to support service users with the physical health examination and/or assessment process. This should focus on helping the service user to understand the information, recommendations and/or advice that is given to them.

If contact vital signs are refused by the service user, non-contact vital signs should be completed. The reasons for not completing contact vital signs should be documented on RiO. The nurse/doctor should return on a regular basis to attempt to gain consent for contact vital signs, with the time interval considered and agreed by the MDT as per clinical need. When contact vital signs are not possible, the MDT will also need to consider if other aspects of a service user's treatment need to be reviewed, such as medications being prescribed. If the service user continues to refuse, the risks to their health should be explained to them and their carers if appropriate.

Consider conducting a mental capacity assessment and initiating a best interest decision if indicated, particularly in emergency situations or where the service user has a diagnosed learning disability. Explore and address any fears, misunderstandings, or barriers to accepting care (e.g. trauma history, paranoia, side effects). If there's an acute or serious medical concern, a formal capacity assessment must be completed. If a service user lacks capacity, the Mental Capacity Act (2005) applies, requiring a best interest meeting and consultation with relevant parties (e.g. multidisciplinary team, family, IMCA), though treatment should not be delayed. Capacity should be decision-specific and time-specific. Please refer to the Trust's Consent to Treatment policy for further information.

6.10 Physical Health Deterioration

Physical health deterioration can occur at any stage of a service user's pathway, however, there are certain circumstances when a patient may be more at risk:

- During the onset of infection or illness
- During procedures such as dental interventions
- Administration of rapid tranquilisation
- During changes of medication
- After a fall

- During a period of deterioration of their mental health
- During an exacerbation of an existing physical long-term condition e.g. Diabetes, COPD etc.

If any new signs/symptoms indicating a deterioration in physical health are noted, a doctor should be contacted immediately. Visual signs/symptoms of physical deterioration may include the below, although the list is not exhaustive:

- Change in respiratory rate
- Rapid/noisy breathing
- Minimal respiratory effort or distress (gasping)
- Pallor, clammy, cyanosis
- Shivering
- New onset of confusion and agitation

Deterioration may be detectable by measuring vital signs and recording the results using NEWS2. The results from these may indicate a need to escalate concerns. Even with normal NEWS2 or vital signs, escalation should take place if patient appears clinically unwell.

When there is a change noted in a service user's physical health presentation, the Registered Nurse must seek advice from a doctor or suitable other professional. Appropriate investigations should be carried out and the results recorded.

When there is significant concern about the physical health of a service user, e.g. the Crash Bag has been used or an ambulance has been called, the overall treatment plan for the service user should be reviewed by the Mental Health Responsible Clinician or a senior doctor on call within six hours of the deterioration in health, or within 24 hours of their return to the mental health unit from an acute Trust.

6.11 Sepsis

Sepsis is life-threatening organ dysfunction due to an abnormal response to infection, leading to tissue damage and organ failure. Early recognition is crucial, especially in high-risk groups. Routinely screen for sepsis if a service user appears clinically unwell, has signs of organ dysfunction or where NEWS2 is triggered or carer/relative expresses concern about deterioration of health. The Sepsis screening tool in Appendix 6 provides a straightforward guide to recognising sepsis and intervention.

Don't just screen intervene! Sepsis red flags require immediate transfer to acute hospital for treatment within the hour. For further information refer The UK Sepsis Trust at **https://sepsistrust.org/** & the ELFT Sepsis Policy (when available).

6.12 Risk Related to Physical Health

Inpatient teams should document the risks associated with a service user's physical health. In doing so, clinicians should be aware that someone's physical health can affect their mental health and vice versa.

Factors to be aware of might include the following, although this will depend upon individual circumstances:

- Possibility of sepsis as a cause of acute illness
- Possibility of delirium as a cause of acute illness
- Possibility of neuroleptic malignant syndrome as a cause of acute illness
- Possibility of impairment of swallow and risk of choking due to side effect of medication or intrinsic due to mental health or physical presentation.
- Risks that may cause the service user to rapidly deteriorate physically
- Risks posed to the service user if they are unable to engage effectively with other healthcare providers
- Experience of barriers to access physical health services e.g. foothealth and community activities as well as, experience of stigma, trauma, social exclusion and isolation.
- Service user's capacity to understand and/or care for their physical health needs

- Service user’s understanding of the health problems they experience
- Potential risks of medication to the service user's health
- Environmental considerations, e.g. use of specialist equipment and space
- The ability to self-provide adequate nutrition and hydration
- Possibility of developing secondary complications and physical deconditioning during inpatient admission including musculoskeletal conditions, pain, reduced mobility and function.
- Self-neglect contributing to poor physical health
- The impact of harmful alcohol use and the risk of withdrawal from alcohol
- The impact of harmful effects of illicit and non-prescribed drugs
- History of falls or at risk of falls associated with identified potential causes such as polypharmacy/incontinence/alcohol
- Risk of pressure ulcers and tissue viability concerns
- Risk of venous thromboembolism (VTE)
- The impact of an individual’s physical disability/impairment on children, families, and carers.
- The risk of infection and its impact on the wider community.
- The impact of significant self-harm, including head banging.

7. Nutrition and Hydration

7.1 Nutritional Screening

ELFT service users are likely to be at risk of food insecurity and the nutritional associated clinical risks. NICE guidelines (Nutrition Support CG32 2017) recommend that all service users should be screened within 48 hours of admission to services, weekly thereafter in inpatients, and at an agreed interval in community services.

Nutritional screening should be completed and recorded on medical records using the trust recommended tool, the St Andrews Nutrition Screening Instruction (SANSI), which is available on RiO. A '*How to guide'* is available on the *Nutrition and Dietetics* ELFT intranet page. Nutrition risk should be fedback at ward round and appropriate nutrition care plans should be formulated and implemented. For assessment of malnutrition risk specifically, please use other nutritional screening tools e.g. MUST (Malnutrition Universal Screening Tool). MUST can be used to compliment SANSI.

Staff can complete the essential Nutrition Training module on the ELFT Learning Academy for more information on nutritional screening.

7.2 Nutritional Risks

Both malnutrition and obesity risk are clinical concerns which can prolong response to treatment and cost to the NHS. If nutritional risk is detected, the MDT should offer first-line advice using trust resources available on the intranet (https://www.elft.nhs.uk/intranet/nutrition-and-dietetics).

Monitoring charts for fluid, food and bowel opening should be used if appropriate. Where suitable, service users can be encouraged to be engaged in monitoring, and easy-read self-completing resources are available.

If nutritional risks do not improve within 2-4 weeks with evidence of monitoring, staff should refer to local dietitians on elft.dietitians@nhs.net. Referrals for malnutrition will be prioritised. Where dietetic service is not provided within the trust, the ELFT dietitians will signpost referrals to appropriate dietetics services where possible.
For further information, please refer to the Trust's nutrition policy

Refeeding Syndrome is a potentially life-threatening condition that can occur when nutrition is reintroduced after a period of starvation. To reduce the risk, nutrition must be reintroduced gradually, with close monitoring of physical health and blood biochemistry, and appropriate supplementation with vitamins and minerals. Effective management requires multidisciplinary input, including a dietitian, medic or physical health practitioner, pharmacist, and staff involved in the patient's food and fluid care. If Refeeding Syndrome is suspected, refer to the Trust's Refeeding Syndrome policy on the intranet before starting nutritional support.

8. Communication between Teams and Transfers of Care

8.1 Acute Setting

Any service users who require a transfer to an acute hospital for assessment and/or admission must have a written handover completed by the ward or duty doctor. The written handover should be sent with the patient and, if possible, a verbal handover for the patient to the relevant registrar or senior. The written handover should include:

- Presenting complaint, with suspected differentials or diagnosis.
- Time of onset.
- Actions that were taken to manage the presenting complaint (including medication administered, last physical observations, News 2 score)
- Mental Health Act status for the patient (for example, section two, three or informal)
- Any potential infection control concerns (for example COVID-19, flu or Norovirus)
- Relevant history. (Including psychiatric and physical health history)
- EMPA (medication) chart printed, or paper chart photocopied and attached.
- The RIO NEWs2 chart is printed or a paper chart photocopied and attached.
- Contact details for the ward from which the patient was transferred.
- For service users with learning disabilities hospital Passport can be used to aid handovers.

The nursing team must inform the relevant psychiatric liaison team of the patient's transfer and contact the appropriate ward or department to obtain feedback on the patient's progress, estimate the discharge date, and determine whether any provisions are required to facilitate the transfer back to a mental health setting.

When returning to a mental health inpatient setting, the ward or duty medic must review the discharge summary and any actions taken appropriately.

8.2 Internal Ward-To-Ward Transfer

If a service user moves from one inpatient ward to another, all relevant physical healthcare needs and management plans must be recorded on RiO and verbally handed over to the new ward. On transferring a service user from one inpatient setting to another within ELFT, it is not necessary to repeat a full Physical Health Assessment if one has already been completed. The admitting team should review what has been done and address any outstanding interventions or monitoring. At a minimum, the receiving ward team must record vital signs and complete a NEWS2 assessment, escalating if required.

8.3 External Ward-to-Ward Transfer

As with an internal transfer, all relevant physical healthcare needs and management plans must be included in the referral information or referral proforma to support effective handover. However, consideration must be given to different computer systems; therefore, the nursing teams should consider alternatives, such as secure email or printed documentation, to manage the transfer. On transfer from an external provider ward, the patient’s medication must be prescribed on EMPA, ELFTs Physical health and medical RIO forms updated with the relevant information.

8.4 Transfer To/Discharge from the Community Team

When service users are discharged to/from community services, any significant ongoing physical healthcare needs must be communicated. For more complex cases, a direct handover between the community team and ward doctors is recommended to ensure continuity of care. All related action plans should be documented on RiO, allowing the inpatient or community staff to support the service user’s physical health on admission and discharge. All relevant information about a service user’s physical health should be communicated to service user’s GP at discharge. Mental health re-referral, crisis and contingency plans should also be included to minimise barriers to ongoing well-being post-discharge.

For further details on transfers, please refer to the ELFT Transfer Policy

9. Standards for Forensic/Long Stay Wards

9.1 On Admission

A baseline Physical Health Assessment must be completed within 24 hours of admission. From this assessment any specific condition identified must be referred to an appropriate primary care service for screening and/or be referred elsewhere for appropriate treatment. This referral must be completed within 72 hours of admission. The assessment and referral letters will be recorded/filed in the service user's current clinical record.

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 ELFT in-house GP provision. A referral will be sent to ELFT in-house GPs (general practitioners) within 5 days of admission. This will inform the GP of the service user's admission, any long-standing issues and need for the annual medical review. A community GP must be identified before discharge to the community.

Inpatients 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.

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. 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 and HIV testing (and subsequent treatment). The discussion and outcome of this will be recorded in the service user's current clinical notes. The requirements documented above will be audited by the Service quarterly with an expected target of 100%.

Patients who smoke should be offered help to stop smoking, even if previous attempts have been unsuccessful. Staff should be aware of the potential significant impact of reducing cigarette smoking on the metabolism of other drugs, particularly clozapine and olanzapine. These medications may need to be reduced if the person stops smoking.

9.2 During Admission

All patients must receive an annual health check. This is completed through the ELFT in-house GP provision. The assessment and outcome are recorded within the GP files with a copy forwarded for the service user's clinical notes using the code GPEN on RiO. In-house GP and ward doctors must ensure that an annual review and comprehensive risk assessment of all long-term chronic conditions are conducted. Wards doctors and nursing staff must ensure that the corresponding physical health care plans are documented in the 'Physical Health' section of the Dialog+ care plan template on RIO. These physical health care plans must accurately reflect the individual's physical health diagnoses, along with appropriate interventions and monitoring arrangements. This includes ensuring ongoing care or health maintenance plans for service users who are currently asymptomatic but have an established physical health diagnosis (e.g. individuals with a confirmed diagnosis of epilepsy who are presently seizure-free).

When a service user 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.
All patients will have their physical baseline vital signs monitored monthly. These checks will consist of Temperature; Weight (kg); BMI (Body Mass Index) (kg/m^2); waist circumference (cm) in people with BMI below 35 kg/m^2 so that waist-to-height ratio can be calculated; Urinalysis; BP; Pulse and Respirations, Smoking status, and alcohol consumption. These records will be audited monthly by the nursing Teams. At ELFT there is a focus on raised BMI, HbA1c, lipids and Q-Risk, indicators for cardiovascular disease.

Requirements for monitoring vital signs 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.

9.3 Lifestyle Assessment and Interventions

Refer to section 6.6 above.

9.4 Other Clinical Screens / Tests / Referrals if Indicated

Refer to section 6.5 above.
Offer or refer eligible service users for national health screening (e.g., cervical, bowel, breast cancer, AAA, Chlamydia) to support early detection, timely treatment, and informed health decisions. Refer to the NHS national screening programme for more details.

10. Standards for Older People's and Continuing Care Wards

Many of the general principles in Sections 6-8 above are relevant.

10.1 On and During Admission

Patients admitted to the Continuing Care Ward should have their Physical Health Assessment completed on admission, Contact and non-contact vital signs, NEWS 2 score, MRSA screening, Waterlow score, body map, SSKIN Bundle, MUST Score (consider completing SANSI for service users with BMI ≥25kg/m^2 or ≥ weight gain) and Falls Risk assessment within 12 hours. The patient's General Practitioner (GP) will be informed of admission.

The ward doctor will admit the patient with the registered nurse. The patient will also be reviewed by the ward GP who visits the continuing care ward twice a week.

All relevant health records including podiatry, speech and language, dental, tissue viability are checked by the admitting Doctor and Registered Nurse, any onward referrals are completed within 72 hours of admission and sent to relevant Services.

The assessment and referral letters are recorded and uploaded in the patient's clinical records. All patients will have documented medicines reconciliation within 72 hours of admission. The reconciliation discussion will be documented in the patient's current MDT clinical notes on RIO.

Vital signs (temperature, Sat, pulse, respirations and blood pressure) should be monitored daily or at a frequency indicated from NEWS 2 score. Patients may have their vital signs recorded more regularly based on their presentation or condition, or if the MDT otherwise decide it is required. Decisions regarding this should be outlined in individual care plans.

Weight and BMI are taken on admission, then repeated after 2 weeks and once each month thereafter unless there are clinical concerns such as clinically significant weight loss or gain. Urinalysis where possible is completed on admission and repeated if clinically indicated.

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 clinical record.

Physical health care plans are reviewed every month by registered nurses with input from the medical team where required. The frequency can be more often where required.

10.2 On Discharge

Prior to discharge from inpatient services, the Community Mental Health Team and the GP should be informed of the planned discharge. This should be managed as in Section 8 above.

Discharge planning requires a multidisciplinary approach. Meetings are held that include relevant community staff and other involved agencies e.g. social services. Information about physical health needs should be discussed in those meetings.

A follow-up check is made by telephone to the service user and carer within 72 hours of discharge.

11. Standards for Community Mental Health Services

It is recognised that community mental health services vary widely in their respective roles and function and is therefore difficult to specify individual guidance and standards within a policy of this level for each individual service. Consequently, the guidance will aim to set collective standards, with specificity where applicable.

Please see Some examples of community mental health services below

Community Integrated Mental Health Services (CIMHS)
Community Recovery Teams (CRT)
Community Learning Disability Teams
Neighbourhood Mental Health Teams (NMHTs)
Community Mental Health Team Older Persons (CMHTOP)
Early Intervention Services (EIS)
Home Treatment Teams (HTT)
Perinatal Mental Health Teams (PMHT)
Crisis Assessment Services (CAS)
Clozapine Services

11.1 Guiding Principles

It is the responsibility of all community mental health teams to engage proactively in the identification and management of the physical healthcare needs of service users with complex or severe and enduring mental illness. It is recognised that this will be tailored to the operational remit of the relevant services and may be delivered through liaison with primary care and/or partner services. Please refer to the relevant service's operational policy.

Example 1:
GPs may offer annual physical health checks for mental health service users, including ECG testing, however, this will be supported by community mental health teams where required and interventions performed using available medical testing equipment within the service as appropriate.

Example 2:
Community Recovery Teams will have ongoing responsibility as the long-term care team for its service users regarding monitoring and follow-up arrangements around physical health. However, other specialist services that may also be involved such as Home Treatment Team or Clozapine Service, will also perform physical health monitoring for shared cases in accordance with their role, function and duration of involvement.

All community mental health services will record their respective physical health interventions in the relevant physical health sections and forms on RiO, to ensure timely capture and information sharing on electronic healthcare records and reporting services.

This will intentionally improve the prevention, detection, assessment, treatment, and management of cardio metabolic risk factors i.e. diabetes, hypertension, hyperlipidaemia and other conditions and

disorders in service users taking antipsychotic or other relevant psychotropic medications. Please see Appendix 9 for a full list of medicines' policies.

The SMI GP register should include all people with a recorded diagnosis of psychosis, schizophrenia, or bipolar affective disorder: QOF (Quality and Outcomes Framework) register name – MH1_REG. In conjunction with Reporting Services, all community mental health teams will assist General Practices to maintain an up-to-date register of people suffering from long term mental health conditions (Revisions to GMS (General Medical practice Service) (General Medical practice Service) contract 2009).

Other service users on lithium therapy are recorded under QOF register MH2_REG. Guidance regarding lithium can be found in ELFT's Lithium Policy.

All service users under QOF register MH1_REG should have an annual physical health check. Whilst service users not on this register are not automatically offered this check, other people prescribed psychotropic medication (i.e. antipsychotics, antidepressants and/or mood stabilisers) should also have their physical health monitored from initiation of these medications. That monitoring should be in line with British National Formulary guidelines or the summary of product characteristics (SmPC) & the Trust Use of Medicines Policy.

12. Annual Physical Health Checks

The core aspects of the annual physical health check, as recommended by NICE and NHSE, are:

- alcohol consumption status
- blood glucose or HbA1c test (as clinically appropriate)
- blood pressure
- body mass index
- lipid profile
- smoking status.

Best practice goes beyond these core requirements. Service users should also be offered a more comprehensive physical health assessment that could include:

- Medical and family history
- Blood-borne virus and liver function screening
- Cardiovascular risk assessment (including Qrisk)
- Relevant national immunisation programmes
- Support to access relevant national screening programmes, including cancer screening
- Oral health advice and brief interventions
- Lifestyle assessment
- Sexual and reproductive health assessment and advice (including contraception)
- Substance misuse assessment
- Medicines reconciliation and monitoring.

Screening is not sufficient to drive improvements in health. The principle should be: 'don't just screen, intervene'. The aim of physical health assessments and screening is to then enable follow-up interventions that are tailored to an individual's needs. The Lester Tool (see Appendix 3) provides a useful guide to help professionals consider interventions to take. All interventions should take account of relevant NICE guidance, use the principles of personalised care and support planning in line with shared decision-making. Patient decision aids and personal health budgets may be of use.

The ongoing monitoring of a service user's physical health and wellbeing should include, as appropriate: regular review, signposting, advice, support relating to health promotion, health screening, dental care, sexual health, chiropody/podiatry services, nutrition, physical function, physical activity, skin integrity, auditory and optometry services.

All discussions, any action taken, or a record of services declined, must be recorded on in the service user's electronic care record.

Fuller details can be found in the NHSE Paper, Improving the physical health of people living with severe mental illness (2024) updated 2025.

In Bedfordshire, the Bedford and Luton (BL) RIO Physical Health editable letter should be used to summarise physical health check-ups for individuals with severe mental illness (SMI). This letter must be sent electronically to the GP surgery within 7 days of the health check. Health Care Assistants, Physical Health Leads, and Registered Nurses can request access to this letter by contacting ELFT IT Services.

Physical health equipment:

Each community mental health service is responsible to audit their team with a view to ensuring procurement of appropriate physical health testing equipment, aligning to the relevant guidance pertaining to the nature and treatment of their caseloads.

12.1 Community Referrals, Assessment and Transfers of Care

12.1.1 Referrals to community mental health assessment services:

Referral documentation will be reviewed and screened according to the operational assessment timeframes of the relevant service. Information about past/current medical history will be included in the referral information, requested via referral proforma or obtained, including from other electronic systems, if necessary, e.g. EMIS, RiO, HIE (Health Information Exchange), System one etc.

Where physical health assessment is not available at point of referral, all service users accessing community Mental Health Services will have a baseline physical health assessment carried out as soon as it is reasonable according to the operational assessment timeframes of the relevant service e.g. 28 Day Waiter guidance, or as clinically indicated.

This may also include a baseline medical assessment of physical health, to be completed according to the operational guidance of the relevant service as clinically indicated or in liaison with GPs and/or other services.
Relevant assessments will be undertaken, recorded in the physical health sections of RiO and a personalised care plan recorded in the service user's RiO record using Dialog+ (including My Safety Plan).

12.1.2 Referral to acute physical health assessment services:

In the event of acute physical health care concerns, each community service will carry responsibility to ensure timely referral and intervention is executed with the correct services according to the presenting need at the time. Including but not limited to: GPs, A&E, London Ambulance Service, Urgent Care Centres and antenatal services. Any such referrals or interventions will be communicated to other relevant teams for their awareness, involvement and further follow-up as appropriate.

Any service users who require a direct referral to A&E or acute hospital assessment and/or admission from a community clinic, must have a written handover completed (e.g. covering letter) and uploaded on RiO. When initiating referral from a public, private or other setting, a written and/or verbal handover of the patient, where possible, will be given and recorded on RiO.

Where applicable, the written handover should include as detailed in Section 8 of this policy.
The referring team must inform the relevant psychiatric liaison team of the patient's transfer and maintain contact with the appropriate ward or department to obtain feedback on the patient's progress, estimate the discharge date, and determine whether any provisions are required to facilitate the transfer back to a community setting.

When returning to a community setting, the discharge destination team will review the discharge summary and any actions taken appropriately.

12.1.3 Internal Transfer between community teams:

If a service user moves from one community team to another, all relevant physical healthcare needs and management plans must be recorded on RiO and handed over to the receiving team. On transferring a service user from one community setting to another within ELFT, it is not necessary to repeat a full Physical Health Assessment if one has already been completed and is contemporaneous, additional physical health observations/results supplied will ideally be obtained within 6 months of the transfer date. The receiving team should review previous assessments and complete any outstanding interventions, monitoring or actions according to the relevant operational policy.

12.1.4 External Transfer between community teams:

As with an internal transfer, all relevant physical healthcare needs and management plans must be included in the referral information or referral proforma to support effective handover. However, consideration must be given to different computer systems; therefore, the community teams should consider alternatives, such as secure email or printed documentation, to manage the transfer. On transfer from an external provider community service, the patient's relevant physical health assessment information must be contemporaneous, additional physical health observations/results supplied will ideally be obtained within 6 months of the transfer date and entered on ELFTs physical health and medical RIO forms upon transfer.

For further details on transfers, please refer to the ELFT Transfer Policy, ELFT CPA Policy & London Mental Health Compact policy (July 2022).

12.1.5 Transfer/discharge from community teams:

When service users are discharged from community services, any significant ongoing physical healthcare needs must be communicated to GP and specialist services (e.g. Community diabetes team) to ensure continuity of care. All related action plans should be documented on RiO indicating the community services supporting the service user's physical health on discharge. Mental health re-referral, crisis and contingency plans should also be included to minimise barriers to ongoing well-being post-discharge.

For further details on transfers, please refer to the ELFT Transfer Policy.

12.2 Liaison with GPs

Medical staff must confirm the GP details of service users under the care of ELFT and request a summary of their physical health needs within 28 days of first contact, if not accessible via HIE.

If the service user is already included on the GP mental health disease register, the staff member will identify the date of the next scheduled annual GP health check. They will include this in their Physical Health Assessment documentation and support the service user to attend.

The Key Worker should verify with the GP practice if the service user has attended their annual health check. If the service user has not attended, they should be supported to make a new appointment and attend.

If the service user is not yet included in the general practice SMI register, the practice should be informed in writing of the service user's 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.

Once the annual health check is completed, any actions arising in relation to health needs must be included in the service user's Physical Health Assessment plan and the service user encouraged to engage with these by relevant staff.

Information about assessments, monitoring, interventions, and signposting should be communicated to the service user's GP following a Physical Health Assessment review.

All community mental health services will work jointly with GP partners and specialist health services to improve service users' access to disease prevention and screening programmes, address inequalities and overcome barriers in accessing these services. This should also include screening for nutritional risks.

12.3 Service Users Not Registered With a GP

All community mental health services will:

Support service users to register at local GP services and encourage engagement with primary care health services.

Support access of service users with a mental illness into primary care and specialist health care services, as well as health promotion and screening services.

If attempts to persuade the service user to register with a GP are unsuccessful, the staff member should arrange an alternative means of completing a medical review, in consultation with medical staff working in the community mental health service.

Including consideration for direct clinic referral:
Phlebotomy referral form (RiO editable forms)
ECG referral form on (RiO editable forms)

12.4 Service Users Declining to Attend Annual Health Checks

Staff members should attempt to arrange an alternative means of completing a physical health check, in consultation with medical staff working in the community mental health service and the GP.

Where assessments and/or interventions are declined, this should be documented alongside a description of what efforts were made to encourage attendance. The service user's decision to refuse their annual health check should be reviewed with them at regular intervals and the discussion documented.

Staff should consider whether any reasonable adjustments could be made to enable attendance and, if appropriate, consider the service user's capacity to make decisions in this regard and their best interests, especially if there are significant health concerns.

13. Management of Long-Term Physical Health Conditions

A long-term/chronic condition is a health need that requires ongoing management over a period of years or decades. Long-term conditions may affect many areas of a person's life including work, relationships, housing and education opportunities. Community mental health teams will take shared responsibility with GPs, specialist clinics, and hospital care providers to ensure that an annual review and comprehensive risk assessment of all long-term chronic conditions are conducted. Corresponding physical health care plans should be documented in the 'Physical Health' section of the Dialog+ care plan (including My Safety Plan) template on RIO. These physical health care plans must accurately reflect the individual's physical health diagnoses, along with appropriate interventions and monitoring arrangements. This includes ensuring ongoing care or health maintenance plans for service users who are currently asymptomatic but have an established physical health diagnosis (e.g. individuals with a confirmed diagnosis of epilepsy who are presently seizure-free).

Where an individual is known to have a physical health related long-term condition:

- If clinicians require advice, this should be sought from specialist services/clinicians within the Trust (e.g. Physical Healthcare Practitioners or Allied Health Professionals from the relevant discipline).
- If necessary, advice should be sought from specialist services, e.g. at the acute hospital. This could arise due to significant changes to the service user's physical and/or mental health which impacts on their long-term condition.
- NICE guidance for the relevant condition should be considered when developing management plans.
- Efforts must be made to ensure that service users are able to attend clinic/outpatient appointments relating to their long-term condition.
- Certain conditions, e.g. diabetes, may have specific regular requirements, e.g. podiatry checks. Services should support service users in accessing appropriate care and checks.
- Long terms conditions should be considered during regular care planning meetings and reviewed at other times as clinically indicated. Management plans should detail monitoring requirements, treatment and procedures to follow if deterioration occurs.
- Where required, reasonable adjustments should be provided to support service users with the ongoing management of a long-term condition and to help service users to understand any information, recommendations and/or advice that is given to them.
- Requests for information/updates from healthcare partners should be sought where applicable with the option to attend CPA, risk management meetings or care reviews where appropriate, either in person or virtually.

14. Health Promotion in the Community

Clinical staff should have access to health promotion materials, including written information on healthy eating, smoking cessation, drug and alcohol and exercise programmes. Staff can then also provide this to service users verbally.

Clinical staff 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. This could involve consideration of local weight management services.

Clinical staff will refer to physical health coaches, where available and required.

Teams are responsible for providing information to 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. Written information leaflets about medicines are available in different languages on the intranet under Information Leaflets / Medicines. Use the following QR code to access the resources:

15. Staff Training

Clinical Teams are provided with support, evidence-based guidance, and Training that will enable them to assess, plan, deliver, monitor, review, and manage the physical health needs of service users within their level of competency.

Staff on inpatient services will complete the two-day Physical Health Course and have access to regular simulated medical emergencies organised by the respective physical health lead.

They will also need to undertake essential annual and refresher training, which will depend on their role and be allocated to their respective online staff training portal. Please visit the ELFT Learning Academy.

Training requirements and opportunities are not limited to:

- All newly qualified nursing staff will complete preceptorship competencies
- Basic, immediate and Advanced life support (dependent on job role)
- NEWS2 Training
- Mouth Care training
- Alcohol and Substance Misuse.
- Smoking Cessation Training. Very Brief Advice V(BA) and one day training
- Infection Prevention and Control
- Medical Devices
- Nutrition Training
- 2-day physical health training (including deteriorating patients & sepsis)

NICE has developed an extensive range of guidelines, publications, and quality standards to support the prevention and management of long-term physical health conditions. These resources provide essential evidence-based recommendations that must be considered when formulating effective and comprehensive intervention plans.

Please visit https://www.nice.org.uk/ or, for relevant examples, refer to Appendix 2.

16. Appendices

Full documents and tools will not be produced here, as updates can quickly make them out of date. Guidance as to where they can be found will instead be included.

Similarly, although this policy has some hyperlinks to external sites, you must ensure you are reading the latest version of any guidance document rather than relying on the links.

Appendix 1: Contact Details for Referrals to ELFT Services

Email addresses within this policy may not be up to date. Check these emails have been received and seek support if you are unsure of how to find an up-to-date email address or how to make a referral.

Specialist Teams	Email Address/link
Diabetes	elft.mhreferrals@nhs.net
Tissue Viability	Tissueviability.service@nhs.net
Dietitian	elft.dietitians@nhs.net For advice and guidance only. There is no clinical dietetic cover for inpatient mental health wards (London) with limited cover in Beds/Luton. Please access up to date contact details on the ELFT intranet Nutrition and Dietetics - Referrals to External Dietitians
Smoking Cessation	elft.stopsmoking@nhs.net
Interpreting and Translation Service	https://www.elft.nhs.uk/intranet/teams-support-me/communications-engagement/interpreting-and-translation
Speech and Language Therapist	Forensic Speech and Language Therapy Service xxx There is no provision for inpatient mental health wards except for within the Forensic directorate. Refer onto local community services as per service provision on discharge.
Physiotherapy	There is no provision for inpatient mental health wards. Refer onto local community services as per service provision on discharge.
ELFT Immunisation Service	https://www.elft.nhs.uk/intranet/teams-support-me/physical-health-teamsfluleadqueries2023-24@nhs.net
Infection Prevention and Control	Elft.infectioncontrol@nhs.net
Medical devices team	elft.medicaldevices@nhs.net

Appendix 2: NICE Guidance

NICE guidance is available across a broad range of mental health and physical health issues. The following guidance may be relevant, but the list is not exhaustive. Staff accessing NICE guidance should confirm that they are using the most up to date version, and thus should not rely on links within this policy.

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

Relevant NICE clinical guidelines

Identification of risk for or presence of a disease following the recommended assessments should be managed in accordance with the relevant disease-specific NICE clinical guidelines.

Core NICE guidelines and quality standards addressing the physical health needs of those living with SMI

- Psychosis and schizophrenia in adults: prevention and management [CG178]
- Psychosis and schizophrenia in adults [QS80]
- Bipolar disorder: assessment and management [CG185]
- Bipolar disorder in adults [QS95]
- Bipolar disorder, psychosis and schizophrenia in children and young people [QS102]
- Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings [CG120]
- Coexisting severe mental illness (psychosis) and substance misuse: community health and social care settings [NG58]
- Mental health problems in people with learning disabilities: prevention, assessment and management[NG54]
- Care and support of people growing older with learning disabilities NICE guideline [NG96]

Relevant NICE clinical guidance to deliver interventions for raised risk of cardio-metabolic disease identified during Physical Health Assessments

- Overweight and obesity management[NG246]
- Cardiovascular disease: risk assessment and reduction; lipid modification [NG238]
- Type 2 diabetes: prevention in people at high risk [PH38]
- Type 2 diabetes in adults: management [NG28]
- Hypertension in adults: diagnosis and management [NG136]
- Physical activity: brief advice for adults in primary care [PH44]

Relevant NICE clinical guidance to deliver interventions for smoking, alcohol or substance use, and oral health

- Tobacco: preventing uptake, promoting quitting, and treating dependence [NG209]
- Tobacco: treating dependence [QS207]
- Alcohol-use disorders: prevention [PH24]
- Alcohol-use disorders: diagnosis and clinical management of alcohol-related physical complications [CG100]
- Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence [CG115]
- Drug misuse in over 16s: psychosocial interventions [CG51]
- Drug misuse in over 16s: opioid detoxification [CG52]
- Oral health: local authorities and partners [PH55]

Appendix 3: The Lester UK Adaptation Tool

The Lester UK Adaptation: Positive Cardiometabolic Health Resource is a tool designed to support the monitoring and improvement of physical health in individuals with psychosis and 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. Aligned with the Core20PLUS5 initiative, it aims to reduce health inequalities and address the 15-year mortality gap affecting those with severe mental illness

At the time of this policy update, the Lester Tool and guidance documents can be found at:
Lester UK Adaptation | 2023 update

The links to NICE guidelines and NHS advice about healthy living, including eating a balanced diet, healthy weight, exercise, quitting smoking and drinking less alcohol are embedded in the Lester tool.

Lifestyle and health behaviour programmes in line with Lester tool and NICE guidance include:

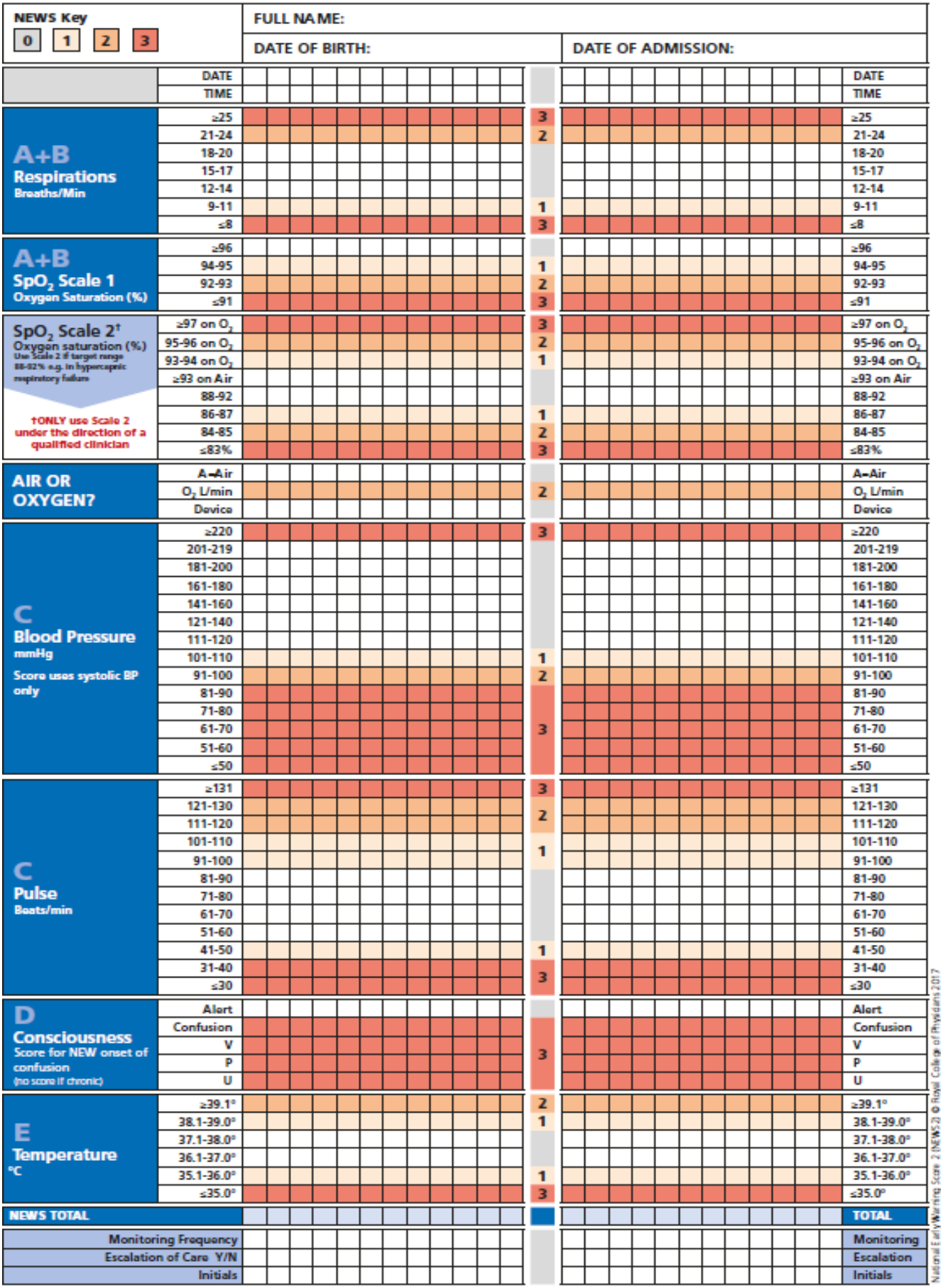
Improving the physical health of people living with severe mental illness which includes links to the Lester UK Adaptation: Positive Cardiometabolic Health Resource, NHS long term plan, Core20Plus5 actions for reducing health inequalities.

Type 2 NHS Diabetes Prevention Programme
Diabetes awareness and rehabilitation training (DART)
The Equally Well UK review
NHS Digital Weight Management Programme
VCSE organisations supporting people living with SMI to improve their physical health

Appendix 4: NHS Population Screening Timeline

Details of the population screening programme can be found here: NHS Population screening timeline

Appendix 5: News 2 (National Early Warning Score)



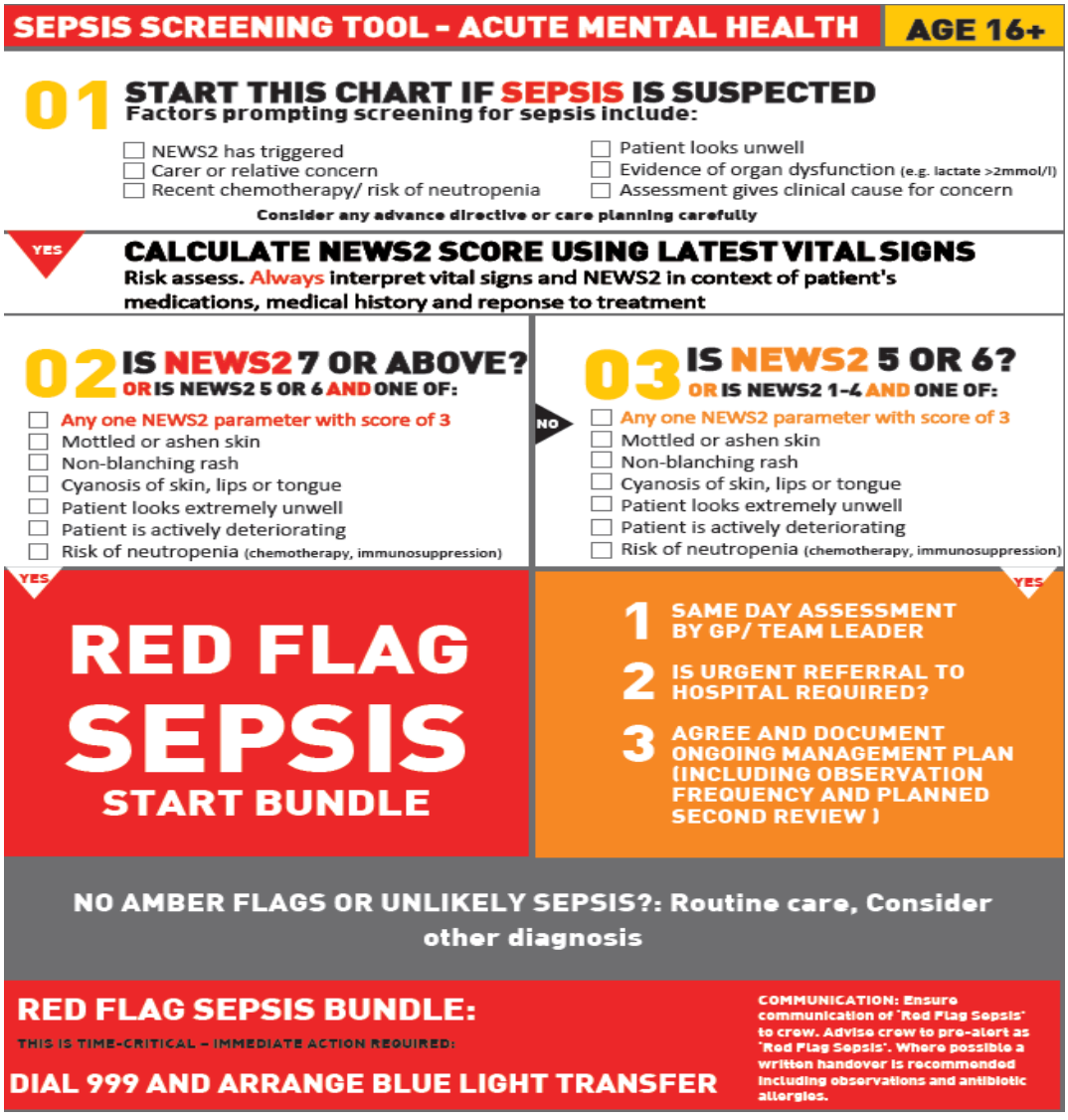
NEWS Key 0 1 2 3	FULL NAME:		DATE OF ADMISSION:	
	DATE / TIME			DATE / TIME
A+B Respirations Breaths/Min	≥25	3		≥25
	21-24	2		21-24
	18-20			18-20
	15-17			15-17
	12-14			12-14
	9-11	1		9-11
	≤8	3		≤8
A+B SpO_2 Scale 1 Oxygen Saturation (%)	≥96			≥96
	94-95	1		94-95
	92-93	2		92-93
	≤91	3		≤91
SpO_2 Scale 2† Oxygen saturation (%) Use Scale 2 if target range 88-92% e.g. in hypercapnic respiratory failure †ONLY use Scale 2 under the direction of a qualified clinician	≥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
	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

National Early Warning Score 2 (NEWS2) © Royal College of Physicians 2017

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	

Royal College of Physicians NEWS2 Resource

Appendix 6: Sepsis Screening Tool



Accessed at: https://sepsistrust.org/

Appendix 7: SBARD Communication Tool

SBARD Communication Tool to Effectively Escalate Concerns

Guidance Notes

1. **S**ituation, **B**ackground, **A**ssessment, **R**ecommendation and **D**ecision known as 'SBARD' is a communication tool used to help frame conversations.
2. **SBARD** aims to help clinicians make escalation communication clear and as assertive as to how quickly patients need to be seen.
3. Always use **SBARD** 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 NEWS2 can be a very powerful tool, just by reciting a high NEWS2 score it signifies the urgency of the situation. Be aware of the escalation process when response is not available.
5. SBARD 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 SBARD actions taken in in patient's clinical record.

S	**Situation**	➢ Identify yourself/the site you are calling from ➢ Identify the person 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 patients' reason for admission (for 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 ➢ NEWS Scores, clinical impressions, concerns
R	**Recommendation**	➢ Explain what you need – be specific about request and timeframe ➢ 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 SBARD. It is important that the receiver of the information reads back a summary of information to ensure accuracy and clarity. This should also be documented in the patient's health records.
D	**Decision**	➢ Agreed-upon course of action or resolution.

Appendix 8: Tissue Viability Service

The Tissue Viability Service offers a Registered Nurse led wound care service to people who suffer from both acute and chronic wounds and those at risk of developing wounds such as pressure ulcers. The service operates to provide hands on specialist clinical care, expert advice and education for patients and all stakeholders involved in wound prevention and treatment. The service provides a range of advanced wound treatment interventions to enable people to receive the right care at the right time and to prevent hospital admission.

The tissue viability teams will support colleagues working in the Trust's mental health settings in Newham, Tower Hamlets, and City & Hackney. Following initial assessment, they will provide a treatment plan of care to manage the wounds. The ongoing day to day management/dressings of the wound will remain the responsibility of the ward Registered Nurses.

A range of guidelines relating to wound care are available on the Trust intranet and all staff caring for a service user with a wound should refer to the appropriate guideline.

Prevention

Preventing pressures ulcers from developing involves collaboration with individuals, families, carers, and healthcare staff. The tissue viability teams support teams, patients and carers by providing training and education on pressure ulcer prevention and management

How to refer
Contact Tel: 0207 909 4970
Teams email: tissueviability.service@nhs.net

Please refer to guidelines on wound management, pressure ulcer, lower limb and managing burns on East London Foundation trust intranet as appropriate.

Appendix 9: Related Documents/Policies

The policy should be read in conjunction with:

- Admission, Transfer and Discharge Policy for Mental Health Service (2024)
- Alcohol and Substance Misuse
- Clozapine Clinic SOP (when available)
- Clozapine Policy
- Community Clozapine Initiation and Re-Titration Guidelines
- Community Health Newham clinical policies and procedures
- Consent to treatment Policy
- Deteriorating Patient Policy (when available)
- Diabetes Policy
- Do Not Attempt Cardiopulmonary Resuscitation Decisions (DNACRD) Policy
- Guidelines for the Management of Antipsychotic-induced Hyperprolactinaemia
- IM Clozapine Protocol
- Incident Management Policy
- Infection Prevention and Control Policy
- Internal Transfer of Detained Patients
- Manual Handling Policy
- Medical Devices Policy
- Nutrition and Hydration Policy (2022)
- Patient Alcohol Detoxification Guidelines
- Policy for the Use of High Dose Antipsychotic Therapy
- Procedure for Medicines Reconciliation
- Protocol for the Safe Use of Lithium
- Rapid Tranquilisation Policy
- Resuscitation Policy
- TB Policy
- Tissue Viability Policy
- Transfer under Section 19 - H1 Hospital Inpatient Report
- Transfer under Section 19 - H2 Hospital Inpatient Record
- Transfer under Section 19 - H3 Detention Record
- Safeguarding Policy
- Sepsis Policy (when available)
- Slips, Trips and Falls Management (Inpatient) Policy Falls Policy (2024)
- Smoke Free Policy (2024)
- Standards for Physical Health Monitoring of Patients on Antipsychotic Treatment
- Valproate Policy Management and Review of Valproate in All Patients
- Venous Thromboembolism; Reducing the Risk (2023)

A full list of Trust Policies are available on the intranet.

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18. Equality Impact Assessment

Name of service, function or policy	Physical Healthcare Policy		
Brief description of service, function or policy (*purpose*)	For adults accessing Community and Secondary Care Mental Health Services		
Is the service, function or policy	☒ Existing	☐ New	☐ Under review
Directorate *(If all groups are impacted, please state 'Trust-wide')*	Trust-wide		
Who is completing the EIA? *(name/role)*	Bernadette Kinsella – Physical Health Lead Nurse / Deputy Director of Infection Control		
Which **Trusts Strategies** are supported by the service?	Population Health	☒	
	The Experience of Care	☒	
	Staff Experience	☒	
	Improved Value	☒	
	None	☐	
Who will benefit from the service, function or policy?	☒ **Workforce**	☒ **Patients, Service Users, and Carers**	
How will the service, function, or policy be implemented to: • Ensure access • Meet health needs • Provide a safe and positive experience for everyone?	Accessible on the Trust Intranet		
How will the service, function or policy be **implemented**?	Approval at Physical Health Committee, Chair's Action by Chief Nurse and Quality Committee		
What are the intended **outcomes** by delivering the activity?	To ensure there is an evidence-based Policy on Physical Health in Mental Health for links to training & practice.		
How will these outcomes be **measured**?	The Policy will be on the Trust intranet and will be rolled-out in a) Inpatient Mental Health Directorates and b) Community Mental Health Services as part of Physical Health training & updates.		
Who are the **key stakeholders** for this activity and **how** have they been **involved**?	Physical Health Nurses, Allied Therapies, Medical & Nursing Directors, Learning Disabilities & membership of the Physical Health Committee.		
Does this service, function or policy impact **other existing policies**?	☒ **Yes**	☐ **No**	
	Impacts are cross-referenced in Appendix 9.		
Is there any **data** available that	☒ **Yes**	☐ **No**	

<table>
<tr><td>influences, affects, or shapes this Equality Impact Assessment?</td><td colspan="4"><u>Improving the physical health of people living with severe mental illness</u> which includes links to the Lester UK Adaptation: Positive Cardiometabolic Health Resource, NHS long term plan, Core20Plus5 actions for reducing health inequalities.</td></tr>
<tr><td rowspan="2">Are there gaps in information?
Consider groups that you have not directly engaged with, or existing data that does not provide then full picture.</td><td colspan="2">☐ Yes</td><td colspan="2">☒ No</td></tr>
<tr><td colspan="4">N/A</td></tr>
<tr><td rowspan="9">Does the service, function or policy have a negative impact on any particular group?</td><td>Protected Characteristic</td><td>Yes</td><td>No</td><td>Unclear</td></tr>
<tr><td>Age</td><td>☐</td><td>☒</td><td>☐</td></tr>
<tr><td>Disability</td><td>☐</td><td>☒</td><td>☐</td></tr>
<tr><td>Race</td><td>☐</td><td>☒</td><td>☐</td></tr>
<tr><td>Marriage and Civil Partnership</td><td>☐</td><td>☒</td><td>☐</td></tr>
<tr><td>Pregnancy and Maternity</td><td>☐</td><td>☒</td><td>☐</td></tr>
<tr><td>Gender re-assignment</td><td>☐</td><td>☒</td><td>☐</td></tr>
<tr><td>Religion or belief</td><td>☐</td><td>☒</td><td>☐</td></tr>
<tr><td>Sex</td><td>☐</td><td>☒</td><td>☐</td></tr>
<tr><td>Sexual Orientation</td><td>☐</td><td>☒</td><td>☐</td></tr>
<tr><td rowspan="2">Could the way the service, function, or policy is implemented have an adverse impact on equality of opportunity or good relations between different groups?</td><td colspan="2">☐ Yes</td><td colspan="2">☒ No</td></tr>
<tr><td colspan="4">N/A</td></tr>
<tr><td>Where a negative impact has been identified, can changes be made to minimise it?</td><td colspan="4">N/A</td></tr>
<tr><td rowspan="2">Is the service, function, or policy indirectly discriminatory, and can it be justified?</td><td colspan="2">☐ Yes</td><td colspan="2">☒ No</td></tr>
<tr><td colspan="4">N/A</td></tr>
<tr><td rowspan="2">Is the service, function, or policy intended to increase equality of opportunity by permitting Positive Action or Reasonable Adjustment?</td><td colspan="2">☐ Yes</td><td colspan="2">☒ No</td></tr>
<tr><td colspan="4">N/A</td></tr>
</table>