Lead Manager:	Laura Nicholson
Responsible Director:	Una Graham
Approved by:	Mental Health Clinical Governance Group
Date approved:	01/11/2024
Date for Review:	30/11/2027
Replaces previous version: [if applicable]	Version 3 – April 2018

Table of Contents

1. Introduction

This policy sets the context and establishes a framework to support the physical health of patients accessing NHS Greater Glasgow & Clyde Mental Health Services (NHS GG&C MHS). The use of the term “patient” throughout this policy refers to patient, client, resident, or service user. In NHSGGC, we use the terms women/woman and men/man. The terms are inclusive of those who may not identify as women or men but who will require access to services related to their birth sex. For example, some trans people, non-binary people, or people with intersex variations in sex characteristics.

NHS GG&C Mental Health Services include a wide range of services including General Adult Psychiatry, Older People Mental Health Services (OPMHS), Addictions services (ADRS), Learning Disability Services (LD), Forensic mental health, Specialist Services including Liaison psychiatry, perinatal services, and Children and Adolescent mental health services (CAMHS). Patients accessing mental health services have a diverse range of health needs and the physical health policy needs to recognise and respond to all these needs. Wider mental health policy supports this.

Patients accessing mental health services often have poor physical health. Patients with Severe and Enduring Mental Illness (such as Schizophrenia or Bipolar Affective Disorder) die an average of 15-20 years earlier than the general population, with two thirds of this from avoidable disease including heart disease, diabetes, lung disease (including COPD) and cancer. Multi-morbidity is more common in people with Severe and Enduring Mental Illness. Patients with learning disabilities have an estimated 20 – 30-year mortality gap, with illness and multi- morbidity beginning earlier in life than the general population. Potentially avoidable causes of death include respiratory infections, diabetes, hypertension, and cancer. Patients accessing addictions services are at high risk of drug- related deaths, with an average age of drug- related death of just forty-five. Blood borne viruses also confer significant morbidity and mortality. People with eating disorders are at risk of several specific physical health problems, and all patient groups are at risk of premature death from suicide.

Improving physical health can directly improve mental health.

A range of factors contribute to morbidity and mortality in patients accessing mental health services.

- Adverse Childhood Experiences and traumatic experiences with consequent impact on both mental health and physical health.
- Patients are more likely to be unemployed, live in socially deprived areas and experience discrimination.
- Poor diet is common and multiple factors contribute to sedentary lifestyle.
- Tobacco, alcohol, and drug dependence.
- The impact of gender. For example, women have higher rates of depression and anxiety, which can be related to stress related physical illnesses; whereas men have higher rates of criminal offending and risky health behaviours, which involve both physical and mental health risks.
- Women with Severe and Enduring Mental Illness are more likely to have pregnancies that are unplanned or unwanted, and pregnancy outcomes may be less favorable for both mother and infant. Patients are less likely to be offered appropriate contraceptive and pregnancy planning advice.
- A few medications prescribed for Mental Health have a direct effect on obesity, cardiovascular disease, and diabetes and this directly impacts on morbidity and mortality.

Despite high physical health needs, many patients with mental health problems have trouble accessing health services, and physical health screening. People with additional inequalities (including protected characteristics) are further disadvantaged. This includes (but is not limited to) disadvantage due to race and ethnicity, gender and sexual orientation, refugees, veterans, deprivation, and homelessness. People who do not speak English as their first language or who have lower levels of education may have additional difficulties in accessing services, especially if they struggle with literacy and IT literacy. Other disadvantaged groups include people with disabilities and people with long term physical and mental health conditions.

Diagnostic overshadowing refers to when people assume that a patient's primary diagnosis (such as a mental health problem or a learning disability) is responsible for unrelated symptoms and behaviours. It can make it harder for people with mental health problems to have their physical health needs recognised. Diagnostic overshadowing is more likely in people who are already disadvantaged as above.

Doctors should be aware of the inherent power imbalance in the doctor-patient relationship and take this into account when discussing physical health and lifestyle.

Mental health services (MHS) are not usually directly responsible for meeting all the physical health needs of their patients. But they have a professional duty of care and a moral responsibility to support and improve the physical healthcare of their patients when it is within their remit. In addition, mental health services are in a unique position to influence health-behaviours through their professional relationships with patients accessing the service. They should use natural opportunities during consultation to try and help improve their health and wellbeing.

2. Scope of Policy and the interface with Primary and Acute Care

NHS GG&C Mental Health Services (MHS) provide care across a range of inpatient and community services. All healthcare professionals working for MHS are included in this policy.

While the policy recognises that patients accessing MHS have a wide range of physical health needs, the policy is not able to give specific directions around what physical health support should be given for every patient. However, the policy intends to give general principles and general direction to support clinicians to take patient centred decisions in relation to physical health. In addition, the policy highlights the role of MHS in promoting and improving physical health.

All patients should be registered with a general practitioner. Where there are difficulties in maintaining registration due to poor mental health, then mental health services should support this as far as possible. In addition, patients may be open to other secondary and tertiary health services. Mental Health services should never seek to replace primary and acute services but should work together with other health services towards a shared outcome. Information should be shared with other services as appropriate. When there is a direct relationship between mental health and a physical health problem, MHS should consider direct communication with the other service, and joint working.

There are a small number of patients who find it extremely difficult to access health services, and whose primary contact is through MHS. Where patients continue to struggle to engage with services because of their mental health, then MHS should consider directly liaising with other services so that patients are able to access care and support through their contact with MHS. This should be an exception and would need to be considered on a case-by-case basis but may be the only way to allow engagement for some patients. In these cases, there needs to be explicit agreement around responsibility for any clinical decisions and follow up. If there is any disagreement around shared care, this should be escalated through the relevant Clinical Directors.

There will also be patients who are unable to access health services for other reasons such as a lack of support, or language/cultural barriers. If MHS become aware of difficulties then they should discuss with the patient and signpost to other services (such as interpreting services, social work, primary care, community services and the third sector) as appropriate.

There are a couple of instances where MHS are solely responsible for physical health:

- Inpatient services. The primary medical responsibility for hospital inpatients lies with the patient's treating consultant psychiatrist.
- Where the patient's physical health problem is likely to be a direct consequence of treatment that MHS have provided. Psychiatrists have shared responsibility for management and monitoring of psychotropic medication. This includes health improvement and lifestyle advice when it is likely that treatment is responsible for factors such as weight gain. Clinicians will also need to ensure that an adequate physical health review has been carried out prior to prescribing medication.

Finally, MHS do not have direct responsibility for supporting Health Improvement guidance when it is unrelated to treatment from MHS. However, patients accessing MHS have high physical health needs, high mortality and often find it difficult to access healthcare due to multiple disadvantages. MHS and the Physical Healthcare Policy strongly advocate that all clinicians have a role and responsibility in improving the wider health of the patients that we work with. Whilst we do not have direct responsibility, we should take the opportunity to raise targeted and specific health improvement advice depending on patient need and wishes. All of these are considered further below.

3. General Principles

People using mental health services have a right to expect the same quality physical health care as the general population. The Patient Rights (Scotland) Act 2011 and Patients Charter (revised 2022) support this.

All care and treatment should be patient-centered, and patients should be involved in decisions around their healthcare, including their physical health.

Care and treatment should be in line with NHS GGC Quality Strategy Aim , Right Care, Right Place, and Realistic Medicine .

In line with these policies, all assessments and investigations should be personalised, in agreement and with the consent of the patient, relevant, and with the potential to lead to a change in management.

Assessments and investigations should not be repeated if the information is already available.

Mental Health Services staff are primarily trained in mental health. They should always work within their capabilities. MHS staff should be actively supported to access training, depending on their role within MHS. It is not expected that MHS staff have the same level of knowledge and skills as primary care or acute services. However, appropriate to their role, they should have some awareness and skills in relation to the more common health conditions encountered in patients accessing their service. If they are caring for a patient with high health needs in relation to a specific physical health condition, then they should seek advice from specialists and make that they have enough knowledge about the condition to ensure safe patient management.

Staff working in MHS should be aware of additional inequalities and the impact of protected characteristics on mental and physical health and accessing health services. They should be able to raise these wider factors as part of the consultation, and if appropriate, should be comfortable to discuss them.

4. Standards of Physical Healthcare

All mental health assessments by all mental health professionals should routinely consider physical health and the impact of physical health on mental health.

Because MHS are so diverse and incorporate so many different professions, it is not possible to give specific direction as to what a “physical health assessment” should comprise. Factors to consider include:

- Patient priorities and whether patients themselves have concerns around their physical health.
- The patient’s medical history and individual patient risk – this is essential in relation to the prescription of psychotropic medication.
- If physical health may be impacting directly on mental health
- Whether the patient’s health needs are already being met by another service or by another member of a mental health team
- Whether the patient is likely to be able to access healthcare for physical health without additional support from MHS
- The patient setting (inpatient settings where patients are unable to access primary care and where physical health is the direct responsibility of MHS)

- An annual full physical health review should be conducted for all inpatients and for all patients where there are significant concerns around their physical health and who have not managed to access alternative services.

- Clinicians should consider using the EMIS Physical Health Assessment template to direct discussions around physical health and lifestyle, and to support coding on EMIS.

5. Health Improvement

Health and Wellbeing services | NHS Inform

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. There is evidence that changing these will have the biggest impact in relation to improving outcomes in physical health. These should therefore be prioritised compared to interventions with a lower impact.

The prevalence of smoking is extremely high in patients with mental health problems. NHS GG&C MHS support smoking cessation through Quit Your Way.

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. Conversations about making changes to smoking, physical activity, diet, alcohol intake etc. or taking part in screening programmes are best undertaken on an ongoing basis. There is no quick fix and talking about many things once a year could be overwhelming. So, it is vital that these topics are discussed at regular reviews and opportunistically.

All health professionals should be able to use a brief intervention approach to identify potential areas for change. Trying to tackle too many things at once can be also overwhelming: asking the patient what they would like to change and making a note in their care plan to revisit, will help support future conversations. This does not have to be owned by a single professional and all professional groups should contribute to this. This is an opportunistic but effective intervention. It may not arise at every patient interaction, but at the least should be raised at presentation/first assessment and at any annual health review. It is important that we do not decide on behalf of the patient that they are not ready to make change, and we should be having supportive conversations at all stages of the patient journey. Working through the lifestyle questions in the physical health assessment tool allows opportunity to assess whether the patient is meeting the recommended guidelines for each topic and advise what these are. It also allows the opportunity to discuss.

6. Medication prescription and ongoing monitoring

6.1 Baseline assessment

Other than first line treatment for depression and anxiety, most psychotropic medication should be prescribed at the request of MHS. Services have a responsibility to ensure that they have the required information to advise safe prescription, and this includes responsibility for any necessary pre- treatment investigations. Primary care has a more complete access to patient health records and have a responsibility for ensuring safe prescription as the primary prescriber.

A full history of cardiovascular risk, a brief medical history and baseline investigations including weight and bloods should be taken by MHS prior to initiating antipsychotic medication (see Appendix two for details.) QRISK3 should be used to support judgements around cardiovascular risk in patients without established cardiovascular disease. It may be that patients are too acutely unwell to participate, in which case this should be carefully documented and investigations completed once the patient is sufficiently recovered. Some patients may refuse baseline assessment (for example, some patients with a learning disability.) Treatment should not be denied. However, the risks of refusing monitoring should be considered when balancing the benefits and risks of treatment.

Baseline assessment including investigations are mandatory for Clozapine and Lithium prescription and there can be no exceptions, due to the risks of these medications. If baseline assessment cannot be completed, then medication cannot be prescribed.

Baseline assessment for other psychiatric medication is summarized in Appendix one. Cardiovascular risk factors may not be as relevant. However, as a minimum, the prescriber should ensure that the patient has no active physical health problems, no allergies and should check what other medication is prescribed.

Pregnancy and future risk of pregnancy should be considered (and discussed as appropriate) with all people at risk of pregnancy who are of childbearing age, this is of particular importance with valproate and staff should follow the guidance MHS MRG 41 - Use of Valproate within MHS

Decisions around medication prescription including risks and benefits of treatment should be taken jointly with the patient whenever possible.

6.2 Initial Monitoring

Initial monitoring for psychotropic medication should be conducted by MHS in line with Appendix two.

In practical terms, the frequency of initial monitoring may need to be balanced against other factors such as practicalities, competing priorities, patient wishes and engagement. More frequent monitoring will be required for patients with high comorbidity, patient frailty, rapid titration, and if initial assessments and investigations show abnormal findings. If adequate monitoring is not possible in the community, then admission should be discussed. The priority is to ensure safe and appropriate prescription for all patients.

Initial monitoring should continue until the patient is established on a stable dose of medication (and has had at least one set of assessment and investigations at that stable dose).

Initial monitoring will need to be repeated if medication is either changed to a different prescription or if there is a notable change in dose of the same medication.

6.3 Ongoing Monitoring

In line with MHS MRG 46 Guidance MHS MRG 46 - Primary Care Psychotropic Good Practice Guidance , the long-term condition management of patients with physical and mental health conditions remains part of general medical services. Monitoring in primary care should therefore be considered as part of Community Treatment and Care services work to support chronic disease management.

Ongoing physical health monitoring through primary care should be considered if:

- The patient has been titrated to an appropriate and stable dose of medication by MHS.
- Medication is prescribed within BNF range.
- The patient is not on more than one medication (from each BNF class) MHS should

Provide ongoing physical health monitoring for patients on:

- Depot medication
- Clozapine
- More than one antipsychotic, and medication prescribed out of BNF range (or total > 100% BNF range)
- Valproate

Further details are provided in MHS MRG 46 Guidance, including guidance for primary care as to what monitoring is advised.

There is limited evidence to support monitoring as advised in Appendix two. When scheduling monitoring, MHS should consider:

- Recent investigations on Clinical Portal. Investigations should not be repeated unnecessarily.
- Whether patients are accessing assessment and investigations elsewhere (such as patients engaging with diabetic monitoring)
- The principles of realistic medicine
- Whether conducting an assessment or investigation is likely to change management
- Whether there are good grounds to request a specific investigation. (For example, lipids should not be tested once a patient is established on a Statin.)
- Patient preference, particularly if an investigation is likely to be normal (for example HbA1C in a patient with no change in weight, a normal BMI and normal previous HbA1C)

Whether or not investigations are undertaken, patients should have a minimum annual review of Clinical Portal and conversation around physical health. This will ensure that any new or additional risk factors are considered when recommending ongoing prescription. This review should help direct future monitoring.

High risk medication is an exception and should always be fully monitored in line with specific guidance. High risk medication requiring full monitoring includes (but is not limited to):

- Clozapine
- Lithium
- LAI
- High dose and multiple antipsychotic therapy

The most recent NHS&GGC guidance should always be used.

MyPsych website homepage: https://rightdecisions.scot.nhs.uk/mypsych-app/

Addictions services have separate guidance around the prescription of Opioid Replacement Therapy and other medication specific to their service.

6.4 Discharging patients requiring ongoing monitoring

Patients that do not require ongoing input from MHS should be discharged to primary care and it is expected that primary care will provide ongoing monitoring where required as part of long-term condition management. This is in relation to low dose antipsychotic medication, and specific guidance has been drawn up around this with particular focus on the potential cardio metabolic side effects. MHS - Low Dose Antipsychotic Treatment (LDAT) and Primary Care

Mental Health Services have a responsibility to ensure that continuing treatment is necessary prior to discharging, particularly if medication is prescribed off license. They should discuss all risks and the need for ongoing monitoring with the patient prior to discharge and consider supporting this discussion with shared written information. MHS should ensure that primary care is given clear recommendations around long term monitoring, including around de- prescribing and when re-referral to or further discussion with MHS is indicated.

When patients are discharged from mental health services, there needs to be a clear discharge plan around follow up for both mental and physical health. For patients with poor engagement and complex needs, there needs to be agreement and confirmation that primary care will provide ongoing care. If there is disagreement around discharge or follow up this should be escalated through the relevant Clinical Directors.

7. Inpatient Services

Patients admitted to MHS Inpatient Services should have a full physical health review including physical examination and physical investigations on admission. This should take place within 24 hours of admission (or if the patient is acutely unwell, as soon as possible).

A physical examination should be recorded on EMIS through completion of the Physical Examination tab on the Adult MH Admission Assessment Template. In addition, the EMIS Physical Health Assessment Template can be used as a prompt and to document a full physical health review.

All services should embed processes around initial physical health assessment in their Admission IPC (or equivalent). Services have patients with quite different physical health needs, and the IPC and details of physical health assessment should reflect this. Inpatient Service Management at a Service Level should own this. Until this is embedded in each service, please refer to the previous version of the Physical healthcare policy for a guide on what should be included in initial assessment. Thereafter, all patients should be offered annual physical health review including medication monitoring and physical examination. The EMIS Physical Health Assessment Template may be used to support this. If a patient becomes acutely unwell, the EMIS Inpatient Physical Examination Template can be used to document physical examination.

Health Improvement advice should be available and offered to patients during their inpatient stay. Not all patients will wish to receive health improvement advice or engage in lifestyle change during their admission. However, the ward environment should promote lifestyle advice including healthy eating and exercise and there should be at least one documented conversation with inpatients around health improvement. (There will be exceptions, including patients who are too unwell to

engage in discussion, and patients who are admitted very briefly to the ward – any exceptions should be documented.) Each service should consider how they will implement this.

Discharge summaries should refer to physical health, noting clinical findings, results of investigations, ongoing needs, referrals made and any follow-up plans or requirements.

Each service should have a clear pathway for recognising the acutely deteriorating patient in line with NHS GG&C policy. (Currently NEWS 2.) They should also have a service specific pathway so that patients can be transferred to Acute Care if their physical health needs cannot be met safely in an MHS Inpatient setting.

8. Medical Emergency and Resuscitation

All new clinical staff should be introduced to the Medical Emergency Response Procedure, response ward model and available equipment 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 annually. All staff must attend NHS GGC mandatory BLS & Anaphylaxis training, also on an annual basis.

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

There is a separate policy around resuscitation equipment and management.

MHS 32 - Guidance on the Recognition and Management of anaphylaxis

9. Working with Particular Groups

Each service should have a Service Specific Physical Health Policy/Work Plan, agreed, and managed by that service. It should be in line with this overarching MHS policy but should consider the specific health needs of the population accessing that service. Until a specific policy is available, services should use the previous version of the NHS MHSGGC Physical healthcare policy for guidance.

If a patient is managed by another service (for example people with eating disorders accessing CMHT, or people with a learning disability being managed on a General Adult ward) then the receiving service should seek advice from the other service as necessary (and in line with any interface guidance).

Specific physical health needs should always be considered for:

- People over the age of sixty-five, particularly if they are also frail.
- People with eating disorders
- People with learning disabilities
- People with long term chronic conditions including diabetes.
- Children and Young Adults
- People with childbearing potential, pregnant, post-partum and going through the menopause.

Mental Health Care and Treatment Act Scotland embeds an equalities and human rights approach. Protected characteristics, further marginsalisation such as homelessness, asylum status and other reasons that could lead to discrimination should always be considered.

10. Training and development

All registered practitioners should conduct CPD in line with their Professional Bodies. This should include training around physical health appropriate to their clinical role. This will include annual Medical Emergency Training and resuscitation training as above**.**

11. Resources

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

12. Monitoring and Review arrangements

The Physical Healthcare Group plan to conduct and support further work around health needs and priorities and to look at whether the current Physical Healthcare Policy recommendations are effective in improving patient health. The work will include patient and staff feedback around physical health.

The policy will be reviewed in three years through the Physical Healthcare Group and Mental Health Governance.

13.References

Supporting the physical health of people with severe mental illness

Severe Mental Illness and inequalities Government briefing

NHS England » Right Care physical health and severe mental illness

Wellbeing and Mental health - Foundation for People with Learning Disabilities

Learning from Lives and Deaths - people with a learning disability and autistic people (LeDeR) | King's College London (kcl.ac.uk)

Multiple physical and mental health comorbidity in adults with intellectual disabilities: population-based cross- sectional analysis | BMC Primary Care (springer.com)

Drug related Deaths 2022

GGC Mental Health Strategy 2023 - 2028

The physical wellbeing of people with mental health problems - Mental Health Strategy 2017-2027 - gov.scot (www.gov.scot)

Prevention and management of physical health conditions in adults with severe mental disorders

Social determinants of health (who.int)

Patient Rights (Scotland) Act 2011

Charter of patient rights and responsibilities - revised: June 2022

Appendix 1

Mood stabilisers:

Lithium – use NHS GGC Community and Inpatient Lithium Bundles

MHS MRG 24 - Lithium Bundle MHS MRG 45 - Community Lithium Bundle

Valproate – LFT and FBC should be taken before initiation. FBC should then be checked prior to surgery, but does not need repeating routinely. LFT should be checked during the first 6 months of therapy, particularly in patients at higher risk, but does not require monitoring thereafter.

Valproate should not be initiated for men or women (of childbearing age) without a second opinion. Please refer to latest guidance for ongoing management.

MHS MRG 41 - Use of Valproate within MHS

Carbamazepine - 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.

The BNF states that the manufacturer recommends blood counts, and checking renal and hepatic function, but that the practical value of this is uncertain (October 2024). Routine monitoring should therefore be considered, particularly if there are known additional risks (including previous abnormal parameters); but is not required under this guideline.

Lamotrigine - 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. Once established on lamotrigine, no additional monitoring is required.

Appendix 2

Antipsychotics (not including Clozapine, HDAT and LAI)

	Frequency of measurements	Comments
Physical measurements Weight and BMI (consider waist circumference) Blood pressure and pulse	Baseline, after three months then annually and after any dose change	If patients are at high risk of weight gain, weight should be measured more frequently on initiation until weight gain stabilises. Pulse and blood pressure should be measured more often during titration for patients who have comorbidity (including frailty). If risks are high, consider inpatient admission to support safe titration.
Bloods Blood Glucose/HbA1C Lipids FBC U+E LFT Prolactin TFT	Baseline, after three months then annually and after any dose change	These guidelines have been amended to align with recent primary care guidance but note that the BNF advises patients taking antipsychotic drugs not normally associated with symptomatic hyperprolactinaemia should only be considered for prolactin monitoring if they show symptoms of hyperprolactinaemia (such as breast enlargement and galactorrhoea). Patients established on a Statin do not require further lipids
ECG	Baseline and following any dose change	
Side effect monitoring	Review side effects during titration and after any dose change	Consider using the GASS or other validated rating scale