NHS GG&C Mental Health Service

Physical Healthcare Policy

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Physical Healthcare Policy

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date	Brief Summary of Changes	Author(s)
1.0	2014	Version 1	M Connolly
2.0	2017	Foreword • Foreword to policy mentions parity of esteem for mental health as described by Mental Health Foundation	Dr M Connolly Consultant Psychiatrist Stephen McGinness Professional Nurse Advisor
2.0	2017	Introduction • The introduction of the policy has been updated to include more recent Scottish and UK national policies. • Results of the Mental Health and Learning Disability In-Patient Bed Census (March 2016) are included.	Dr M Connolly Consultant Psychiatrist Stephen McGinness Professional Nurse Advisor
2.0	2017	Policy Statement & Scope of Policy • The policy statement and Scope of Policy now includes a reference to the Equality Act 2010.	Dr M Connolly Consultant Psychiatrist Stephen McGinness Professional Nurse Advisor
2.0	2017	Health Improvement • Previous reference to 'Health Promotion' has been removed and now referred to as 'Health Improvement.'	Dr M Connolly Consultant Psychiatrist Stephen McGinness Professional Nurse Advisor
2.0	2017	Standards of Physical Healthcare • Physical health screen now includes lifestyle and behaviours enquiry, nutritional screening assessment and chronic disease management.	Dr M Connolly Consultant Psychiatrist Stephen McGinness Professional Nurse Advisor
2.0	2017	Hospital In-patients in Mental Health Services • This now includes a table specifying the physical health assessments that are required on admission for all patients. • This includes a separate table of recommended blood tests for all patients admitted to hospital. • There is a new section 'Recognising the acutely deteriorating patient.' • Revisions include latest medicine related guidance.	Dr M Connolly Consultant Psychiatrist Stephen McGinness Professional Nurse Advisor

2.0	2017	'Working with Particular Clinical Groups' • This replaces the previous 'Special Clinical Groups' section • This includes the following new sections o Patients with Learning Disabilities o Patients with SMI or learning disabilities within the prison population	Dr M Connolly Consultant Psychiatrist Stephen McGinness Professional Nurse Advisor
2.0	2017	Special Treatments • The special treatments section has been revised and now appears in tabular form. • Tables 3; 4; 5; 6; and 7 reference specific medications used in mental health practice and include the appropriate parameters, frequencies and actions to be taken if outside the reference range for these medications.	Dr M Connolly Consultant Psychiatrist Stephen McGinness Professional Nurse Advisor
2.0	2017	Appendix B. Physical Health Form • This has been updated to reflect guidelines including on alcohol, physical activity , diet and smoking Screening Programmes information has been updated including the addition of Abdominal Aortic Aneurysm Screening and Diabetic Retinopathy Screening (DRS)	Dr M Connolly Consultant Psychiatrist Stephen McGinness Professional Nurse Advisor
2.0	2017	Appendix C Physical Health Examination Guide on Admission to Hospital • Revised	Dr M Connolly Consultant Psychiatrist Stephen McGinness Professional Nurse Advisor
2.0	2017	Appendix E. Evidence, Sources and Supporting Materials • This has been updated July 2017 to reflect all new guidelines, policies, standards and research publications since the last policy was published in March 2014.	Dr M Connolly Consultant Psychiatrist Stephen McGinness Professional Nurse Advisor
2.1	Oct 2018	**Section 5.1** Inclusion of consent issues Re Montgomery rules **Section 6.4** Inclusion of checking date of last menstrual period at admission **Section 7.1** Inclusion of child & adolescent patients **Section 7.9** All staff must attend NHS GGC mandatory BLS & Anaphylaxis training **Section 8.11** National Children's Inpatient unit is now on Ward 4, Royal Hospital for Children **Section 8.16** Involvement of agencies to support the patient's access to appropriate healthcare e.g. Acute & Community Paediatrics, Education & Social Work post-discharge **Section 8.30** Protocols involving particular drugs e.g Sodium Valproate should be followed	Dr A Addo Consultant Psychiatrist Stephen McGinness Professional Nurse Advisor

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Foreword

In recent years, there has been increasing focus on the notion of 'parity of esteem' for mental health, that emotional and mental healthcare should be deserving of equal status with physical healthcare, as highlighted in this description from the Mental Health Foundation;

A 'parity approach' enables NHS and local authority health and social care services to provide a holistic, 'whole-person' response to each individual in need of care and support, with their physical and mental health needs treated equally. The relationship between physical and mental health is such that poor mental health is linked with a higher risk of physical health problems, and poor physical health is linked with poor mental health.[1] *:*

The push for parity of esteem comes from the recognition that people with long-term mental health problems experience a major inequality in terms of life expectancy and have often failed to receive a truly joined up approach to care. But the need to remove silos and promote holistic service responses is a key part of the way ahead. As the 2016 Kings Fund report "Bringing Together Physical and Mental Health" demonstrated, the cost to the NHS from not creating integration between physical and mental health is staggering. They highlighted a range of recommendations that could drive real improvements in the health prospects for people with mental health problems and other long-term conditions. The sub-title of this report: "A New Frontier for Integrated Care" also resonates with the advent of Health and Social Care Partnerships and further opportunities to create fully integrated approaches to health and social care.[2]

Within Greater Glasgow and Clyde, we have been embarked for some time on a policy-led improvement approach to physical healthcare for people with mental health problems. In simple terms, this policy aims to support best practice in securing better health outcomes for our patients and enabling them to live longer and healthier lives.

There is increasing interest from our patients in having their physical health assessed as part of a holistic approach to their care. We hear this from focus groups and from patients' representatives who have worked with us on developing this policy.

For clinicians, it is as important to know where clinical responsibility lies as it is to know what should be done. At times, misunderstanding about "whose responsibility" it is to test, refer or initiate treatment can and does arise. In producing this policy, we have attempted to be clear on the issue of clinical responsibility where possible, but have had to concede that, at times, some degree of ambiguity remains. Healthcare professionals all share a duty of care towards improving the physical health of people with mental illness.

Just as the number of external drivers to improve physical healthcare for people with mental illness increases so too does our knowledge on how well we are doing in response to these drivers. We have our academic and research colleagues to thank for that, as well as those responsible for creating and maintaining our health informatics systems which help to drive up the standard of care we deliver.

Dr Moira Connolly, Dr Kerri Neylon, Dr Trevor Lakey, Mr. Colin McCormack

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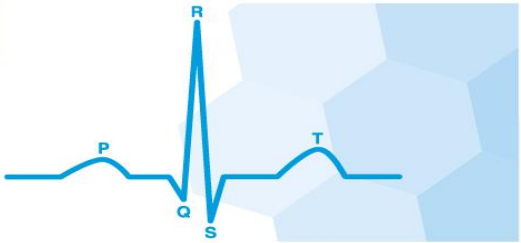
[1] Mental Health Foundation. Parity of Esteem. [Last accessed 05.07.17]

[2] The King's Fund. Bringing together physical and mental health: a new frontier for integrated care. (2016) [Last accessed 05.07.17]

Executive Summary

PHYSICAL HEALTH IN MENTAL HEALTH SERVICES



NHS Greater Glasgow and Clyde Mental Health Services

Physical health using ***Q***uality improvement, ***R***eliably and ***S***ystematically every ***T***ime

- Evidence clearly indicates that the physical health care needs of people with a Serious Mental Illness (SMI) are as important as the individual's mental health care needs. Both must be considered **and** addressed as part of a person-centered package of care to reduce health inequality and premature mortality in this patient group.

- This policy is intended to assist mental health care practitioners to assess physical health care needs of patients in our care, particularly those illnesses most likely to affect their general wellbeing and quality of life.

- Physical health checks should pay particular attention to endocrine disorders, such as diabetes and hyperprolactinaemia, cardiovascular risk factors such as blood pressure and lipids, metabolic syndrome, side effects of medication and lifestyle factors such as smoking, alcohol, illicit substance use, physical inactivity and diet.

- Once identified, physical health care needs must be included within the individual's care plan and other health care records. Any action taken must also be recorded within the care plan and included in discharge or care transfer documentation.

- The Mental Health Service must work closely with patients, community based and acute care services to ensure that people with a SMI have their physical health monitored and managed effectively with no barriers to healthcare access.

- The Mental Health Service is committed to a programme of training and development for its staff to ensure that the delivery of physical healthcare meets current standards

1. Introduction

1.1 This policy sets the context and establishes minimum standards for the physical healthcare of service users across NHS Greater Glasgow & Clyde (NHS GG&C) Mental Health Service.

1.2 Mental health service users have a right to expect the same quality physical health care as the general population. The requirement to improve standards of physical health care for those with mental illness is supported by a number of Scottish and UK national policies: -

- Realising Potential – An Action Plan for Allied Health Professionals (Scottish Government 2010),
- No Health Without Mental Health Implementation Framework (Centre for mental health 2012)
- Five year forward view for Mental Health (Mental Health Task Force 2016)
- Bringing Together Physical and Mental Health: A New Frontier for Integrated Care (King's Fund 2016)
- Improving the Physical health of People with Mental Conditions: Action for Mental Health Nurses (Nursing, Midwifery and Allied Health Professions Policy Unit, 2016)
- Improving the Physical Health of Adults with Severe Mental Illness: Essential Actions (Academy of Medical Royal Colleges 2016)
- The Mental Health Strategy for Scotland 2017-2027

1.3 People with mental health problems have high levels of physical ill health. It is now well recognised that individuals with severe mental illness (SMI) have high levels of physical health problems and substantial premature mortality, dying around 15-20 years earlier than the general population.

1.4 The March 2017 Mental Health & Learning Disability Inpatient Bed Census reported that 58% of all inpatients in mental health services in Scotland had at least one physical health co-morbidity. In 2016 31% of NHS GG&C inpatients had two or more physical health problems.

1.5 Multimorbidity is common. They are more likely to have had Adverse Childhood Experiences. They tend to develop heart disease, diabetes and cancer at a younger age than the general population. In general, they are more likely to live in socially deprived areas, eat a less nutritionally rich diet, and lead more sedentary lifestyles. They are more likely to have difficulties with tobacco, alcohol and drug dependence. These issues are compounded by the side-effects of some prescribed medications, which can increase the risk of obesity, cardiovascular disease and diabetes.

1.6 Non-modifiable risk factors include ethnicity and family history of physical health problems such as heart disease and diabetes. Of particular note in this regard is the substantially increased risk of Type II Diabetes in individuals of South Asian background.

1.7 People with SMI experience a range of health inequalities, including poorer access to physical health screening, fewer preventative interventions and lower engagement with specialist and primary medical care.

1.8 In keeping with the 'Rights for Life' agenda, people with mental health problems should have "the right to the highest attainable standard of physical and mental health, (including) timely access to a range of quality care and treatment, without discrimination."[3]

1.9 Systematic assessment of mental and physical health and the health improvement needs of patients must be embedded in the provision of inpatient and community mental health services and address issues appropriate to the individual's quality of life and well being.

1.10 Women with SMI are more likely to have pregnancies that are unplanned or unwanted, and pregnancy outcomes may be less favourable for both mother and infant. They are less likely to be offered appropriate contraceptive and pregnancy planning advice.

2. Policy Statement & Scope of Policy

General

2.1 NHSGG&C Mental Health Service include a group of services which provide physical and mental health care across a diverse range of settings including inpatient and community settings. This policy establishes standards to ensure the appropriate and equitable delivery of physical health care across those settings.

2.2 These standards will apply to all inpatient services and community and forensic mental health services for children, young people, adults of working age, individuals with substance misuse problems, older people and people with learning disabilities. The use of the term "patient" throughout this policy refers to patient, client, resident or service user.

2.3 All patients will be given the opportunity to have a physical assessment and receive physical healthcare provision in line with the requirements of this policy. Stage of illness, complexity of comorbidity, place of treatment and patient choice must be considered when making such arrangements.

2.4 Approaches to physical health and wellbeing must comply with the Equality Act 2010 with regard to all protected characteristics and should pay particular attention to socially excluded groups.

3. Patients at the Interface of Mental Health and Primary Care

3.1 All individuals are entitled to receive primary health care from their registered GP surgery whether they have a mental health problem, a physical illness or are generally in good health. This policy is not intended to replace such care.

[3] Rights for Life [Last accessed 05.07.17]

3.2 Mental health services will work collaboratively with other local providers to ensure people with mental health needs access general medical services, health promotion advice and health screening appropriate to need, age and gender. If necessary, their attendance could be facilitated by Community Adult/Older People's Mental Health Team (CMHT) members or social care support workers. Where people opt not to participate this should be clearly documented.

3.3 Under the extant General Medical Services Contract most GP practices in NHS GG&C offered annual health screens for patients on their practice based severe mental illness registers. With the new contract, from 2017/18 GPs will work to locally agreed priorities aligning with agreed Quality Standards and are likely to include a focus on;

- people whose health status is characterized by co-morbidity and often polypharmacy
- people who experience both health and general deprivation
- people who could benefit from anticipatory care planning
- or who might otherwise be considered 'hard to reach'.
- The onus to work in collaboration with Primary Care is therefore greater than ever.

3.4 Several guidelines emphasise the importance of information sharing between Mental Health services and Primary Care[4]. Significant findings from GP annual health screens should be communicated to all interests to ensure appropriate follow up. The outcome of annual reviews may be requested from GPs by Mental Health services, and the sharing of relevant clinical information with Primary Care including care plans is encouraged.

3.5 There will be evidence in Mental Health service patient records of an annual physical health assessment for patients with severe mental illness or confirmation that a review in Primary Care is appropriate for individual needs and that this has been organised and followed up.

4. Health Improvement

(refer also to NHS GG&C Health Improvement Service Directory)

4.1 Many of the risks associated with physical morbidity and premature mortality are modifiable. Such risks include behavioural factors (e.g. diet, physical inactivity, tobacco use, alcohol consumption); biological factors (e.g. dyslipidemia, hypertension, overweight, hyperinsulinaemia); and finally, societal factors, which include a complex mixture of interacting socioeconomic, cultural and other environmental parameters.

4.2 This policy supports the Health Promoting Health Service (HPHS) vision that every contact is a health improvement opportunity by including the promotion of healthier behaviours and discouraging detrimental ones.

[4] Integrated Physical Health Pathway (2014) [Last accessed 05.07.17]

4.3 Where possible a brief intervention approach should be used to identify any behaviour requiring to be addressed;

- Work through lifestyle questions on the physical health screen to determine whether or not a patient is meeting the recommended guidelines for each topic
- Find common ground on what you consider to be a priority for the patient and what the patient wishes to discuss. It is important to limit the number of topics for discussion to 1 or 2 in one contact.
- Signpost/refer to appropriate service for support

5. Standards of Physical Health Care

Consent

5.1 Health professionals must ensure that before they commence any treatment or intervention that they discuss:

- The prognosis.
- The various treatment options and their benefits (including the option of not to treat).
- The individual circumstances and preferences of the patient (Montgomery).
- The risks associated with the intervention (consider significant risks, risks which are less severe, but which occur frequently and risks which this patient may attach significance to (Montgomery).
- The alternatives available.
- Additional procedures, including those which may become evident at a later stage.

Environment

5.2 Community mental health teams and in-patient units must identify accessible areas within which physical examinations and investigations can be carried out while maintaining the patient's dignity and privacy with the offer of a chaperone as appropriate.

Equipment

5.3 Appendix A lists equipment, laboratory and referral forms to meet recommended standards for physical healthcare in mental health services.

Physical Health Screen

5.4 A core health screen should include attention to the following, repeated at appropriate intervals e.g annually;

- A medical history including record of all medication, including regular Over the Counter medications and supplements
- Family History
- Physical systems enquiry
- Lifestyle and behaviours enquiry – smoking, alcohol, drugs, physical activity

- Sexual health enquiry, including, for all women, menstrual cycle, pregnancy and contraception status.
- Usual population screening of relevance to age and sex
- Nutritional Screening Assessment guided by HIS (2014) Food, Fluid and Nutritional Care Standards
- Brief physical findings (psychiatric outpatients or immediate on admission)
- Extended physical check (within 24 hours of admission or where clinical concerns arise – see Section 6)
- Medication side effects (e.g. using Glasgow antipsychotic side effect scale – GASS)
- Relevant investigations (See table 2)
- Chronic disease management where significant comorbidity exists (e.g. diabetes)

5.5 The NHS GG&C Mental Health Services Physical Health and Wellbeing group have developed **The Physical Health Form (**Appendix B). This tool supports mental health practitioners in meeting standards of physical healthcare and will be incorporated into EMIS web.

6. Hospital In-Patients in Mental Health Services

6.1 Primary medical responsibility for hospital inpatients lies with the patient's treating consultant. All patients must have a full physical health examination within 24 hours of admission to hospital. Exclusions must be documented while continued attempts are made to complete the examination.

6.2 In keeping with the Health Promoting Health Service (HPHS) CMO letter 2015 the admission of a psychiatric patient must always be accompanied by a detailed physical assessment and follow-up using the locally agreed examination template. (See table 1 and Appendix C)

Table 1: Physical health of acute inpatients: assessments required on admission

ADMISSION[5]		
What needs to be completed?	**Who is responsible?**	**Time Scale[6]**
Physical Examination	Admitting Doctor	Within 24 hours
Routine bloods	Admitting Doctor	Within 24 hours
ECG	Admitting Doctor	Within 24 hours
Dipstick Urinalysis	Nursing Staff	Within 24 hours
Urine Drug Screen/Alcometer	Nursing Staff	If Indicated
Assessment of readiness for programmed physical activity	Physiotherapy Team or Junior Doctor	Within 72 hours

[5] Any exceptions due to mental state must be documented and followed up

[6] Timescale for review to be indicated in care plan

ADMISSION[5]		
Physical Health Careplan	Nursing Staff	Within 24 hours
GGC local physical healthcare Measure or Lester screen]	Named Nurse/Team Doctor	If indicated via Care Plan
MUST – record height, weight and MUST score	Nursing Staff	Within 24 hours
VTE* assessment	Admitting Doctor	Within 24 hours
Falls Assessment	Started by Nursing Team, in liaison with Physiotherapy Team	Within 24 hours

*Venous thromboembolism

6.3 All patients will have their blood pressure, pulse, temperature, respiratory rate, oxygen saturation and ward urinalysis recorded on admission. An ongoing monitoring plan and actions taken for any abnormal findings should form part of the care plan.

6.4 Investigations carried out on admission must include metabolic parameters and any blood tests for medication monitoring as a patient safety requirement. Pregnancy, last menstrual period or suspicion of pregnancy must be noted. (See table 2)

Table 2 Blood tests recommended on admission to hospital

Blood Test	Suggested for
U&E, LFT, Bone Profile, TFT, CRP, glucose, lipid profile, FBC	All inpatients
Lithium Levels	For all patients on lithium
Prolactin	• At baseline for patients who are starting antipsychotic medication and thereafter for patients who are prescribed medicines known to increase prolactin, and where clinically indicated
B12 & Folate	• In patient groups which have increased prevalence of deficiency, for example, in older adults, poor diet, malabsorption, alcohol excess • In acute psychosis patients • If otherwise indicated (including but not exclusively, blood markers that may indicate deficiency, neurological symptoms/ signs)
Vitamin D[7][8]	• Only for patients with low adjusted serum calcium (< 2.1 mmol/L) and / or where other blood results suggest possible osteomalacia • Patients with malabsorption syndromes • As per GGC guidelines: See link below

[7] NHSGGC. Vitamin D: Prevention & Treatment of Deficiency in Adults (2016) [Last accessed 05.07.17]
[8] Scottish Government. Vitamin D. [Last accessed 05.07.17]

6.5 All patients should have an ECG carried out within 24 hours of admission. This should be done at ward level by suitably trained staff with access to a regularly maintained ECG machine.

6.6 Annual reviews for patients, whose admission has exceeded 12 months, should include an update of the admission physical examination, additional monitoring and access to national health screening programmes as required. Importantly, patients must continue to be offered health improvement advice in keeping with HPHS recommendations.

6.7 Discharge letters to GPs should include a section on physical health noting clinical findings, results of investigations, ongoing needs, referrals made and any follow-up plans or requirements. These should be copied to Acute Care services as appropriate.

Recognising the acutely deteriorating patient

6.8 Efforts should be made to screen for risk factors for delirium, intervene early to prevent delirium and manage conditions that may be contributing to delirium.

6.9 Systematic application of tools such as the NEWS (used in acute services and implemented in Older Peoples MH wards) can assist in the recognition of the acutely deteriorating patient. Where no such tool is in use, the care plan must be clear about when to escalate the care of a patient and who to involve in intervening.

Inpatients Requiring Acute Specialties Input or Advice

6.10 When advice is needed from Acute Care Specialists for an acutely deteriorating patient, contact must be made by either the Charge nurse (for specialist nursing advice) or the ward doctor. The consultant psychiatrist should be included in decisions about continuing to treat within MH services or transferring for other specialist care.

6.11 In an emergency, ward staff will arrange for the immediate transfer of acutely ill patients for specialist care. Ward and duty medical staff must ensure that a copy of the careplan outlining how to contact the named nurse, referring doctor or consultant and full details of treatments underway are sent with or as soon as possible after the patient.

6.12 An acutely sick patient who is too psychiatrically unwell for immediate transfer to an acute specialties service must have their care reviewed by an appropriate specialist within the time-frame requested by their nominated consultant psychiatrist and agreed with an acute care specialist. A consultant to consultant discussion is required.

6.13 Before receiving patients back from acute care services, MH medical and nursing staff must ensure that full details of treatment needs are communicated to them and details recorded of who to contact within acute services for any ongoing treatment queries. The local careplan must be updated to reflect and meet these needs.

7. Medical Emergency & Resuscitation

7.1 Patients in mental health, addictions, psychiatry of old age, child & adolescent and learning disability inpatient settings are at risk of rapid physical deterioration and cardiac or respiratory arrest due to coexisting physical illness, the effects of medications, self-harm or disturbed behaviour. Patients are also vulnerable to choking, due to physical illness or harmful behaviours.

7.2 NICE Guideline 25 requires that any setting where physical intervention may be used have staff who are trained to immediate life support (ILS) standards level and have appropriate equipment for ILS provision including an automated external defibrillator (AED).

7.3 The Medical Emergency Training (MET) programme emphasises the need to be alert to deteriorating physical status and avert a catastrophic event by getting help early while continuously assessing patients using the Systematic Approach to acute physical illness (ABCDE).

7.4 The response ward model delivers additional skills and resuscitation equipment to the scene of an emergency, triggered by a 2222 call. A paramedical response is also provided, with time from call to arrival being no longer than 8 minutes.

7.5 Cardiopulmonary resuscitation is always carried out unless a 'Do Not Attempt CPR (DNA CPR)' decision has been made and clearly documented.

Resuscitation Equipment

7.6 Resuscitation equipment across inpatient settings is standardised and a list of all equipment is kept on the response wards.

7.7 Resuscitation equipment for community mental health settings is of a basic level (Appendix D) with a focus on a Basic Life Support approach.

7.8 Nursing staff have the responsibility to ensure that all medical equipment held at ward or community level:

- is available and accessible
- is demonstrated to all new clinical staff, orientating to the equipment, its purpose and use for that area.
- is regularly maintained and checked to be in functioning order.
- and that drugs and sterile equipment on the resuscitation trolley are in date.

7.9 All new clinical staff, should be introduced to the Medical Emergency Response Procedure, response ward model and equipment available as part of their mandatory induction. All staff must be familiar with the location, content and uses of emergency resuscitation equipment and undertake MET training within agreed frequency intervals. All staff must attend NHS GGC mandatory BLS & Anaphylaxis training.

8. Working with Particular Clinical Groups

People experiencing a first episode of psychosis (Refer also to the 'Esteem' Physical Health and Lifestyle Assessment Booklet' available on request from 'Esteem early intervention in psychosis service')

8.1 Within NHS GG&C, most patients in the age range 16 - 35 years presenting with a first episode of psychosis are under the care of the ESTEEM early intervention team. The ESTEEM Service co-ordinates an initial core health screen in collaboration with primary care as part of the Integrated Care Pathway (ICP), for those patients not admitted to hospital.

8.2 In keeping with the internationally agreed 'Health Active Lives' (HeAL) standards[9], patients with first episode psychosis or first treatment with antipsychotics must be made aware of the potential for metabolic side effects and the importance of avoiding weight gain, maintaining exercise and reducing smoking right from the outset of their illness and its treatment.

People with long term conditions

8.3 The presence of depression in individuals who have diabetes or cardiovascular disease can worsen outcome. Chronic disease management processes in Greater Glasgow & Clyde increasingly take account of this however, severe depressive illness is recognised as an independent risk factor for significant physical illness. This and the likelihood of co-morbid physical illness need to be considered when treating individuals with severe depression.

8.4 Where a patient is known to have a long-term condition such as diabetes or cardiovascular disease, staff should ensure that they are facilitated in their efforts to manage their physical health and that there are no barriers to access to appropriate healthcare. Mental health services are included in the Diabetes 'Think Check Act' initiative.

People Over 65

8.5 The management of physical health care of older patients differs to that of a younger population for the following reasons;

- Bioavailability of medication
- An increase in the sensitivity to medication effects
- Increased frailty and multi-morbidity.

The older adult patient should receive the same standard of physical health care as that of the younger adult, paying attention to these special features.

[9] International Physical Health in Youth (iphYs) working group. Healthy Active Lives (HeAL) consensus statement (2013) [Last accessed 05.07.17]

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People with Eating Disorders
(refer also to MHS 02 - Adult Eating Disorder Service Operational Policy)

8.6 The Adult Eating Disorder Service (AEDS) operates as a tertiary service supporting adult CMHTs in the management of people with moderate to severe eating disorders. The service has access to 4 specialist beds, in Armadale Ward, Stobhill Hospital however, patients may also be admitted to locality psychiatric wards and acute medical wards across NHS GG&C.

8.7 Patients with eating disorders may require physical health monitoring, including physical observations, blood investigations and ECGs. AEDS provide medical monitoring for patients under their care, however, due to limited resources are unable to meet all demands for this. AEDS will liaise with the patient's GP and CMHT to discuss who will medically monitor the patient. This decision will be made on an individual basis and take into account factors including the patient's engagement with services, their illness severity and level of medical risk, and proximity to AEDS. AEDS will provide guidance around physical risk assessment and management for patients under their care.

8.8 Patients admitted with eating disorders often present a significant risk of both physical complications as a result of their eating disorder and refeeding risk. Patients require a dietetically prescribed menu plan to reduce the risk of refeeding problems and an individualised care plan, taking account of the nature and severity of their eating disorder and the degree of risk (physical complications, refeeding risk, self harm/ suicide). Armadale ward staff and AEDS can provide guidance on care and treatment plans for patients with moderate to severe eating disorders admitted to both psychiatric and acute medical wards. Detailed guidance can be found in the RCPsych 'MARSIPAN' document.[10]

Children and Adolescents in mental health services

8.9 The day-to-day healthcare of children and adolescents is the responsibility of the GP. Where Child and Adolescent Mental Health service (CAMHS) Teams initiate drug treatments, they must take a full developmental and medical history and liaise with the GP and where appropriate, Children's Services or Adult Medical Services should this be required. Where specialist monitoring is indicated for the safe initiation of treatment, this should be organised by the Child and Adolescent Mental Health Team.

8.10 Some treatments require specific types of monitoring and national guidelines on the management of ADHD, Eating Disorders and the Maudsley Guidelines chapter on child and adolescent prescribing may be a useful reference. Lines of clinical responsibility must be clearly documented.

[10] Royal College of Psychiatrists. MARSIPAN: Management of really sick patients with Anorexia Nervosa (2014) [Last accessed 05.07.17]

8.11 Children admitted to Ward 4, The Royal Hospital for Children and adolescents admitted to Skye House, Stobhill Hospital or other mental health services inpatient site should have a full physical assessment on the day of admission including full history, physical examination and investigations as indicated including liaison with paediatric or adult health services as appropriate.

8.12 Prescribing for children and adolescents is very specialised and proper physical assessment including investigations relevant to the drugs prescribed should be completed on every patient prior to prescribing any psychotropic medication. Reasons for any exclusions should be documented. Side effects monitoring is essential and regular review of all medications should be undertaken (weekly if an inpatient).

8.13 Where patients are aggressive or violent, developmentally appropriate child and adolescent protocols should be used and medication should only be prescribed under the guidance of a doctor who has experience of working with children and adolescents. Very careful monitoring needs to take place. Children and adolescents are still growing and restraint may cause damage to their epiphyses.

8.14 Patients presenting with psychosis should have a full and thorough investigation for organic psychoses according to the adolescent service protocols.

8.15 Inpatients with Anorexia should be managed according to the Child and Adolescent Re-feeding Policy (available from Skye House inpatient unit).

8.16 All discharge summaries of inpatients in child and adolescent psychiatry should include a summary of the patient's medical wellbeing and be sent to the community psychiatry team as well as the General Practitioner. This may also include alerting other agencies to support the patient's access to appropriate healthcare e.g Acute & Community Paediatrics, Education & Social Work.

Patients with Learning disabilities

8.17 People with learning disabilities experience high rates of physical and mental ill health, are more likely to die prematurely and are less likely to receive effective treatment for medical problems. Gastroesophageal reflux disorder, epilepsy, constipation, sensory impairments, osteoporosis, dental disease, accidents and nutritional problems are all thought to be much more commonly experienced in adults with learning disabilities with a high rate of multi-morbidity and polypharmacy.

8.18 People with learning disabilities often experience diagnostic overshadowing, where behavioural change is attributed to the person's learning disability rather than to physical health (such as pain or constipation) or poor mental health. If patients with learning disabilities are admitted under non-specialist services, all clinicians should be aware of the risk of diagnostic overshadowing and the high prevalence of physical morbidity. They should link with specialist services for support as soon as possible.

8.19 Due to the differing pattern of multi-morbidity in adults with learning disabilities, all patients admitted to the Specialist Learning Disability Assessment & Treatment Units should have a C21st Health Check (a comprehensive learning disability specific health check that includes review of primary care notes) in addition to the admission physical health assessment as described in section 6, and annually thereafter for those whose admission exceeds 12 months.
(http://www.staffnet.ggc.scot.nhs.uk/Partnerships/Learning%20Disability/Nursing/Pages/Nursing.aspx)

8.20 As recommended by NICE (NG54, Sept 2016)[11], annual physical health checks for all people with learning disabilities should be undertaken within primary care with support from the Community Learning Disability Teams where needed. There is a learning disability specific annual health check template available to GP's/Practice Nurses for this. Appropriate alternatives would be the NHS GGC Learning Disabilities Nursing Assessment, the NHS GCC Mental Health Service Physical Health Measure or, for those with the most complex health needs, the C21st Health Check.

8.21 There is no current evidence to suggest that adults with learning disabilities and serious mental illness have higher physical health needs than adults with learning disabilities who do not have serious mental illness and thus all adults with learning disabilities should receive the same standard of physical health care.

Patients with SMI or Learning Disabilities within the prison population

8.22 Prisoners, including those with SMI or Learning difficulties are at increased risk of long-term conditions and co-morbid addictions problems, and have higher rates of blood borne viruses. They warrant the same core screening as community-based patients with SMI (see sections 5.3 and Appendix B).

8.23 It is acknowledged that loss of continuity of care and the loss of autonomy which comes with being imprisoned can make it difficult for services to deliver healthcare and health improvement opportunities appropriate to the needs of prisoners. Therefore, to ensure that the specific health needs of prisoners with SMI or Learning disabilities are met, clarity of roles and collaboration must be established within prison-based healthcare teams.

Women who are of childbearing potential, pregnant or postpartum

8.24 The management of pregnant and postnatal women with mental ill health is usually carried out by the Perinatal Mental Health Service (PMHS), although care may be jointly managed with the local, or other specialty, team based on clinical need.

[11] NICE Guideline. Mental health problems in people with learning disabilities: prevention, assessment and management (2016) [Last accessed 06.07.17]

8.25 The service can admit mothers and babies to the 6-bed Mother and Baby Unit at Leverndale Hospital. The physical healthcare of babies on the MBU is the responsibility of a contracted GP practice.

8.26 Women of childbearing potential may be taking psychotropic medications that are teratogenic. They should have the expectation that they will receive appropriate information to help them make informed choices about medication in relation to childbearing *in advance* of a pregnancy. This information should be provided at the time of prescribing.

8.27 Discussion of pregnancy plans and contraceptive choice should be part of the routine assessment for all women of childbearing potential.

8.28 Women with SMI are more likely to have pregnancies which are unplanned and unwanted, are less likely to engage in routine ante/postnatal care and are more likely to have adverse outcomes of pregnancy.

8.29 Late pregnancy and the early postpartum period is a time of increased risk of physical disorder, including hypertension, pre-eclampsia, sepsis, DVT and pulmonary embolism. A guide to symptom presentations and appropriate investigation can be found in Oates et al (2011)[12].

8.30 Protocols involving particular drugs e.g Sodium Valproate should be followed.

9. Special Treatments

ECT (Refer also to NHS GG&C ECT Staffnet site)

9.1 Electroconvulsive therapy (ECT) is delivered at 3 sites in GG&C; Leverndale Hospital, Stobhill Hospital and Inverclyde Royal Hospital. Each ECT suite follows the guidance of the Scottish ECT Accreditation Network (SEAN). This treatment is most often offered for severe depression and is performed under a general anaesthetic.

9.2 Prior to treatment, screening for physical health problems must be completed by the referring team in discussion with an anaesthetist. Information is available on Staffnet where a referral form and physical investigation sheet can be found which cover the necessary pretreatment screening and ongoing assessment.

Medications specific to mental health – antipsychotics (Tables 3-4)

9.3 All prescribers have responsibility for physical health monitoring in long term therapy. Prescribers must actively monitor patients for physical side effects of medicines in the short and long term.

[12] Back to Basics *in* Centre for Maternal and Child Enquiries (CMACE). Saving Mothers' Lives: reviewing maternal deaths to make motherhood safer: 2006–08. The Eighth Report on Confidential Enquiries into Maternal Deaths in the United Kingdom. BJOG 2011; 118 (Suppl. 1): 16-21. (http://onlinelibrary.wiley.com/doi/10.1111/j.1471-0528.2010.02847.x/epdf)

9.4 Psychiatrists in NHSGG&C Mental Health Service should take a personal and family history of cardiovascular problems and diabetes and define ethnicity prior to recommending any antipsychotics for any treatment indication.

9.5 The prescriber should ensure that physical screening has taken place. GPs should be asked to ensure the patient is on their mental health register and care plans should include details of how monitoring for any emergent metabolic side effects will take place in keeping with relevant guidelines and accepted arrangements within GG&C.

9.6 It is especially important that psychiatrists follow up and inform patients about the results of investigations ordered in secondary care. Where results indicate abnormalities which are ordinarily managed within primary care it is the psychiatrist's responsibility to draw this to the attention of the patient's general practitioner. This is a professional responsibility, and an important patient safety issue.

9.7 The preferred community-based pathway for ECGs is by referral to local open-access ECG department. Abnormal ECG results or medication-related concerns must be discussed with Pharmacy, Cardiology or the GP as appropriate.

9.8 Enquiry as to medication-related sexual dysfunction is desirable, and Prolactin levels checked where raised Prolactin is suspected. Abnormal levels should prompt a medication review. Standard rating scales like GASS may help identify sexual related side-effects.

9.9 In the main, arrangements for high dose antipsychotic monitoring sit with secondary care. Outcomes should be discussed with Primary Care on an individual patient basis.

9.10 Clozapine prescribing is almost exclusively carried out in secondary care and is accompanied by mandatory Full Blood Count (FBC) checks in view of the small but serious risk of fatal blood dyscrasias.

9.11 The measurement of Troponin and CRP at initiation is aimed at reducing the risk of Clozapine induced myocarditis and associated cardiotoxicity in line with national standards.

9.12 Clozapine induced constipation is a potentially fatal complication of treatment. The risk should be clearly identified in the care plan and patients assessed for constipation frequently during the initial titration and stabilisation phase and at every visit for their FBC using a tool such as the Bristol Stool Chart.

Table 3: Antipsychotics - Clozapine

Parameter/test	Frequency	Action if outside reference range
Full Blood Count	Follow manufacturer's mandatory protocol	
BMI	Baseline, 1 month then 3 monthly up to 1 year, then annually.	Offer lifestyle advice.
HbA1c/Glucose	Baseline, 1 month then 3 monthly up to 1 year, then 6 monthly.	Offer lifestyle advice. Consult with GP and/or specialist as appropriate.
Blood lipids	Baseline, 1, month then 3 monthly for 1 year, and then 6 monthly.	Offer lifestyle advice and consult with GP and/or specialist for consideration of treatment e.g. statin therapy as appropriate.
Blood pressure	Baseline, as per initiation protocol, 3 monthly for 1 year, then annually. Also following dose changes.	If hypotensive: Consider slower titration or dose reduction. If hypertensive: Offer lifestyle advice and consult with GP and/or specialist for consideration of treatment.
Pulse	Baseline and as per initiation protocol, at 3 months, then annually	Consider slower titration or dose reduction. If tachycardia persistent, observe for other indicators of myocarditis or cardiomyopathy.
ECG	Baseline, 3 weeks, at 3 months and then annually. Additional ECGs should be performed as clinically indicated (see actions)	Act on abnormality according to significance, clinical indication. Refer to Cardiology if in doubt. Continue Clozapine with daily CRP and troponin monitoring and request echocardiography if: • Signs or symptoms of unidentified illness OR • HR ≥ 120bpm or increased by >30bpm over 24 hours OR • CRP 50 – 100 mg/l OR • Mild elevation of troponin I ≤ 2 x Upper limit of normal <u>Stop Clozapine</u>, consult a cardiologist and request echocardiogram if: • Troponin > 2 x upper limit of normal OR • CRP >100mg/l
Troponin I	Baseline, day 7, 14, 21 & 28	
CRP	Baseline, day 7, 14, 21 & 28	
Urea & electrolytes	Baseline then as clinically indicated.	Investigate as clinically appropriate.

Parameter/test	Frequency	Action if outside reference range
Liver function tests	Baseline, 6 months then annually or more frequently if clinically indicated.	Investigate as clinically appropriate.
Side-effects	"GASS for Clozapine" or other recognised side-effect questionnaire for antipsychotic medication during initiation and regularly thereafter, with general side-effect enquiry at least at any point of blood sampling.	As clinically appropriate.
Constipation	Assess bowel habits at baseline, any point of blood sampling and ideally at every point of contact. Ensure patients and carers are aware of the risks associated with Clozapine induced constipation.	Treat symptomatically and seek help from physicians if complete obstruction or poor response to conservative laxative treatment.
Smoking status	On initiation and at regular intervals thereafter, at least annually. Warn patient regarding effect of changes in smoking status on Clozapine levels and side-effects	Check Clozapine level and GASS for Clozapine if change of status.
Women of reproductive age	Pregnancy/contraceptive status on initiation and at regular intervals thereafter, at least annually	In all cases: Pre-pregnancy discussion of pregnancy intentions. Offer advice/signposting on contraception. Early discussion of options if unplanned pregnancy.

Table 4: Antipsychotics - General

(see also above advice regarding clozapine)

Parameter/test	Frequency	Action if outside reference range
Side-effects	GASS or other recognised side effect questionnaire for antipsychotic medication during initiation and regularly thereafter	As clinically appropriate
Weight, BMI, waist circumference	Weight • Baseline • Weekly for first 6 weeks • At 12 weeks • Annually (Refer to Lester Tool)[13] Waist Circumference • Baseline • Annually	Review including modifiable risk factors
Full blood count	Baseline, then annually or as clinically indicated	Investigate as clinically appropriate.
HbA1c/Glucose	Baseline, then 4-6 monthly	Offer lifestyle advice. Consult with GP and/or specialist as appropriate.
Blood lipids	Baseline, every 3 months for 1 year then annually	Offer lifestyle advice and consult with GP and/or specialist for consideration of treatment e.g. statin therapy as appropriate.
Urea & Electrolytes	Baseline, then annually or as clinically indicated	Investigate as clinically appropriate.
Liver function tests	Baseline, then annually or as clinically indicated	Investigate as clinically appropriate.
Prolactin	Baseline, at 6 months then annually or as clinically indicated.	Investigate as clinically appropriate. Consider switch if antipsychotic implicated in raised levels
ECG	Baseline and thereafter when clinically indicated.	Act on abnormality according to significance and clinical indication. Consult with cardiologist if in doubt.
Blood pressure	Baseline, during titration and general physical health monitoring	
Women of reproductive age	Pregnancy/contraceptive status on initiation and at regular intervals thereafter, at least annually	In all cases: Pre-pregnancy discussion of pregnancy intentions. Offer advice/signposting on contraception. Early discussion of options if unplanned pregnancy.

[13] http://www.rcpsych.ac.uk/quality/nationalclinicalaudits/schizophrenia/nationalschizophreniaaudit/nasresources.aspx

Medications specific to mental health – lithium and mood stabilisers (Tables 5-7)

9.13 Local arrangements should be explicitly agreed and maintained to determine who takes responsibility for checking the lithium level. Psychiatrists within CMHTs should ensure arrangements for lithium monitoring are explicitly agreed with primary care and with their patients.

9.14 Access to the results of lithium checks may be via the Clinical Portal, or by phone call to the local laboratory if needed urgently. Response to toxicity should be from the clinician ordering the blood levels who should take appropriate action and share this information across primary/secondary care.

9.15 Valproate *should not be prescribed for women of childbearing potential*. Where no effective alternative to valproate can be identified effective contraception, which in general means a form of long acting reversible contraception must be used. The risks of taking valproate during pregnancy should be explained. Specific written informed consent should be obtained using the MHRA valproate toolkit, and consent documented. The routine measurement of valproate levels is not recommended unless evidence of ineffectiveness, poor adherence or toxicity. MHRA Toolkit on the risks of valproate medicines in female patients https://www.gov.uk/government/publications/toolkit-on-the-risks-of-valproate-medicines-in-female-patients

9.16 Prescribers should be aware that carbamazepine has a greater potential for drug interactions than other drugs used to treat Bipolar Disorder. When offering carbamazepine to women taking oral contraceptives, it must be explained that the drug may decrease their effectiveness and alternative methods of contraception discussed.

9.17 The dose of lamotrigine should be titrated gradually to minimise the risk of skin rashes including Stevens-Johnson syndrome. Patients should be advised to seek medical attention urgently if a rash develops. Patients should have an annual health check but no special monitoring tests are needed.

Table 5: Mood Stabilisers - Lithium

Parameter/test	Frequency	Action if outside reference range
Urea & Electrolytes	Baseline (Include Creatinine & eGFR. Patients must have adequate renal function (eGFR>60ml/min) before commencing lithium. Note in some populations the eGFR may over estimate renal function and therefore calculation of creatinine clearance would be more appropriate), 6 monthly. Monitor more frequently if evidence of deterioration or if the patient is prescribed or takes medicines known to affect renal function.	If eGFR falls rapidly to <45ml/min review Lithium treatment and refer to renal medicine.
Thyroid function	Baseline & 6 monthly	Treat as necessary
ECG	Baseline & 6 monthly especially for patients with known cardiac disorders or risk factors for arrhythmia including drugs known to prolong QTc interval on ECG. The timescale for ECG is under review nationally (December 2017)	Review Lithium treatment
Calcium	Baseline & 6 monthly	
Weight, BMI, and waist circumference	Weight • Baseline • Weekly for first 6 weeks • At 12 weeks • Annually Waist circumference • Baseline • Annually	Review including modifiable risk factors
Side effects	At every clinical contact	Review lithium treatment if problematic
Signs & symptoms of toxicity	At every clinical contact	Under take an urgent lithium level and suspend lithium treatment.
Lithium levels	Weekly until level stabilisation then 3 monthly	On admission, if there is any deterioration in the patient's physical health.and if there is any suspicion of toxicity.
Interacting drugs	At every clinical contact	Review all drugs known to affect renal function

Parameter/test	Frequency	Action if outside reference range
Women of reproductive age	**Baseline and yearly** Lithium is a known teratogen. In severe mental illness up to 80% of pregnancies are unplanned. Risks and benefits in relation to childbearing must be discussed fully with all women of childbearing potential prior to prescription and consent appropriately recorded. This should be revisited at least annually. Discussion should include regular review of contraception status and advice/signposting on effective contraception for the duration of prescribing, with preference for long-acting reversible methods.	For all women of childbearing potential: Discussion of childbearing intentions and contraception status. Advice on risks and benefits in relation to childbearing. Advice/signposting on contraception (incl. LARC). Informed consent provided in writing. The 'BUMPS' website should be used to reinforce verbal information. www.medicinesinpregnancy.org For women who become pregnant on lithium: Review risks and benefits of continuing treatment or discontinuation. Seek specialist advice regarding ongoing prescribing
Patient & care education	Baseline and as necessary	Provide patients with the education necessary to support informed choice and suited to their individual needs. The Choice and Medication website is recommended http://www.choiceandmedication.org/nhs24/

Table 6: Mood Stabilisers - Sodium Valproate

Parameter/test	Frequency	Action if outside reference range
Weight, BMI,and waist circumference	Weight • Baseline • At6 weeks • At 12 weeks • Annually Waist circumference • Baseline • Annually	Review including modifiable risk factors
Full blood count	Baseline, then at 6 months	Investigate as clinically appropriate.
Liver function tests	Baseline, at 6 months, then annually	Investigate as clinically appropriate
Women of reproductive age	**Valproate should not be prescribed for women of childbearing potential.**	

Table 7: Mood Stabilisers - Carbamazepine

Parameter/test	Frequency	Action if outside reference range
Weight, BMI and waist circumference	Weight • Baseline • At 12 weeks • Annually Waist circumference • Baseline • Annually	Review including modifiable risk factors
Urea & Electrolytes	Baseline, then at 6 months	Investigate as clinically appropriate.
Full blood count	Baseline, then at 6 months	Investigate as clinically appropriate.
Liver function tests	Baseline, then at 6 months	Investigate as clinically appropriate.
Women of reproductive age	Pregnancy/contraceptive status before initiation and at regular intervals thereafter, at least annually	In all cases: Pre-pregnancy discussion of pregnancy intentions. Offer advice/signposting on contraception. Early discussion of options if unplanned pregnancy.

1.
- NHS Scotland National standard for monitoring the physical health of people being treated with clozapine (2017) [Last accessed 05.07.17]

2.
- NHS Scotland National standard for monitoring the physical health of people being treated with lithium (2017) [Last accessed 05.07.17]

Medications specific to Mental Health - Stimulant medications for ADHD

9.18 Pre-treatment screening should include height, weight (bmi or centiled), heart rate, blood pressure and sleeping pattern. Weight (bmi or centiled), blood pressure and heart rate in addition to side-effect monitoring should be completed at each dose titration review and once stabilised every 6 months.

Medications specific to Mental Health - Methadone and Buprenorphine (refer also to NHS GG&C guideline on Clinical Management of Drug Misusing patients)

9.19 A standard physical health assessment and physical examination must be carried out on all patients entering methadone maintenance treatment and care taken in view of the risk of toxicity when initiating methadone treatment. Clinical assessment must cover assessment of heart or liver disease, especially presence of current or past infection with blood-borne viruses, HIV and risk factors for QT interval prolongation such as concomitant treatment with CYP 3A4 inhibitors, other drugs

with the potential to cause QT interval prolongation and the presence of electrolyte abnormalities.

9.20 Testing for the presence of hepatitis C, hepatitis B and HIV, and hepatitis B immunisation should be offered where appropriate (i.e. if not immune or already a carrier). Buprenorphine should not normally be used in people with liver dysfunction.

9.21 A baseline ECG must be considered in patients who have risk factors for QT interval prolongation. Patients with risk factors for QT interval prolongation requiring more than 100 mg of methadone per day must have ongoing cardiac monitoring.

Medications specific to Mental Health - Disulfiram (Antabuse)

9.22 Risk factors that would contraindicate use of disulfiram should be excluded before initiating treatment. These include heart or liver disease, previous cerebrovascular accident and hypertension. An ECG should be performed if there is a cardiac history or the patient is over 40. Baseline Liver & Kidney Function tests should be obtained and repeated after 3-4 weeks due to rare reports of hepatitis on initiation, mostly in women. Regular liver function tests for those maintained on disulfiram are also recommended.

10. Mental Health Legislation

Adults with Incapacity (Scotland) Act 2000, Part 5 Medical Treatment and Research

10.1 The law in Scotland generally presumes that adults (aged 16 or over) legally have capacity to make personal decisions and manage their own affairs, this includes the right to give or withhold consent to treatment.

10.2 For those persons under 16 years section 2(4) Age of Legal Capacity (Scotland) Act 1991 applies:

"A person under the age of 16 years shall have legal capacity to consent on his own behalf where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences of the procedure or treatment."

10.3 Lack of decision-making capacity, as regards healthcare treatment, is verified by an assessment of the adult. An adult who lacks capacity is defined as being incapable of:

- Acting; or
- Making decisions; or
- Communicating decisions; or
- Understanding decisions; or
- Retaining memory of decisions

By reason of mental disorder or an inability to communicate due to a physical disability

10.4 Any person carrying out an assessment and further treatment must follow the principles of the Act, any intervention must:

- benefit the adult
- take account of the adult's wishes both past and present if these can be ascertained
- take account of the views of relevant others as far as it is reasonable and practicable
- minimise the restriction of the adult's freedom while achieving the desired benefit
- encourage the adult to use existing skills or develop new skills

10.5 Where a healthcare practitioner responsible for providing the proposed treatment determines that the adult lacks capacity to give or refuse consent, they will complete a Certificate of Incapacity under Section 47 of the Adults with Incapacity (Scotland) Act 2000.

This certificate provides a general authority to treat an adult the scope of which is to:

"Do what is reasonable in the circumstances to safeguard or promote physical or mental health of the adult".

10.6 In patients with complex healthcare who need multiple medical interventions for single or multiple conditions then a Treatment Plan will often be appropriate. The Section 47 Certificate can authorise this treatment plan by simply saying "see attached treatment plan" under the section on proposed treatments.

The Treatment Plan must indicate for each condition or treatment whether the adult is capable or Incapable of consenting. The term "Fundamental Healthcare Procedures" may be used in the Treatment Plan to include all measures relating to nutrition, hydration, hygiene, skin care and integrity, elimination, relief of pain and discomfort, mobility, communication, eyesight, hearing and simple oral hygiene.

Name of Patient ……..…….. Date of Birth / /

Address ……

……

I have examined the patient named above on ….. /……/ …….. (Date) and consider that he/she needs to undergo procedures to safeguard or promote physical or mental health in relation to the treatment plan below. I have assessed his/her capacity to consent to treatment in relation to each area of intervention.

Disorder/intervention (see note A)	Capacity C = Capable I = Incapable
• Fundamental healthcare procedures include all measures to promote or safeguard the following: Nutrition, hydration, hygiene, skin care and integrity, elimination, relief of pain and discomfort, mobility, communication, eyesight, hearing and simple oral hygiene. • Immunisation in accordance with the guidance issued annually by the Chief Medical Officer. • NHS Screening Programmes. • Dental assessment & treatment. • Additional treatment/conditions •	

I have consulted the following people over this treatment plan and over the patient's capacity.

Name ……..……..…..... Designation ….……..……

Address ……..…….

Name ……..……..…..... Designation ….……..……

Address ……..…….

Signed ……..

Mental Health (Care and Treatment) (Scotland) Act 2003

10.7 The 2003 Act is about securing benefits for, and protecting the rights of, people with mental disorder. Its primary objective is to make sure people with mental disorder can receive effective care and treatment.

10.8 Part 16 of the Act provides a framework of powers, safeguards and restrictions in relation to medical treatment for patients with mental disorder who are the subject of certain orders[14] within the 2003 Act or the Criminal Procedures (Scotland) Act 1995 (1995 Act). This part of the act only applies to **treatment for mental disorder**. Any patient not capable of giving or refusing consent to treatment offered for anything other than the mental disorder would be subject to the provisions of Part 5 of the Adults with Incapacity (Scotland) Act 2000.

10.9 Medical treatment for the patient's mental disorder has a broad definition with the 2003 Act, this may include:

- Nursing
- Care
- Psychological intervention
- Habilitation (including education, and training in work, social and independent living skills)
- Rehabilitation.
- Pharmacological interventions
- Physical interventions, ECT Neurosurgery

10.10 Certain treatments for mental disorder may attract "special protections" these protections are consent in writing or a second opinion from an independent Designated Medical Practitioner appointed by the Mental Welfare Commission.

11. Training and Development – evidence base and competencies

11.1 Evidence used in producing this policy is listed at Appendix E and includes a range of source materials and on-line resources. All staff are encouraged to draw from this rich resource in support of their individual Educational or Personal Development Plans.

Medical

11.2 Early career training and ongoing continuing professional development should equip psychiatrists to be able to deliver their responsibilities as outlined by the Academy of Medical Royal Colleges in 2016

11.3 Responsibilities of a psychiatrist include competence in;

- The identification of physical causes of illnesses which can present as psychiatric
- Investigation for physical causes and refer on when appropriate

[14] The use of the term orders covers all certificates, court or Mental Health Tribunal orders.

- Obtaining a medical history and functional enquiry
- Recognising the onset of acute illness
- Safe prescribing and recognition of side effects of all medications administered to patients
- Long term conditions monitoring and treatment
- In co-morbidity such as with drug or alcohol addiction, recognising factors which may affect patients' physical health
- Disease prevention and health promotion
- Use of screening tools on admission to hospital to minimise harm (nutrition etc.)
- Managing specific population needs (e.g. refugees)
- Involving other specialists in the rehabilitation of the patient's physical health

Nursing and Allied Health Professionals (AHPs)

11.4 Mental Health Nurses are responsible for the assessment, identification, monitoring and management of the physical needs of the patients they care for.

11.5 Mental Health Nurses and AHPs are ideally placed to engage with and educate patients in relation to their physical health needs and how they are inextricably linked to their mental health and wellbeing.

11.6 Mental health Nurses and AHPs recognise the importance of using psychological approaches to facilitate health behaviour change within a recovery-based model of care.

11.7 Mental health nurses and AHPs have a critical role in the promotion of physical and mental well being including the importance and benefits of Nutrition care, regular physical exercise, alcohol consumption within national limits harmful effects of smoking and meaningful occupation.

11.8 Mental Health Nurses who are qualified Nurse Prescribers bring an increased expertise to the care and treatment of the physical health care needs of patients. They possess an increased knowledge of the effects of commonly used medication on the physical health of patients. NHSGGC Mental Health services offer supervision and guidance to all non-medical prescribers.

11.9 Mental Health Nurses and AHPs will be supported to continually improve their knowledge, skills and competencies in performing physical health care assessments, interventions and the development of treatment plans.

11.10 The physical health care policy implementation group has identified a need for continued education of Mental Health Nurses and AHPs in the management of long-term conditions and strategies to promote behavioural change. A supporting education package is currently being developed.

11.11 Clinical supervision and continued professional development for Mental Health Nurses and AHPs underpins the delivery of effective assessment and treatment of

physical health care conditions and will help achieve improved health outcomes for patients.

11.12 The role of employment/or voluntary work is recognised as important in maintaining health & well being and is considered an appropriate area of inquiry undertaken by Mental Health Nurses and AHPs.

12. Monitoring and Review Arrangements

12.1 The Primary Care and Mental Health Interface Group continues to work towards emerging consensus with primary care on the shape, character and recording of information about annual physical reviews and about how this information is shared.

12.2 There is a need for feedback and ongoing audit of the revised NHS GG&C Mental Health Service Physical Health Measure via EMIS reporting and linking to and collaborating with primary care.

12.3 The PsyCIS Team is committed to maintaining the PsyCIS register, providing summary reports for Consultants and assisting with clinical audit. It is important that psychiatrists review and update the PsyCIS record for patients to ensure accuracy, maintain ongoing links to primary care, and facilitate outcomes monitoring via local audit and Safe Haven for this particular patient group.

12.4 The assessment and management of patients' physical health care needs both in hospital and in the community will be subject to clinical audit. This will be undertaken by the Practice Development Nurse staff at least annually.

12.5 There is a need for reviewing and updating the policy in response to feedback, with results of audit and to take account of other policy, guideline and systems changes. This should occur within 1 year of implementation and 2 yearly thereafter.

Appendix A

Proposed Equipment to Meet Standards for Physical Health Care in Inpatient & Community Mental Health Service Areas

- 1 set portable wheelchair beams, power unit and carrying bags (Calibrated annually)
- 1 set stand on scales and carrying bag (calibrated annually)
- 1 Diagnostic Set
- 1 Electronic Sphygmomanometer
- 1 Manual Sphygmomanometer
- Various sizes of Sphygmomanometer cuffs (small, medium & large)
- 1 Stethoscope
- 1 Glucose meter, test strips and lancets
- Ear thermometer & disposable covers
- Peak Flow meter and disposable mouthpieces (if applicable)
- 1 BMI calculator
- NHSGGC BMI MUST Charts
- 1 flexible measuring tape
- Tourniquet – Various sizes
- 1 Pen torch
- Blood specimen equipment – e.g. Bottles & Needles (Butterfly & standard), sharps disposal container, tourniquet
- Rubber gloves - Latex free
- Various sundries items e.g. micropore, cotton wool, mediswabs, foil bowls, disposal bags and plasters
- 1 sanitising hand disinfectant gel
- Height / Weight conversion chart
- (LD) Pictorial aids*****
- Health promotional materials (pictorial format)
- Urine testing strips
- Assorted blood forms and specimen bags
- ECG referral forms
- Core resuscitation equipment and drugs
- ECG machine (In-patients only

* Learning Disabilities only.

Appendix B

PHYSICAL HEALTH FORM

Parameter/Topic	Guidance	Recommendations
Annual health and wellbeing review.	All community patients must receive an Annual Review that sufficiently meets their needs.	If yes, either (a) check if any follow-up health improvement advice needed and offer to facilitate or do, (b) Check if any specific extra screening required and offer to facilitate or do. (See high dose prescribing, Lithium) If no, offer to arrange with GP or do at CMHT. (Proceed to full screen below if patient refuses to attend GP and is on antipsychotic medication, especially Clozapine)
	In-patient > 12 months	If yes, proceed to full health and wellbeing review.
	If patient chooses NOT to proceed with review at this point:	Record patient's wishes in care plan including willingness to be approached at a future date.
Admission to psychiatric unit.	Patients have full system examination and clinically appropriate investigations in addition to health and wellbeing review.	Complete all sections and enter additional details of physical examination in free text box at end. Make note in care plan of any follow-up or referrals required.
Satisfactory level of activity	Aim for at least 150 minutes of physical activity per week	Provide general advice and consider referral to a local exercise scheme (e.g. local health walks, GP exercise referral scheme)
Satisfactory Diet	Eat a balanced diet, with at least 5 portions of fruit and vegetables per day and adequate water intake and limit caffeine (≤ 5 cups of coffee or ≤ 10 cups of tea per day)	General dietary advice. Consider referral to local dietitian if required
Smoking	Aim to be non-smoker	• Assess nicotine need and encourage patient to be tobacco-free • General advice re harm from tobacco and refer to Quit Your Way Services local to patient. • Educate patient re change in **Clozapine** uptake. • Monitor **Clozapine** serum levels when tobacco use changes
Alcohol	No more than 14 units per week for men and women spread over a minimum of 3 days with several alcohol-free days each week. In pregnancy, the safest choice is to avoid alcohol completely.	General advice and consider referral to local community addiction services as required or provide information about basic alcohol screening and signposting for brief interventions
Illicit drugs	Aim for abstinence	General advice and consider referral to local community addiction services as required
Sleep	Ask if any problems with sleep pattern, such as insomnia, snoring, daytime sleepiness	If problems noted, give general sleep hygiene advice. If sleep apnoea suspected, refer to GP

Parameter/Topic	Guidance	Recommendations
Urinary function	Ask if any problems (especially any change in function such as hesitancy, increased frequency &/or incontinence)	If problems noted, refer to GP (inpatient Medical staff)
Bowel function & Bowel Screening	Ask if any problems (especially change of bowel habit, unexplained weight loss &/or rectal bleeding/blood in stool) ***Assess bowel function at every visit if on clozapine.*** Bowel Screening invitations are sent to individuals' homes every 2 years between the ages of 50 and 74 yrs.	If problems noted, refer to GP/inpatient medical staff irrespective of screening results. If patient has not returned a screening kit that was sent to them, a new one can be requested by filling in an online form (https://www.nhsinform.scot/healthy-living/screening/bowel-screening/request-a-bowel-screening-test-kit), phoning 0800 0121 833 or emailing bowelscreening.tayside@nhs.net
Menstrual function	Ask if any problems. Regular cycle of approx 28 days (24-35 days range)	If problems noted, refer to GP (or Psychiatrist if psychotropic drug side-effect suspected)
Currently or potential for pregnancy	Every 3 years for females 20-60 yrs	Give advice about risks of relapse in relation to pregnancy and postnatal period (particularly for bipolar illness and schizophrenia). Give advice about pros and cons of medication in pregnancy and consideration of change of medication, if indicated, prior to pregnancy
Contraception	Every 3 years for females 20-60 yrs	Give advice regarding contraception (may include referral to GP or family planning clinic, e.g. Sandyford Sexual Health Clinic/ Hub) and risks of unplanned pregnancy while on medication
Cervical screening	GP will arrange screening for women aged 25-64 years then- every 3 years from age 25-49 and every 5 years from age 50-64 yrs	Refer to GP/inpatient medical staff if any genito-urinary symptoms, irrespective of screening results. If patient has not taken part in screening but is willing to do so, contact GP
Breast & Breast screening	Breast Screening Unit will send out invitations to women aged 50-70 yrs every 3 yrs.	Advice should be given on self examination https://www.breastcancercare.org.uk/information-support/have-i-got-breast-cancer/checking-your-breasts Refer to GP/ inpatient medical staff if any breast symptoms, irrespective of screening results. If patient has not responded to a screening invitation but is willing to do so, contact the Breast Screening Unit (phone 0141 800 8800)
Abdominal Aortic Aneurism (AAA) screening	AAA screening invitations are sent to men aged 65 yrs will be invited to take part in abdominal aortic aneurysm screening	If patient has not responded to a screening invitation but is willing to do so, contact Screening Unit (phone 0141 277 7677)

Parameter/Topic	Guidance	Recommendations
Diabetic Retinopathy Screening (DRS)	DRS screening invitations are sent to anyone with diabetes over the age 12 yrs are invited to have an annual eye health check	If patient has not responded to a screening invitation but is willing to do so, contact Screening Unit (phone 0141 277 7417)
Sexual wellbeing	Use opportunity to discuss general sexual health issues and sexual side effects of medications.	Refer to GP (or Psychiatrist if psychotropic drug side-effect suspected)
Safe sex	Always	Provide advice on sexual health. Identify if the patient is in high risk category for STI and consider referral to Sandyford Clinic or Sandyford Hub
Vision	Aim for a check-up at least every 2 years	Consider referral to optician. Inform patient of free annual eye tests
Hearing	Ask if any problems	Refer to GP as required
Teeth	Aim for a check-up once a year	General advice and refer to local dental service as required
Feet	Ask if any problems Patients with diabetes • Screened annually in line with the Scottish Diabetes Foot Action Group risk stratification algorithm on SCI Diabetes. • Refer to NHSGGC Clinical Guideline Diabetes, Prevention and Management of Associated Complications	General advice and refer to podiatry service as required http://www.nhsggc.org.uk/your-health/health-services/podiatry/# Patients with diabetes • NHSGGC Diabetes Clinical Guidelines Podiatry
Nutrition	Ask if any recent weight loss/gain, decrease in appetite, speech or swallowing problems and refer to NHSGGC Community MUST nutritional profile(s) or inpatient MUST nutritional profile. Note within NHSGGC Mental Health Forensic wards The State Hospital Nutritional Screening Tool is used.	• Weigh patient on set of recommended NHSGGC calibrated scales, note weight and refer to inpatient Nutritional Profile or Community MUST Nutritional Profile(s) includes Community Learning Disability MUST profile also. • Carry out a full Nutritional screen and document Nutritional score according to specific area Nutritional Profile(s) guideline - update regularly within the Nutritional Profile and each patient care plan accordingly

Parameter/Topic	Guidance	Recommendations
Height, weight and BMI	Aim for BMI of 18.5 – 24.9	**If outcome is between 25-29.9 (overweight) Give** general advice about diet & exercise **BMI < 45 and no co-morbidities or decline weight management service** Consider referral to Live Active or other local weight management opportunities **If outcome is between ≥180 kg, BMI ≥ 45 or ≥ 25 with co-morbidities** Consider referral to Glasgow Weight Management Service
Waist circumference	Aim for no more than 35" for females and 40" for males	Follow recommendations for BMI as above
Pulse	60 – 100 bpm	If <60 or >100 bpm, repeat and refer for ECG and medical review
B.P.	Diastolic < 90 Systolic <140 As per clozapine standards Patients with diabetes target BP <130/80 (NHSGGC Clinical Guidelines Hypertension Management; and Diabetes, Prevention and Management of Associated Complications)	If diastolic >90 &/or systolic >140 refer to GP For patients with diabetes: If blood pressure >130/80 refer to GP/diabetes specialist
MUST score	To be completed within 24 hours of admission	Repeat MUST screening as per MUST Nutritional profile Management Plan
Concordance	Fully informed and agreeable to taking medication as prescribed	If any problems, general advice and refer for medical review as required
Medicines Reconciliation	Medication the patient should be prescribed is correctly identified at admission and discharge	If any problems, general advice and refer for medical review as required
Side effects	Use side effects rating scales e.g. GASS (clozapine) and LUNSERS	General advice and consider medical review
High dose prescribing and Clozapine	Refer to existing guidelines	
Glucose	≤ 11.1 mmol/L (random) or ≤ 7.0 mmol/L (fasting)	If >11.1 (random) or ≥7.0 mmol/L (fasting) diagnosis of diabetes is highly likely - refer to GP Refer to GP if patient identified as high risk of diabetes (fasting glucose 6.1-6.9 mmol/L)

Parameter/Topic	Guidance	Recommendations
Lipids	Cardiovascular Risk Score ASSIGN • NHS Scotland ASSIGN Cardiovascular Risk Score Refer to NHSGGC Clinical Guideline: Coronary Heart Disease and Stroke, Primary and Secondary Prevention Guideline (Cholesterol)	Refer to ASSIGN
FBC	If anaemia or infection etc suspected	Any abnormalities, refer for medical review
U&E	If dehydration etc suspected or concerns about kidney function. Every 6months as per lithium standards	Any abnormalities, refer for medical review
LFT	If alcohol problems etc are suspected. Annually if prescribed Sodium Valproate	Any abnormalities, refer for medical review
Calcium	Baseline and every 6 months if on lithium	Any abnormalities, refer for medical review
TFT	In cases of anxiety &/or depression etc Every 6 months as per lithium standards	Any abnormalities, refer for medical review
Troponin	Refer to NHSGGC clozapine standards	
CRP	If an inflammatory process is suspected e.g. sepsis Refer to NHSGC Clozapine Standards	Any abnormalities, refer for medical review
Prolactin	If sexual dysfunction, amenorrhoea or galactorrhoea.	Any problems, refer for medical review
Lithium	Every 3 months if on stable dose (range 0.4-1.0) and on admission to hospital	Any problems, refer for review by psychiatrist
ECG	If on clozapine or high dose anti-psychotics (see guidelines)	Refer to guidelines

Explanatory notes;

1. There is a higher morbidity and mortality risk in Asian populations for BMIs even at levels below the usual 30 kg/m^2 "cut off". The definitions for "overweight" and "obese" in this patient group has been modified to BMIs of ≥23 kg/m^2 and ≥25 kg/m^2. This needs to be taken into account for prescribing and monitoring for people with mental health problems from BME groups
2. This table does not replace the need for particular monitoring at the point of admission to hospital, initial diagnosis or when initiating new treatments

Appendix C

Patients Name		CHI No.	

Chaperone Required – yes/no **Potential safety issues regarding risk if restraint necessary** **General Impression / End of Bed examination**	**Neuro response** ☐ Alert ☐ Verbal ☐ Pain ☐ Unresponsive

Systematic enquiry:

CVS:	Chest pain	Palpitations	S.O.B.	Ankle Swelling			Normal
Resp:	Cough	Wheeze	Sputum	Haemoptysis			Normal
Gastro:	Abdo pain	Dyspepsia	Constipation	Diarrhoea	Nausea	Vomiting	Normal
CNS:	Headache	Dizziness	Vision	Hearing	Numbness	Fits/Faints	Normal
GU:	Dysuria	Frequency	Haematuria	Nocturia	Incontinence	Discharge	Normal
MS:	Joint pain	Swelling	Weakness	Stiffness	Restlessness		Normal
Endocrine:	Thirst	Polyuria	Weight loss/Gain	Heat/Cold Intolerance	Sweating		Normal

Temperature:	**Pallor**	**+ / -**
Pulse rate:	**Oedema**	**+ / -**
BP:	**Clubbing**	**+ / -**
Respiratory rate:	**Goitre**	**+ / -**
SaO2:	**Jaundice**	**+ / -**
NEWS score:	**Cyanosis**	**+ / -**
WEIGHT **HEIGHT** **BMI** **WAIST CIRCUMFERENCE** **MUST SCORE ON ADMISSION**		

Admission ECG - Date _____

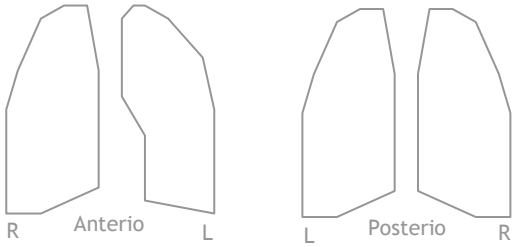
Result:

QTc result……..ms

Normal	
Males	**Females**
< 440 ms	< 470 ms

At 500ms seek urgent advice

Respiratory



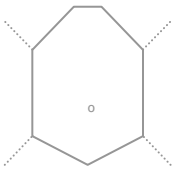
Cardiovascular

Heart Sounds:

Peripheral Pulses:

Peripheral Oedema:

Abdominal



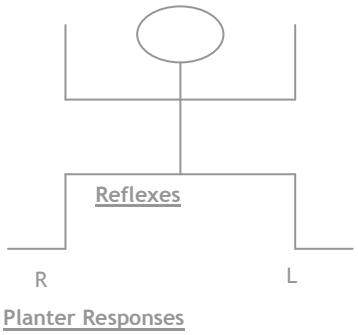
Neurological and Musculoskeletal Exam

Gait:

Cranial nerves (including pupils and eye movements)

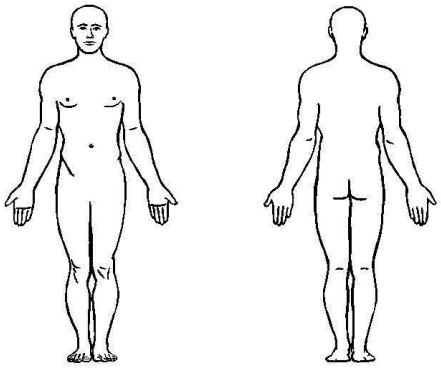
	LUL	RUL	LLL	RLL
Tone				
Power				
Sensation				

Limbs



Co-ordination (including any cerebellar signs, tremor and abnormal movements)

Musculoskeletal System/Skin/Other



Antipsychotic naïve?

Possibility of Pregnancy?

Urine drug screen requested?

Admission bloods sent?

If it is not possible to carry out full physical, ECG or bloods at admission the reason must be documented here

Appendix D

CMHT Resuscitation Equipment

RESUSCITATION PROVISION

A Basic Life Support (BLS) approach should be employed within community settings in a collapsed, unconscious victim. This implies correct application of:-

- Assessment of consciousness
- Getting help immediately (999 call)
- Opening the airway using the head tilt/ chin lift technique
- Checking breathing
- Giving 30 compressions
- Open airway and giving 2 breaths with a pocket mask.
- Continue cycle of 30 compressions to 2 breaths until help arrives

EQUIPMENT:

The only equipment required for the BLS procedure is a pocket mask available from central stores. It is advisable for each base to have at least 3 masks available at any given time to ensure availability/ accessibility at all times.

MINIMAL DRUGS:-

The recommended minimal 'resuscitation' drugs are:

Adrenaline 1 in 1,000 for IM injection. 0.5 mg of Adrenaline is the immediate first line treatment recommended in Anaphylaxis. Two x 1 ml amps should be available. Dose of 0.5 mg (0.5 ml) can be repeated after 5 minutes if no clinical improvement.

NHSGGC MHS Clinical Guideline 32 Recognition and Management of Anaphylaxis

Naloxone (Narcan) for IM injection in known opiate overdose. Dose is 400 micrograms. Can be repeated after 2 minutes if no clinical improvement. 3 x amps available.

Hypostop (Glucogel) x 2 (25g) tubes for hypoglycaemia in a known diabetic. Insert 1 tube content into oral cavity, inside of cheeks for mucous membrane absorption. Second tube can be used if required.

Appropriate syringes and needles (Blue-23G / 25mm and Green-21G/ 38mm) should be available for IM drug delivery and stored with these drugs.

RESPONSIBILITIES:

All resource centres/ bases must identify one nurse with overall responsibility for:-

- Setting up and maintaining a weekly checking system for equipment/ drugs location maintenance and expiry dates.
- Signposting the location of pocket mask/ drugs and communicating this to all staff.

NB: Those services that currently have an emergency tray with more drugs than described above please contact your local mental health dispensary to arrange for its withdrawal from use.

ADDITIONAL ITEMS/ DRUGS:

Where local areas have access to other emergency equipment e.g. Magill's forceps for high risk of choking or Emergency Defibrillator training in their use must be available for staff.

Any further detail or information that may be required should be communicated to:

jonathan.kerr@ggc.scot.nhs.uk
Donald.fraser2@ggc.scot.nhs.uk

Appendix E

Evidence Sources and Supporting Materials [Last updated 06.07.17]

NHSGGC Guidelines, Policies & Standards

Food, Fluid and Nutritional Care

- NHSGGC Nutrition Resource Manual
- NHSGGC Food, Fluid and Nutritional Care (Partnership) Homepage
- NHSGCC Food, Fluid and Nutritional Care Policy (2015)
- NHSGGC Hydration Policy (2012)
- Nutritional Profile including Malnutrition Universal Screening Tool (MUST)
- Guidance and considerations for using the 'Malnutrition Universal Screening Tool' ('MUST')
- Charts and Alternative Measurements for using the 'Malnutrition Universal Screening Tool' ('MUST')
- NHSGGC Community MUST Patient Pathway

NHSGGC Mental Health Services – Suggested Policies, Guidelines and Medicine Related Guidance

- NHSGGC MHS 40 Guideline for the use of Intramuscular Medication for Acutely Disturbed Behaviour in Mental Health and Associated Service (2018)
- NHSGGC MHS 32 Guidance and Management of Anaphylaxis (2017)
- NHSGGC MHS 02 Adult Eating Disorder Service (AEDS) Operational Policy (2016)
- NHSGGC MHS MRG 26 Lithium Good Practice Standards (2017)
- NHSGGC Mental Health Partnership Non-Medical Prescribing Strategy & Implementation Recommendations (2008)
- NHSGGC MHS 34 High Dose Antipsychotic Therapy Guideline (2016)
- NHSGGC MHS MRG 03.01 Clozapine Service Standards (2016)
- NHSGGC MHS MRG 3.02 Clozapine Side Effects Monitoring Care Plan (2016)
- NHSGGC MHS MRG 03.08 Assessment and Treatment of Clozapine Induced Constipation (2017)
- NHSGGC Guidelines on the management of Drug Misusers in Glasgow and Clyde Acute Hospitals (2013)
- Glasgow Addiction Services Guidelines for the prescription and supervision of Disulfiram (2007)
- NHSGGC Mental Health Service ECT Services
- NHSGGC MHS 14 Hospital Smoking Cessation Service Guidance (2017)

NHSGGC Clinical Information Homepage

- NHSGGC Clinical Guidelines
    - NHSGGC Diabetes Guidelines
    - NHSGGC Vitamin D: Prevention & Treatment of Deficiency in Adults (2016)
    - NHSGGC Guidance on the use of electronic cigarettes (2017)
    - NHSGGC Smoke Free Policy (2017)

NHSGGC Policy Manual

NHSGGC Health & Wellbeing Directory

NHSGGC Public Health Screening Unit

Sandyford Sexual Health Services

NHSGGC Long Term Condition Managed Clinical Networks

NHSGGC MH Services Medical Emergency Training Course Manual - available from local hospital Medical Emergency Trainers.

Service User Groups

- ACUMEN
- Mental Health Network Greater Glasgow
- Glasgow Carers Forum

National Guidelines, Policies & Standards

Scottish Government

- Mental Health Strategy: 2017 – 2021 – a 10 year vision
- National standard for monitoring the physical health of people being treated with clozapine (2017)
- National standard for monitoring the physical health of people being treated with lithium (2017)
- Decisions about Cardiopulmonary Resuscitation - Integrated Adult Policy (2016)
- Vitamin D
- Health Behaviour Change Competency Framework (2010)
- Health Promoting Health Service
    - SGHD/CMO(2015) 19
- National Physical Activity Policy
- Realising Potential: An Action Plan for Allied Health Professionals (2010)
- Department of Health (England) and the devolved administrations - Drug Misuse and Dependence: UK Guidelines on Clinical Management (2007)
- Adults with Incapacity (Scotland) Act 2000: Code of Practice (Third Edition): For Practitioners Authorised to Carry Out Medical Treatment or Research Under Part 5 of the Act (2010)
- Age of Legal Capacity (Scotland) Act 1991

Healthcare Improvement Scotland

- Scottish Patient Safety Programme – Deteriorating patient (including cardiac arrest and sepsis)
- NHS Scotland Diabetes Think Check Act Toolkit
- NHS Quality Improvement Standard, Heart Disease, Clinical Standards (2010)

SIGN Guidelines

- NHS Scotland ASSIGN Cardiovascular Risk Score
- SIGN Guideline - Care of Deteriorating Patient (2014)
- SIGN Guideline - Management of Schizophrenia (2013)
- SIGN Guideline - Management of Diabetes (2010)
- SIGN Guideline - Management of attention deficit and hyperkinetic disorders in children and young people (2009)
- SIGN Guideline - Risk estimation and the prevention of cardiovascular disease (2017)
- SIGN Guideline - Pharmacological management of glycaemic control in people with type 2 diabetes (2017)

NICE Guidelines

- NICE Guideline - Eating Disorders: recognition and treatment (2017)
- NICE Guideline - Violence and aggression: short-term management in mental health, health and community settings (2015)
- NICE Guideline – Physical health of people in prison (2016)
- NICE Guideline - Mental health problems in people with learning disabilities: prevention, assessment and management (2016)
- NICE Guideline - Attention deficit hyperactivity disorder: diagnosis and management (2016)
- NICE Guideline - Psychosis and schizophrenia in children and young people: recognition and management (2016)
- NICE Clinical Guideline - Psychosis and schizophrenia in adults: prevention and management (2014)
- NICE Clinical Guideline - Acutely ill adults in hospital: recognising and responding to deterioration (2007)

National Patient Safety Alerts

- National Patient Safety Agency – Patient Safety Alert 2009/ PSA005; Safer Lithium Therapy.
- National Patient Safety Agency Rapid Response Report – Resuscitation in Mental Health and Learning Disabilities (2008)

Other Guidelines and Resources

- Resuscitation Council (UK) Adult Basic & Advanced Life Support Guidelines (2015)

- Lester UK Adaptation Positive Cardiometabolic Health Resource (2014)
    - Ward Poster
- Royal College of Psychiatrists - Integrated Physical Health Pathway (2014)
- Royal College of Psychiatrists - MARSIPAN: Management of really sick patients with Anorexia Nervosa (2014)
- International Physical Health in Youth (iphYs) working group. Healthy Active Lives (HeAL) consensus statement (2013)
- Royal College of Physicians - National Early Warning Score (NEWS): standardising the assessment of acute illness severity in the NHS (2012)
- Mental Health Foundation - Primary Care Guidance: Early intervention in psychosis – Looking after bodies as well as minds (2009)
- Health and Social Care Alliance Scotland
- ALISS (A Local Information System for Scotland)

Research Publications

Academy of Medical Royal Colleges and Royal College of Psychiatrists - No health without mental health: the supporting evidence (2010) and Summary Report (2009)

Academy of Medical Royal Colleges – Exercise: the miracle cure and the role of the doctor in promoting it (2015)

Annual Report of the Chief Medical Officer 2013 – Chapter 13: Physical Health and Mental Illness (2013)

British Medical Association - Recognising the importance of physical health in mental health and learning disability: achieving parity of outcomes (2014)

Centre for Mental Health - No Health Without Mental Health Implementation Framework (2012)

Diabetes UK and South Asian Health Foundation - Recommendations on diabetes research priorities for British South Asians (2009)

Glasgow Centre for Population Health - Let Glasgow Flourish (2006)

GMS contract, Quality and Outcomes Framework

Mental Health Taskforce - Five year forward view for Mental Health (2016)

NHS England – Improving the physical health of people with mental health problems: actions for mental health nurses (2016)

Scottish Public Health Observatory: Amenable mortality

Scottish Public Health Network – 'Polishing the diamonds' addressing adverse childhood experiences in Scotland (2016)

The King's Fund - Bringing together physical and mental health: a new frontier for integrated care (2016)

Working Group for Improving the Physical Health of People with SMI - Improving the physical health of adults with severe mental illness: essential actions (OP100) (2016)

GRAY, R., et al, 2009. Physical health and severe mental illness: If we don't do something about it, who will? *International Journal of Mental Health Nursing,* 18(5), pp. 299-300.

JONES, A. and HARBORNE, G.C., 2009. Independent mental health nurse prescribing. *Journal of psychiatric and mental health nursing,* 16(6), pp. 508-515.

RELTON L, FROST R, GAMBLE L., 2009. Is it possible to influence lifestyle choices people make who have a severe and enduring mental health problem? A motivational interviewing principles group approach. *Clinical Psychology Forum,* (May), pp. 13-17.

SHIERS, D., et al, 2009. Early intervention in psychosis: keeping the body in mind. *The British Journal of General Practice,* 59(563), pp. 395-396.

JONES, M., et al, 2008. Nurse prescribing in mental health: a person-centred approach. *Nursing Standard,* 22(52), pp. 35-38.
HUGHES, F., 2008. Leadership in mental health nursing. *Journal of Psychosocial Nursing & Mental Health Services,* 46(9), pp. 8-9.

OSBORN, D.J., et al. 2007. Relative risk of cardiovascular and cancer mortality in people with severe mental illness from the united kingdom's general practice research database. *Archives of General Psychiatry,* 64(2):242

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GARDEN, G., 2005. Physical examination in psychiatric practice. *Advances in Psychiatric Treatment,* 11(2), pp. 142-149.

GOURNAY, K., 2005. The changing face of psychiatric nursing.

CORMAC, I., et al, 2004. Improving the physical health of long-stay psychiatric in-patients. *Advances in Psychiatric Treatment,* 10(2), pp. 107-115.

GRAHAM, I., 2003. Leading the development of nursing within a Nursing Development Unit: The perspectives of leadership by the team leader and a professor of nursing. *International journal of nursing practice,* 9(4), pp. 213-222.

HARRIS, E.C. and BARRACLOUGH, B., 1998. Excess mortality of mental disorder. *The British Journal of Psychiatry,* 173(1), pp. 11-53.

BROWN, S., 1997. Excess mortality of schizophrenia. A meta-analysis. *The British Journal of Psychiatry,* 171(6), pp. 502-508.

CHICK, J., 1996. Medication in the Treatment of Alcohol Dependence. *Advances in Psychiatric Treatment,* 2(6), pp. 249-257.

Educational Resources

NHSGGC Mental Health Services Physical Health Challenges in Mental Health Practice Bulletin

NHSGGC Managed Clinical Network Diabetes – Education

NHSGGC eHealth Information on Clinical Applications Training (TrakCare, Clinical Portal etc.)

NHSGGC Health Improvement Training Information & Calendar

NHS Scotland Learn Pro Modules (search under all courses)

- Alcohol awareness
- Chronic pain
- Diabetes Think Check Act Modules
- Nutritional screening: a MUST for all healthcare
- Oral health
- Raising the issue of physical activity
- Tobacco awareness
- Weight management awareness

Chest Heart & Stroke Scotland Training and Education

- STARs Stroke Training and Awareness Resources
- HEARTe Heart Education Awareness Resource and Training through E-learning

Diabetes UK - Diabetes in Healthcare online training course (accredited by RCN)

Mental Health Foundation - Parity of Esteem

National Early Warning Score (NEWS) online training resource

Rights for Life

ReThink E-learning Module on Physical Health Care

Royal College of Psychiatrists' website – Improving physical & mental health

Update on ECG Skills for Psychiatrists