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Physical Health and Wellbeing Policy

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1 Introduction

Tees Esk and Wear Valleys (TEWV) NHS Foundation Trust promotes the provision of collaborative mental and physical health to ensure that all service users receive the right care, at the right time, in the most suitable health care environment. All collaborative mental and physical healthcare including: assessment, intervention, treatment, monitoring and review should follow best practice principles and incorporate national and/or local guidance and recommendations wherever possible. Likewise, collaborative care delivery should be provided as part of a broader, holistic approach to supporting our service users Trust wide. In order to do this, staff must be able to access and utilise appropriate resources, develop knowledge and skills to fulfil their role, and also, be able to seek advice, guidance and support from other professionals, NHS organisations or specialist services where necessary.

It is also important to recognise that the priority of care (be that from a mental health, or alternatively, a physical health perspective) may vary, depending on the individual's presentation, urgency of the situation or specific circumstance to which a particular decision or intervention must be considered. Despite these potential challenges, collaborative mental and physical health is paramount to ensure the needs of the individual are met at any given time, and to maintain parity so that our service users receive appropriate, safe, high quality combined care regardless of the Trust care setting.

As stated by the Department of Health (2016), people with a mental illness should be offered the same physical health screening, monitoring and review as the general population, and where indicated, have any required interventions undertaken or be signposted to address any issues identified. 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 a SMI (Public Health England (PHE), 2018a [online]). People with a mental illness such as Schizophrenia or Bipolar Disorder die on average 15-20 years sooner than the general population. This can be attributable to preventable physical conditions such as respiratory and cardiovascular disease and/or poor access to physical healthcare monitoring and assessment (PHE, 2018a [online]).

In general, people with a learning disability have poorer health and die on average 20 years younger than people without a learning disability. Many of the causes of poor health are avoidable. Inpatient admissions offer an invaluable opportunity to monitor and manage the physical health of people with a learning disability (University of Bristol - Confidential Inquiry into Premature Deaths of People with Learning Disabilities (CIPOLD), 2013 [online]). Additionally, individuals with autism are more prone to the side effects of psychiatric drugs. Therefore, lower doses and shorter duration of treatment should be considered. The national guidance relating to the stopping over medication of people with a learning disability, autism or both (STOMP) agenda should be considered (NHS England, 2020 [online]).

Where required, reasonable adjustments must be provided to support service users to access relevant and appropriate physical healthcare, and also, to help service users to understand the information, recommendations and/or advice regarding physical health that is given to them. It is

also important to acknowledge a service user's personal preferences and wishes. Wherever possible, these preferences must be taken into account 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 also, the **Privacy and Dignity Policy**, both of which are available via the Trust intranet.

The Trust is committed to providing holistic care and promoting the wellbeing of service users. We believe that service users of mental health and learning disability services should have access to the same quality of physical healthcare as the general population. A service user's physical health is of equal importance to their mental health and must be reflected in the care they receive. As such, a person's mental and physical health requirements are intrinsic to the care planning process as it is often the combination of both of these key elements that optimises patient specific goals and objectives.

2 Why we need this policy

2.1 Purpose

Whilst the delivery of specialist physical healthcare provision is not the main clinical purpose of TEWV NHS Foundation Trust, it is acknowledged that TEWV Trust staff are required to facilitate, support, monitor and respond to the physical health needs of our service users.

It is also important that those accessing TEWV services are offered physical health screening, intervention and ongoing monitoring and that individuals' physical healthcare needs are not overlooked or disadvantaged because of their mental illness and/or learning disability.

As people live longer, there are an increasing number of service users who have comorbid physical and mental illnesses or learning disability conditions, many of which require complex, skilled interventions and require delivery of care within mental health and/or learning disability inpatient settings such as the inpatient services provided by TEWV NHS Foundation Trust.

Additionally, those already known to TEWV services may unexpectedly present with an acute physical health related complaint and require a physical health assessment/examination and subsequent investigation because they display specific signs and/or symptoms.

As an organisation, the Trust recognises the importance of physical healthcare as an integral part of the good health and social care that everyone should receive. Therefore, the purpose of this policy is to:

- Ensure that all staff are aware of the agreed physical healthcare standards required to comply with Care Quality Commission (CQC) standards, National Health Service Litigation

Authority (NHSLA) standards, National Institute for Health and Care Excellence (NICE) and local guidance.

- Ensure that clinical teams are provided with support and guidance that will enable staff to assess, monitor, review and manage the physical healthcare needs of service users within their level of competency.
- Ensure that service users receive physical healthcare that is individualised, holistic and evidence based, in accordance with their needs, preferences and wishes.
- Ensure that the delivery of physical healthcare is of an optimal standard.
- Ensure that the service user and those identified as important to the service user are involved in discussions and decisions about physical healthcare.
- Ensure that any major physical health issues and/or physical health issues that impact on mental health, are captured in the service user's Safety Summary, and where relevant, also in the Safety Plan.
- Ensure that an individual physical health care plan and/or any individualised physical health intervention plans are implemented, revised and updated regularly by the relevant qualified physical healthcare professionals.
- Ensure that physical healthcare is delivered to individuals with dignity, sensitivity and compassion.

2.2 Objectives

The objectives of this policy are to:

- Ensure that a standardised approach to physical healthcare is maintained by TEWV Trust staff.
- Minimise the risk of harm to service users receiving care by outlining best practice principles in relation to the provision and delivery of appropriate and timely 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, and promote staff to seek advice or refer to an appropriate healthcare professional or specialism where necessary
  - Promote clear, concise contemporaneous record keeping in relation to physical healthcare
  - Support individuals, family/carers, fellow service users and staff
- Ensure that fair and equal treatment is offered to all service users across the Trust (who may require physical healthcare).
- Ensure that TEWV Trust staff are aware of the importance of physical healthcare including the significance of a holistic, person-centred approach to care delivery.
- Support the implementation of high quality physical healthcare Trust wide.

3 Scope

3.1 Who this policy applies to

This policy applies to all staff working within TEWV NHS Foundation Trust who have a responsibility for promoting and providing good physical healthcare. All clinical staff have a responsibility to take every opportunity to advise, signpost, support and empower service users in relation to physical healthcare including the importance of healthy lifestyle choices and potential risk factors.

Although the policy applies to all healthcare professionals, key roles and responsibilities are outlined in **Section 3.2 Roles and Responsibilities**.

3.2 Roles and Responsibilities

Role	Responsibility
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 service users.
Executive Director of Nursing and Governance	• 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, Heads of Service and Locality 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 service users 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 service users. • 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 service users 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 service users. • 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 service users 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 service users. • Responsible for accessing and completing resuscitation training as required to maintain competency.
Care Coordinators	• 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 service user's physical healthcare CPA review. • Responsible for providing support to service users 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 service users. • 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 service users, and signposting to appropriate services. • Responsible for the ongoing monitoring of service users' physical health through a variety of methods (e.g. observational skills, communication skills, service user 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 service users. • 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 service users. • 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 service users 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 service users. • 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 service users. • 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 service users. • 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 service users.
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 service users, fellow service users, 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 recognises the importance of supporting primary care colleagues to ensure ongoing, appropriate physical healthcare is maintained and that physical health examination, assessment, treatment and review are effectively managed within the community setting.

Where required, reasonable adjustments must be provided to support service users to access physical healthcare in the community, and also, to help service users to understand the information, recommendations and/or advice regarding physical health that is given to them.

It is also important to acknowledge a service user's personal preferences and wishes. These preferences must be taken into account to promote collaborative decision making. Staff should have an awareness of a person's trauma history and consider with the patient if and how this may need to be taken into account in order to promote their privacy and dignity, and be aware of how breaching this may potentially cause iatrogenic harm. Further information to support staff can be obtained from the **Privacy and Dignity Policy** and the **Consent to Examination or Treatment Policy**, available via the Trust intranet.

As part of robust physical healthcare provision, all service users should be offered and encouraged to have the necessary investigations required to establish a comprehensive physical health baseline e.g. physiological observations, bloods, electrocardiogram (ECG) and urinalysis (where indicated). Additional investigations and/or physical health risk assessments may also be necessary depending on the individual's mental health diagnoses, prescribed medication, lifestyle factors and physical health comorbidities.

In accordance with the **Consent to Examination or Treatment Policy**, staff must ensure the following:

- Ascertain whether the service user is registered with a GP. Encourage, and where appropriate facilitate registration with a GP if not already registered.
- Care Coordinators/Lead Professionals must ensure that physical health assessment forms part of the MDT approach to care and review, and where required, support the service user to access their local GP practice.
- Service users should be encouraged to attend their own GP practice for an annual health care review. There are specific annual health checks provided by GPs for people with a learning disability and/or a SMI. Current NHS guidance states that anyone with a learning disability over the age of 14 years is eligible to access an annual health check from their GP.

- Children and young people must be encouraged and (where clinically appropriate) be supported to attend regular health care checks/reviews with their Paediatrician or GP.
- With consent from the service user, request relevant background medical history from the GP or appropriate clinician.
- People with a learning disability should have a 'summary care record' from their GP to inform health care professionals about information which is important to the person, including medications, allergies, communication and what reasonable adjustments are required for that person. Accessing the summary care record is recommended where possible.
- Secondary care mental health and learning disability services have specific responsibilities for monitoring such service users who have commenced on certain prescribed medications (i.e. antipsychotics for 12 months or longer, or until the service user is stable (NICE, 2014a [online]). Monitoring is therefore an essential component of physical healthcare provision.
- If the service user is unable or unwilling to attend a GP appointment for a physical health assessment or review, alternative arrangements within the MDT should be offered.
- Individual care plans should be co-produced with the service user and documented on the patient's electronic care record.
- If necessary, service users must be provided with easy read information and/or translated information to support them to understand the information and/or the advice given to them.
- Where required, reasonable adjustments must be provided to enable service users to access healthcare settings and services.

It is the responsibility of the requesting clinician to ensure that all required physical health assessments and/or investigations are tasked and completed accordingly, and that the review or follow-up of results and/or actions are completed appropriately and in a timely manner. All results from any assessments/investigations must be reviewed by an appropriately qualified clinician.

All discussions, care provision, interventions and results relating to an individual's physical healthcare should be documented on the service user's electronic care record, including any necessary treatment/management or further monitoring plans.

4.1.2 Ongoing Physical Healthcare Monitoring within Community Services

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

- Care Coordinators/Lead Professionals must ensure that ongoing physical healthcare monitoring is part of the care coordination/care programme approach (CPA) review process.
- As part of the care coordination/CPA process, ensure that physical healthcare is reviewed and/or evaluated when: there is a clinical need, there is clinical contact with the service user, and also, every 6 months as part of a full review. All reviews/evaluations should be clearly documented on the service user's electronic care record. Further information can be obtained from the **Care Programme Approach and Standard Care Policy and Framework** which can be accessed via the Trust intranet.
- During a CPA review and planned visits, observe for evidence of physical health deteriorating including deterioration from pre-existing long term physical health conditions such as Diabetes, Chronic Obstructive Pulmonary Disease (COPD) or Cardiovascular Disease (CVD),

and liaise with appropriate healthcare professionals where necessary e.g. GP/Specialist Teams/Acute Hospital Trusts.

- Ensure that any major physical health issues and/or physical health issues that impact on mental health, are captured in the service user's Safety Summary, and where relevant, also in the Safety Plan.
- People with autism may have difficulties accessing mainstream health services. Visiting a GP can in some instances be anxiety-provoking as it may be an unfamiliar environment. It can be helpful to prepare the service user by visiting the clinic a day or two before the actual appointment date and where possible, consider the first or last appointment of the day to avoid prolonged waiting times.
- Encourage and facilitate service users to access relevant health promotion services within the community.
- Where required, provide reasonable adjustments to enable service users to access health promotion services.
- Adhere to relevant Trust policy, procedure and/or guidelines for any specific physical health monitoring.
- Review and document any medication side effects and/or allergy status on the electronic care record.
- Ensure that medication review dates are clearly documented on the electronic care record including the professional(s) role responsible.
- Ensure that all monitoring schedules (required for specific medications) are clearly documented on the electronic care record including the professional(s) role responsible.
- Document any reasonable adjustments required to support and enable the service user to access healthcare settings and services on the electronic care record.

4.2 Physical Healthcare Provision within Inpatient Settings

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

All service users admitted to an inpatient ward/unit must be offered and encouraged to have a physical health examination and assessment commencing within 24 hours of admission. Ideally, and wherever possible, this should be undertaken as part of the admission clerking process. If the examination and assessment cannot be completed at this time, a clear plan detailing when this is to be undertaken must be documented on the service user's electronic care record. A verbal or written 'handover' is also required (from the clerking clinician to the subsequent clinician or team whose responsibility it is to further attempt the physical health examination and assessment). Wherever possible, staff should try to facilitate the service user's request regarding the gender of the clinician performing the physical health examination.

When providing a physical health examination and assessment, service users must be offered a chaperone. Further information regarding the Trust's required practice for the use of chaperones can be obtained from the Trust's **Chaperone Procedure**, available via the Trust intranet. Wherever possible, staff should try to facilitate the service user's request regarding the gender of the chaperone.

It is also important that staff have an awareness of a person's trauma history and consider with the patient if and how this may need to be taken into account to promote their privacy and dignity, and be aware of how breaching this may cause iatrogenic harm. Further information can be obtained from the **Privacy and Dignity Policy**, available via the Trust intranet.

Staff should also be aware of the language/communication needs of the individual and consider whether there is a need for an interpreter, or other reasonable communication adjustment be implemented to support the individual to be involved as part of the physical health examination and assessment process. Further information can be obtained from the **Interpreting and Translation Guidance for Staff**, available via the Trust intranet.

Once performed, the comprehensive physical health examination and assessment, and subsequent findings (inclusive of any necessary treatment plan) must be documented on the service user'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 service user's Safety Summary, and where relevant, also in the Safety Plan.

In addition, and as part of the physical health examination and assessment, all service users should be offered and encouraged to have the necessary investigations required to establish a comprehensive physical health baseline e.g. physiological observations, bloods, ECG and urinalysis (where indicated). Additional investigations and/or physical health risk assessments may also be necessary depending on the individual's mental health diagnoses, prescribed medication, lifestyle factors and physical health comorbidities.

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

All discussions, care provision, interventions and results relating to an individual's physical healthcare should be documented on the service user's electronic care record, including any necessary treatment/management or further monitoring plans.

Where required, reasonable adjustments must be provided to support service users with the physical health examination and assessment process, and also, to help service users to understand the information, recommendations and/or advice that is given to them.

If on admission there is uncertainty regarding a person's gender, ask discreetly where the person would be most comfortably accommodated, and where possible, facilitate 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 service user 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 service users should have the following assessments and investigations undertaken:

- **Physical health examination and assessment**
- **Full set of physiological observations including National Early Warning Score (NEWS)**
- **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 service users 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 Service Users 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 service users 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 service users 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 service users 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 service users 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 service users 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 service user'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 service user, 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 service user 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.
- **Dysphagia Assessment** – if the service user 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 service user, 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 service user, or concerns regarding urine output?
- **Food Record Chart** - is the service user underweight or at risk of malnutrition?
- **Patient Stool Record Chart** - is the service user constipated or at risk of constipation? Alternatively, does the service user have loose stools or diarrhoea?
- **Wound Assessment and Management Chart** - does the service user present with a wound/pressure ulcer?
- **Positional Change Chart** - can the service user reposition independently and/or are they at risk of developing a pressure ulcer?
- **Sleep -** does the service user have difficulties sleeping or require their sleeping pattern to be monitored?

In terms of harm minimisation, consider the service user's assessment and management of clinical risk in order to promote recovery and enhance safety - Please refer to the **Policy for Harm Minimisation**, available via the Trust intranet.

During the admission process, service users will be cared for utilising a MDT approach. Trust staff must work together to establish and promote the mental, physical, psychological and emotional health needs of individuals. The importance of continuity of care must also be considered and where required, collaborative input sought from community mental health teams (CMHTs), liaison/crisis involvement and non-trust staff and/or organisations where necessary (e.g. from an Acute Hospital Trust should a person require a direct hospital admission/transfer into TEWV services. Anyone admitted to an assessment and/or inpatient ward environment will automatically be placed onto the CPA. Further information can be obtained from the **Care Programme Approach and Standard Care Policy and Framework** which can be accessed via the Trust intranet.

Admissions to Specific Services

Learning Disability Inpatient Services

Service users admitted to a learning disability inpatient ward/unit should have a Health Action Plan completed as part of the admission process by the Care Coordinator/Lead Professional, or the initial assessor.

The Health Action Plan is a document that helps to plan the care needs of an individual (including any relevant management strategies) to assist in supporting the ongoing health requirements of the person e.g. attending regular dental appointments. This document should be regularly updated as the person attends the relevant appointments and can be shared with those healthcare professionals involved in delivering such care.

Eating Disorder Inpatient Services

Service users admitted to an eating disorder inpatient ward/unit should have their physical health assessment/examination and management plan formulated with specific consideration given to:

- Adults: MARSIPAN: Management of Really Sick Service users with Anorexia Nervosa
- Children and Young People: Junior MARSIPAN: Management of Really Sick Service users under 18 with Anorexia Nervosa.

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

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

If the service user continues to decline a physical health examination and assessment, this should be reviewed by the senior medical doctor responsible for the individual. The review should be documented on the electronic care record and a care-plan formulated as to how the team intends to proceed.

Where required, reasonable adjustments must be provided to support service users with the physical health examination and assessment process, and also, to help service users to understand the information, recommendations and/or advice that is given to them.

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

4.2.3 Medication

It is essential that when service users are admitted to hospital, an up-to-date and accurate medication list is obtained detailing all medicines prescribed for any mental health and/or physical health related conditions. Please refer to the Trust's **Procedure for Medicines Reconciliation** for further information, available via the Trust intranet.

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

All TEWV learning disability services adhere to the stopping over medication of people with a learning disability, autism or both (STOMP) agenda (NHS England, 2020a [online]) when prescribing medication.

It is important to remember that primary medication administration routes may vary from one service user to another. Some routes of administration such as percutaneous endoscopic gastrostomy (PEG) and Jejunostomy (JEJ) are often used for service users with profound and multiple learning disabilities. Please refer to the **Enteral Feeding (PEG) Procedure (Adults)** or the **Enteral Feeding Jejunostomy (JEJ) Procedure for Learning Disabilities Adult and Children**, both available via 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 service user

safety improved.

Service users on antipsychotic medication are at an increased risk of developing diabetes, heart disease and stroke, weight gain and obesity.

Support must be offered to service users 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 Service Users with a SMI** and **Section 4.4 Health Promotion**.

4.2.4 Transfer between Inpatient Settings within the Trust

On transfer from one inpatient setting to another (within TEWV), it is not necessary for the receiving ward/unit to repeat a full physical health assessment and examination as for a newly admitted patient. Rather, it will be the responsibility of the admitting team to check what has already been completed for the patient, and also, what remains outstanding in terms of any further treatment or monitoring.

As a minimum on transfer, physiological observations and NEWS must be recorded by the receiving ward/unit team, and should staff have any concerns from a physical health perspective, a referral to the most appropriate professional should be undertaken as soon as possible. In circumstances requiring more urgent attention, the Duty Doctor should be informed and/or consideration given to contacting the emergency services.

Similarly, when preparing a service user for transfer to another inpatient setting within TEWV, the transferring team should ‘hand over’ any outstanding or ongoing physical healthcare needs and requirements that the person may have. This should include any physical health related treatment(s) or interventions.

Further information regarding the transfer of a service user within Trust inpatient settings can be obtained from the **Admission, Transfer and Discharge Policy**, and also, from the **Care Programme Approach and Standard Care Policy and Framework**, both of which can be accessed via the Trust intranet.

4.2.5 Ongoing Physical Healthcare Monitoring within Inpatient Settings

All ongoing physical healthcare monitoring, treatment, intervention and review should be clearly documented on the service user’s electronic care record.

It is essential that processes are in place locally to ensure that information relating to the service user's physical health is shared as part of a collaborative MDT approach to care provision.

Ongoing physical healthcare monitoring not only includes the required interventions, care and regular review necessary to manage existing conditions but also, includes all physical healthcare monitoring that may help to recognise and identify any potential deterioration to physical health.

Physical health deterioration can occur at any stage of a service user'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 service users 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 recognised track and trigger tool that is used to record physiological observations (vital signs), and which generates a score for each observation. The accumulated scores are then added together to produce an overall total score (NEWS). The total score provides a sensitive indicator of abnormal physiology, enabling staff to effectively identify the physically deteriorating or acutely ill patient by recognising the vital sign (or signs) that is below or beyond normal parameters.

All staff involved in the performing, recording, reporting and/or reviewing of physiological observations must be familiar with the **Procedure for Using the National Early Warning Score (NEWS) 2 for the Early Detection and Management of the Deteriorating Service User in Adults (aged 16 and above)**, available via the Trust intranet.

Although early warning score systems have been used for many years within NHS organisations, the key difference with NEWS is that it is nationally recognised, and so, the parameters are standardised rather than there being variability between hospital Trusts. NEWS is now used throughout the NHS including Acute Hospital Trusts, Ambulance Services, Primary Care and many Private Healthcare Sectors.

When used correctly NEWS supports the escalation of concerns - be that to a Senior Nurse, a Doctor or Physical Healthcare Practitioner to promote the fast and effective management of a service user's physical health. 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 service users 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 service users who are transferred between inpatient settings, NEWS should be completed on arrival at the receiving ward/unit and if there are no changes to presentation, further monitoring can continue as agreed by the previous MDT, unless there is a cause for concern (necessitating an increase in 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 service user'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.

In addition to the ongoing monitoring of physiological observations, the ongoing monitoring of a service user's physical health and wellbeing must include regular review, signposting, advice and support relating to: health promotion, health screening, dental care, sexual health, chiropody/podiatry services, nutrition, physical function, physical activity, skin integrity, auditory and optometry services. Access to these services should 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 service user's electronic care record. See additional information detailed in **Section 4.4 Health Promotion**.

Where required, reasonable adjustments must be provided to support service users with ongoing physical health monitoring, and also, to help service users 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, service users 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 Service User 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 service user who has been an inpatient for 12 months (or longer) must be offered an annual physical health review inclusive of a comprehensive physical health re-assessment and examination.

Any service user 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 service user's electronic care record.

4.2.6 Management of Long Term Conditions

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. Long term conditions can affect many parts of a person's life, from their ability to work and have relationships to housing and education opportunities (Department of Health, 2012).

More than 8 million people in England live with three or more long term health conditions. Improving integrated care and collaborative services can have a huge impact on the lives of people with several long term conditions, how they manage their health and wellbeing and how they encounter the health and care system.

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

- Advice should be sought from specialist services/clinicians within the Trust (e.g. Physical Healthcare Practitioners or Allied Health Practitioners from the relevant discipline), and if necessary, or if there are significant changes to the service user's physical and/or mental health which impacts on their long term condition, from specialist services at the local Acute Hospital Trust.
- It is essential that all efforts are made to ensure that service users attend clinic/outpatient appointments, and receive appropriate screening and review associated with their long term condition.

NICE has produced a vast number of guidelines, publications and quality standards to aid in the prevention and also, the ongoing management of physical health related long term conditions. These must be taken into consideration when developing appropriate and robust intervention plans Examples include: Type 2 Diabetes in Adults: Management (NICE, 2015, updated 2020 [online]); Hypertension in Adults: Diagnosis and Management (NICE, 2019 [online]); Cardiovascular Disease: Risk Assessment and Reduction, including Lipid Modification (NICE, 2014, updated 2016 [online]); Chronic Obstructive Pulmonary Disease in Over 16s: Diagnosis and Management (NICE, 2018, updated 2019 [online]).

Where required, reasonable adjustments must be provided to support service users with the ongoing management of a long term condition (including any monitoring and/or treatment plans), and also, to help service users to understand any information, recommendations and/or advice that is given to them in respect of their condition.

Service users 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

Service users 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 service users to attend all healthcare related appointments.

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

Further information regarding the attendance of a service user 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

Service users who require specialist physical healthcare or intervention should be referred and/or transferred to the appropriate clinician/specialism at the applicable Acute Hospital Trust for assessment, examination and treatment, and to establish a suitable management plan. 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 service user is transferred from an Acute Hospital Trust to a TEWV inpatient setting, staff must also follow the **Protocol for Hospital Transfers between TEWV NHS FT and Acute Hospitals** and complete all required assessment documentation.

Further information regarding the transfer of a service user 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 provided to enable service users to access services provided by other healthcare providers, and also, to help service users to understand the information, recommendations and/or advice that is 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 service user 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 service user from an inpatient setting should commence at the earliest opportunity. Evidence shows that discharges that are planned are the safest and most appropriate method. Discharge planning should be undertaken in collaboration with the service, the service user and the wider MDT providing ongoing continuity of care.

If a service user is receiving care from more than one healthcare professional or service, there must be a clear plan on how services will share information and communicate effectively to manage the continuation of physical healthcare intervention plans.

When a service user is discharged to a CMHT or other service, a Care Plan Review Meeting must include documented details of the physical health assessment and ongoing physical health needs.

Further information regarding discharge from an inpatient setting can be obtained from the **Admission, Transfer and Discharge Policy**, and also, 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 Service Users with a SMI

As mentioned, all service users who are diagnosed with a SMI should have their cardiometabolic health assessed on admission, as part of a wider physical health assessment. Any advice, treatment and/or subsequent investigations or monitoring (depending on the findings of the assessment) should be offered as standard, and clearly documented on the service user'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 physical health conditions such as CVD, respiratory disease, diabetes and hypertension (PHE, 2018a [online]).

In order to promote and support care delivery to service users 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, one of the greatest risks to the physical health of service users with a SMI is the high incidence of CVD caused by the potential metabolic side effects of some medications (i.e. antipsychotics), and other lifestyle factors such as smoking, diet and physical activity. See additional information in **Section 4.3.2 Other Recommended Assessment Tools**.

In addition NICE/PHE publish a range of material such as clinical guidelines, quality standards and public health guidance relating to numerous physical health diagnoses and conditions including the ways in which these should be clinically managed. Such publications are updated frequently. All clinicians who are responsible for the diagnosis, treatment and ongoing monitoring/management of such physical health conditions must continue to update their knowledge and awareness of national guidance and maintain their understanding regarding best practice principles.

4.3.1 Lester Tool Framework

The Lester Tool (2014, [online]) is the recognised tool/framework that supports the comprehensive cardiometabolic risk assessment and intervention/monitoring plan for those individuals who are diagnosed with a SMI and/or prescribed antipsychotic medications.

The Lester Tool emphasises the importance of initial screening in order to establish a baseline assessment where ongoing monitoring, intervention and treatment options can be formulated and implemented. Screening includes: lifestyle factors such as smoking history, dietary habits and current levels of physical activity. Attempts must also be made to gain consent in order to acquire the relevant measurements to calculate body mass index (BMI), blood pressure readings and blood samples to ascertain glucose regulation and blood lipids.

Where indicated, secondary care services may need to be contacted as part of a specialist physical healthcare referral so appropriate interventions can be offered (i.e. Diabetic Specialist

Nurse, Cardiologist etc.), or alternatively, the service user should be signposted to the relevant clinic and/or team to improve their physical health condition.

If specific medications are to be initiated, a baseline physical health examination and associated tests must be completed prior to their commencement, and repeated at particular intervals during treatment - as indicated within the Lester Tool (Table1).

Where required, reasonable adjustments must be provided to support service users 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 service users 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 Settings**.

Table 1: Lester Tool Monitoring

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]	■		■	■

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

In addition to the screening and monitoring interventions outlined in the Lester Tool (2014, [online]), any abnormal results must be followed up appropriately, and in accordance with national and/or local guidance. In relation to CVD risks, if a service user has a high cholesterol result (and is aged between 25 to 84 years of age), further assessment is recommended using the QRISK®3 risk calculator (qrisk.org 2018 [online]). The QRISK®3 algorithm calculates a person's risk of developing a heart attack or stroke over the next 10 years. Further information regarding CVD, associated risks and the QRISK®3 can be obtained by accessing the **Cardiovascular Risks Guideline (Adults)** via the Trust intranet.

Service users who do not have a SMI but have been identified or are considered as having an increased risk of CVD should be assessed using a validated CVD risk assessment tool (NICE, 2014b, updated 2016 [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]).

As mentioned previously, where required, reasonable adjustments must be provided to support service users to participate in the physical health risk assessment process and also, to help service users to understand the information, recommendations and/or advice that is given to them.

4.4 Health Promotion

People with a mental illness, autism or a learning disability should have the same access to health promotion advice/support and NHS screening as the general population (Department of Health, 2016). Some of the lifestyle risk factors which contribute to preventable physical conditions include: smoking, alcohol misuse, physical inactivity and poor diet (Naylor et al, 2012). There are also a number of correlations between wellbeing and positive physical health outcomes such as: improved immune system response, improved cardiovascular health and slower disease progression (Department of Health, 2014 [online]). Additionally, physical healthcare provision should not only include the promotion of healthy living advice and support, but also, include advice relating to any preventative measures required to reduce the potential side effects associated with mental health treatments (Department of Health 2015, updated 2017).

Service users should be advised (age appropriate), signposted and encouraged by all staff to adopt healthy lifestyle choices to reduce risk factors which can lead to physical health deterioration and to promote recovery and wellbeing. Connecting with people, learning something new and being active are all components which are important to improve health and wellbeing, and which can be applied through health promotion activities.

When health promotion advice, information or screening is offered to a service user, this must be documented on the service user's electronic care record.

Staff must also be aware of the importance of promoting health and encouraging service users to stay healthy during exceptional events (by engaging in healthy lifestyle choices and by following local and national guidance). Coronavirus disease 2019 (COVID-19) is an infectious respiratory disease which resulted in a worldwide pandemic in 2020. Those with underlying health conditions such as: CVD, COPD, diabetes and some cancers were found to be more susceptible to contracting COVID-19. People living with severe obesity (BMI ≥40kg/m2) are also deemed to be clinically more vulnerable (PHE, 2020 [online]).

Further to this, research has shown that a decline in physical health can impact significantly on an individual's emotional and/or mental state. During exceptional events such as a pandemic, or deterioration in mental health, it can be easy to adopt unhealthy patterns of behaviour which, in turn, can negatively impact an individual's health. Trying to maintain a structured routine, eating healthy, well-balanced meals and exercising regularly can help support both health and wellbeing.

Where required, reasonable adjustments must be provided to support service users to participate in health promotion, NHS screening, and also, to help service users to understand the information, recommendations and/or advice that is given to them.

Importantly, staff should have an awareness of a person's trauma history and consider with the patient if and how this may need to be taken into account when discussing health promotion and potential NHS screening opportunities. A sensitive, compassionate approach is not only necessary to promote the individual's privacy and dignity, but also, helps to ensure that any physical healthcare offered does not cause iatrogenic harm to the service user. Further information can be obtained from the **Privacy and Dignity Policy**, available via the Trust intranet.

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 3 can be used by staff to signpost service users 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 service users)
- Screening in pregnancy

All screening is a balance of potential benefits versus potential harms. Deciding whether or not 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 [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.

However, as stated, service users 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 in order 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 service user's consent).

Importantly, it is essential to have realistic expectations of what a screening programme 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 at a later date. As with all screening programmes, 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 service user 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 service user declines to have NHS screening, this should be clearly documented on their electronic care record.

Long term inpatient users of Trust services (12 months or more) should be provided with relevant information and access to screening programmes e.g. cancer screening

programmes. See Appendix 3.

Where required, reasonable adjustments must be provided to support service users to access relevant and appropriate screening programmes, and also, to help service users to understand the information, recommendations and/or advice regarding screening that is given to them. It is also important to acknowledge a service user's personal preferences and wishes. Wherever possible, these preferences must be taken into account 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 also, 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 an approach to behaviour change that utilises the millions of day-to-day interactions that organisations and individuals have with other people to support them in making positive changes to their physical and mental health and wellbeing. 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 offers practical advice on how to carry out opportunistic chats, signpost to other services and helps staff to encourage people to make positive steps towards making a lifestyle change, ensuring that that there is 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

There are high rates of co-existing substance use (alcohol and/or illicit drug use) in people with mental health problems (Department of Health, 2016).

Harmful psychoactive substance use, either alcohol or illicit drugs or both, is defined as a pattern of use that causes health problems. This could include psychological problems, such as episodes

of low mood, anxiety or psychosis, and physical health problems such as acute pancreatitis or hepatitis.

In addition to harmful use, service users might present as intoxicated, in withdrawals, dependent on one or more substances or as psychotic. Service users, both inpatients and outpatients, should be screened for problematic alcohol and illicit drug use using relevant tools, for example AUDIT-C and DUDIT. Where appropriate, they should be referred to drug and alcohol services in the community.

The Trust's **Management of Coexisting Mental Illness and Substance Misuse (Dual Diagnosis) Policy** (available via the Trust intranet) explains substance misuse in more detail. Additionally, there are several other relevant documents relating to substance misuse which are also accessible 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 is a major contributor to many serious illnesses including respiratory problems, vascular disease and various forms of 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]).

Supporting people with mental health problems to quit smoking is the single largest, most effective intervention to reduce physical ill health and premature death (NHS England, 2016).

The NHS Long Term Plan (NHS England, 2019 [online]) identifies the development of a new universal smoking cessation offer which will be available as part of specialist mental health services for long-term users of specialist mental health, and in 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 service users and staff to reduce the harm from smoking with the aim to improve physical health. In line with the Trust's **Nicotine Management Policy** and **Guidance on the use of Stop Smoking Products** (both available on the Trust Intranet), all patients will be offered nicotine management on admission to hospital should they smoke.

NRT can be offered to smokers over the age of 12 years and e-Cigarettes are available for those over the age of 18 years (except within secure inpatient services where e-Cigarettes are identified as a significant risk). Any service user under the age of 12 years should 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.

Service users 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 cessation clinics where service users 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 **Guidance on the Use of Stop Smoking Products** available via the Trust intranet.

4.4.5 Sexual Health

Good sexual health is important for physical, mental and social wellbeing. There is a strong correlation between poor sexual health and other key determinants of health and wellbeing, such as: alcohol and substance misuse, smoking, obesity and some mental health presentations, contributing to health inequalities.

Trust staff are ideally situated to engage in discussion regarding sexual health and function. Service users should be offered screening as part of routine and ongoing assessment and should include: contraception, sexual partners, use of condoms, sexual health check-ups (including cervical screening), violence and abuse in relationships and issues with sexual identity (Department of Health, 2016).

Where required, reasonable adjustments must be provided to support service users to access relevant and appropriate advice and/or treatment regarding their sexual health, and also, to help service users to understand the information, recommendations and/or advice that is given to them. It is also important to acknowledge a service user's personal preferences and wishes. Wherever possible, these preferences must be taken into account 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 also, the **Privacy and Dignity Policy**, both of which are available via the Trust intranet.

Some of the Trust's community nursing teams provide educational courses that are aimed at improving service users understanding about the risks associated with sexual health and increasing their ability to protect their bodies effectively.

Activities to achieve change:

- Include sexual health as part of the initial and ongoing comprehensive assessment of the service user 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 service users 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 Oral Health

People with mental health problems are at a higher risk of poor dental and oral health. Good dental and oral health is 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 SMI 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)

Where required, reasonable adjustments must be provided to support service users to access dental appointments, and also, to help service users 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 service users 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. This makes up just over one third of food eaten each day.
- Base meals on starchy foods e.g. potatoes, bread, rice or pasta. This makes up just over one third of food eaten each day. Choose wholegrain options where possible.
- Have some dairy or dairy alternatives e.g. soya drinks. Aim for low fat and low sugar options.
- Eat some beans, pulses, fish, eggs, meat and other protein. Include 2 portions of fish each week, one of which should be oily e.g. salmon, mackerel or trout.
- Choose unsaturated oils and spreads and eat in small amounts.
- 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 to consume food and drinks high in fat, sugar and/or salt less often and in smaller portions.

4.5.3 Weight Management and Obesity

The prevalence of 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]).

Physical inactivity, unhealthy diets and weight gain from psychotropic medication are all factors that contribute to this (NICE, 2014c [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 service user's care in order to advise regarding weight management. Some service users may experience problems with maintaining their current weight and require an increased calorie intake. Others may have problems associated with swallowing and need an assessment from the Speech and Language Team (SLT).

Service users who require enteral feeding require close monitoring from professionals with regards to weight management and monitoring. For further guidance, please refer to the **Enteral Feeding (PEG) Procedure (Adults)** or the **Enteral Feeding Jejunostomy (JEJ) Procedure for Learning Disabilities Adult and Children**, both available via the Trust intranet.

Obesity is often defined using the 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 should 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.

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 service users 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 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/salad and the remainder of the plate split between lean protein foods such as fish/ meat (remove fat where possible)/eggs/beans and starchy carbohydrates such as potato/pasta/rice/bread.
- 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 meal times.

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.

Identification of those at risk of malnutrition (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.

4.5.5 Refeeding Syndrome

Refeeding Syndrome is a potentially fatal syndrome that occurs after a period of starvation which must be treated under supervision from a Dietitian. Please refer to the Trust's **Refeeding Syndrome Procedure** (available via the Trust intranet) if refeeding syndrome is suspected **prior** to providing nutritional support.

For those service users at risk of malnutrition, a nutritional support plan should be implemented. This will take into account the individual's needs for increased calories and protein to facilitate weight gain.

Training on how to prepare a nutritional care plan is provided within the SANSI training delivered by the Dietetic Team.

- Ensure three meals, two snacks and supper are offered daily
- Encourage puddings at lunch and dinner
- Attempt to 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 kcal to by adding butter, cream and cheese
- Add protein by adding skimmed milk powder to full fat milk
- Consider small and often for those with a small appetite or finger foods
- Offer nourishing fluids throughout the day such as milky tea/coffee, smoothies, milkshakes, hot chocolate and/or malted hot drinks

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 known as the main source. 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 Physical Activity

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 many conditions including CVD, cancer, diabetes, musculoskeletal disorders, obesity and stroke (Department of Health, 2011, updated 2019 [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]).

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 4 to support staff in discussing the benefits of physical activity with service users.

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 service users 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 service users for whom an increase in physical activity can be potentially risky and their graduated physical activity requires specialist input and monitoring e.g. service users 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.

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.

Service users 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 can be defined as a growing specialty that primarily considers 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 audit and research.

The Trust's Tissue Viability service offers a referral system for staff requiring expert tissue viability advice for service users 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 Pressure Ulcers Procedure**
- **Skin Tear Prevention and Management Procedure**
- **Digital Wound Photography 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 service users across several specialties and localities, all of whom require varying degrees of need and support. This includes the delivery of

care for service users 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, should 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

Term	Definition
AUDIT-C Tool	The Alcohol Use Disorders Identification Test - Concise (AUDIT-C) is a brief alcohol screening tool that can help identify service users 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.
Care Programme Approach (CPA)	The CPA describes the approach used in secondary mental health and learning disability services to; assess, plan, review and co-ordinate care, treatment and support for people with complex needs, relating to their mental illness or learning disability.
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 service user'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 service user 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
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
Harm Minimisation Policy
Interpreting and Translation Guidance for Staff
Junior MARSIPAN: Management of Really Sick Service Users 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 Service Users with Anorexia Nervosa
Nicotine Management Policy
Pain Assessment and Management Overarching Guideline
Policy for Harm Minimisation
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 Service user in Adults (aged 16 and above)
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
The Care Programme Approach and Standard Care Policy and Framework
Tissue Viability Policy
Vitamin D: Testing and Treatment for Adult Inpatients Not Already Receiving Supplements

7 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 Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
Registered MH/LD Nursing Staff (Inpatients): AMH, Forensics, MHSOP, LD	Physical Health Core Skills Training Day (Registered Nurse: Inpatients)	1 day	Once Only
Registered MH/LD Nursing Staff (Community): All Adult Services, MHSOP, LD	Physical Health Core Skills Training Day (Registered Nurse: Community)	1 day	Once Only
Non-Registered MH/LD Nursing Support Staff inc Nursing Associates (Inpatients): AMH, Forensics, MHSOP, LD	Physical Health Core Skills Training Day (Non-Registered Nurse: Inpatients)	1 day	Once Only
Non-Registered MH/LD Nursing Support Staff inc Nursing Associates (Community): All Adult Services, MHSOP, LD	Physical Health Core Skills Training Day (Non-Registered Nurse: Community)	1 day	Once Only

8 How the implementation of this policy will be monitored

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	Annually	Clinical Effectiveness Group
2	Clinical Audit of the National Early Warning Score (NEWS) Procedure for patients 16 years of age and over	Annually	Clinical Effectiveness Group
3	Clinical Audit of Serious Mental Illness and Physical Health (currently in development)	Annually	Clinical Effectiveness Group

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10 Document control (external)

Date of approval:	14 July 2021	
Next review date:	28 February 2025	
This document replaces:	Physical Health and Wellbeing Policy (Inpatients and Community) CLIN-0084-V2	
This document was approved by:	Name of committee/group	Date
	IPC/PH Group	22 June 2021
This document was ratified by:	Name of committee/group	Date
	Senior Leadership Group	14 July 2021
An equality analysis was completed on this document on:	12/04/2021	
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	Published
3	Jul 2024	Review date extended from 14 July 2024 to 30 November 2024.	Published.
3	Oct 2024	Review date extended till 28 Feb 2025	Published

Appendix 1 - Equality Analysis Screening Form

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

Name of Service area, Directorate/Department i.e. substance misuse, corporate, finance etc.	Nursing and Governance/ Physical Health					
Policy (document/service) name	Physical Health and Wellbeing Policy					
Is the area being assessed a…	Policy/Strategy	√	Service/Business plan		Project	
	Procedure/Guidance				Code of practice	
	Other – Please state					
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 (This is the date you are asked to write or review the document/service etc.)	June 2020					
End date of Equality Analysis Screening (This is when you have completed the equality analysis and it is ready to go to EMT to be approved)	12/04/21 and additions made 05/07/21					

You must contact the EDHR team if you identify a negative impact. Please ring the Equality and Diversity Team on 0191 3336267/3046

1. Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?

The Policy benefits service users and staff by standardising the processes/interventions required to provide appropriate physical healthcare. The information contained within the Policy is also aimed at reducing the clinical risk(s) associated with inappropriately managing the physical health of service users. Similarly, the information within the Policy will help support the provision and timely management of physical healthcare delivery, treatment and intervention to ensure that patients receive speedy, safe and (potentially) effective care that is supported by current local and national guidance in accordance with best practice.

2. Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups below?

Race (including Gypsy and Traveller)	No	**Disability** (includes physical, learning, mental health, sensory and medical disabilities)	No	**Sex** (Men, women and gender neutral etc.)	No
Gender reassignment (Transgender and gender identity)	No	**Sexual Orientation** (Lesbian, Gay, Bisexual and Heterosexual etc.)	No	**Age** (includes, young people, older people – people of all ages)	No
Religion or Belief (includes faith groups, atheism and philosophical belief's)	No	**Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave)	No	**Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners)	No

Having identified a 'potential' negative impact to the protective characteristic of age due to <12yrs not being able to receive NRT, staff are advised to refer service users of this age range to primary care services to ensure parity across all age groups.

The positive impacts of the policy are: service users 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.

3. Have you considered other sources of information such as; legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.? **If 'No', why not?**	**Yes**	√	**No**	

Sources of Information may include: • Feedback from equality bodies, Care Quality Commission, Equality and Human Rights Commission, etc. • Investigation findings • Trust Strategic Direction • Data collection/analysis • National Guidance/Reports	• Staff grievances • Media • Community Consultation/Consultation Groups • Internal Consultation • Research • Other (Please state below)

4. Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the following protected groups?: Race, Disability, Sex, Gender reassignment (Trans), Sexual Orientation (LGB), Religion or Belief, Age, Pregnancy and Maternity or Marriage and Civil Partnership

Yes – Given that this Trust Policy has been developed in accordance with a number of national key documents published by NICE, the Department of Health, NHS England and also, Public Health England, there has been no consultation with service users in terms of the actual writing of this document. However, there has been significant involvement with the various healthcare professionals from the various localities and specialisms within the Trust. The Policy is therefore a standardised approach that enables clinical staff working within TEWV NHS Foundation Trust to adhere to national recommended best practice and guidance in relation to providing physical healthcare.

5. As part of this equality analysis have any training needs/service needs been identified?

Yes	Trust wide Physical Health Core Skills Training is available for all Registered Nurses and Nursing Support Staff

Trust staff	Yes	Service users	No	Contractors or other outside agencies	No

Make sure that you have checked the information and that you are comfortable that additional evidence can provided if you are required to do so

If you need further advice or information on equality analysis, the EDHR team host surgeries to support you in this process, to book on and find out more please call: 0191 3336267/3046

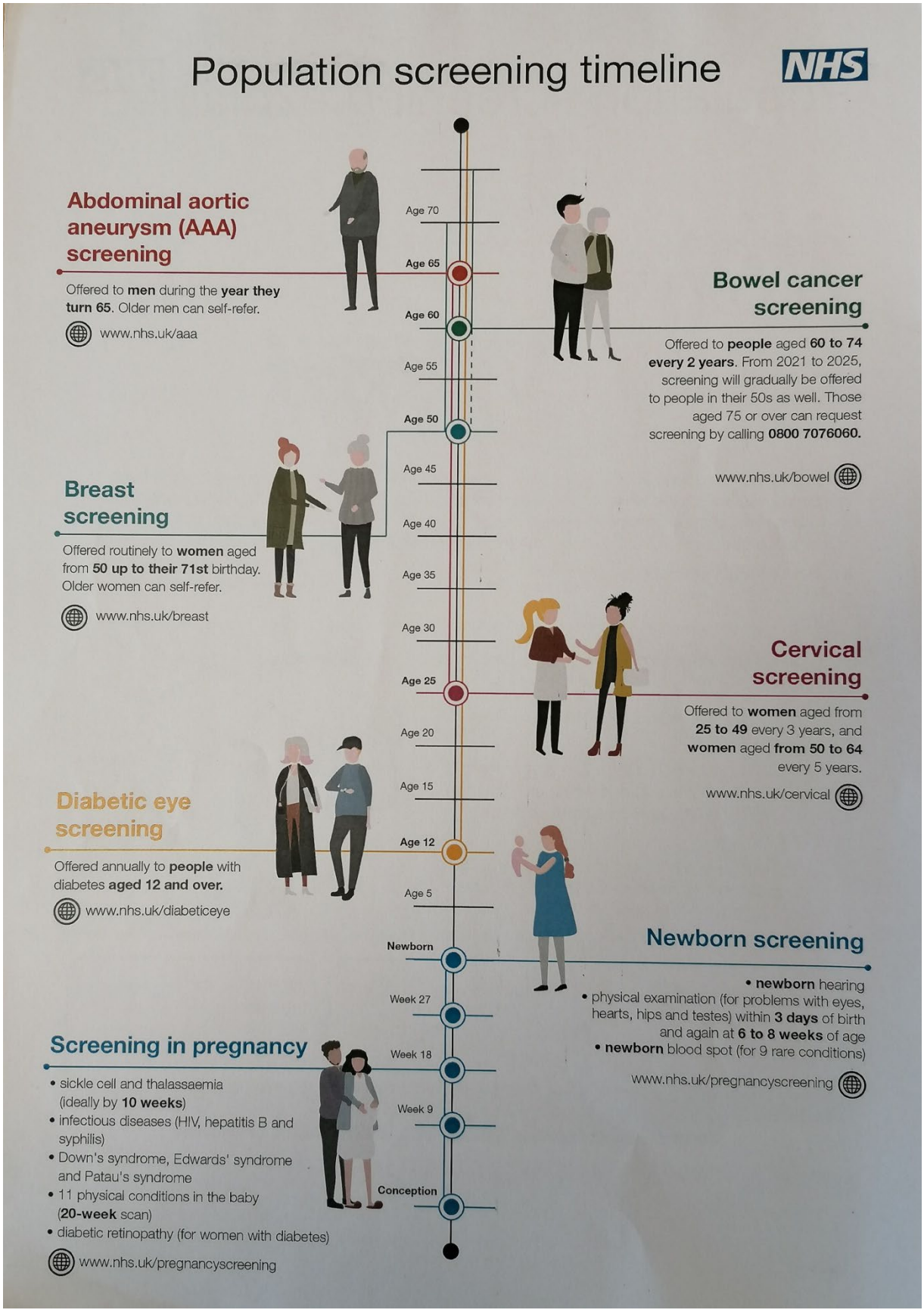
Appendix 2 – Approval checklist

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?	Yes	
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**		

	Title of document being reviewed:	Yes/No/ Not applicable	Comments
	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?	N/A	

Appendix 3 - NHS Population Screening Timeline



For more information, please see: www.gov.uk/guidance/nhs-population-screening-explained

Appendix 4 - Physical Activity Benefits Guide for Adults and Older People

UK Chief Medical Officers' Physical Activity Guidelines 2019