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Physical Health and Wellbeing Policy

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Contents

1 Introduction

Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) promotes collaborative mental and physical health care. It aims to ensure all patients receive the right care, at the right time, in the best setting. We must follow best practice guidance and should use national and local guidance and recommendations where possible. This includes assessment, intervention, treatment, monitoring, and review. Also, collaborative care should be part of a broader, holistic approach to support our patients Trust-wide. To do this, staff must access and use the right resources. They must develop the knowledge and skills to do their jobs. Also, they must seek advice from other professionals, NHS organisations, or specialists when needed.

The priority of care, mental or physical, may vary. It depends on the person's condition, the urgency, or the need for a decision. Despite these challenges, we must focus on collaborative mental and physical health. We must meet individuals' needs and ensure parity. Our patients must receive safe, high-quality, combined care, regardless of the Trust care setting.

> *"People living with SMI face one of the greatest health equality gaps in England. Their life expectancy is 15–20 years shorter than that for the general population, and this disparity is largely due to preventable physical illnesses".*
>
> **(NHS England, 2024)**

In January 2024 NHS England published key actions for Improving the physical health of people living with severe mental illness guidance for integrated care systems. This included the need to co-produce services in equal partnership with people who use our service and those that care for them.

Care must boost equality by meeting the needs of diverse groups, including those with protected traits and at-risk groups.

We must use targeted outreach and health promotion to help people with SMI. They face barriers in accessing physical support and adopting healthy habits. There must be a complete health check for those with severe mental illness. It's important to "make every contact count." We must help people access follow-up care (see the Lester Tool). Discuss possible medication side effects, like rapid weight gain from new antipsychotics. Also, support healthy habits. These include exercise, good nutrition, quitting smoking, and moderating alcohol.

There is a need to consider the support network of a person. It calls for joined-up, collaborative care with system partners for holistic care and the sharing of information on medications, diagnoses, and the delivery of the SMI physical health check.

It recommends personalised care and support plans that address the full needs of the individual, including mental, physical and social needs such as loneliness and

isolation, and workforce and leadership to support this agenda (Improving the physical health of people living with severe mental illness (SMI), NHS England, January 2024

NHS England » Improving the physical health of people living with severe mental illness (SMI)

People with a learning disability often have poorer physical and mental health than other people and may face barriers to accessing health and care to keep them healthy. Too many people with a learning disability are dying too young. Many die from treatable or preventable causes. The average age at death for people with a learning disability is 23 years younger for men and 27 years for women, compared to the wider population. (NICE impact on people with a learning disability.) The LEDER process submits its yearly report. The 2023 report can be found at: Learning Disabilities Mortality Review (LeDeR) Annual Report April 2023 to March 2023 - NHS BNSSG ICB.

We must support patients by making reasonable adjustments where necessary. This is to help them access relevant physical healthcare. It is also to help them understand the information and advice given about their physical health. It is also important to acknowledge a patient's personal preferences and wishes. To promote collaboration, privacy, and dignity, we must consider these preferences. They also aim to prevent iatrogenic harm. More information is in the Consent to Examination or Treatment Policy and the Privacy and Dignity Policy. Both are on the Trust intranet.

The Trust commits to providing holistic care and promoting the well-being of patients. Patients with mental health issues or learning disabilities should be able to access equitable and high-quality physical healthcare. Patient care balances physical and mental well-being as equal priorities. A person's mental and physical health needs are vital to care planning. It is often the blend of which best meets patient goals.

2 Why we need this Policy

2.1 Purpose

Mental and physical health intertwine, requiring a unified approach to merge them. This policy requires TEWV Trust staff to address our patients' physical health needs. They must ease, support, check and respond to them.

It is also important to screen, intervene, and monitor the physical health of those using TEWV services. This ensures their physical health needs are not overlooked due to their mental illness or learning disability.

As people live longer, there are more patients with physical and mental illnesses, and learning disabilities. These patients need complex, skilled care in mental health or learning disability inpatient settings, like those of the TEWV NHS Foundation Trust.

Individuals familiar with TEWV services exhibit abrupt physical health deterioration. They need physical health assessments, examinations, and investigations due to signs. Specific symptoms trigger these medical responses.

The Trust knows that physical healthcare is vital. It is part of the high-quality health and social care that everyone deserves. Therefore, the purpose of this policy is to:

- Ensure that all staff are aware of the agreed physical healthcare standards required to follow Care Quality Commission (CQC) standards, National Health Service Litigation Authority (NHSLA) standards, National Institute for Health, and Care Excellence (NICE) and local guidance.
- Ensure clinical teams guide staff to assess and manage patients' physical health. They should do this within their competency.
- Ensure healthcare providers tailor plans to each patient's unique needs and preferences. They use evidence to inform their comprehensive approach to care. Providers rank patient wishes to deliver personalized healthcare services.
- Ensure that the delivery of physical healthcare is of an optimal standard.
- Patient and key individuals join discussions, make decisions on physical healthcare.
- Include any major physical health problems in the patient's Safety Summary. Also note any that effect mental health. Include them in the Safety Plan, if applicable.
- Skilled healthcare providers craft tailored wellness strategies for ongoing improvement.
- Deliver physical healthcare to individuals with dignity, sensitivity, and compassion.

2.2 Objectives

The objectives of this policy are to:

- TEWV Trust staff must use a standardised approach to physical healthcare.
- Minimise harm to patients by outlining best practices for timely, proper physical healthcare.
- Provide TEWV Trust staff with support, information and guidance which will assist to:
    - Enable the early identification and swift response to physical health deterioration.
    - Enable quick escalation of concerns. Encourage staff to seek advice or refer to a healthcare professional if needed.
    - Promote clear, concise contemporaneous record keeping in relation to physical healthcare.
    - Support individuals, family/carers, fellow patients and staff.
- Ensure all patients across the Trust get fair and equal treatment. They may need physical healthcare.
- Ensure that TEWV Trust staff know the importance of physical healthcare. This includes a holistic, person-centred approach to care.
- Support the implementation of high-quality physical healthcare Trust wide.

3 Scope

3.1 Who this Policy Applies to

This policy applies to all TEWV NHS Foundation Trust staff. They must promote and provide good physical healthcare. All clinical staff must advise, support, and empower patients on physical healthcare. This includes healthy lifestyle choices and potential risks. They should do this at every opportunity. The policy applies to all healthcare professionals. Key roles are in Section 3.2.

3.2 Roles and Responsibilities

Role	Responsibility
Executive Medical Director	• Responsible for ensuring that all Medical Staff and Physician Associates are aware of this policy, and other policies, guidance and procedures which relate to this policy. • Responsible for ensuring that adequate training is given to allow Medical Staff to implement this policy. • Responsible for ensuring that all Medical Staff are aware of their role in assessing, reviewing, maintaining, and monitoring the physical health of patients.
Chief Nurse	• Responsible for ensuring that all Registered Nursing Staff are aware of this policy, and other policies, guidance and procedures which relate to this policy. • Responsible for ensuring that adequate training is given to allow Registered Nursing staff to implement this policy. • Responsible for the development, review and monitoring of this policy and associated practice standards regarding physical healthcare provision. • Responsible for the provision of appropriate training and education to support physical healthcare provision.
Directors of Operations, Associate Directors, General Managers and Service Managers	• Be fully aware of the contents of this policy and other policies, guidance and procedures which relate to this policy. • Responsible for the implementation and monitoring of this policy within their respective services,

	specialties and/or localities. • Responsible for ensuring that systems and processes are in place to monitor and meet the requirements outlined within this policy.
Matrons, Team Leaders, Departmental Heads, Ward, and Unit Managers	• Be fully aware of the contents of this policy and other policies, guidance and procedures which relate to this policy. • Responsible for ensuring that staff have read and have an awareness of the policy. • Responsible for ensuring that staff undertake appropriate training required to perform their role and to achieve and maintain a level of competence in relation to physical healthcare. • Responsible for ensuring that systems and processes to monitor training compliance are implemented.
Medical Staff	• Be fully aware of the contents of this policy and other policies, guidance and procedures which relate to this policy. • Responsible for undertaking the appropriate training required to perform their role and to achieve and maintain a level of competence in relation to physical healthcare, assessment and examination, investigations, monitoring, ongoing review, and management. • Responsible for undertaking appropriate continual professional development in relation to physical health. • Responsible for maintaining an appropriate knowledge base in relation to physical health and associated national guidelines and/or best practice. • Responsible for performing physical health

	assessments and examinations, investigations, monitoring, ongoing review, and physical health screening as outlined in this policy. • Responsible for completing all relevant documentation in relation to physical health assessment and examination, investigations, monitoring, ongoing review, and health screening. • Responsible for ensuring that all appropriate actions are taken for patients with an abnormal finding upon an examination or investigation. • Support Physical Healthcare Practitioners, Physician Associates, Registered Nursing Staff, Allied Health Professionals and Non-Registered Clinical Staff to implement this policy. • Support multi-disciplinary team (MDT) colleagues with regards to the physical healthcare needs of patients. • Responsible for accessing and completing resuscitation training as required to maintain competency.
Physical Healthcare Practitioners	• Be fully aware of the contents of this policy and other policies, guidance and procedures which relate to this policy. • Responsible for undertaking the appropriate training required to perform their role and to achieve and maintain a level of competence in relation to physical healthcare, assessment and examination, investigations, monitoring, ongoing review, and management. • Responsible for undertaking appropriate continual professional development in relation to physical health. • Responsible for maintaining an appropriate knowledge base in relation to physical health and

	associated national guidelines and/or best practice. • Responsible for performing physical health assessments and examinations, investigations, monitoring, ongoing review, and physical health screening as outlined in this policy. • Responsible for completing all relevant documentation in relation to physical health assessment and examination, investigations, monitoring, ongoing review, and health screening. • Responsible for ensuring that all appropriate actions are taken for patients with an abnormal finding upon an examination or investigation. • Support Medical Staff, Physician Associates, Registered Nursing Staff, Allied Health Professionals and Non-Registered Clinical Staff to implement this policy. • Support MDT colleagues with regards to the physical healthcare needs of patients. • Responsible for accessing and completing resuscitation training as required to maintain competency.
Physician Associates	• Be fully aware of the contents of this policy and other policies, guidance and procedures which relate to this policy. • Responsible for undertaking the appropriate training required to perform their role and to achieve and maintain a level of competence in relation to physical healthcare, assessment and examination, investigations, monitoring, ongoing review and management. • Responsible for undertaking appropriate continual professional development in relation to physical health.

	• Responsible for maintaining an appropriate knowledge base in relation to physical health and associated national guidelines and/or best practice. • Responsible for performing physical health assessments and examinations, investigations, monitoring, ongoing review, and physical health screening as outlined in this policy. • Responsible for completing all relevant documentation in relation to physical health assessment and examination, investigations, monitoring, ongoing review, and health screening. • Responsible for ensuring that all appropriate actions are taken for patients with an abnormal finding upon an examination or investigation. • Support Medical Staff, Physical Healthcare Practitioners, Registered Nursing Staff, Allied Health Professionals and Non-Registered Clinical Staff to implement this policy. • Support multi-disciplinary team (MDT) colleagues with regards to the physical healthcare needs of patients. • Responsible for accessing and completing resuscitation training as required to maintain competency.
Care Coordinators / Key Workers	• Be fully aware of the contents of this policy and other policies, guidance and procedures which relate to this policy. • Responsible for undertaking the appropriate training required to perform their role and to achieve and maintain a level of competence in relation to physical healthcare, assessment, observation, monitoring, and management. • Responsible for undertaking appropriate continual professional development in relation to physical

	health. • Responsible for maintaining an appropriate knowledge base in relation to physical healthcare required to perform the role. • Where indicated as part of the role, responsible for performing physical health assessments, observation, monitoring, and physical health screening as outlined in this policy. • Responsible for ensuring the patient's physical healthcare CPA review. • Responsible for providing support to patients in order to attend physical health appointments (e.g. assessment, review, and/or screening) and follow-up appointments dependent on individual physical healthcare needs. • Responsible for completing all relevant documentation in relation to any physical healthcare plans, interventions and/or support provided. • Support Medical Staff, Registered Nursing Staff and Non-Registered Clinical Staff to implement this policy. • Support MDT colleagues with regards to the physical healthcare needs of patients. • Responsible for accessing and completing resuscitation training as required to maintain competency.
Registered Clinical Nurses	• Be fully aware of the contents of this policy and other policies, guidance and procedures which relate to this policy. • Responsible for undertaking the appropriate training required to perform their role and to achieve and maintain a level of competence in

	relation to physical healthcare, assessment, observation, monitoring, and management. • Responsible for undertaking appropriate continual professional development in relation to physical health. • Responsible for maintaining an appropriate knowledge base in relation to physical healthcare required to perform the role. • Responsible for raising awareness of both health promotion and health screening to patients, and signposting to appropriate services. • Responsible for the ongoing monitoring of patients' physical health through a variety of methods (e.g. observational skills, communication skills, patient interaction etc.) and also, from a range of tools (e.g. physiological observation charts, sepsis screening tools, food charts, fluid balance charts etc.). • Responsible for promoting the early detection, recognition, prevention, and management of physical health deterioration through swift reporting and escalation to the most appropriate professional. • Responsible for completing all relevant documentation in relation to any physical healthcare plans, interventions and/or support provided. • Support Medical Staff, Allied Health Professionals and Non-Registered Clinical Staff to implement this policy. • Support MDT colleagues with regards to the physical healthcare needs of patients. • Responsible for accessing and completing resuscitation training as required to maintain competency.

Non-Registered Clinical Staff	• Be fully aware of the contents of this policy and other policies, guidance and procedures which relate to this policy. • Responsible for undertaking appropriate training and to achieve and maintain a level of competence in relation to physical healthcare required to perform the role. • Responsible for maintaining an appropriate knowledge base in relation to physical healthcare required to perform the role. • Where indicated as part of the role, responsible for completing all relevant documentation in relation to any physical healthcare interventions and/or support provided. • Support Medical Staff, Registered Nursing Staff and Allied Health Professionals to implement this policy. • Support MDT colleagues with regards to the physical healthcare needs of patients. • Responsible for accessing and completing resuscitation training as required to maintain competency.
Allied Health Professionals	• Be fully aware of the contents of this policy and other policies, guidance and procedures which relate to this policy. • Responsible for undertaking the appropriate training required to perform the role and to achieve and maintain a level of competence in relation to physical healthcare, assessment and examination, investigations, monitoring, ongoing review, and management. • Responsible for undertaking appropriate continual professional development in relation to physical

	health. • Responsible for maintaining an appropriate knowledge base in relation to physical health and associated national guidelines and/or best practice relevant to the professional discipline. • Responsible for performing physical health assessments and examinations, investigations, monitoring, ongoing review, and physical health screening relevant to the professional discipline and role. • Responsible for completing all relevant documentation in relation to physical health assessment and examination, investigations, monitoring, ongoing review, and health screening as appropriate to the professional discipline and role. • Responsible for ensuring that all appropriate actions are taken for patients with an abnormal finding upon an examination or investigation as appropriate to the professional discipline and role. • Support Medical Staff, Registered Nursing Staff and Non-Registered Clinical Staff to implement this policy. • Support MDT colleagues with regards to the physical healthcare needs of patients. • Responsible for accessing and completing resuscitation training as required to maintain competency.
Pharmacy	• Be fully aware of the contents of this policy and other policies, guidance and procedures which relate to this policy. • Responsible for undertaking the appropriate training required to perform the role and to achieve and maintain a level of competence in relation to

	physical healthcare associated prescribing including the monitoring that is required. • Responsible for maintaining an appropriate knowledge base in relation to physical health and associated national guidelines and/or best practice relevant to the professional discipline. • Support the prescribing, dispensing and availability of necessary medication and equipment in order to facilitate the physical healthcare needs of patients. • Responsible for providing medicines reconciliation within inpatient settings. • Support Medical and Registered Nursing Staff in terms of providing guidance, information and advice regarding drugs/medications that may be prescribed and/or administered as part of facilitating the physical healthcare needs of patients. • Support Medical Staff, Physical Healthcare Practitioners, Registered Nursing Staff, Allied Health Professionals and Non-Registered Clinical Staff to implement this policy. • Support MDT colleagues with regards to the physical healthcare needs of patients.
Patient Safety Team	• Responsible for collating data relating to physical healthcare related incidents.
Clinical Audit and Effectiveness	• Responsible for facilitating the review and baseline assessment of NICE guidance. • Assist in the design and development of physical health audits. • Collate and report audit data in relation to physical health audits.

Chaplaincy	• Support patients, fellow patients, family/carers, and staff with spiritual and/or religious needs.

4 Policy

4.1 Physical Healthcare Provision within Community Settings

4.1.1 Physical Healthcare on Referral to Community Services

The Trust knows that supporting primary care colleagues is vital. It ensures ongoing, appropriate physical healthcare. It also helps manage community health exams, tests, treatments, and reviews.

Where needed, reasonable adjustments must support patients in accessing community healthcare. They must also help patients understand any advice about their physical health.

It is also important to acknowledge a patient's personal preferences and wishes. To promote collaborative decision making, we must take these preferences into account. Staff should know a person's trauma history. They should discuss with the patient how to use this knowledge to protect their privacy and dignity. Breaching this could cause harm. Staff can find more support in the Trust intranet. See the Privacy and Dignity Policy and the Consent to Examination or Treatment Policy.

Good healthcare requires providers to test all patients. These tests will set a baseline for their physical health. They should encourage patients to take the tests. These include physiological observations, blood tests, an ECG, and urinalysis (if needed). Based on the person's mental health, medications, lifestyle, and physical health, we may need to conduct further tests. Primary care and community mental health services are communicating to avoid duplicate investigations.

The Consent to Examination or Treatment Policy requires staff to ensure the following:

- Check if the patient has registered with a GP. Encourage, and where appropriate facilitate registration with a GP if not already registered.
- Care Coordinators/Lead Professionals must ensure that the MDT approach to care and review includes a physical health assessment. If needed, support

the patient to access their local GP. Some cases within the CAMHS service are seen/discussed by one professional only (i.e. mental health support teams in schools, Getting Help teams).

- Encourage patients to attend their GP for an annual health review. There are specific annual health checks provided by GPs for people with a learning disability and/or a SMI. NHS guidance says that anyone over 14 with a learning disability can get an annual health check from their GP.

- Encourage, and if appropriate, support children to attend regular health checks with their Paediatrician or GP.

- With the patient's consent, request their medical history from the GP or relevant clinician.

- People with a learning disability must have a 'summary care record' from their GP. It should inform health care professionals of key details. These include medications, allergies, and communication needs. The statement should also specify the reasonable adjustments required for that person. Access the summary care record where possible is recommended.

- TEWV must check patients on certain prescribed medications. This applies to its mental health and learning disability services. This includes antipsychotics for 12 months or more, or until the patient is stable (NICE, 2014a [online]). Monitoring is therefore an essential component of physical healthcare provision.

- If the patient can't or won't attend a GP appointment for a health check, the MDT should offer alternatives.

- Co-produce individual care plans with the patient. Document them on the patient's electronic care record.

- If needed, provide patients with easy-read and/or translated information, to help them understand the information and advice given to them.

- If required, healthcare services must adjust to help patients access them.

The requesting clinician must ensure to perform all necessary physical health tests. They must also ensure a timely review of the results and any actions taken. A clinician with relevant expertise conducts a thorough review and document's all discussions, care, interventions, and results about a patient's physical healthcare on their electronic care record. This includes any treatment, management, or monitoring plans.

4.1.2 Ongoing Physical Healthcare Monitoring within Community Services

As part of ongoing physical healthcare provision, staff must ensure the following:

- Watch for signs of poor health, from conditions like Diabetes, COPD, or CVD. Contact the relevant healthcare professionals, e.g., GP, specialists, or hospitals, if needed.

- Document any major physical health issues in the patient's Safety Summary. Also, note any issues that affect mental health. Include them in the Safety Plan if needed.

- People with autism may have difficulties accessing mainstream health services. A GP visit can be anxiety-provoking due to an unfamiliar environment. It can help to prepare the patient by visiting the clinic a day or two before the appointment. If possible, consider the first or last appointment of the day to avoid long waits.

- Encourage and help patients to access relevant health promotion services within the community.

- Where required, provide reasonable adjustments to enable patients to access health promotion services.

- Adhere to relevant Trust policy, procedure and/or guidelines for any specific physical health monitoring.

- Document any medication side effects and allergies on the care record.

- Record medication review dates accurately in the electronic care record. Include the responsible professional(s) role.

- Document all monitoring schedules for specific medications on the electronic care record. Include the responsible professional(s).

- Document any adjustments needed to help the patient access healthcare. Record this in the electronic care record.

- For children – not being taken to health care appts – may become a safeguarding issue.

4.2 Physical Healthcare Provision within Inpatient Settings

4.2.1 Physical Health Examination and Assessment on Admission to an Inpatient Ward/Unit

On Admission, assess and record the physical health of all patients. If the patient can consent to a health test but refuses, document this in the care record, then, try again as soon as possible.

The first 4 hours:

It starts by covering:

a. Baseline observations including blood pressure, heart rate and respiratory rate and temperature and oxygen saturation.

b. Details of existing physical health conditions and any acute changes since the last clinical review

c. Current medication (physical and mental health) including side effects and adherence.

d. Whether the patient is at risk of withdrawal from drugs/alcohol.

e. Height, weight, relevant blood tests (use recent blood tests if appropriate) and an ECG[MA(EAWVNF1]

f. Hydration status and a fluid balance plan

g. The presence of any existing eating, drinking and swallowing (EDS) plan or recommendations.

g. Dietary status, with input from the nutrition team as necessary

h. Review of physical health risks associated with rapid tranquilisation.

i. The frequency of repeat physical health observations, relevant to the patient's condition, using the National Early Warning Score (NEWS2) where appropriate.

*This is in line with the Royal College of Psychiatrists Standards for Inpatient Mental Health Services (2022)

The first 24 hours NCEPOD recommendations "A picture of Health?"

Within 24 hours of admission to a mental health unit, develop and document a physical healthcare plan with each patient. Do this based on their initial physical health assessment.

Where applicable include:

a. The best place to treat the patient's physical health needs. This includes a mental or physical health hospital.

b. Monitoring and treatment plans, including: - how often to review the physical health risk assessment, recognising acute or chronic health conditions - how often to repeat physical health observations and whether to use early warning tools (National Early Warning Score (NEWS2) - a nutrition plan.

c. The physical health support needed.

d. Plans to escalate if the NEWS2 score worsens or if a patient refuses assessment. Include who to contact and when.

e. Identification of gaps in clinical history and a plan to address them.

When providing a physical health examination and assessment, patients must be offered a chaperone. For more on the Trust's chaperone use policy, see the Chaperone Procedure on the Trust intranet. Wherever possible, staff should try to facilitate the patient’s request regarding the gender of the chaperone.

Staff must know a person's trauma history. They should discuss with the patient how to protect their privacy and dignity. Breaching this may cause iatrogenic harm. Further information can be obtained from the Privacy and Dignity Policy, available via the Trust intranet.

Staff must know the individual's communication needs. They should consider if an interpreter is needed. Or, if other adjustments can help the individual take part in the exam. Further information can be obtained from the Interpreting and Translation Guidance for Staff, available via the Trust intranet.

After the exam, document the results and any treatment plans in the patient's electronic care record. Ensure that any major physical health issues and/or physical health issues that impact on mental health, are captured in the patient’s Safety Summary, and where relevant, also in the Safety Plan.

All results from any investigations must be reviewed in a timely manner by an appropriately qualified clinician.

Document all discussions, care, interventions, and results about a patient's physical health on their electronic care record. This includes any needed treatment or monitoring plans.

Where required, reasonable adjustments must support patients with the physical health exam and assessment. They must also help patients understand the given information, recommendations, and advice.

If there is uncertainty about a person's gender on admission, ask discreetly where they would be most comfortable. If possible, accommodate their preference. Further information can be obtained from the Privacy and Dignity Policy, available via the Trust intranet.

Further information regarding the admission of a patient to an inpatient setting can be obtained from the Admission, Transfer and Discharge Policy, available via the Trust intranet.

It is the responsibility of the clinician completing the overall physical health examination and assessment to ensure that all relevant assessments and/or investigations are tasked and completed.

On admission, and in accordance with the **Consent to Examination or Treatment Policy**, all patients should have the following assessments and investigations undertaken:

- **Physical health examination and assessment**
- **Full set of physiological observations including National Early Warning Score (NEWS) or Paediatric Early Warning Score (PEWS) under the age of 16.**
- **Glasgow Coma Scale (GCS) Score**
- **ECG** (unless a normal ECG has been documented within the last 3 months **and** there are no other indications e.g. recent cardiac event, current patient presentation etc.)
- **Waterlow Pressure Ulcer Risk Assessment** and reassessed as per the guidelines in the **Assessment, Prevention and Management of Pressure Ulcers Procedure**, available via the Trust intranet. See additional information in **Section 4.7 Tissue Viability**.
- **All patients with a SMI should have their cardiometabolic health assessed using the Lester Tool Framework**. See additional information in **Section 4.3 Physical Health Provision for Patients with a SMI**.
- **Full set of baseline bloods** (these may differ slightly from person to person dependent on physical health comorbidities, prescribed medication, mental health diagnoses and/or findings from the physical health assessment/examination and/or the Lester Tool assessment).
- **Venous Thromboembolism (VTE) Risk Assessment** (for all patients aged 18 years or over) and be reassessed within 24 hours of admission and whenever the clinical situation changes. See **Risk Assessment for Venous Thromboembolism Guideline**, available via the Trust intranet.
- **Manual Handling Risk Assessment** - all patients must have a manual handling risk assessment and handling plan initiated and documented on admission as per the **Manual Handling of People Procedure**, available via the Trust intranet.
- **Nutritional Screening** - all patients aged 12 years and above (with the exception of those accessing Eating Disorder Services) require a nutritional screen performed on admission using the St Andrew's Healthcare Nutrition Screening Instrument (SANSI), and an appropriate care plan provided following assessment. This tool will also indicate

if referral to a Dietitian is necessary. See additional information in **Section 4.5 Nutrition and Hydration**.

- **Smoking Status Assessment** - all patients must have their smoking status reviewed on admission to hospital (smoker, non-smoker, never smoker or ex-smoker). This information should be added to the electronic care record and should also include an appropriate care plan inclusive of the following:
  - number of cigarettes smoked per day and the offer of brief advice.
  - identify the treatment offered/accepted i.e. Nicotine Replacement Therapies (NRT) and/or e-Cigarettes (provided within 30 minutes of admission to limit nicotine withdrawal)
  - details of any side effects to treatment and a weekly planned review date
  - document if temporary abstinence or a full quit attempt made.
  - Consideration needs to be given to whether the patient has recently, or intends in the immediate future, to change their smoking status as this may affect medication levels, such as Clozapine and Olanzapine.

  See additional information in **Section 4.4.4 Smoking**.
- **Alcohol Status Assessment** – all patients must have their alcohol status assessed and/or reviewed on admission to hospital. See additional information in **Section 4.4.3 Alcohol and Substance Misuse**.

All information relating to any assessments and investigations should be clearly documented on the patient's electronic care record including details of further investigations, monitoring, treatment, or necessary referrals to specialist services and/or the local Acute Hospital Trust.

Additional assessments and investigations that may be necessary on admission will depend on the individual patient, and, the risk status identified following physical assessment and examination, for example:

- **Urinalysis**
- **Pregnancy Test**
- **Pain/Distress Score Assessment** - e.g. DisDat, Visual Analogue Scale, Abbey Pain Score Assessment. Please refer to the **Pain Assessment and Management Guideline**, available via the Trust intranet.
- **Falls Assessment (for Adult Mental Health (AMH), Learning Disability (LD) and Forensic services only)** - if the patient is considered at risk of falls.
- **Clinical Frailty Scale (for Mental Health Services for Older People (MHSOP) only)**. Please refer to the **MHSOP Frailty Clinical Link Pathway (CLiP)** available via the Trust intranet.
- **Eating, drinking and/or swallowing assessment (Dysphagia) Assessment** – if the patient has any problems or concerns eating, drinking and/or swallowing.

Additional monitoring that may also need to be considered on admission will again, depend on the individual patient, and, the risk status identified following physical assessment and examination, for example:

- **Fluid Intake/Output Record Chart** - are there concerns regarding the hydration status of the patient, or concerns regarding urine output?
- **Food Record Chart** - is the patient underweight or at risk of malnutrition?
- **Patient Stool Record Chart** - is the patient constipated or at risk of constipation? Alternatively, does the patient have loose stools or diarrhoea?
- **Wound Assessment and Management Chart** - does the patient present with a wound/pressure ulcer?
- **Positional Change Chart** - can the patient reposition independently and/or are they at risk of developing a pressure ulcer?
- **Sleep -** does the patient have difficulties sleeping or require their sleeping pattern to be monitored?

In terms of harm minimisation, consider the patient's assessment and management of clinical risk in order to promote recovery and enhance safety - Please refer to the **Safety and Risk Management Policy**, available via the Trust intranet.

During the admission process, patients will be cared for utilising an MDT approach. Trust staff must work together. They must promote the health needs of individuals. This includes their mental, physical, psychological, and emotional health. We must consider the need for continuity of care. If needed, we should seek input from CMHTs, liaison teams, and non-trust staff. This includes input from an Acute Hospital Trust if a person needs a direct hospital admission or transfer to TEWV services.

4.2.2 Declining a Physical Health Examination and Assessment on Admission to an Inpatient Ward/Unit

If a patient does not fully consent to a physical exam, offer an alternative date or time to complete it. Document the patient's decision in the electronic care record. Discuss it with the MDT at the earliest opportunity. Record each attempt to complete a physical exam with the patient on the electronic care record.

If the patient keeps refusing a physical exam, a senior doctor should review this. The review must be documented on the electronic care record and a care-plan formulated as to how the team intends to proceed.

Make reasonable adjustments to support patients in the exam, where needed. They must also help patients understand the given information, recommendations, and advice.

Please read the Consent to Examination or Treatment Policy for further information, available via the Trust intranet.

4.2.3 Medication

It is essential to obtain an accurate, up-to-date medication list when patients are admitted to the hospital. It must detail all medicines prescribed for any mental or physical health conditions. For more info, see the Trust's Procedure for Medicines Reconciliation on the Trust intranet.

Staff must inform patients and carers about prescribed medications. They should know the use, dose, frequency, side effects, cautions, and contraindications. This should be provided in easy read and/or a translatable format for patients/carers if needed.

All TEWV learning disability services follow the STOMP agenda (NHS England, 2020a [online]) when prescribing medication for people with a learning disability, autism, or both.

It is important to remember that primary medication administration routes may vary from one patient to another. Some routes, like PEG and JEJ, are often used for patients with profound, multiple learning disabilities. Please see the Enteral Feeding (PEG) Procedure (Adults) or the Enteral Feeding Jejunostomy (JEJ) Procedure for Learning Disabilities Adult and Children. Both are on the Trust intranet.

 All staff should be aware of the side effects of any medication used in the management of mental health conditions or learning disabilities so that physical health problems can be identified, and appropriately managed, metabolic risk factors reduced, and patient safety improved.

Patients on antipsychotic medication are at an increased risk of developing diabetes, heart disease and stroke, eating, drinking, swallowing difficulties (EDS, also known as dysphagia) weight gain and obesity.

Support must be offered to patients who receive antipsychotic medication in relation to specific lifestyle interventions: stopping smoking, encouraging healthy diet and the importance of physical activity to reduce the cardiometabolic risk.

See additional information detailed in Section 4.3 Physical Health Provision for Patients with a SMI and Section 4.4 Health Promotion.

4.2.4 Transfer between Inpatient Settings within the Trust

On transfer between inpatient settings (within TEWV), the receiving unit need not repeat a full physical health assessment and examination as for a new patient. Rather, it will be the responsibility of the admitting team to check what has already been completed for the patient, and, what remains outstanding in terms of any further treatment or monitoring.

Upon transfer, the receiving team must record vital signs and the NEWS. If staff have concerns about physical health, they must refer to the appropriate professional as soon as possible. In urgent cases, inform the Duty Doctor. Consider contacting emergency services.

Also, when transferring a patient to another TEWV inpatient setting, the transferring team must 'hand over' any ongoing physical healthcare needs. This should include any physical health related treatment(s) or interventions.

For more info on transferring a patient within Trust inpatient settings, see the Admission, Transfer and Discharge Policy. Also, check the Care Programme Approach and Standard Care Policy and Framework. Both are on the Trust intranet.

4.2.5 Ongoing Physical Healthcare Monitoring within Inpatient Settings

All ongoing physical healthcare work must be documented on the patient's electronic care record. This includes monitoring, treatment, intervention, and review.

Local processes must ensure that a patient's health info is shared. This is part of a collaborative MDT approach to care.

Ongoing healthcare monitoring includes required interventions and regular reviews. It aims to manage existing conditions. It also includes all monitoring that may help identify any deterioration in physical health.

Physical health deterioration can occur at any stage of a patient's pathway. However, there are specific circumstances when a patient may be more at risk:

- **During the onset of infection or illness**
- **During procedures such as dental interventions**
- **Administration of rapid tranquilisation**
- **During changes of medication**
- **After a fall**
- **During a period of deterioration of their mental health**
- **During an exacerbation of an existing physical long-term condition e.g. Diabetes, COPD, CVD**

The majority of patients who physically deteriorate tend to present with abnormalities that are detectable by undertaking physiological observations and recording the results using an appropriate track and trigger tool.

NEWS is a nationally recognized track and trigger tool. It records vital signs and generates a score for each observation. The accumulated scores are then added together to produce an overall total score (NEWS). The total score is a sensitive test of abnormal physiology. It

helps staff spot patients who are acutely ill or deteriorating. They can do this by recognizing any vital signs that are outside normal limits.

All staff involved in any aspect of physiological observations must know the Procedure for Using the National Early Warning Score (NEWS) 2 for the Early Detection and Management of the Deteriorating Patient in Adults (aged 16 and above). It is on the Trust intranet.

NHS organisations have used early warning score systems for many years. The key difference with NEWS is that it is nationally recognised. So, the parameters are standardised, unlike the variability between hospital Trusts. NEWS is now used across the NHS, including Acute Hospital Trusts, Ambulance Services, Primary Care, and many Private Healthcare sectors.

When used correctly, NEWS supports raising concerns to a Senior Nurse, a doctor, or a Physical Healthcare Practitioner. This helps to manage a patient's physical health quickly and effectively. The NEWS chart recommends the most appropriate clinical response (depending on the score). When reporting concerns and/or requesting assistance, the actual figures from NEWS should be used to ensure the appropriate assistance for a deteriorating/unwell patient is received.

NEWS must be recorded for all newly admitted patients to the Trust in order to establish a baseline. This includes respite and ECT suites. NEWS monitoring should then continue as a minimum of twice daily until reviewed by the MDT. For patients transferred between inpatient settings, complete NEWS on arrival at the receiving ward/unit. If there are no changes, continue monitoring as agreed by the previous MDT. If there are concerns, increase physiological observations.

Escalation, response, and all interventions relating to NEWS must be documented on the electronic care record. Reasons not to act or respond to the NEWS should also be clearly recorded (including the clear rationale for non-action).

If a patient's physical health deteriorates, any assessments that were previously completed on admission (as part of the physical health examination and assessment process, should be reassessed and documented accordingly e.g. Falls Assessment (AMH, LD and Forensics only), Clinical Frailty Scale (MHSOP only), Waterlow Pressure Ulcer Risk Assessment, Dysphagia Assessment and/or SANSI etc.

Ongoing monitoring of a patient's health must include:

Regular review, signposting, advice, and support for:

- health promotion
- health screening
- dental care
- sexual health
- chiropody/podiatry services
- nutrition

- eating, drinking, swallowing difficulties (EDS, also known as dysphagia)
- physical function and activity
- skin integrity
- auditory and optometry services

Access to these services must be offered regularly and form part of the individual's annual physical health review. All discussions, any action taken, or a record of services declined, must be recorded on in the patient's electronic care record. See additional information detailed in Section 4.4 Health Promotion.

Where required, reasonable adjustments must be provided to support patients with ongoing physical health monitoring and to help patients to understand any information, recommendations and/or advice that is given to them.

NEWS must always be documented following the administration of any Rapid Tranquilisation.

All clinical staff within inpatient settings who may be expected to be involved in the implementation of rapid tranquilisation must be aware and familiar with the Rapid Tranquilisation (RT) Policy, available via the Trust intranet. In the event of administration of rapid tranquilisation, patients must be monitored in accordance with the Rapid Tranquilisation (RT) Policy and also, the Procedure for Using the National Early Warning Score (NEWS) 2 for the Early Detection and Management of the Deteriorating Patient in Adults (aged 16 and above), also available via the Trust intranet.

- **Following parenteral RT, the patient's physiological observations must be recorded at 10-minute intervals for one hour, then every hour for three hours.**
- **Recordings must still be performed if the patient is asleep, and/or if the patient is sedated or immobile.**
- **If the patient refuses to have physiological observations performed, then staff must record as a minimum: conscious level and respiration rate and observe for any visual signs of physical deterioration.**
- **Further attempts to perform physiological observations must be made (at least within 12 hours). All attempts must be documented on the patient's electronic care record and on the NEWS chart.**
- **Visual signs/symptoms of physical deterioration may include:**
  - **Change in respiratory rate.**

- **Rapid/noisy breathing**
- **Minimal respiratory effort or distress (gasping)**
- **Pallor, clammy, cyanosis**
- **Shivering**
- **New onset confusion/agitation**

If any new signs/symptoms are noted, a doctor must be contacted immediately

Annual Physical Health Assessment and Examination Review

Any patient who has been an inpatient for 12 months (or longer) must be offered an annual physical health review inclusive of a comprehensive physical health re-assessment and examination.

Any patient who has been accessing respite care for 12 months (or longer) must be offered an annual physical health review inclusive of a comprehensive physical health re-assessment and examination.

The physical health review and any subsequent findings (inclusive of any necessary treatment or monitoring plans) must be documented on the patient's electronic care record.

4.2.6 Management of Long-Term Conditions

A long-term condition, or chronic condition, is a health problem. It needs management for years or decades. A long-term condition is usually incurable. However, it can be controlled with medication or other therapies. Long-term conditions can affect many aspects of life. They can limit work, relationships, housing, and education (Department of Health, 2012).

More than 8 million people in England live with three or more long term health conditions. Better integrated care and collaboration can greatly improve the lives of people with multiple long-term conditions. It can help them manage their health and navigate the care system.

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

- Seek advice from specialist services/clinicians within the Trust (e.g. Physical Healthcare Practitioners or Allied Health Practitioners). If needed, or if the patient's physical or mental health changes significantly, consult specialists at the local Acute Hospital Trust.

- All must make every effort to ensure that patients attend clinic/outpatient appointments. They must receive screening and review for their long-term condition.

NICE has produced many guidelines and standards. They aim to help prevent and manage physical health-related long-term conditions. These must be considered when developing robust intervention plans. Examples include Type 2 Diabetes in Adults: Management (NICE, 2015, updated 2022 [online]); Hypertension in Adults: Diagnosis and Management (NICE, 2019, updated 2023 [online]); cardiovascular disease: Risk Assessment and Reduction, including Lipid Modification (NICE, 2023 [online]); Chronic Obstructive Pulmonary Disease in Over 16s: Diagnosis and Management (NICE, 2018, updated 2019 [online]).

Where needed, reasonable adjustments must support patients with a long-term condition. This includes any monitoring or treatment plans. They must also help patients understand any information, recommendations, or advice about their condition.

 Patients with an identified long-term condition on admission must have an intervention plan in place detailing frequency of monitoring, treatment, and the procedure to follow if there is deterioration of their long-term condition. This should reflect current NICE guidance.

4.2.7 Referral and Attendance to Outpatient Appointments

Patients who are admitted to TEWV inpatient settings and who have an existing or require a subsequent outpatient appointment at an Acute Hospital Trust or Primary Care setting should, wherever possible, attend such appointments. Trust staff should facilitate, support, escort and encourage patients to attend all healthcare related appointments.

Where necessary, reasonable adjustments must be provided to enable patients to access services provided by other healthcare providers, to help patients to understand the information, recommendations and/or advice that is given to them.

Further information regarding the attendance of a patient at the Acute Trust for an outpatient appointment can be obtained from the Trust's Protocol for Hospital Transfers between TEWV NHS FT and Acute Hospitals, available via the Trust intranet.

4.2.8 Referral and Transfer to/from an Acute Hospital Trust

Refer patients needing specialist physical care to the appropriate Acute Hospital Trust. They must be assessed, examined, and treated. A suitable management plan must also be established. The Protocol for Hospital Transfers between TEWV NHS FT and Acute Hospitals (available via the Trust intranet) details a flowchart for staff to follow in such circumstances.

If a patient is transferred from an Acute Hospital Trust to a TEWV inpatient setting, staff must follow the Protocol for Hospital Transfers between TEWV NHS FT and Acute Hospitals. They must also complete all required assessment documentation.

Further information regarding the transfer of a patient to other hospital services can be obtained from the Admission, Transfer and Discharge Policy, available via the Trust intranet.

Where required, reasonable adjustments must be made to help patients. They must be able to access services from other healthcare providers. Also, they must understand the information, recommendations, and advice given to them.

For people with a learning disability, a hospital passport is a useful document that not only highlights the person's health needs and history but also, identifies how to effectively support the individual. The document can be used for whenever the person accesses services within an Acute Hospital Trust. A hospital passport should be completed with the patient and their families/carers and should stay with the person (as part of their clinical notes) for whenever they attend acute services.

Some Acute Hospital Trusts also employ Liaison Learning Disability Teams or Liaison Learning Disability Nurses who, on notification that someone with a learning disability has been admitted, can become involved to ensure all necessary, reasonable adjustments are being made through their acute inpatient admission.

4.2.9 Physical Healthcare on Discharge from Inpatient Settings

Planning the discharge of a patient from an inpatient setting must commence at the earliest opportunity. Evidence shows that discharges that are planned are the safest and most appropriate method. Discharge planning should involve the service, the patient, and the MDT. This will ensure ongoing, continuous care.

If a patient is cared for by multiple providers, there must be a clear plan. It should detail how to share information and communicate to continue physical healthcare interventions.

Upon discharging a patient to a CMHT or other service, a Care Plan Review Meeting must document the physical health assessment and ongoing needs.

Further information regarding discharge from an inpatient setting can be obtained from the Admission, Transfer and Discharge Policy and the Care Programme Approach and Standard Care Policy and Framework, both available via the Trust intranet.

 On discharge from inpatient settings, it is the responsibility of medical staff to ensure that the GP receives a full discharge summary which must include all physical health investigations undertaken and medication prescribed.

4.3 Physical Health Provision for Patients with a Severe Mental Illness (SMI)/Severe Mental Health Problem (SMHP)

Public Health England (2018a) recognise, 'the phrase severe mental illness (SMI) refers to people with psychological problems that are often so debilitating that their ability to engage in functional and occupational activities is severely impaired. Schizophrenia and Bipolar disorder are often referred to as an SMI'. As mentioned, assess the cardiometabolic health of all patients with a severe mental illness (Schizophrenia, other Psychosis, Bipolar) on admission. This is part of a broader physical health assessment. Any advice, treatment, and follow-up must be standard. It should be based on the assessment's findings. Document it clearly in the patient's electronic care record.

People with SMI are at a greater risk of poor physical health and have a higher premature mortality than the general population. People with SMI in England:

- On average die 15-20 years earlier than the general population
- Have a 3.7 higher death rate for those aged under 75 (compared to the general population)
- Experience a widening gap in mortality rates over time.

It is estimated that for people with a SMI, 2 in 3 deaths are from physical illnesses that can be prevented. Major causes of death include chronic conditions, like CVD, respiratory disease, diabetes, and hypertension (PHE, 2018a [online]).

In order to promote and support care delivery to patients with the aforementioned physical health conditions, TEWV NHS Foundation Trust has developed guidance to inform and assist staff. The following guidance is accessed via the Trust intranet:

- Cardiovascular Risks Guideline (Adults)
- Diabetes Management for Inpatients Guideline
- Chronic Obstructive Pulmonary Disease (COPD) in adults (aged 16 and above) Guideline
- Asthma Guidance for Adults and Children

See additional information in Section 4.2.6 Management of Long-Term Conditions.

As mentioned, patients with a SMI face a high risk of CVD. This is due to some medications (antipsychotics) and lifestyle factors, like smoking, diet, and lack of exercise. See additional information in Section 4.3.2 Other Recommended Assessment Tools.

Also, NICE/PHE publish materials like clinical guidelines and quality standards. They include public health guidance on various physical health diagnoses. These documents cover how to manage these conditions clinically. Such publications are updated frequently. All clinicians who diagnose and treat physical health conditions must stay updated on national guidance and best practices.

4.3.1 Lester Tool Framework

The Lester Tool (2023, [online]) is the recognized framework. It supports a full cardiometabolic risk assessment and a treatment plan. It is for those with a SMI and/or those on antipsychotic medications.

The Lester Tool stresses the need for initial screening. It sets a baseline for ongoing monitoring, intervention, and treatment. Screening includes lifestyle factors: smoking, alcohol use, diet, and exercise. Also, try to get consent to measure BMI, blood pressure, and blood samples. This will check glucose regulation and blood lipids.

Where indicated, secondary care services may need to be contacted as part of a specialist physical healthcare referral. This is to offer appropriate interventions (i.e. Diabetic Specialist Nurse, Cardiologist, etc.). Alternatively, the patient should be directed to the relevant clinic or team to improve their physical health.

If specific medications are to be started, a baseline physical exam and tests must be done beforehand. They must be repeated at intervals during treatment, as indicated in the Lester Tool (Table 1).

Where required, reasonable adjustments must be provided to support patients with the various risk assessments, screening and the monitoring processes required as part of the Lester Tool Framework. Similarly, reasonable adjustments should also be made to help patients to understand the information, recommendations and/or advice that is provided.

Any person diagnosed with a SMI must be offered, as a minimum, an annual physical health check. See **Section 4.2.5 Ongoing Physical Healthcare Monitoring within Inpatient Setting**

Monitoring: How often and what to do

Applies to patients prescribed antipsychotics and mood stabilizers.

	Baseline	Weekly first 6 weeks	12 weeks	Annually
Personal/FHx	■			■
Lifestyle Review[1]	■		■	■
Weight	■	■	■	■
Waist circumference	■			■
BP	■		■	■
FPG/HbA_{1c}	■		■	■
Lipid Profile[2]	■		■	■

Table 1: Lester Tool Monitoring

Staff should be aware of the Trust's Psychotropic Medication Monitoring Guide, available via the Trust intranet.

Enhanced monitoring must be provided for those on High Dose Antipsychotic Treatment (HDAT), or at risk of HDAT due to 'as required' medications. Please refer to the Guidance on the use of High Dose Antipsychotic Treatment, also available via the Trust intranet.

4.3.2 Other Recommended Assessment Tools

Along with the Lester Tool (2023, [online]) screening, any abnormal results must be followed up as per national or local guidance. For CVD risks, if a patient aged 25-84 has high cholesterol, use the QRISK®3 risk calculator (qrisk.org 2018 [online]) to assess them further. The QRISK®3 algorithm calculates a person's risk of developing a heart attack or stroke over the next 10 years. For more on CVD, its risks, and QRISK®3, see the Cardiovascular Risks Guideline (Adults) on the Trust intranet.

Patients without a SMI, but at increased CVD risk, must be assessed using a validated CVD risk tool (NICE, 2023 [online]). The NHS Health Check, as recommended by the Department of Health and is a national risk assessment, awareness and management programme for those aged 40 to 74 who do not have an existing vascular condition, and who are not currently being treated for specific risk factors. The NHS Health Check is aimed at preventing heart disease, stroke, diabetes, and kidney disease (PHE, 2018b, 2019 [online]).

Reasonable adjustments must also be made, where required. They are to support patients in the physical health risk assessment. They should also help patients understand the information, recommendations, and advice given to them.

4.4 Health Promotion

Those prescribed antipsychotics or mood stabilizers should have their health monitored from the start of these medications. This is in line with British National Formulary guidelines or the summary of product characteristics (SmPC).

Support must not end with the physical health check. Rather, 'don't just screen, intervene'. Support people with SMI to access follow-up, tailored interventions. Delivery of the checks and follow-up care must be trauma informed. We should also make reasonable adjustments. This will help people access SMI annual health checks and follow-up interventions. This is a statutory duty under the Equality Act. NHS E recommends, beyond the 'core' health assessments, a best-practice, comprehensive health check. It should build on the 2023-updated Lester resource on positive cardiometabolic health. It must also consider:

- Medical and family history
- Blood-borne virus and liver function screening
- Cardiometabolic risk assessment
- Relevant immunisation programs
- Support to access relevant national screening programs.
- Oral health advice and brief interventions
- Levels of physical activity
- Sexual and reproductive health assessment and advice (including contraception)
- Substance misuse assessment (illicit or non-prescribed drug use)
- Medicines reconciliation and monitoring
- Ask open questions about what affects their health and well-being. This will help identify social and economic factors impacting their physical or mental health.

(NHS England, January 2024 NHS England Improving the physical health of people living with severe mental illness (SMI))

NICE recommends supporting access to a robust health check for people with a learning disability. It should be done by a trained professional, usually in primary care:

- Support access to screening programs. Have a health plan, created by the person with a learning disability and their practitioner, to stay healthy.
- Making reasonable adjustments to ensure care and support if accessible.
- Reducing overmedication and long-term hospital care
- Recording that a person had a learning disability clearly in their medical record.

https://www.nice.org.uk/about/what-we-do/into-practice/measuring-the-use-of-nice-guidance/impact-of-our-guidance/nice-impact-people-with-a-learning-disability

All staff must advise and encourage patients (if appropriate) to adopt healthy lifestyles. This will reduce risk factors that can harm their health and promote recovery and well-being. To improve health and well-being, connect with people, learn new things, and be active. Health promotion activities can help with this.

Document any health promotion advice, info, or screening offered to a patient on their electronic care record.

Staff must promote health during exceptional events. They should encourage patients to stay healthy by following local and national guidance. COVID-19 is an infectious respiratory disease. It caused a global pandemic in 2020. People with health conditions like CVD, COPD, diabetes, and some cancers were more likely to catch COVID-19. People living with severe obesity (BMI ≥40kg/m2) are also deemed to be clinically more vulnerable (PHE, 2020 [online]).

Also, research shows that poor health can harm a person's mood and mind. During exceptional events, like a pandemic or poor mental health, it is easy to adopt unhealthy behaviours. These can harm an individual's health. A structured routine, healthy meals, and regular exercise can boost health and wellbeing.

Where required, reasonable adjustments must be made to support patients. This includes helping them to join health promotion and NHS screening. It also includes helping them understand the information, recommendations, and advice given to them.

Staff should know a person's trauma history. They must discuss with the patient if and how to consider it when talking about health promotion and possible NHS screenings. A sensitive, compassionate approach is vital. It protects the person's privacy and dignity. It also prevents any healthcare from harming the patient. Further information can be obtained from the **Privacy and Dignity Policy**, available via the Trust intranet.

A high percentage of CAMHS caseloads are not classed as having an SMI. They might be seen in schools and have mild-moderate needs. Therefore, in relation to CAMHS our input needs to be proportionate in relation to health promotion staff should:

- Work with families and children to emphasise a family approach to healthy lifestyle, including weight. This will include working with the wider public health strategy and include supported signposting to relevant external agencies such as schools, colleges and third sector organisations.

- Encourage daily physical activity with the aim of reaching recommended levels of 60 minutes a day for 5 – 18year olds. We will encourage families to maintain a healthy lifestyle, participating in more physical activity as part of their everyday family routines, which can support their physical and mental health. This will build on schools' responsibility to support young people to participate in 30 minutes of physical activity a day.

- Encourage families and young people to eat healthy food and snacks which can be reviewed at regular intervals by their lead professional/care coordinator/appropriate clinician.

- Develop training for staff around managing healthy eating and physical activity in the context of mental health, learning disabilities and autism so that staff can support families and young people to adopt a healthy lifestyle.

- Support all children in our care gain access to appropriate physical health care so that their mental health, learning disability and autism is not a barrier to receiving the support they need and to ensure all reasonable adjustments are considered.

4.4.1 NHS Population Screening Programme

Screening is the process of identifying healthy people who may have an increased chance of a disease or condition. It can be helpful to think of screening like a sieve. The sieve represents the screening test with most people passing through the sieve without any identifiable concerns. This means that for these people, they have a lower chance of having the disease or condition concerned. The remaining people left in the sieve have had concerns identified and therefore are at an increased risk of developing or being diagnosed with the relevant disease or condition. The screening provider can then offer advice, support, and/or arrange further tests or treatment as appropriate, or alternatively, signpost the individual to the correct health professionals.

The NHS Population Screening Timeline (PHE, 2021 [online]) provides a visual representation of the national screening programmes available as part of NHS provision in England. Appendix 4 can be used by staff to signpost patients to the relevant screening available:

- Abdominal Aortic Aneurysm (AAA) screening
- Bowel cancer screening
- Breast screening
- Cervical screening
- Diabetic Eye screening
- Newborn screening (parents may be patients)
- Screening in pregnancy

All screening is a balance of potential benefits versus potential harms. Deciding whether to have a screening test is a personal choice and one which only the concerning individual can make. Each person has the right to accept or decline screening. At every stage of the screening process, the individual can make their own choices about any further tests, treatment, advice, and support (PHE, 2021 updated 2023 [online]). Staff should be mindful of Trans patients and their personal preferences and/or requests. For further guidance, please contact the Trust wide Equality, Diversity and Human Rights Team and refer to NHS England NHS population screening: information for trans and non-binary people - GOV.UK (www.gov.uk)

However, as stated, patients should be advised (age appropriate), signposted, supported and encouraged by TEWV staff to take advantage of NHS screening and if indicated, relevant interventions must be implemented to address any issues identified to promote recovery and wellbeing. Healthcare professionals must ensure that the information and advice they provide is within their scope of practice and, if not, refer or signpost to the relevant service (with the patient's consent).

Importantly, it is essential to have realistic expectations of what a screening program can do.

Screening can:

- Save lives or improve an individual's quality of life through early identification of a disease or condition.
- Reduce the chance of developing a serious condition, or from developing complications in the future.

Screening does not guarantee protection. Receiving a low-risk result does not prevent the person from developing the disease or condition later. As with all screening programs, there is the potential for false positive and/or false negative results:

- False positive: wrongly reported as having the disease or condition.
- False negative: wrongly reported as not having the disease or condition.

For those accessing services provided by TEWV, it is recommended that staff ascertain as to whether the patient has had the opportunity to access the appropriate NHS health screening available (age appropriate).

Ideally, this information should be obtained within 6 weeks of assessment. If screening has not been accessed, a relevant appointment, referral or signposting should be made (where possible) following assessment. If a patient declines to have NHS screening, this should be clearly documented on their electronic care record.

Long term inpatient users of Trust services (6 months or more) should be provided with relevant information and access to screening programmes e.g. cancer screening programmes. See Appendix 4.

Where required, reasonable adjustments must be provided to support patients to access relevant and appropriate screening programmes, and to help patients to understand the information, recommendations and/or advice regarding screening that is given to them. It is also important to acknowledge a patient's personal preferences and wishes. Wherever possible, these preferences must be considered to promote collaborative decision making, privacy and dignity, and to prevent the breach of iatrogenic harm. Further information can be obtained from the Consent to Examination or Treatment Policy and the Privacy and Dignity Policy, both of which are available via the Trust intranet.

4.4.2 Making Every Contact Count (MECC)

Making Every Contact Count (MECC) is a behaviour change approach. It uses the millions of daily interactions that organisations and individuals have with others. These interactions aim

to help people improve their physical and mental health. MECC enables the opportunistic delivery of consistent and concise healthy lifestyle information and enables individuals to engage in conversations about their health at scale across organisations and populations.

When addressed, MECC can make the greatest improvement to an individual health by focusing on lifestyle issues such as:

- Healthy eating
- Stopping smoking
- Drinking alcohol only within the recommended limits
- Being physically active
- Keeping to a healthy weight
- Improving mental health and wellbeing

MECC training gives practical tips. It teaches how to have opportunistic chats, signpost to other services, and encourage positive lifestyle changes. It ensures a consistent approach to these messages (NHS Health Education England, 2021 [online]). TEWV Trust staff are encouraged to undertake MECC training.

4.4.3 Alcohol and Substance Misuse

Many people with mental health problems misuse substances (alcohol and/or drugs) (Department of Health, 2016).

Harmful use of psychoactive substances, either alcohol or illicit drugs, is a pattern that causes health problems. This could include psychological issues, like low mood, anxiety, or psychosis. It could also include physical health problems, like acute pancreatitis or hepatitis.

Patients might be intoxicated, in withdrawals, dependent on drugs, or psychotic, in addition to harmful use. Patients, both inpatients and outpatients, should be screened for problematic alcohol and drug use. Use tools like AUDIT-C and DUDIT for this. Where appropriate, they must be referred to drug and alcohol services in the community.

The Trust's Dual Diagnosis Policy (on the intranet) explains substance misuse in more detail. Also, several other relevant documents on substance misuse are available to support staff.

· **Alcohol Detoxification: Inpatient Clinical Algorithm**

- **Managing Substance Misuse on Trust Premises Policy**
- **Managing Substance Misuse on Trust Premises Procedure**
- **Protocol for Management of Substance Misuse in Inpatient Settings**

4.4.4 Smoking

Smoking causes many serious illnesses, such as respiratory problems, vascular disease, and cancer. Smoking prevalence is particularly high among people with mental health problems and has changed little in this group in the past 20 years, with smoking identified as the single largest cause of the gap in life expectancy (Action on Smoking and Health, 2016 [online]).

Helping people with mental health issues quit smoking is the most effective way to reduce illness and early death (NHS England, 2016).

The NHS Long Term Plan (NHS England, 2019 [online]) calls for a new universal smoking cessation service. It will be for long-term users of specialist mental health services and learning disability services. On the advice of PHE, this will also include the option to switch to e-Cigarettes whilst in inpatient settings.

The Trust has a responsibility to support all patients and staff to reduce the harm from smoking with the aim to improve physical health. As per the Trust's Nicotine Management Policy and Medicines and Smoking (both on the Intranet), all smokers will be offered nicotine management on hospital admission.

NRT can be offered to smokers over 12. e-Cigarettes are for those over 18. They are a risk in secure inpatient services. Any patient under the age of 12 years must be referred to primary care services for further support. Treatment should be offered within 30 minutes of admission to an inpatient unit, to limit the effects from nicotine withdrawal.

Patients can access additional support on discharge by linking to the National Smokefree NHS site at: https://www.nhs.uk/smokefree.com. Staff can also access this site to stop smoking should they wish. There are also bespoke Trust wide community and in-patient cessation clinics where patients can access support. Further details of these clinics are available from the Trust Smokefree Lead or Physical Health Community Clinics across the Trust.

Smoking can affect the way some psychiatric drugs are metabolised so individuals who quit smoking or restart smoking whilst taking medication should be closely monitored so that medication levels can be adjusted, if required. Particular vigilance is required for Clozapine and Olanzapine. Please refer to the Trust medicine and Smoking guidance available via the Trust intranet.

4.4.5 Sexual Health

Good sexual health is important for physical, mental, and social wellbeing. Poor sexual health strongly correlates with key health factors. These include alcohol and substance misuse, smoking, obesity, and some mental health issues. This contributes to health inequalities.

Trust staff are ideally situated to engage in discussion regarding sexual health and function. Patients must be offered screening as part of routine assessments. It must include contraception, sexual partners, condom use, and sexual health check-ups (including cervical screening). Also, it should cover violence and abuse in relationships and issues with sexual identity (NHS England 2024).

Where required, reasonable adjustments must be made to support patients. They need to access relevant advice and treatment for their sexual health. Also, the adjustments must help patients understand the information and advice given to them. It is also important to acknowledge a patient's personal preferences and wishes. These preferences must be considered, to promote collaboration, privacy, and dignity. They aim to prevent iatrogenic harm. For more info, see the Consent to Examination or Treatment Policy and the Privacy and Dignity Policy on the Trust intranet.

Some of the Trust's community nursing teams offer courses. They aim to improve patients' understanding of sexual health risks. The courses also seek to boost their ability to protect their bodies.

Activities to achieve change:

- Include sexual health as part of the initial and ongoing comprehensive assessment of the patient and identify their level of understanding relating to sexual health issues.
- Offer clear and understandable information on the types of activities that may pose an increased risk of sexually transmitted infections (STIs) or blood borne viruses (BBVs) and offer advice in preventing such infections e.g. consistent condom use and regular testing.
- Ask about sexual dysfunction and refer or sign post as is required.
- Provide guidance and information about contraception, particularly the more effective long-acting methods, and support access to family planning services to reduce the risk of unintended pregnancies.
- Ensure that all patients are advised of the availability of emergency contraception from local pharmacies.
- Provide information on local sexual health services and if required support people in attending such services.

(Department of Health, 2016)

4.4.6 Menopause

What is menopause?

Menopause is when a woman's periods stop due to lower hormone levels. It usually affects women between the ages of 45 and 55, but it can happen earlier.

Menopause occurs naturally, or for reasons such as surgery to remove the ovaries (oophorectomy) or the uterus (hysterectomy), cancer treatments like chemotherapy, or a genetic reason. Sometimes the reason is unknown.

Perimenopause is when you have symptoms of menopause, but your periods have not stopped. Perimenopause ends and you reach menopause when you have not had a period for 12 months.

Menopausal/perimenopausal symptoms include the following:

· No or infrequent periods (taking into account whether the women has a uterus, or is taking any contraception which may stop her having periods)

· Hot flushes

· Night sweats

· Mood changes

· Memory and concentration loss

· Vaginal dryness

· Lack of interest in sex

· Headaches

· Joint and muscle stiffness.

[Adapted from NICE's guideline on menopause, context section and recommendations 1.2.1 and 1.3.2]

Menopause and perimenopause symptoms can have a big impact on a woman's physical and mental health, their family life, relationships, and work.

Diagnosis:

This varies depending upon age, contraception, and symptoms.

Women over 45 with normal menopausal symptoms are diagnosed with perimenopause or menopause based on their symptoms alone, without lab tests. Follicle-stimulating hormone results are not of any diagnostic value in healthy women within this age group as hormone

levels fluctuate during perimenopause and therefore knowing these results will not change management.

However, women **over 50 years** who are using progesterone-only contraceptives will need their FSH checking. – x2 FSH with results >30iu/L, 4-6 weeks apart

Women **40-45 years** with menopausal symptoms – x2 FSH with results >30iu/L, 4-6 weeks apart are needed to diagnose perimenopause.

Women under 40 with menopausal symptoms must have their FSH levels checked for premature ovarian insufficiency (premature menopause). Unlike women over 45, diagnosis is made initially through menstrual history, and confirmed with persistently elevated FSH levels (x2 FSH >30iu/L, 4-6 weeks apart) as menstrual changes alone could be attributed to other conditions such as pregnancy and polycystic ovarian syndrome. If left untreated, these women are at risk of developing osteoporosis and cardiovascular disease.

Menopause: identification and management

Ardens Health Informatics Ltd

Treatment

Hormone replacement therapy (HRT) may help with many menopausal symptoms. This is if it is suitable for the patient.

This involves replacement of oestrogen and progesterone in a balanced way following a clinical discussion with the patient about what formula and combination would be best suited to their needs and preferences (e.g. gel/transdermal patch/vaginal tablet etc).

Treatment should be initiated following discussion of findings (clinical and/or laboratory) with the patients GP and agree a plan for treatment based upon current guidance.

Individual HRT requirements may take a while to get right and may change due to several factors, including lifestyle and personal preference, therefore is best managed within primary care.

4.4.7 Oral Health

Poor oral hygiene can mean that the consequences of eating, drinking and swallowing difficulties are much more severe because the lungs can be colonised with harmful bacteria that develop in the mouth. People with mental health difficulties are at a higher risk of poor dental and oral health. Good dental and oral health are essential to general health and wellbeing as poor oral health can reduce self-confidence and increase the likelihood of cardiovascular ill-health.

People with a severe mental illness are susceptible to oral disease and tooth decay which can be due to poor diet, side effects of antipsychotic medications (especially dry mouth) or difficulties in accessing dental services. Substance misuse is also associated with poor oral health. Stimulant drugs are linked to teeth grinding and drugs such as heroin can cause people to crave sugar. Poor oral hygiene can also increase the risk of chest infections in people with a learning disability who already have poor respiratory health.

The following is recommended:

- Monitor whether people have access to a dental practice and that they attend for check-ups at recommended intervals.
- Ensure people have access to appropriate oral hygiene equipment e.g. toothbrush and fluoride toothpaste and support with this as needed.
- Encourage brushing twice a day using fluoride toothpaste, and the use of dental floss or silicon interdental brushes.
- Encourage use of mouthwash after meals but not after tooth brushing
- Encourage people to chew sugar free gum to stimulate saliva to help neutralize acids- especially for individuals who are unlikely to carry out routine oral hygiene.
- Encourage people to stop smoking.
- Encourage people to eat less sugary food and drinks.

(Department of Health 2016)

There are many ways mouth care can be completed. There have been ongoing discussions around the use of pink mouth sponges when used inside the oral cavity. The pink sponges are currently on a Medical Device Alert (MDA/2012/020) in the U.K. and are banned in Wales following an incident where a sponge head became detached in a patient's mouth resulting in a fatality. The sponges were designed to moisten the oral cavity and loosen secretions/food debris and are often used as part of palliative mouthcare. They were not designed to remove plaque from the teeth and gums. There are alternatives which can be considered:

- 360-degree toothbrush
- MC3 sticks
- Small headed toothbrush.

Lemon and glycerine swabs have also been used to moisten the oral cavity for those experiencing dry mouth (Xerostomia). The use of these is not recommended as they can often exacerbate the symptoms of a dry mouth whilst potentially causing acid erosion due to constant exposure of acid to the tooth surfaces.

When someone is receiving palliative care, it is essential somebody receives the appropriate mouth care to maintain function of the mouth and prevent infection. End-of-life mouth care aims to keep the persons mouth clean and comfortable (Royal College of Nursing, 2021). This may involve using dry mouth products, completing mouth care on a more regular basis, and ensuring people have access to alternative mouth care products such as mouth hydrators and softer toothbrushes.

People with a learning disability may be more susceptible to some of the risk factors contributing to poor oral health including:

- Difficulty accessing dental practices.
- Frequent sugar intake
- Side effects from prescription medications which may reduce saliva flow or gingival inflammation.
- Gastroesophageal reflux
- Reduced dexterity making it difficult to complete mouth care.
- Sensory sensitivity
- Difficulty in understanding the importance of oral care.

(Public Health England, 2019).
Public Health England recognise the evidence of high rates of poor oral health and difficulties accessing services highlights the need for reasonable adjustments for people with a learning disability to access the care they need.

There is a legal requirement, under the Equality Act 2010, for organisations to make reasonable adjustments where necessary so people with a disability can access the care they need. Reasonable adjustments can look different for everyone and are not limited to people with a learning disability. Reasonable adjustments can include ensuring access into a setting, extended appointment times, tactile signage and easy read information so that people have a clear understanding of what will happen during their visit to a dentist.

Mouth Care Matters have provided helpful resources to assist people visiting the dentist. Resources such as visual pain scales can help individuals express their needs and receive the care they need. Communication resources are also available from the Team Smile website.

Team Smile is a collaboration made up from the Northeast and North Cumbria Multi-Professional Dental Education team at NHS England, together with the British Dental Association, the Makaton Charity, IT Matters, MiXit and Positive choices. Team Smile aim to inform people of what to expect during dental appointments and ease people's anxieties when visiting the dentist. Their website includes Makaton signs, fact sheets and video guides about different dental procedures.

There are many factors to consider when thinking about a person's oral health. It is important that whilst we recognise the importance a healthy mouth, we must acknowledge the barriers people may face and work together with those people to ensure they have access to the resources they need to have and maintain an oral cavity which is clean, comfortable and healthy.

The following is recommended:

- Monitor whether people have access to a dental practice and that they attend for check-ups at recommended intervals.
- Ensure people have access to appropriate oral hygiene equipment e.g. toothbrush and fluoride toothpaste and support with this as needed.
- Encourage brushing twice a day using fluoride toothpaste, and the use of dental floss or silicon interdental brushes.
- Encourage use of mouthwash after meals but not after tooth brushing
- Encourage people to chew sugar free gum to stimulate saliva to help neutralize acids- especially for individuals who are unlikely to carry out routine oral hygiene.
- Encourage people to stop smoking.
- Encourage people to eat less sugary food and drinks.

(Department of Health 2016)

Where required, reasonable adjustments must be provided to support patients to access dental appointments and to help patients to understand the information, recommendations and/or advice that is given to them.

4.5 Nutrition and Hydration

4.5.1 The SANSI Nutritional Screening Tool

The assessment of nutritional status and management of both undernutrition and over nutrition are essential elements of healthcare and are monitored by the Care Quality Commission (CQC). Traditional nutritional screening has involved using the Malnutrition Universal Screening Tool (MUST). However, MUST is an acute-based tool that only identifies undernutrition and can only be used to screen those aged 18 and above. An alternative nutritional screening tool that has been validated in mental health and learning disability settings has therefore been identified for use within TEWV NHS Foundation Trust - the St Andrew's Healthcare Nutrition Screening Instrument (SANSI). This tool can be used to screen patients aged 12 and above and forms a fundamental part of the Trust's Nutrition Pathway. It has been incorporated into the electronic care record (with kind permission from St Andrew's Healthcare).

4.5.2 Healthy Eating and Fluid Intake

A healthy, balanced diet plays a vital role in promoting good physical and mental health (NHS Choices, 2020 [online]).

To have a healthy, balanced diet, the UK's national food guide, the Eatwell Guide recommends:

- Eat at least 5 portions of fruit and vegetables per day.
- Base meals on starchy foods e.g. potatoes, bread, rice, or pasta. Choose wholemeal/wholegrain options where possible.
- Include some beans, pulses, fish, eggs, meat, and other protein sources at each meal. Try to have two portions of fish each week, one of which should be oily e.g. salmon, mackerel, or trout.
- Aim for two servings of dairy products or dairy alternatives each day e.g. soya. Aim for low fat and low sugar options.
- Avoid saturated fats and opt for small amounts of unsaturated oils and spreads.
- Drink 6-8 cups of fluid each day.

Healthy eating can help control weight, blood pressure and cholesterol levels and reduce the risk of developing cardiovascular disease. Therefore, it is important that food and drinks high in fat, sugar and/or salt are consumed less often and in small amounts.

4.5.3 Weight Management and Obesity

Physical inactivity, unhealthy diets and psychotropic medication are all factors that contribute to weight gain in those with SMI (NICE, 2014c [online]). The prevalence of overweight obesity has been reported to be as high as 55% amongst individuals with a SMI and 50% amongst adults with a learning disability (NICE, 2014c [online]). This compares with 25% of the general population (NHS Digital, 2020 [online]). However, there are higher proportions in the more severe category of obese (31% of men and 45% of women compared to 24% of men and 27% of women without a learning disability) (NHS England, 2020b [online]).

Dietitians may become involved in a patient's care to provide advice regarding weight management. Others may have problems associated with swallowing and need an assessment from the Speech and Language Team (SLT).

Obesity is often defined using body mass index (BMI). This index is calculated by dividing an individual's weight in kilograms by their height in metres squared:

BMI = weight in kg/ (height in m)^2

BMI is used to classify an individual's weight status as follows:

BMI Ranges	Weight Status
18.5 kg/m2 or less	Underweight
18.5–24.9 kg/m2	Healthy weight
25–29.9 kg/m2	Overweight
30–34.9 kg/m2	Obesity I
35–39.9 kg/m2	Obesity II
40 kg/m2 or more	Obesity III

23 kg/m2 and 27.5 kg/m2 cut-offs are recommended for black African, African-Caribbean, and Asian (South Asian and Chinese) groups.

BMI must be interpreted with caution as it is not a direct measurement of an individual's adiposity levels (NICE, 2014c [online]) and can be affected by other factors such as high muscle mass and oedema. Measurement of an individual's waist circumference can provide additional information about an individual's risk of developing obesity-related comorbidities. Interpretation of BMI for children and adolescents must be gender and age specific. Note: CAMHS services use height to weight measurements.

BMI classification	Waist circumference		
	Low	**High**	**Very high**
Overweight	No increased risk	Increased risk	High risk
Obesity	Increased risk	High risk	Very high risk

For Men:

Low: waist circumference of less than 94cm

High: waist circumference of 94-102cm

Very High: waist circumference more than 102cm

For Women:

Low: waist circumference of less than 80cm

High: waist circumference of 80-88 cm

Very high: waist circumference more than 88cm

For patients who are identified as overweight or obese, a reduction in calorie intake and increase in physical activity is usually recommended. However, this should also take individual preferences and needs into account.

General principles include:

- Eat a healthy, balanced breakfast.
- Eat regular meals; skipping meals is not recommended and individuals should be encouraged to eat 3 balanced meals throughout the day (some people prefer 4 smaller meals).
- Keep snacking to a minimum and opt for lower calorie options such as fruit, low fat yoghurt, slices of lean meat, vegetable sticks and low-fat dips.
- Increase fruit and vegetable intake, aiming for at least 5 portions per day.
- At mealtimes, the plate should ideally be ½ filled with vegetables and/or salad and the remainder of the plate split between lean protein foods (such as fish, lean meat eggs, beans) and starchy carbohydrates such as whole grain/wholemeal pasta, rice bread and potatoes (ideally with skins on)
- Drink approximately 2 litres of fluid per day (approx. 6-8 cups). Opt for water and low calorie (sugar-free) drinks.
- Avoid eating whilst engaging in other activities such as watching TV (British Dietetic Association, 2020 [online]).

Within inpatient services, balanced choice options are available and should be recommended at mealtimes

4.5.4 Malnutrition

Malnutrition is the 'state in which a deficiency of nutrients such as energy, protein, vitamins and minerals, causes measurable adverse effects on body composition, function or clinical outcome'. This can be a cause, or as a result, of poor physical and mental health and increases the individual's vulnerability to disease (NICE, 2006, updated 2017 [online]). Malnutrition can also lead to a worsening in mental health.

Patients at risk of malnutrition include those with: (Todorovic and Mafrici, 2018)

- BMI of less than 18.5kg/m2
- Unintentional weight loss in past 3-6months of
  - <5% - Within normal intra-individual variation
  - 5-10% - Greater than normal variation, early indication of increased risk of malnutrition
  - >10% - Clinically significant weight loss

If a patient is identified, through SANSI screening, as being at risk of malnutrition, then a referral to a Dietitian is required.

For those patients at risk of malnutrition, a nutritional support plan must be implemented. This will consider the individual's needs for increased calories and protein to reduce risk of further weight loss and promote weight gain.

Recommendations on how to develop a nutritional care plan is provided within the SANSI training and includes.

- Offer **three** meals, two snacks and supper daily.
- Encourage puddings at lunch and dinner.
- Avoid 'healthy' options if on an inpatient ward- these are denoted by a red heart and are typically lower in fat and sugar.
- Add extra calories to food by adding products such as butter, cream, cheese, honey and sugar as appropriate.
- Add extra calories and protein by adding dried skimmed milk powder to whole milk.
- Consider offering smaller meals, snacks, and finger foods more often for those with a small appetite.
  Offer nourishing fluids throughout the day such as milky tea/coffee, smoothies, milkshakes, hot chocolate and/or malted hot drinks

4.5.5 Refeeding Syndrome

Refeeding Syndrome is a potentially fatal syndrome that can occur on the reintroduction of nutrition following a period of starvation. To manage and reduce the risk of Refeeding Syndrome, gradual reintroduction of nutrition is required, alongside close physical health and biochemical monitoring and prescribing of multivitamin and mineral supplements. MDT working is imperative to manage and reduce the risk of Refeeding Syndrome on our inpatient units and requires involvement from a dietitian, medic and/or physical health practitioner and pharmacist as well as those staff who are directly responsible for the patient's food and fluid provision. Refer to the Trust's **Refeeding Syndrome Procedure** (available via the Trust intranet) if refeeding syndrome is suspected **prior** to providing nutritional support.

4.5.6 Vitamin D

Vitamin D helps regulate calcium and phosphate which makes it particularly important to ensure bones, teeth and muscles are all healthy. It also has strong links with mental health and wellbeing. The body creates Vitamin D from direct sunlight on the skin when outdoors which is the bodies main source however- Vitamin D can also be found in certain foods such as:

- Oily fish- salmon, sardines, trout and kippers

- Red meat
- Egg yolks
- Fortified foods (fat spreads and cereals)

Current government advice on Vitamin D is based on the recommendations of the Scientific Advisory Committee on Nutrition (SACN) publication on Vitamin D and Health (SACN, 2016 [online]). The UK government advises that all people should consider taking a daily supplement containing the recommended 10 micrograms during autumn and winter months. Further advice for those whose skin has little or no exposure to sunlight and ethnic minority groups with dark skin should consider taking a Vitamin D supplement all year round. Further guidance relating to **Vitamin D: Testing and Treatment for Adult Inpatients (not already receiving supplements)** can be accessed via the Trust intranet.

4.6 Eating, Drinking and/or Swallowing Difficulties (EDS also known as Dysphagia)

Dysphagia is the medical term for difficulty with eating, drinking or swallowing (EDS).

Management of EDS difficulties requires close collaboration between Speech and Language Therapists (SLTs), the MDT, the patient, their families and carers. By reducing the risks and complications associated with EDS difficulties (such as chest infections, pneumonia, choking, dehydration etc) we can help improve physical health and quality of life and support safer discharge from hospital.

Signs and symptoms of EDS difficulties may include:

- coughing on food or drink
- recurrent chest infections or pneumonia
- unexplained weight loss
- difficulties chewing
- choking
- breathing difficulties at mealtimes
- food sticking or feeling that it is sticking in the throat
- holding food in the mouth without being chewed or swallowed
- nasal regurgitation
- changes to voice quality during mealtimes

Other signs which may be of concern:

- rushing food
- long mealtimes
- food refusal
- changes in behaviour around mealtimes
- food/drinks falling from mouth

If these are observed, please contact SLT for your service to discuss a referral. The Trust **eating, drinking and swallowing difficulties procedure** has more detailed guidance on referrals, assessment and interventions.

Where patients are admitted or transfer to a ward any existing EDS plan must be incorporated into the patient's care plan and signposted/flagged in the safety summary. Where concerns have been raised or the plan does not appear to reduce the identified risks, please contact SLT for advice or to make a referral.

SLTs work to reduce the risks associated with EDS difficulties through a range of interventions which may require joint working with the MDT (eg. Physiotherapist to support posture management) including:

- Changes to positioning to promote a safer swallow and reduce potential reflux (usually in conjunction with Physiotherapist or Occupational Therapist).
- Changing food or fluid textures.
- Enhancing the sensory experience of eating and drinking by recommending cold, fizzy, sweet or strong flavours to increase perception of bolus to be swallowed.
- Adapting the way the person is supported at mealtimes, e.g. advice to support staff who are assisting or supervising patients, provision of training.
- Adapting the environment to enhance the person's focus on mealtime
- Advising on adapted utensils or other equipment, usually in conjunction with OT.
- In severe or complex cases, the provision of non-oral nutrition and/or hydration, in conjunction with dietetics.

SLTs work with the individual, their family and carers, to co-create a plan that supports them (where possible) to have the food and drink they enjoy in the safest way possible. Underlying health concerns or other conditions may mean it is not possible to eradicate the health risks posed by eating, drinking and swallowing. This will be discussed with the person, their family/carers and MDT, with advice given to reduce the risk as much as is possible.

4.6 Physical Inactivity & Physical Activity

Physical inactivity and high sedentary behaviour are one of the top 10 causes of disease and disability in England (Public Health England, Health Inequalities: Physical Activity [accessed online 2024]). People with SMI, Learning Disabilities and or Autism are less physically active than the general population (Public Health England; Hassan et al 2022 [both accessed online 2024]). In England 22.6% of adults over 19yrs old were classed as inactive in 2022-23 (OHID: Fingertips/public health data/physical inactivity [accessed online 2024])

Increasing physical activity has the potential to significantly improve both physical and mental wellbeing, reduce all-cause mortality and improve life expectancy. For example, increasing activity levels will help prevent and manage over 20 chronic conditions including CVD, cancer, diabetes, musculoskeletal disorders, obesity, and stroke (Department of Health, 2011, updated 2019 [online], OHID 2022 (online)). Exercise also helps keep symptoms under control, prevent additional conditions from developing, reduces inequalities and contributes to healthy ageing (Department of Health, 2011, updated 2019 [online]).

Physical activity also has a role in enhancing psychological wellbeing by improving mood, self-perception, self-esteem and reducing stress (Department of Health, 2011, updated 2019 [online]).

It is important to understand that any activity is better than none and even low levels of physical activity can improve a person's physical health and reduce their risk of developing co morbidities even in the absence of weight loss and that the emphasis should be on reducing time spent in sedentary behaviours even if in short bursts.

Benefits of Physical Activity:

- Prevents and helps to manage conditions such as CVD, type 2 diabetes, stroke, (some) mental illness, musculoskeletal conditions, and some cancers.
- Helps maintain a healthy weight.
- Enhances psychological wellbeing by improving mood, self-esteem therefore reduces symptoms relating to anxiety and depression.
- Has a positive effect on wellbeing, mood, sense of achievement, relaxation, and release from daily stress.

Physical activity includes everyday activity such as walking and cycling to get from A to B, work-related activity, housework, DIY, and gardening. It also includes recreational activities such as working out in a gym, dancing, or playing active games, as well as organised and competitive sport. A Physical Activity Benefits Guide for adults and older people is available in Appendix 3 to support staff in discussing the benefits of physical activity with patients.

The Following is Recommended:

- ✓ Adults should aim to be active daily. Over a week, activity should add up to at least 150 minutes (2½ hours) of moderate intensity activity in bouts of 10 minutes or more (such as brisk walking and cycling) – one way to approach this is to do 30 minutes on at least 5 days a week.
- ✓ Alternatively, comparable benefits can be achieved through 75 minutes of vigorous intensity activity (such as running) spread across the week or combinations of moderate and vigorous intensity activity.
- ✓ Adults should also undertake physical activity to improve muscle strength on at least two days a week. These could include heavy gardening, carrying heavy or resistance exercise.
- ✓ Adults 65yr and over should also undertake activities that not only improves strength, but also balance and flexibility on at least 2 days a week in order to reduce the risk of falls.
- ✓ All adults should minimise the amount of time spent being sedentary (sitting) for extended periods. Long periods of inactivity should be broken up with light physical activity when physically possible.

Individual physical and mental capabilities should be considered when interpreting the above guidelines.

Out of the UK population 44% of disabled adults are physically inactive. It concluded that for substantial health gains, disabled adults should:

- ✓ Do 150 minutes of physical activity at a moderate to vigorous intensity.
- ✓ Do 2 sets of challenging strength and balance exercises 2 times per week.
- ✓ Minimise sedentary time as per whole population guidelines.

Individuals with uncontrolled symptoms for cardiac, metabolic, renal and some musculoskeletal conditions should seek advice before greatly increasing physical activity.

(Public Health England, 2020 [online])

As part of MECC, it is every health professional's responsibility to reduce sedentary behaviours and to promote physical activity with patients, but specialist advice can be sought regarding appropriately increasing an individual's physical activity from Trust Physiotherapists who are exercise experts. This is particularly important for those patients for whom an increase in physical activity can be potentially risky and their graduated physical activity requires specialist input and monitoring e.g. patients with unstable or newly diagnosed angina, Downs syndrome, post viral fatigue (as seen post COVID-19) etc. Occupational Therapists can also advise on different types of physical activities available.

Patients who as part of their intervention plans are recommended to take part in structured supervised physical activity e.g. within a TEWV gym with a fitness instructor, should have their physical health assessed beforehand in order to identify any contraindications to exercise, and/or to identify people who should have a medical review before undertaking physical activity.

4.7 Tissue Viability

Tissue Viability is a growing specialty. It studies all aspects of skin and soft tissue wounds, including acute surgical wounds, chronic wounds, pressure ulcers, skin tears, trauma wounds, and leg ulcerations (Tissue Viability Society, 2014 [online]). However, wound care is not the only aspect of the tissue viability role; Tissue Viability Nurses (TVNs) also deliver education and training, develop practice, and undertake audits and research.

The Trust's Tissue Viability Service offers a referral system for staff requiring expert tissue viability advice for patients with wounds or pressure area prevention strategies. The referral form can be accessed via the tissue viability page of the Trust intranet.

The **Tissue Viability Policy** (also available via the Trust intranet) explains wound care management in more detail. Additionally, there are several other relevant procedures/guidelines relating to tissue viability which are referred to in this policy and which are also accessible from the Trust intranet:

- **Assessment, Prevention and Management of Moisture Associated Skin Damage**
- **Assessment, Prevention and Management of Pressure Ulcers Procedure**

- **Digital Wound Photography Procedure**
- **Lower Limb Wound Protocol**
- **Skin Tear Prevention and Management Procedure**
- **The Management of Wound Infections or Suspected Wound Infections Protocol**
- **Waterlow Pressure Ulcer Risk Assessment Interventions Protocol**
- **Wound Glue Procedure**

Where required, Physiotherapists can also advise on individual positional changes to reduce the risk of pressure sores.

4.8 Recovery and Wellbeing

In mental health services the term recovery is most frequently used to describe the personal lived experiences and journeys of people as they work towards living a meaningful and satisfying life. Recovery principles focus on the whole person in the context of their life, considering what makes that person thrive. For further information, please refer to the **Recovery and Wellbeing Strategy 2017-2020**, available via the Trust intranet).

The CHIME Framework describes the factors that contribute to personal wellbeing:

- **C**onnectedness
- **H**ope
- **I**dentity
- **M**eaning and purpose
- **E**mpowerment

(Leamy et al, 2011)

There is a two-way relationship between wellbeing and health: health influences wellbeing and wellbeing influences health (Department of Health, 2014 [online]). There are a number of correlations between wellbeing and physical health outcomes: improved immune system response, higher pain tolerance, increased longevity, cardiovascular health and slower disease progression.

Evidence suggests there are five actions into day-to-day lives that are important for health and wellbeing:

Connect…

With people around you, family, friends, colleagues, and neighbours either at home, work, school, in the local community or via the online community e.g. Virtual Recovery College.

Be active…

Go for a walk, run, or cycle. Step outside, play a game or do some gardening. Do an indoor activity e.g. physical workout app or housework. Most importantly, discover a physical activity that is enjoyable and is appropriate for your level of mobility and fitness either indoor or outdoor.

Take notice…

Be curious and aware of the world around you and what you are feeling. Reflecting on experiences can help people appreciate what matters to them.

Keep learning…

Try something new, rediscover an old interest, set a challenge that will be enjoyable to achieve. Learning new things can improve confidence as well as being fun.

Give…

Do something nice for a friend or a stranger. Thank someone. Smile. Volunteer your time or join a community group. Seeing yourself, and your happiness, linked to the wider community can be incredibly rewarding and creates connections with the people around you.

(New Economics Foundation, 2008 [online])

4.9 Palliative and End of Life Care Provision

The Trust provides care to a diverse range of patients across several specialties and localities, all of whom require varying degrees of need and support. This includes the delivery of care for patients who may have a palliative diagnosis or, who may be approaching the end of their life.

All staff who may be expected to care for patients requiring palliative care or end of life care must read and be familiar with the Trust's **End of Life Care Provision and Care After Death Policy**. The policy is available via the Trust intranet and contains comprehensive information on all aspects of end-of-life care provision and details essential information in order for staff to provide appropriate care after death.

What is Palliative Care?

Palliative care is treatment, care and support for people diagnosed with a life-limiting illness. The aim of palliative care is to provide a holistic approach to help individuals have the best quality of life possible. This means caring for the person's physical, emotional, psychological, social and other needs.

Palliative care involves:

- Managing physical symptoms (e.g. pain)
- Emotional, spiritual, and psychological support
- Support with activities of daily living (e.g. washing, dressing, or eating)

- Support for the individual's family and friends.

Staff may be required to care for patients who have life threatening or life limiting conditions - whether a form of cancer or non-cancer related physical and/or mental health diagnoses (i.e. dementia, frailty, heart failure, COPD). A life-limiting illness is an illness that can't be cured and is therefore life- threatening/terminal. Often, the terms 'progressive' (gets worse over time) or 'advanced' (at a serious stage) are also used to describe these illnesses. An individual may require palliative care at any stage of their illness. Delivering palliative care doesn't necessarily mean that the patient is expected to die soon - some individuals may require palliative care for months or even years. Palliative care may also be delivered alongside treatments, therapies and medicines aimed at controlling the illness, such as chemotherapy or radiotherapy. However, palliative care does include caring for people who are nearing the end of their life – this is sometimes called end of life care.

What is End of Life Care?

End of life care involves treatment, care and support for people who are nearing the end of their life. It is an important part of palliative care. Often, a specific end of life timeframe is difficult to predict and although some people may require end of life care for a longer period of time, many only require such care in their last weeks or days. End of life care aims to support the individual to be as comfortable as possible in the remaining time they have left.

End of life care involves:

- Managing physical symptoms (e.g. pain, nausea, secretions, agitation)
- Emotional, spiritual, and psychological support
- Support with activities of daily living (e.g. personal hygiene, pressure area care, continence care). It is important to understand and acknowledge that an individual's needs at end of life may differ to those requiring palliative care.
- Emotional support for the individual's family and friends

Specific e-learning training modules relating to end-of-life care are available to staff via ESR.

Registered Nurses working within MHSOP inpatient settings should undertake (as a minimum) the following end of life care training modules available via ESR:

- **000 e-ELCA 0.0 End of Life Care: Introduction**
- **000 e-ELCA 1.0 Advance Care Planning: Principles**
- **000 e-ELCA 2.0 Assessment: Principles**
- **000 e-ELCA 3.0 Communication Skills: Principles**
- **000 e-ELCA 4.0 Symptom Management: Principles**

Registered Nursing Staff working within all other inpatient settings, must undertake (as a minimum) the above end of life care training modules if there is an expectation that staff may be required to provide end of life care within the ward environment.

Additional modules can also be selected via ESR and completed (by all clinical staff) as needed to further enhance knowledge and understanding.

5 Definitions

[This section is a list of the terms used in this policy and what they mean]

Term	Definition
AUDIT-C Tool	• The Alcohol Use Disorders Identification Test - Concise (AUDIT-C) is a brief alcohol screening tool that can help identify patients who are hazardous drinkers or have active alcohol use disorders (including alcohol abuse or dependence).
Body Mass Index (BMI)	• BMI is a numerical measure of relative size based on the mass and height of an individual.
Chronic Obstructive Pulmonary Disease (COPD)	• COPD is a common, preventable, and treatable lung disease that is characterised by persistent respiratory symptoms and chronic obstruction of lung airflow that interferes with normal breathing and respiratory function.
Cardiovascular Disease	• Cardiovascular disease (CVD) describes disease of the heart and blood vessels caused by the process of atherosclerosis. The underlying cause of cardiovascular disease is the formation of plaques of atheroma that form in the walls of blood vessels. There are many risk factors that increase the likelihood of forming atheroma and its rate of development.
Diabetes Mellitus	• Diabetes mellitus is a condition characterised by raised blood glucose concentration. It is caused by an absolute or relative lack of the hormone insulin. This means that insulin is not being produced by the pancreas, or, that there is insufficient insulin being produced, or inadequate insulin action for the body's needs.

Diagnostic Overshadowing	• Diagnostic overshadowing refers to the process of over-attributing a patient's symptoms to a particular condition, resulting in key comorbid conditions being undiagnosed and untreated.
Dietitians	Dietitians are qualified and regulated health professionals who assess, diagnose, and treat dietary and nutritional problems. • Dietitians use the most up-to-date public health and scientific research on food, health, and disease which they translate into practical guidance to enable people to make appropriate lifestyle and food choices.
E-Cig/E-Cigarette/Electronic Cigarette Tank Model E-Cigarette	A battery powered device that delivers nicotine via inhaled vapour.
Lester Tool	• The Lester Tool is a framework which aims to guide healthcare professionals to assess the cardiometabolic health of individuals with serious mental illness in order to reduce mortality and to enable safe and effective physical healthcare.
Long Term Condition	• A long-term condition also known as a chronic condition is a health problem that requires ongoing management over a period of years or decades. A long-term condition is usually one that cannot be cured but can be controlled with the use of medication and/or use of other therapies.
NEWS	• The National Early Warning Score is based on a simple scoring system in which a score is allocated to six physiological observations. Each individual observation generates a score. When all six scores are added together, this provides the overall NEWS which is set to trigger when a patient is acutely unwell or has abnormal physiology.
NRT	• Nicotine Replacement Therapy

Physiotherapists	Physiotherapists consider the body as a whole, rather than just focusing on the individual aspects of an injury or illness. Some of the main approaches used by physiotherapists include: • Education and advice – physiotherapists can give general advice about things that can affect an individual's daily lives, such as posture and correct lifting or carrying techniques to help prevent injuries. • Movement, tailored exercise, and physical activity advice. Exercises may be recommended to improve general health and mobility, and to strengthen specific parts of the body. • Manual therapy – where the physiotherapist uses their hands to help relieve pain and stiffness, and to encourage better movement of the body.
Physiotherapy	Physiotherapy can be helpful for people of all ages with a wide range of health conditions, including problems affecting the: • Bones, joints, and soft tissue - such as back pain, neck pain, shoulder pain and sports injuries. • Brain or nervous system - such as movement problems resulting from a stroke, multiple sclerosis (MS) or Parkinson's disease. • Heart and circulation - such as rehabilitation after a heart attack. • Lungs and breathing - such as COPD and cystic fibrosis.
Reasonable Adjustments	• Removing barriers that people with disabilities face or providing extra support for individuals with disabilities to enable them to access the healthcare they need. This could relate to people with learning and/or physical disabilities, sensory impairments and/or individuals who are neuro diverse, as well as people living with mental illness (e.g. offering extra time to individuals who have particular communication needs and offering information and advice in a language and format that the individual can understand).

SANSI	• The St Andrews Nutrition Screening Instrument (SANSI) is a comprehensive screening tool developed for the use in inpatient mental health and learning disability settings.
Speech and Language Therapists (SLT)	Speech and Language Therapists (SLTs) provide life-improving treatment, support and care for children and adults who have difficulties with communication, eating, drinking, or swallowing. SLTs use specialist skills to: • Assess and offer advice, resources, and training to support people with communication difficulties to understand information and express their thoughts, wishes and needs. • Assess and offer advice, resources, and training to support people with eating, drinking or swallowing difficulties to maximise the enjoyment and safety of their mealtimes. • Work as part of the MDT to co-produce personalised support plans that the individual can understand and engage with.
Urinalysis	• Urinalysis is the physical, chemical, and microscopic examination of urine. It involves a number of tests to detect and measure various compounds that pass through the urine.
Venous Thromboembolism (VTE)	VTE is the collective term for: • Deep Vein Thrombosis (DVT) - a blood clot in in one of the deep veins in the body, usually in one of the legs. • Pulmonary Embolism - a blockage (most often from a blood clot) in one of the pulmonary arteries found in the lungs.
Waterlow Pressure Ulcer Risk Assessment Tool	• The Waterlow Pressure Ulcer Risk Assessment Tool is a recognised risk assessment tool to identify those at risk of developing pressure ulcers.

6 Related Documents

Admission, Transfer and Discharge Policy

Alcohol Detoxification: Inpatient Clinical Algorithm

Assessment, Prevention and Management of Pressure Ulcers Procedure

Asthma Guidance for Adults and Children

Cardiovascular Risks Guideline (Adults)

Chaperone Procedure

Clinical Link Pathway Falls (AMP, LD, Forensics only)

Clinical Link Pathway Frailty (which includes falls in MHSOP only)

Chronic Obstructive Pulmonary Disease (COPD) in adults (aged 16 and above) Guideline

Consent to Examination or Treatment Policy

Diabetes Management for Inpatients Guideline

Digital Wound Photography Procedure

Eating, drinking, swallowing difficulties (EDS, also known as dysphagia) Procedure

End of Life Care Provision and Care after Death Policy

Enteral Feeding (PEG) Procedure (Adults)

Enteral Feeding Jejunostomy (JEJ) Procedure for Learning Disabilities Adult and Children

Guidance on the use of High Dose Antipsychotic Treatment

Safety and Risk Management Policy (formerly called Harm Minimisation Policy)

Interpreting and Translation Guidance for Staff

Junior MARSIPAN: Management of Really Sick Patients under 18 with Anorexia Nervosa

Management of Coexisting Mental Illness and Substance Misuse (Dual Diagnosis) Policy

Managing Substance Misuse on Trust Premises Policy

Managing Substance Misuse on Trust Premises Procedure

MARSIPAN: Management of Really Sick Patients with Anorexia Nervosa

Nicotine Management Policy

Pain Assessment and Management Overarching Guideline

Safety and Risk Management Policy

Privacy and Dignity Policy

Procedure for Medicines Reconciliation

Procedure for Using the National Early Warning Score (NEWS) 2 for the Early Detection and Management of the Deteriorating Patient in adults (aged 16 and above)

Physical Health Delivery Plan 2024-26

Protocol for Hospital Transfers between TEWV NHS FT and Acute Hospitals

Protocol for Management of Substance Misuse in Inpatient Settings

Psychotropic Medication Monitoring Guide

Manual Handling of People Procedure

Rapid Tranquilisation (RT) Policy

Recovery and Wellbeing Strategy

Refeeding Syndrome Procedure

Risk Assessment for Venous Thromboembolism (VTE) Guideline

Royal Marsden

Skin Tear Prevention and Management Procedure

Stop Smoking Products Guidance

Tissue Viability Policy

Vitamin D: Testing and Treatment for Adult Inpatients Not Already Receiving Supplements

5 How this Policy will be Implemented.

- This policy will be published on the Trust's intranet site
- Line managers will disseminate this policy to all Trust employees through a line management briefing
- Each team/ward manager will ensure that staffs training needs are met in accordance with the Trust's training needs analysis
- Each healthcare professional is responsible for his or her own professional development and an individual's needs should be addressed through appraisal and training needs analysis
- Physical Health Core Skills Training (including refresher training) is available across the Trust for all mental health and learning disability registered nursing and nursing support staff.

7.1 Implementation Action Plan

[This section is only used for introducing **new processes** and sets out the explicit steps needed for the policy to work.]

Activity	Expected outcome	Timescale	Responsibility	Means of verification/ measurement
n/a				

7.2 Training Needs Analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
Registered and non-registered MH/LD Nursing Staff	Physical Health Core Skills Training Day (Registered Nurse: Inpatients)	1 Day	Once Only

Defined groups of staff will require additional education and training and this can be found within the education delivery plan section of the Trust Physical Health delivery plan

6 How the Implementation of this Policy will be Monitored.

Number	Auditable Standard/Key Performance Indicators	Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented, and monitored; (this will usually be via the relevant Governance Group).
1	Clinical Audit of Physical Health Assessments	Frequency = Annually Method = Audit Check List Person responsible = Audit Lead/Clinical Audit and effectiveness team	Executive Quality, Performance, and Improvement group. (EQAIG)
2	Clinical Audit of the National Early Warning Score (NEWS) Procedure for patients 16 years of age and over	Frequency = Annually Method = Audit Check List Person responsible = Audit Lead/ Clinical Audit and effectiveness team	Executive Quality, Performance, and Improvement group. (EQAIG)
3	Clinical Audit of Serious Mental	Frequency = Annually Method = Audit Check List	Executive Quality, Performance, and Improvement group. (EQAIG)

	Illness and Physical Health	Person responsible = Audit Lead/ Clinical Audit and effectiveness team	

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11 Document control (external)

To be recorded on the policy register by Policy Coordinator

Required information type	Information
Date of approval	18 March 2025
Next review date	18 March 2028
This document replaces	CLIN-0084-v3 Physical Health and Wellbeing Policy
This document was approved by	Fundamental standards of holistic care CAG
This document was approved	05 February 2025
This document was ratified by	Management Group
This document was ratified	18 March 2025
An equality analysis was completed on this policy on	30 September 2024

Document type	Public
FOI Clause (Private documents only)	n/a

Change record.

Version	Date	Amendment details	Status
1	02 Sep 2015	New policy	Withdrawn
2	03 May 2017	Full review to include the standards for physical healthcare on referral and ongoing monitoring within community services	Withdrawn
2	07 Feb 2020	Review date extended from 03/05/2020 to 31/12/2020.	Withdrawn
2	10 Dec 2020	Review date extended six months to 30 June 2021	Withdrawn
3	14 July 2021	Full review and update with additional sections added and evidence-based references	Withdrawn
3	06 September 2023	New date references and link to Lester Tool 2023 from 2014 version and 'alcohol use' added to 4.3.1, paragraph 2, pg 29	Withdrawn
4	18 Mar 2024	Full Review and updated in line with national policies including NICE guidance. The policy has had an additional section to include menopause.	Ratified

Appendix 1 - Equality Impact Assessment Screening Form

Please note: The Equality Impact Assessment Policy and Equality Impact Assessment Guidance can be found on the policy pages of the intranet

Section 1	Scope
Name of service area/directorate/department	Nursing and Governance/Physical Health
Title	Physical Health and Wellbeing Policy
Type	Policy
Geographical area covered	Trust wide
Aims and objectives	To support the implementation of physical healthcare provision across the Trust in keeping with current evidence-based practice.

	To ensure patients and employees are provided with appropriate information and guidance with regard to physical healthcare, NHS screening and health promotion.
Start date of Equality Analysis Screening	10th July 2024
End date of Equality Analysis Screening	30th Sept 2024(additions made through August and September)

Section 2	Impacts
Who does the Policy, Procedure, Service, Function, Strategy, Code of practice, Guidance, Project, or Business plan benefit?	The Policy benefits patients and staff. It standardises the processes to provide proper physical healthcare. The Policy also aims to reduce clinical risks. These arise from mismanaging patients' physical health. The Policy will also help manage and deliver physical healthcare. It aims to ensure patients receive safe and effective care. This care should follow the latest local and national best practices.
Will the Policy, Procedure, Service, Function, Strategy, Code of practice, Guidance, Project, or Business plan impact negatively on any of the protected characteristic groups? Are there any Human Rights implications?	• **Race** (including Gypsy and Traveller) **NO** • **Disability** (includes physical, learning, mental health, sensory and medical disabilities) **NO** • **Sex** (Men and women) **NO** • **Gender reassignment** (Transgender and gender identity) **NO** • **Sexual Orientation** (Lesbian, Gay, Bisexual, Heterosexual, Pansexual and Asexual etc.) **NO** • **Age** (includes, young people, older people – people of all ages) **NO**

	• **Religion or Belief** (includes faith groups, atheism, and philosophical beliefs) **NO** • **Pregnancy and Maternity** (includes pregnancy, women / people who are breastfeeding, women / people accessing perinatal services, women / people on maternity leave) **NO** • **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) **NO** • **Armed Forces** (includes serving armed forces personnel, reservists, veterans, and their families) **NO** • **Human Rights Implications NO** (Human Rights - easy read)
Describe any negative impacts / Human Rights Implications	Having identified a 'potential' negative impact to the protective characteristic of age due to <12yrs not being able to receive NRT (nicotine replacement therapy), staff are advised to refer patients of this age range to primary care services to ensure parity across all age groups.
Describe any positive impacts / Human Rights Implications	The positive impacts of the policy are patients receive effective and appropriate physical healthcare provision that is standardised Trust wide and supported by current local and national guidance in accordance with best practice.

Section 3	Research and involvement
What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)	NICE Guidance. National NHS England Guidance. Government legislation.
Have you engaged or consulted with patients, carers, staff, and other stakeholders including people from the protected groups?	Yes
If you answered Yes above, describe the engagement and involvement that has taken place	The Trust Guideline follows key national documents from NICE, the Department of Health, NHS England, and Public Health England. There was no patient consultation when writing this document. However, there has been involvement with various healthcare professionals within the Trust. This Guideline is a standardised approach. It helps clinical staff at TEWV NHS Foundation Trust follow national best practices and guidance.
If you answered No above, describe future plans that you may have to engage and involve people from different groups	

Section 4	Training needs
As part of this equality impact assessment have any training needs/service needs been identified?	Yes
Describe any training needs for Trust staff	There are no specific training needs identified for this specific guideline. However, some of the required interventions within the guideline may be cross-referenced as training needs specific to other guidelines, policies, and procedures. The Physical Health Core Skills Training is therefore identified as a training need.
Describe any training needs for patients	Nil
Describe any training needs for contractors or other outside agencies	Nil

Check the information you have provided and ensure additional evidence can be provided if asked.

Appendix 2 – Approval Checklist

To be completed by lead and attached to any document which guides practice when submitted to the appropriate committee/group for consideration and approval.

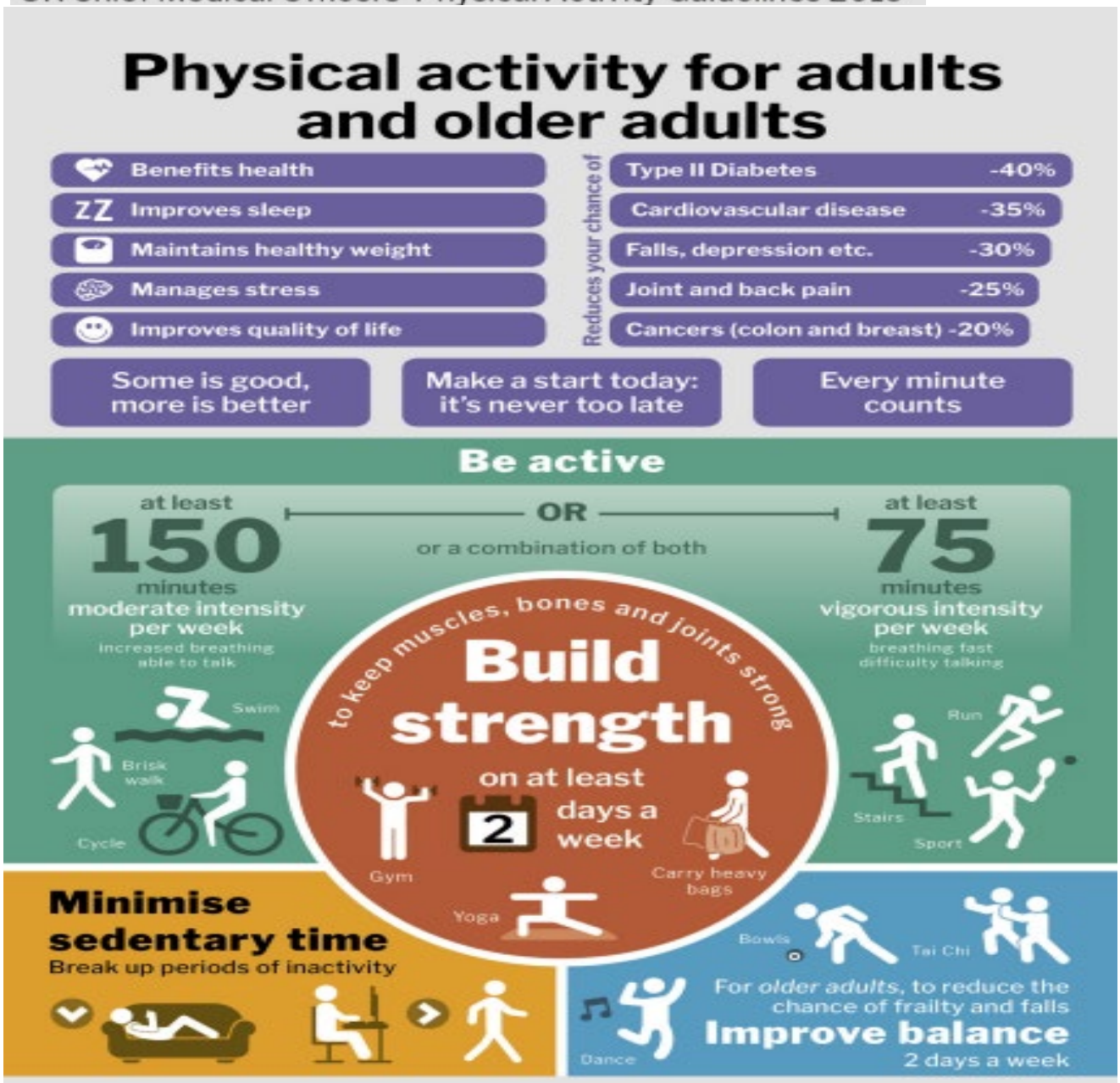
Title of document being reviewed:	Yes / No / Not applicable	Comments
1. Title		
Is the title clear and unambiguous?	Yes	
Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2. Rationale		
Are reasons for development of the document stated?	Yes	
3. Development Process		
Are people involved in the development identified?	Yes	
Has relevant expertise has been sought/used?	Yes	
Is there evidence of consultation with stakeholders and users?	Yes	
Have any related documents or documents that are impacted by this change been identified and updated?	Yes	
4. Content		
Is the objective of the document clear?	Yes	
Is the target population clear and unambiguous?	Yes	
Are the intended outcomes described?	Yes	
Are the statements clear and unambiguous?		
5. Evidence Base		
Is the type of evidence to support the document identified explicitly?	Yes	

Are key references cited?	Yes	
Are supporting documents referenced?	Yes	
6. Training		
Have training needs been considered?	Yes	
Are training needs included in the document?	Yes	
7. Implementation and monitoring		
Does the document identify how it will be implemented and monitored?	Yes	
8. Equality analysis		
Has an equality analysis been completed for the document?	Yes	
Have Equality and Diversity reviewed and approved the equality analysis?	Yes	
9. Approval		
Does the document identify which committee/group will approve it?	Yes	
10. Publication		
Has the policy been reviewed for harm?	Yes	
Does the document identify whether it is private or public?	Yes	
If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	Yes	
11. Accessibility (See intranet accessibility page for more information)		
Have you run the Microsoft Word Accessibility Checker? (Under the review tab, 'check accessibility'. You must remove all errors)	Yes	
Do all pictures and tables have meaningful alternative text?	Yes	

Do all hyperlinks have a meaningful description? (do not use something generic like 'click here')	Yes	

Appendix 3 - Physical Activity Benefits Guide for Adults and Older Adults

UK Chief Medical Officers' Physical Activity Guidelines 2019



Appendix 4 – NHS Population Screening Timeline

Please see over page for poster.

Or use this link to access https://assets.publishing.service.gov.uk/media/6560bf130c7ec8000d95be1f/Population_screening_timeline_national_Nov_2023.pdf

Population screening timeline

NHS

Abdominal aortic aneurysm (AAA) screening

Offered to **men** during the **year they turn 65**. Older men can self-refer.

www.nhs.uk/aaa

Age 70

Age 65

Age 60

Bowel cancer screening

Offered to **people** aged **60 to 74 every 2 years**. Screening is gradually being offered to people in their 50s as well. Those aged 75 or over can request screening by calling **0800 7076060.**

www.nhs.uk/bowel

Age 55

Age 50

Breast screening

Offered routinely every 3 years to **women** aged from **50 up to their 71st** birthday. Older women can self-refer.

www.nhs.uk/breast

Age 45

Age 40

Age 35

Age 30

Cervical screening

Offered to **women** aged from **25 to 49** every 3 years, and **women** aged **from 50 to 64** every 5 years.

www.nhs.uk/cervical

Age 25

Age 20

Diabetic eye screening

Offered to **people** with diabetes **aged 12 and over** every 1 or 2 years depending on the results from their last 2 screening tests

www.nhs.uk/diabeticeye

Age 15

Age 12

Age 5

Newborn screening

- **newborn** hearing
- physical examination (for problems with eyes, hearts, hips and testes) within **3 days** of birth and again at **6 to 8 weeks** of age
- **newborn** blood spot (for 9 rare conditions)

www.nhs.uk/pregnancyscreening

Newborn

Week 27

Week 18

Screening in pregnancy

- sickle cell and thalassaemia (ideally by **10 weeks**)
- infectious diseases (HIV, hepatitis B and syphilis)
- Down's syndrome, Edwards' syndrome and Patau's syndrome
- 11 physical conditions in the baby (**20-week** scan)
- diabetic retinopathy (for women with diabetes)

www.nhs.uk/pregnancyscreening

Week 9

Conception