# Policy:

## NP 020 - Physical Health

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| **Executive Director Lead** | Executive Director of Nursing, Professions and Quality |
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| **Ratified By** | Quality Assurance Committee |
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| **Date for Review** | June 2028 |


**Summary of policy**

The purpose of the policy is to ensure that the physical health of service users receiving care from Sheffield Health and Social Care NHS Foundation Trust services is assessed and care planning and that they receive physical health monitoring, interventions and escalation as required.

Such physical health assessments must be completed in line with this policy and the relevant Standard Operating Procedures (SOP) for each service/team and approved evidence based clinical guidance. This will ensure that the physical health assessment adheres to best practice, which is to include good standards of recording within the electronic patient record.

The policy provides direction and guidance for the planning and implementation of high-quality physical health support to ensure high quality assessment, care planning and interventions within the organisation. It sets out the expectations of interventions that should

be provided by staff employed within SHSC and those which will require advice and /or intervention from other specialist services.

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

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

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| **Keywords** | Physical Health, Assessment |

**Storage & Version Control**
Version 8 of this policy is stored and available through the SHSC intranet/internet. This version of the policy supersedes the previous version (V8 March 2024). Any copies of the previous policy held separately should be destroyed and replaced with this version.

## Version Control and Amendment Log

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

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| 7.0 | Review of policy due to expiry date | 03/2022 | Policy reviewed for accuracy and any immediate changes required to content whilst new PH strategy drafted. New policy to be developed to support new strategy. |
| 8.0 | New draft policy created | 03/2024 | Replaces the previous version (V7.0), issued in April 2022. Policy reviewed for accuracy and any immediate changes required. |
| 9.0 | Review of policy due to expiry date | 06/2025 | Replaces the previous version (V8.0), issued in April 2022. Policy reviewed for accuracy and any immediate changes required. |

## Contents

# 1. Introduction.

1.1 The physical health needs, co-morbidities and reduced life expectancy of people with serious mental illness are comprehensively documented within both national policy and clinical academic literature. Despite this, people with mental illnesses continue to experience poor physical healthcare and are dying prematurely from preventable conditions. This can be attributable to preventable physical conditions such as respiratory and cardiovascular disease and poor access to physical healthcare monitoring and assessment (Department of Health 2011). Globally patients with serious mental illness (SMI) have reduced life expectancy of 15-25 years.

1.2 People with mental health problems have higher rates of obesity, smoking, heart disease, stroke, hypertension, respiratory disease, diabetes, substance misuse and breast cancer in comparison to the general population. A holistic approach is therefore required across the Trust to ensure that care delivered addresses mental and physical well-being, reduces health inequalities, and improves the wellbeing and outcomes for service users.

1.3 Physical healthcare needs should be assessed and addressed including promotion of healthy living and management to support reduction of any potential side effects associated with treatments (Department of Health 2015).

1.4 In general, people with a learning disability (LD) have poorer health and die on average 20 years younger than people without an LD. Many of the causes of poor health are avoidable. The main causes of premature mortality in the population include diagnostic overshadowing (attributing symptoms of physical ill health to people's learning disability), respiratory disease and epilepsy.

1.5 Overall, the life expectancy of someone with autism is 16 years less than the general population. People with autism are more prone to the side effects of psychiatric drugs. Therefore, lower doses and shorter duration of treatment should be considered.

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

1.7 The National Institute for Health and Care Excellence (NICE) (2014) recommends annual physical health checks for people with a SMI. For service users accepted by mental health services, who have a diagnosis of SMI, prescription of anti-psychotic and/ or a diagnosis of an eating disorder, secondary care mental health services should undertake a regular and full assessment of the mental and physical health of the service user, addressing all issues relevant to the individual's quality of life and well-being (NICE, 2002).

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

Specific factors leading to poor physical health include:

- Lack of Physical Activity.
- Diagnostic Overshadowing. (Diagnostic Overshadowing is the attribution of a persons symptoms to a psychotic problem when such symptoms actually suggest a comorbid condition).
- Diet.
- Obesity.

- Harmful effects of psychotropic medication: (includes movement disorders; weight gain; toxicity issues; development of short-term and long-term physical health conditions e.g. diabetes, lithium levels, renal and thyroid function).
- Stigma, discrimination, and exclusion.
- Access to healthcare.
- Substance Misuse.
- Tobacco Smoking.
- Other social determinants of health, such as access to adequate housing, employment, and education.

1.9 This policy has been written to support SHSC's Physical Health Strategy 2023 - 2026 which aims to improve the mental, physical, and social wellbeing of the people in our communities.

## 2. Scope

2.1. This policy applies to the following services/teams within SHSC – all inpatient wards, Mental Health Recovery teams, Older Adults Community Mental Health Teams, Adult and Older Adult Home Treatment Teams, Community Enhancing Recovery Team, Early Intervention in Psychosis team, Community Learning Disability Team, and relevant Specialist Service teams.

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

2.3. This policy applies to all adult patients over 16 years of age under the care of Sheffield Health and Social NHS Foundation Trust.

2.4. This policy does not cover resuscitation attempts. Staff should refer to the Resuscitation Policy 2025 and Deteriorating Patient Identification and Management Policy 2023.

2.5 This practice standard draws together the recommended monitoring required to facilitate the safe and effective use of antipsychotics, mood stabilisers and antidepressants based on NICE guidelines. The monitoring parameters are not exhaustive and do not intend to provide treatment recommendations for individual patients. Additional tests may be required, and these should be guided by the individual's risk factors, co-morbidities, and physical conditions. The standards set out the minimum physical health checks that should be provided to all patients regardless of medication prescribed.

## 3. Purpose

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

3.2. The aims are twofold:

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

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

## 4. Definitions

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| ACOMHS | Accreditation for Community Mental Health Services |
| AHC | Annual Health Check |
| BMI | Body Mass Index |
| ECG | Electrocardiogram |
| GASS, | Glasgow Antipsychotic Side Effect Scale |
| LD | Learning Disabilities |
| MDT | Multiple Disciplinary Team. |
| NEWS2 | National Early Warning Score 2. |
| SHSC | Sheffield Health and Social Care NHS Foundation Trust |
| SMI | Serious Mental Illness |
| SOP | Standard Operating Procedure. The purpose of a SOP is to conduct the operations correctly and always in the same manner. |

## 5. Duties

5.1 **Chief Executive.**

The Chief Executive on behalf of the Trust retains ultimate accountability for the health, safety and welfare of all service users, carers, staff, and visitors; however key tasks and responsibilities will be delegated to individuals in accordance with the content of this policy.

5.2 **Director of Nursing and Quality.**

The Director of Nursing and Quality is chair of the Physical Health Committee. The group is responsible for the monitoring and auditing outcomes and reports to the Quality Assurance Committee and to Trust Board, plus directly feeding into local patient safety clinical groups for improvements at an individual service level.

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

5.3 **Head of Physical Health.**

The Head of Physical Health for SHSC oversee the physical health service throughout the Trust and are responsible for:

- Updating policies and guidelines for physical health within the Trust, reflecting national recommendations and guidelines outlined by Resuscitation Council (UK) and NICE Guidance.
- Provision of appropriate training to ensure that staff are competent in the application of this policy.
- Works in conjunction with Heads of Nursing, Matrons, and Managers to develop action plans for staff members who do not meet the requirements.
- Reviewing of incident reports involving all deteriorating health incidents and contribute to their investigation.

- Supports with any staff debrief following medical emergency where required.
- Responsible for establishing the standards for physical health promotion and monitoring within the organisation, seeking advice from relevant specialists as required.

5.4 **Heads of Nursing, Modern Matrons and Ward Managers.**

Responsible for ensuring that high standards are maintained within their areas of responsibility and the standards set out in this policy and are adhered to. It is the responsibility of each line manager to ensure staff attend all relevant statutory and mandatory training; and to monitor attendance on a routine basis, ensuring systems are in place for. They must ensure all appropriate physical health monitoring equipment is available and in good working order and to ensure staff can identify and manage the deteriorating patient in terms of physical health when needed. Ensure risk assessment forms are completed in accordance with the Risk Management Policy and incidents are managed in accordance with the incident management policy.

5.5 **Clinical Educators.**

Responsible for delivering high quality teaching, learning and assessment of staff in respect of managing the deteriorating patient in line with national guidance.

5.6 **Substantive Medical Staff.**

Responsibility to be aware of and act in line with this policy. Ensure that junior medics are aware of and practice in line with this policy.

5.7 **All clinical staff.**

Staff in inpatient, residential and community care setting delivering clinical care are required to adhere to the requirements of this policy but in particular: Medical Staff, Nurses, Physician's Associates, Advanced Clinical Practitioners, Specialist Nurse Practitioners and Nurse Associates will:

- perform physical examinations, investigations and health screening as outlined in this policy.
- complete all relevant documentation in relation to physical examination, investigations, and health screening.
- ensure the appropriate actions, onward referrals, escalation to specialist services are taken and completed for patients with an abnormal finding upon examination or investigation.
- identify and maintain individual competence in physical health assessment, observation, and management.
- identify and raise awareness of research opportunities related to physical health.

All staff will be trained via a comprehensive training programme in the recognition, management and escalation of the deteriorating patient and must be always aware of the Identification and Management of a Deteriorating Policy 2023 and act in line with it.

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

5.8 **Nurse in Charge.**

The nurse in charge for each shift has the responsibility for ensuring that all required physical health observations are obtained and recorded in line with this policy, confirming the accuracy of the observations.

5.9 **Employee.**

It is the responsibility of each staff member to ensure they attend and maintain all relevant mandatory training and other training if relevant for their role and keep themselves up to date. Support will be given by the Clinical Educators to staff who don't feel confident or competent to undertake physical health checks.

5.10 **Health Care Assistants (Support Workers/HCA/Student Nurse).**

Health Care Assistants trained to undertake physical observations can record NEWS2 however if the score is 3 in a single field or a total score of 5 or higher, they will be expected to escalate to a qualified nurse.

5.11 **Ward Medical Team.**

The Ward Medical Team retain the overall responsibility for the management of the patient during working hours and are responsible for seeking appropriate review by other specialist teams, where relevant, responding to escalations as per this policy and the Identification and Management of the Deteriorating Patient Policy. Where a medical review is needed the reviewing clinician is responsible for developing and documenting a management plan and communicating to the ward nursing team, including the triggers for further review and escalation where warranted. Where the clinician reviewing the patient has concerns or is unable to stabilise the patient, they must seek urgent help from a senior colleague. Or call 2222 to the ambulance service.

5.12 **On call Medical Team.**

Out of hours the care of the patients reverts to the on-call medical team, and they assume the responsibilities as described above for the Ward Medical Team.

5.13 **Out of Hours GP.**

Out of hours the care of the patients in our Nursing Home setting should revert to the Out of Hours GP service or ambulance service if unable to contact on call medical team.

5.14 **Medical Devices Safety Officer.**

To provide any equipment required to support delivery of any approved physical health assessment. To ensure that all equipment is well maintained and serviced, as appropriate, and staff are supported with any purchase of consumables or replacements. Where any machine or equipment is noted as faulty, Medical Devices Safety Officer along with clinical staff report and arrange for a suitable replacement.

## 6 Procedure

6.1. Service users who have a SMI or who are receiving care from a SHSC Community Mental Health services and/or a Learning Disability team should have an Annual Health Check, AHC, completed, Appendix 3.

6.2. Most service users will have their AHC in Primary Care. For these service users who have had a AHC within Primary Care the SHSC teams will check when the AHC took place, record the results of the reviews on electronic patient records and work with the service users to agree a care plan that addresses any identified needs.

6.3. For community-based patients a baseline physical health check, Appendix 6, should be completed prior to the initiation of psychotropic medication and then reviewed accordingly in line with medication guidelines. If there is an urgent need for a physical health check to be performed this should be completed as soon as practicable. If offered and refused a risk/benefit decision neds to be made and documented.

6.4. For community-based patients not currently prescribed psychotropic medication, ensure that they are receiving appropriate physical health monitoring from their GP, dentist and optician and provide information or signpost to services as needed.

6.5. Service users who have not attended their AHC in Primary Care will be encouraged and where necessary supported to attend.

6.6. Service users who are unwilling to access a review in Primary Care will be offered a AHC by their SHSC community team and recorded on the Physical Health Review documentation. This must be recorded on the person's Electronic Care Record (Rio). The results of these reviews will be shared with Primary Care and the SHSC team will work with the service users to agree a care plan that addresses any identified needs.

6.7. Once identified, physical health care needs must be included within the individuals collaborative care plan. Any action taken must also be recorded within the care plan and or patient notes.

6.8. If any identified physical health care need requires immediate management, this should be referred to the appropriate service.

6.9. Consideration of reasonable adjustments for individuals e.g. with Autism Spectrum Disorder Neurodevelopment disorder where sometimes monitoring is not undertaken as it is emotionally distressing to the individual. Holistic planning with other services may make this achievable.

6.10 Everyone admitted as an inpatient should have a physical health examination **within 24 - 72 hours of admission,** this must be recorded on the person's Electronic Care Record. On admission this examination needs to be completed by the ward doctor or appropriate clinician or on-call junior doctor if the person arrives "out of hours". For any service user who has been discharged from an inpatient area back to the community there is also a requirement for a post discharge follow up.

6.11. Initial baseline physical health observations to be completed within all teams and services are to be:

- respiratory rate.
- oxygen saturation.
- blood pressure.
- pulse.
- level of consciousness.
- temperature.

Which will establish a NEWS2 score and should be escalated if required as detailed in the Deteriorating Patient Identification and Management Policy.

A non-contact NEWS2 set of observations are to be conducted where necessary, which should include:

- respiratory rate and level of conscious.

Which will establish a non-contact NEWS2 score and should be escalated if required as detailed in the Deteriorating Patient Identification and Management Policy.

6.12. Service users admitted to an SHSC ward will have a Physical Health Lifestyle Assessment, Appendix 1, based on national best practice, including being offered an Annual Health Check, Appendix 3 during their admission. This must be recorded on the person's Electronic Care Record (RIO).

6.13. It is essential that physical assessments and examinations be conducted in a manner and environment that protects people's choices, privacy, dignity, and safety and in rooms furnished with equipment that is well maintained for the task. In addition, a chaperone should be offered.

6.14. To support the physical health reviews, which are in place for inpatient wards, nursing homes and community mental health and learning disability teams, there are Standard Operating Procedures, Appendix 1, Appendix 2 and Appendix 3. This explains in clear and unambiguous language the actions or performance expected of the relevant staff, and teams in these areas of service delivery. They describe the procedures to follow and set the standards to be met.

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

- Implement appropriate and timely interventions and improve the patient experience.
- Improve the clinical information we record and use.
- Support staff to improve their awareness, knowledge, and skills.
- Collaborate and coordinate and integrate information across organisations.

6.16. Physical health assessment rest with our partners in Primary Care and Appendix 1 will explain in what circumstances the responsibility may transfer to SHSC.

6.17. For all service users, consideration must be given as to whether mental health symptoms can be misattributed to physical ill health or vice versa

6.18. Any new Trust adopted policy, protocol, procedure, SOP or local and national guidance with a physical health element or any existing document when reviewed/updated should follow these principles:

- All policies, protocols and SOPs with a physical health element should be based on national guidance to ensure that the content and timing of physical health assessments, investigations, monitoring requirements and interventions are based on best practice.
- All protocols and SOPs with a physical health element are to be reviewed by the Physical Health Management Group. All policies with a physical health element must then be approved by the Physical Health Committee before approval by Trust process.

6.19. Physical healthcare is the multi-disciplinary and multi-professional responsibility. Where standards are not maintained by a professional group or individual, the wider team has a responsibility to ensure that best practice is undertaken.

6.20. Once identified, physical health care needs must be included within the individuals care plan and documents. Any action taken must also be recorded within the care plan.

6.21. If any identified physical health care need requires immediate management, this should be referred to the appropriate service.

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

6.23. Medical staff are responsible for physical health assessment, history taking and examination. Detailed in the Appendices.

6.24. It is medical staff's responsibility to interpret the results of the initial physical examination and refer to services as appropriate or request further investigations.

6.25. It is the medical staff's responsibility to determine the appropriate frequency of on-going physical health monitoring.

6.26. If the individual requires treatment at a general hospital, it is the medical staff's responsibility to arrange transfer of care and ensure the necessary paperwork is completed. If detailed under Mental Health Act, then Section 17 leave must be used to allow them to leave the ward for treatment. If clinically urgent/emergency completion of Section 17 paperwork should not delay transfer, and this can be completed in retrospect.

6.27. Individuals experiencing extended lengths of stay should have access to National Screening programmes, dental care, podiatry, sexual healthcare, and an optician.

6.28. Any physical health related forms must be uploaded to clinical documentation on electronic patient records and referenced in progress/review notes, e.g. fluid and nutritional record charts, physical health monitoring forms, NEWS2 charts, non-contact NEWS2.

6.29. Health promotion is the responsibility of all staff but Ward Managers and Clinical Team Managers should ensure that access to resources are provided and displayed within clinical areas or links to universal services are supported to enable people to access:

- Health promotion advice, information, and activities relevant to their needs e.g. exercise, smoking cessation support, sexual health, dietary advice.
- Appropriate vaccination/immunization screening programmes.

## *7.* Development, Consultation and Approval

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

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

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

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

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

## 8. Audit, Monitoring and Review

| Minimum Requirement | Process for Monitoring | Responsible group/committee | Frequency of Monitoring | Review of Results process | Responsible group/ committee for action plan development | Responsible group/ committee for action plan monitoring and implementation |
|---|---|---|---|---|---|---|
| Implementation of policy | Review of new/updated policies, procedures, or SOPs with a physical health element | Physical Health Management Group (PHMG) | Monthly | Physical Health Management Group (PHMG) | Physical Health Management Group (PHMG) | Physical Health Management Group (PHMG) Agenda and Minutes |
| Proportion of staff in each team who have completed training as required | Team governance reports Physical Health Management Group (PHMG) | Clinical team governance meetings | Monthly | Physical Health Management Group (PHMG) | Governance meetings | Physical Health Management Group (PHMG) |
| Proportion of people with SMI and LD receiving SHSC services who have had a physical health review with appropriate interventions offered. | Team governance reports and QPRs<br><br>Physical Health Management Group (PHMG) | Physical Health Management Group (PHMG) | Monthly | Physical Health Management Group (PHMG) | Physical Health Management Group (PHMG) | Physical Health Management Group (PHMG) |

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

## 9. Implementation Plan

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

## 10. Dissemination, Storage and Archiving (Control)

| Version | Date added to intranet | Date added to internet | Date of inclusion in Connect | Any other promotion/ dissemination (include dates) |
|---|---|---|---|---|
| 5.0 | | | | The previous policy will be removed from the Trust intranet by the Director of Corporate Governance. Team managers are responsible for ensuring that it is also removed from any policy and procedure manuals or files stored in their offices and destroyed.<br>Archiving – The Clinical Governance team will keep an electronic version of the previous policy for archive purposes. |

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| 6.0 | | | | Archiving – The Clinical Governance team will keep an electronic version of the previous policy for archive purposes. Please contact them if a copy is needed |
| 7.0 | April 2022 | April 2022 | April 2022 | Archiving – The Clinical Governance team will keep an electronic version of the previous policy for archive purposes. Please contact them if a copy is needed |
| 8.0 | March 2024 | March 2024 | March 2024 | Archiving – The Clinical Governance team will keep an electronic version of the previous policy for archive purposes. Please contact them if a copy is needed |
| 9.0 | March 2025 | March 2025 | March 2025 | Available trust-wide on the intranet |

## 11. Training and Other Resource Implications.

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

i. Specific training requirements and rationale.

ii. How many staff need training?

iii. How to meet training needs.

iv. Appropriate environment and infrastructure for training.

v. Links with other training/policies.

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

11.3 Staff have access to Clinicalskills.net and are able to access an evidence based clinical procedures resource.

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

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

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

| **References** | |
|---|---|
| Department of Health (2016) | Improving the physical health of people with mental health problems: Action for mental health nurses: DH, Public Health England & NHS England. London |
| Department of Health (2005) | National Services Framework for Long Term Conditions: DH. London |
| Department of Health (2006) | Choosing Health: Supporting the physical health needs of people with severe mental illness. DH. London |
| NICE (2014). | CG178 Psychosis and schizophrenia in adults: treatment and management. |
| Public Health England | NHS England / HEE (2016) Making Every Contact Count: A Consensus Statement |
| National Audit of Schizophrenia (2013) | Royal College of Psychiatrists |
| Schizophrenia Commission (2012) | The Abandoned Illness: A report by the Schizophrenia Commission |
| Wahlbeck K et al., (2011) | Outcomes of Nordic mental health systems: life expectancy of patients with mental disorders. British Medical Journal 2011 199 (6) 453-8 |

| **Policies** |
|---|
| Development, Management and Review of Policies |
| Resuscitation Policy (NPCS 007 V6 Feb 25) |
| Deteriorating Patient Identification and Management Policy (NP 045 V2 Nov 23) |
| Infection Prevention and Control Policy (NPCS 005 V9 May 2024) |
| Medical and Therapeutic Devices Policy (MD 021 V6 April 2024) |
| Smoke Free Policy (MD 005 V3 March 21) |
| Inpatient Discharge Policy (OPS 016 V6 Oct 2024) |
| Medicines Optimisation Policy (MD 013 V11 Feb 23) |
| Safe Supportive and Engagement Observation Policy (NPCS 001 V4 Oct 220 - Extension Dec 2024 |
| Rapid Tranquillisation Policy (MD011 V7 July 23) |
| Use of Force Policy (NP 030 V6.1 Mar 24) |
| Seclusion and Segregation Policy (NPCS 009 V9.2 Mar 24) |
| Back Care and Manual Handling Policy (HR 051 V10 May 24) |
| Adult Learning Disabilities Service Dysphagia Protocol for Mental Health Referrals |

## 13 Contact Details

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| Medical Devices Safety Officer | Sharlene Rowan | | Sharlene.rowan@shsc.nhs.uk |

**Appendix 1**

# Standard Operating Procedure (SOP) – Physical Health Lifestyle Assessment for Patients Admitted to SHSC wards.

## Physical Health Lifestyle Assessment following admission.

a. A National Early Warning Score 2 (NEWS2) assessment will be completed as soon as possible after admission and within 4 hours. An urgent Physical Health Assessment will be undertaken if indicated by an elevated NEWS score to do so.
b. Ensure that information is gathered about the following:
   - Past Medical History.
   - Nutritional Intake including - Weight/Height/BMI.
   - Physical activity.
   - Smoking status.
   - Alcohol Screening.
   - Substance use.
   - Sexual Health.
   - Mobility.
   - Dental Health.
   - Infection Status including MRSA.
c. A 12-lead ECG
d. Additional screening tools if required (smoking form, infection screening, VTE risk screening) will be completed within 24 hours of admission.
e. Routine blood tests will be completed within 24 hours of admission:
   - FBC (full blood count)
   - U&E (Urea and electrolytes)
   - LFT (Liver function test)
   - HbA1C
   - Random Glucose
   - Lipid Profile
   - Prolactin level (if likely to receive an antipsychotic)
   - TFT (thyroid function test) and others if clinically indicated

| | Ref protocol | ACOMHS |
|---|---|---|
| FBC | √ | X |
| B12 & Folate | √ | X |

| | | |
|---|---|---|
| U&E | √ | X |
| LFT | √ | X |
| TFT | √ | X |
| Fasting glucose/HbA1C | √ | √ |
| Lipid Profile | X | √ |
| Calcium | √ | X |
| Prolactin | √* | X |

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

f. A Physical Health Examination, Appendix 7, will be completed by a Doctor, Physician's Associate or Advanced Clinical Practitioner within 24 hours of admission. The examination completed will be based on the service users past medical history and current presentation and will be documented in the patient record.
g. Additional investigations will be requested if clinically indicated and justified.
h. The Physical Health Lifestyle Assessment document will be commenced within 24 hours of admission and must be completed within 7 days.
i. Referral to other MDT professional if required - e.g. Dietician, Pharmacist or member or the Medicines Optimisation Team, Occupational Therapist, Physiotherapist, Speech & Language Therapist. Escalation will be done on a case by case to provide appropriate support.
j. Nutrition - MUST screening tool should be completed for all patients within 48 hours of admission. If the individual is identified as being at risk of malnutrition or has specific dietary requirements then a care plan needs to be established, this should focus on the individual's usual routine for eating and drinking, what if any type of assistance they require e.g. choosing meals, completing menus, religious or cultural dietary needs, special equipment to assist feeding, environmental issues to support meals, allergies & intolerances etc.
k. Medication - If the individual is or it is suspected that they might be experiencing any side effects of medication, then discussion with the medical staff and Medicine Optimisation Team may be appropriate. For individuals prescribed antipsychotic medication an adapted Glasgow Antipsychotic Side Effect Scale, GASS, is available on the Trust's Medicine Management section of the intranet.
l. A clinical management plan and emergency rescue plan will be developed to meet the patient's known physical health needs and documented in their Collaborative Care plan.
m. In the event of any abnormal findings in screening and examination undertaken after admission an individualised management plan will be documented in the patient's care plan.
n. If specialist medical/surgical assessment or treatment is required, the patient will be referred to the appropriate medical specialist and supported to attend any appointments. Recommended treatment will be delivered on return to the ward and documented in the care plan according to the clinic letter/discharge summary from the specialist team.
o. On discharge from the ward the discharge summary will include relevant information about physical health investigations and treatment and will be sent to the patients GP and available in the patient record for SHSC community teams to access.
p. If an admitted service user is already under care of a specialist team, e.g, HIV/Oncology – the specialist team should be contacted to supply the written care plan including any medications.

**Review of SOP**

Review to be completed annually.

**Appendix 2**

# Standard Operating Procedure (SOP) – Physical Health Assessments within all Nursing Home areas.

Obtaining and ensuring correct documentation of the following when required:

- NEWS2
- Height, weight = BMI.
- Blood glucose monitoring (with on-going monitoring for those with diabetes or on prescribed medication that may increase the risk of diabetes).
- Nutrition screening.
- Fluid intake and urine output of those who dehydrated or on fluid restriction.
- Urinalysis, universal urine testing as clinically indicated.
- Skin condition and pressure area assessment.
- Mobility.
- Sleep pattern.
- Personal hygiene.
- Continence, bladder & bowel function.
- Medication compliance and side effects

- Referral to other professional - e.g. Dietician, Pharmacist or member or the Medicines Optimisation Team, Occupational therapist, Physiotherapist, Speech & Language Therapist. Escalation will be done on a case by case to provide appropriate support
- Nutrition - MUST screening tool should be completed for all patients within 24 - 72 hours of admission. If the individual is identified as being at risk of malnutrition or has specific dietary requirements then a care plan needs to be established, this should focus on the individual's usual routine for eating and drinking, what if any type of assistance they require e.g. choosing meals, completing menus, religious or cultural dietary needs, special equipment to assist feeding, environmental issues to support meals, allergies & intolerances etc.
- Medication - If the individual is or it is suspected that they might be experiencing any side effects of medication, then discussion with the medical staff and Medicine Optimisation Team may be appropriate. For individuals prescribed antipsychotic medication an adapted Glasgow Antipsychotic Side Effect Scale, GASS, is available on the Trust's Medicine Management section of the intranet.

**Review of SOP**
Review to be completed annually.

**Appendix 3**

# Standard Operating Procedure (SOP) – Physical Health Review within Community and Learning Disability services.

Teams are responsible for ensuring the relevant physical health checks are done for individuals within scope of the service and that the results are communicated to the relevant health professionals to resolve those problems. This may involve ensuring these are conducted in Primary Care, via third party providers or via workers within the team.

For people with Serious Mental Illness (SMI) or those people prescribed antipsychotic medication the following should be monitored and correctly documented:

- Past medical history.
- Nutrition screening.
- Physical activity.
- Substance use.
- Alcohol screening.
- Smoking Status.
- Height & Weight = BMI.
- Blood pressure.
- Blood testing.
- Cancer screening
- Sleep pattern.
- Personal hygiene.
- Medication compliance and side effects

Specific guidance of which parameters should be measured, and the intervals is available.

- Referral to other professional - e.g. Dietician, Pharmacist or member or the Medicines Optimisation Team, Occupational therapist, Physiotherapist, Speech & Language Therapist. Escalation will be done on a case by case to provide appropriate support.

- Medication - If the individual is or it is suspected that they might be experiencing any side effects of medication, then discussion with the medical staff and Medicine Optimisation Team may be appropriate. For individuals prescribed antipsychotic medication an adapted Glasgow Antipsychotic Side Effect Scale, GASS, is available on the Trust's Medicine Management section of the intranet.

- Community Mental Health Team, CHMT, and Learning Disability service users and people may require support to access universal services in Primary Care for long term health conditions and National Screening Programmes for Bowel, Cervical, Abdominal Aortic Aneurysm, Diabetic Retinopathy and Breast screening.

- CMHT and Learning Disability multidisciplinary team clinicians are required to assess each person for their individual physical health needs and include these in the care plan and work collaboratively with Primary Care and secondary acute health services where required to ensure the person has appropriate access and advocacy where required to engage in physical health care.

- People with an open episode of care to a Community Mental Health Team service should have their lifestyle parameters reviewed. If needs are identified, they should be offered referral or support to access public health interventions through the established pathways.

- People with Learning Disabilities should have their lifestyle parameters reviewed as part of their Annual Health Check. However, in line with Making Every Contact Count (MECC), clinicians should use every opportunity to raise the issue of healthy lifestyle e.g. smoking cessation, healthy eating, and physical activity whenever possible and appropriate to do so.

**Review of SOP**
Review to be completed annually.

**Appendix 4**

# Standard Operating Procedure (SOP) – Physical Health Assessments for Allied Health Professionals.

**Dietitian** - Following completion of physical health and nutritional assessment on the person's care records, referral to Dietician may be considered appropriate for further assessment and care planning.

**Medicines Optimisation Team** - Pharmacist or member of the Medicine Optimisation Team to discuss and agree any changes in prescriptions which may adversely affect physical health and provide education to individuals about potential side effects of medications and how to take their medicines correctly.

**Physiotherapist** - Following completion of physical health assessment, referral to physiotherapist may be required for further assessment and care planning.

**Occupational Therapist** - To be aware of physical health issues when planning/undertaking activities and to alert appropriate healthcare professional as applicable if an individual's physical health state alters whilst undertaking activities.

**Speech and Language Therapist** - Following completion of physical assessment, referral to speech and language therapist may be required to undertake full assessment of swallowing and communication.

**Review of SOP**
Review to be completed annually.

**Appendix 5**

# Standard Operating Procedure (SOP) – Physical Health Review - Community Older Adult Teams

Applies to patients admitted to SHSC Community Mental Health Teams: Older Adult Community Mental Health Team, Older Adult Home Treatment Teams and relevant Specialist Services

## Procedure

1. A Physical Health Review will be completed:

    a. For new patients, unless it has been recently completed by another SHSC service or in Primary Care as part of the referral process.
    b. For existing patients on mood stabilisers or antipsychotic medication (initiation and annual), at annual review, or all other patients where there has been a significant change in physical presentation since the last review.

2. The following information will be required:
    a. Information from Primary Care including physical health summary and up to date medication list.
    b. Recent blood results.
    c. Any other recent physical health investigations.

3. Ensure that information is gathered about the following:
    - Past Medical History
    - Nutritional Intake
    - Smoking status
    - Physical activity
    - Substance use
    - Alcohol Screening
    - Weight/BMI
    - Blood pressure
    - Blood results

| | Ref protocol | ACOMHS |
|---|---|---|
| FBC | √ | X |
| B12 & Folate | √ | X |
| U&E | √ | X |
| LFT | √ | X |
| TFT | √ | X |

| | | |
|---|---|---|
| Fasting glucose/HbA1C | √ | √ |
| Lipid Profile | X | √ |
| Calcium | √ | X |
| Prolactin | √* | X |

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

4. If the information within procedural points 1 or 2 are more than 12 months ago, or if there has been a significant change in physical presentation then the team will be required to conduct the necessary interventions directly with the patient to obtain relevant, up to date information.

   Additional investigations should be ordered if clinically indicated and justified e.g. lithium level or thyroid function test. Changes in medication since last blood test may be necessary earlier than 12 months. Weight gain or loss may be more recent than over a 12-month period. Establish if any sexual dysfunction prior to treatment and report any changes that occur.

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

5. Results of the Physical Health Review may be recorded in the patient care record:

   - Physical Health Review form
   - Antipsychotic check list.
   - Scanned documents.
   - ICE Lab reports.
   - Physical Health Review for people prescribed Antipsychotic and/or Mood Stabiliser.
   - Initial Assessment/SCP Initial Assessment information.

   If patients refuse examination/investigations or interventions:
   - Document refusal on the Physical Health Review form.
   - Develop a management plan within the patient's care plan.
   - Give patient information about the importance of investigations and repeatedly attempt to engage patient with the required interventions.
   - Monitor and record progress as part of care planning.

**Review of SOP**

Review to be completed annually.

**Appendix 6**

# Standard Operating Procedure (SOP) – Physical Health Monitoring for Service Users Commenced on a New Antipsychotic or Mood Stabiliser.

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

**Baseline investigations are**

- ECG, required if the patient is prescribed antipsychotics required by the drug Summary Product Characteristic, SPC, or prescribed High Dose Antipsychotic Therapy, HDAT. Or if the service user has a personal history of cardiovascular disease.
- Weight.
- Waist circumference.
- Pulse and blood pressure (NEWS2 to be completed if out of normal range and observation and escalation policy to be followed).
- Blood tests including HbA1c, lipid levels, prolactin, TFT, FBC, U&E.
- Nutritional status and Diet.
- Physical activity.

## Monitoring

The service user should be weighed weekly for the first six weeks and in the community setting the service user should be encouraged to do this themselves and record. At 12 weeks if the service user is still an inpatient the baseline investigations should be repeated but not an ECG or prolactin levels. If the patient is discharged before 12 weeks the community team should be informed of the date the investigations should be completed.
Actions to be taken if the service user is found to be gaining weight or developing metabolic disturbance include advice about diet and activity, referral to Community services that provide support with health behaviours and signposting to the service users GP.
Consider if pulse blood pressure/ECG are required after each dose of titration.

https://www.nice.org.uk/guidance/cg178/chapter/Recommendations

**Review of SOP**
Review to be completed annually.

**Appendix 7**

# Standard Operating Procedure (SOP) – Guidance on Physical Health Examination in In-patient areas.

- **General Observation** - anaemia, cyanosis, jaundice, cleanliness, state of clothing, smell of urine, dentition, scars, particularly relating to self-harm and other injuries, areas of skin breakdown, infection, or abnormality.
- **Cardiovascular System** - pulse, blood pressure, heart sounds, swelling of ankles (oedema), ECG.
- **Respiratory System** – trachea position, percussion note, breath sounds, air entry, respiratory distress (including at rest), sputum, respiratory rate, oxygen saturation.
- **Abdomen** - bowel sounds, scars, any abnormal masses, or areas of tenderness
- **Nervous System** – assess cranial and peripheral nervous system including assessment of vision pupils and fundi. Inspect ear canals and check hearing. Review co-ordination and signs of dystonia, akathisia, and involuntary movements.
- **Blood Tests** - Full blood count, urea, renal, liver, and thyroid function tests, HbA1C, electrolytes and creatinine, prolactin, blood lipid profile, or other test of glucose, pregnancy test and others as appropriate.
- **Venous Thromboembolism (VTE)** - risk assessment and prevention.
- **Serious Mental Illness (SMI)** - those people prescribed antipsychotic medication: blood pressure, pulse rate, blood lipids, HbA1c, lifestyle review and weight/height/BMI should be completed. (Appendix 5)
- **ECG** - All admissions should have an ECG performed. ECG needs to be performed on an Annual Health Check if the patient is prescribed antipsychotics and if required by the drug Summary Product Characteristic, SPC, or prescribed High Dose Antipsychotic Therapy, HDAT. May also want to consider an ECG if:
  - combination of medication known to prolong QT intervals.
  - drug interactions resulting in an increased plasma level of drug(s) associated with a risk of QTc prolongation.
  - treatments which may cause electrolyte imbalance e.g. diuretics.
  - specific medical conditions (e.g. anorexia nervosa) associated with electrolyte abnormalities.
- **Do not** routinely request a brain scan unless clinically indicated e.g. evidence of neurological disease.
- Document clinical management / action plans within the Rio and develop a physical health goal with identified steps within the Collaborative Care Plan.

Further considerations:

| Investigation | Intervention |
|---|---|
| Smoking | All smokers to be given very brief advice and offer referral to smoking cessation worker in team if available and / or Sheffield stop smoking service. |
| Harmful use of alcohol | Complete alcohol screening tool and provide very brief advice. |
| Substance use | Discuss potential adverse impact on mental and physical health and offer referral to the opiate or non-opiate service. |
| Diet and activity | Consider advice on:<br>• healthy balanced diet<br>• reducing sugar and salt intake<br>• increasing fruit and veg<br>• increasing activity levels and refer |
| Weight | Consider effect of recent medication changes. Give advice on diet and activity as above. |
| Blood pressure | Give advice on diet and activity as above. Refer to GP if any concern. |
| High blood glucose levels | Advise on diet and activity as above and refer to GP. |
| Diabetes | Community teams have a duty to ensure that monitoring for diabetes is conducted by GP, diabetic clinic, or other community team. Ask patient about diabetic review and check physical health summary from GP. |
| Cholesterol | Give advice on diet and activity as above. Advise to attend GP if abnormal blood results (Lipids). |

- **In the event of an acute physical health emergency, staff to ring 2222 from Trust connected phone or 999 from outside line. For all non-urgent matters, staff to consult with team medic.**

**Review of SOP**
Review to be completed annually.

# Appendix 8

## Equality Impact Assessment Process and Record for Written Policies

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

**NO** – No further action is required – please sign and date the following statement.
**I confirm that this policy does not impact on staff, patients, or the public.**

***I confirm that this policy does not impact on staff, patients, or the public.***

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

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

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

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

Impact Assessment Completed by: Interim Head of Physical Health and Resuscitation Officer.
Name /Date: Mo MacKenzie 09/03/25

## Appendix 9 - Review/New Policy Checklist

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

| | | Tick to confirm |
|---|---|---|
| | **Engagement** | |
| 1. | Is the Executive Lead sighted on the development/review of the policy? | Yes |
| 2. | Is the local Policy Champion member sighted on the development/review of the policy? | Yes |
| | **Development and Consultation** | |
| 3. | If the policy is a new policy, has the development of the policy been approved through the Case for Need approval process? | N/A |
| 4. | Is there evidence of consultation with all relevant services, partners, and other relevant bodies? | Yes |
| 5. | Has the policy been discussed and agreed by the local governance groups? | Yes |
| 6. | Have any relevant recommendations from Internal Audit or other relevant bodies been considered in preparing the policy? | Yes |
| | **Template Compliance** | |
| 7. | Has the version control/storage section been updated? | Yes |
| 8. | Is the policy title clear and unambiguous? | Yes |
| 9. | Is the policy in Arial font 12? | Yes |
| 10. | Have page numbers been inserted? | Yes |
| 11. | Has the policy been quality checked for spelling errors, links, accuracy? | Yes |
| | **Policy Content** | |
| 12. | Is the purpose of the policy clear? | Yes |

| | | |
|---|---|---|
| 13. | Does the policy comply with requirements of the CQC or other relevant bodies? (where appropriate) | Yes |
| 14. | Does the policy reflect changes as a result of lessons identified from incidents, complaints, near misses, etc.? | Yes |
| 15. | Where appropriate, does the policy contain a list of definitions of terms used? | Yes |
| 16. | Does the policy include any references to other associated policies and key documents? | Yes |
| 17. | Has the EIA Form been completed (Appendix 1)? | Yes |
| | **Dissemination, Implementation, Review and Audit Compliance** | |
| 18. | Does the dissemination plan identify how the policy will be implemented? | Yes |
| 19. | Does the dissemination plan include the necessary training/support to ensure compliance? | Yes |
| 20. | Is there a plan to<br>i. review<br>ii. audit compliance with the document? | Yes |
| 21. | Is the review date identified, and is it appropriate and justifiable? | Yes |