Lester UK Adaptation 2023 update. *Adolescent supplement added 2025.**

Positive Cardiometabolic Health Resource

Lester UK Adaptation: Positive Cardiometabolic Health Resource

This Cardiometabolic Health Resource supports the recommendations relating to monitoring physical health in the NICE guidelines on psychosis and schizophrenia in adults (**www.nice.org.uk/guidance/cg178**) and young people (**www.nice.org.uk/guidance/cg155**). In addition it also supports the statement about assessing physical health in the NICE quality standard for psychosis and schizophrenia for adults (**www.nice.org.uk/guidance/qs80**).

National Institute for Health and Care Excellence, November 2015

This resource aligns with the Core20PLUS5 initiative aimed at addressing the 15-year mortality gap experienced by individuals with severe mental illness.

The primary factors driving this decreased life expectancy are comorbid cardiometabolic and cardiovascular diseases. There is a pressing need to concentrate on potentially preventable health issues, medication side effects, and limited access to healthcare services.

Although this resource primarily addresses antipsychotic treatment, its principles are equally applicable to other psychotropic medications used in managing long-term mental health conditions, such as mood stabilisers.

For all people in the "red zone" (see next page): Care should always be person-centred, tailoring discussion to enable shared decision-making.

The primary healthcare team and specialist mental health team will collaborate to support the individual, ensuring appropriate monitoring and interventions are provided and communicated.

Don't just
SCREEN – INTERVENE
for all people in the "red zone"

** In 2025, the authors added an adolescent supplement targeted to those aged 14-17 years experiencing psychosis.*

ADULT Positive Cardiometabolic Health Resource

An **intervention framework** for people aged 18yrs and over experiencing **psychosis** and **schizophrenia**.

Smoking	Health Behaviours and Life-skills	Body Mass Index (BMI) Weight	Blood Pressure	Glucose Regulation Assess by fasting blood glucose (FPG) and HbA1c	Blood Lipids
RED ZONE					
Current smoker	**Unhealthy diet** **AND/OR** **Physical inactivity/sedentariness** **AND/OR** **Harmful alcohol intake** (>14 units/wk)	**BMI ≥25 kg/m²** (≥23 kg/m² if from Black, Asian, minority ethnic background) **AND/OR** Rapid weight gain: particularly after new antipsychotic initiation	>140 mm Hg systolic **AND/OR** >90 mm Hg diastolic	**HbA1C or Glucose threshold:** HbA1C ≥42 mmol/mol (≥6%) **AND/OR** FPG ≥5.5 mmol/l **OR** RPG ≥ 11.1 mmol/l	**High risk of CVD by validated tool,** e.g. QRisk3 http://qrisk.org *NB: Current CVD risk scores likely to underestimate risk in people aged <30*
INTERVENTIONS					
CARE SHOULD ALWAYS BE PERSON-CENTRED, TAILORING DISCUSSION TO THE NEEDS OF THE PERSON TO ENABLE SHARED DECISION-MAKING					
Follow NICE guidelines on tobacco use www.nice.org.uk/ng209 **Brief intervention/ behavioural support** **Offer combined NRT and/or varenicline** **Referral to Smoking Cessation service**	**Promote positive health behaviours:** • Healthy eating guidance www.nhs.uk/live-well/eat-well **Follow UK Chief Medical Officers' Guidance on:** • Physical Activity • Low-risk alcohol intake	**Follow NICE obesity guidelines:** www.nice.org.uk/cg189 **Clinical review if** >5% (av.3-4kg) wt gain within 4 weeks of taking a new antipsychotic	Refer for investigation, diagnosis and treatment by appropriate clinician if necessary. *Note: family history of diabetes and/or premature heart disease heightens cardiometabolic risk.* **Offer antihypertensive therapy** if safe and appropriate Follow NICE hypertension guidelines www.nice.org.uk/ng136 Limit salt intake in diet	**At High Risk of Diabetes** HbA1c 42-47 mmol/mol (6.0%–6.4%) FPG 5.5–6.9 mmol/l i Offer referral to evidence-based, lifestyle-change programme ii. If ineffective, offer metformin modified release if safe and appropriate	**Diabetes** HbA1c ≥48 mmol/mol (≥6.5%) FPG ≥7.0 mmol/l RPG ≥11.1 mmol/l Diabetes review Follow NICE diabetes guidelines www.nice.org.uk/ng28	**Offer lipid lowering therapy if safe and appropriate** Follow NICE guidelines www.nice.org.uk/ng238 **AND** Refer to specialist if total cholesterol >9, non-HDL chol >7.5 or TG>20 (mmol/l)
TARGET					
Stop smoking **Anticipate impact on antipsychotic drug metabolism; alter dose appropriately**	**Improve quality of diet** **Daily physical activity** ≥30 mins/day **Alcohol intake** <14 units/wk	**BMI 18.5-24.9 kg/m²** (18.5-22.9 kg/m² if from Black, Asian, minority ethnic background)	**<140/90 mm Hg**	**Prevent or delay onset of diabetes** HbA1c<42 mmol/mol (<6%) FPG <5.5 mmol/l	**Individualise HbA1c target** but typically 47-58 mmol/mol (6.5–7.5%)	**Primary Prevention:** Offer atorvastatin 20mg od if ≥10% risk (validated risk tool) **OR** **Secondary Prevention:** Offer atorvastatin 80mg od Aim: reduce non-HDL chol by 40%; review 3 months

FPG = Fasting Plasma Glucose | **RPG** = Random Plasma Glucose | **BMI** = Body Mass Index | **Total Chol** = Total Cholesterol | **HDL** = High Density Lipoprotein | **TRIG** = Triglycerides |

ADULT Positive Cardiometabolic Health Resource

An **intervention framework** for people aged 18yrs and over experiencing **psychosis** and **schizophrenia**.

History and examination following initiation or change of antipsychotic medication

When initiating or reviewing medications it is important to discuss possible side effects and interactions with other medications as part of Personalised Care and Support Planning (PCSP).

Frequency: Normally psychiatrist-led. Planned physical assessment should follow the table below during the first twelve months following initiation or switch to a new antipsychotic. Baseline assessment is essential. Weight should be assessed weekly for the first six weeks of taking a new antipsychotic, as rapid early weight gain (e.g., 3-4 kg within the first 4 weeks) predicts severe long-term weight gain and higher risk of cardiometabolic disorders. In the longer term, review annually unless an abnormality emerges requiring more intensive monitoring and/or intervention.

At review

History: Seek history of rapid weight gain. Also review smoking, exercise, diet and alcohol use. Ask about family history (diabetes, obesity, CVD in first degree <55 yrs male relatives and <65 yrs female relatives) and gestational diabetes. Note and record ethnicity.

Examination: Weight, BMI, waist circumference, BP, pulse (developmentally appropriate norms should be used for people under age 18). Note differing BMI and waist circumference thresholds across racial/ethnic groups reflect differences in regional body fat and body composition.

Investigations: Plasma glucose (FPG), HbA1c, and lipids (total cholesterol, non- HDL, HDL, triglycerides). Non-fasting samples are satisfactory but note reference ranges for glucose and triglycerides differ. Also note HbA1c may be falsely low if glucose is rising rapidly as this measurement reflects average glucose of the previous 6-8 weeks.

Risk assessment tools: QRisk3 (https://qrisk.org) for CVD and QDiabetes (https://qdiabetes.org) for type 2 diabetes account for severe mental illness (SMI). However, these tools were not developed for this group. The Primrose Research Programme has shown that current CVD risk scores are likely to underestimate risk. PsyMetRiC (https://psymetric.app/) provides an SMI-specific tool tailored for ≤35s with first episode psychosis to assess risk of short-term weight gain, medium-term metabolic syndrome and longer-term type 2 diabetes. Irrespective of tool used, risk scores should always be weighed alongside individual factors, including patient preference, to inform rather than dictate clinical decisions.

ECG: Include if there is specific risk of CVD (e.g., co-existing hypertension, diabetes), personal history of CVD, family history of CVD, or examination reveals irregular pulse (if ECG confirms atrial fibrillation, follow NICE guidelines www.nice.org.uk/ng196); or if person taking certain antipsychotics (see SPC) or other drugs known to cause ECG abnormalities (e.g., erythromycin, tricyclic anti-depressants, anti-arrhythmics – see British National Formulary for further information).

Chronic Kidney Disease (additionlly increases risk of CVD): Screen those with co-existing diabetes, hypertension, CVD, family history of chronic kidney disease, structural renal disease (e.g., renal stones):

1. Monitor renal function with creatinine and estimated glomerular filtration rate (eGFR).
2. Monitor for early proteinuria: urine albumin creatinine ratio (laboratory analysis) If evidence of chronic kidney disease, follow NICE guidance www.nice.org.uk/ng203.

Monitoring: How often and what to do

Applies to adults prescribed antipsychotics and mood stabilizers.

	Baseline	Weekly for first 6 weeks	12 weeks	Annually
Personal/Family History	●			●
Lifestyle review[1]	●		●	●
Weight	●	●	●	●
Waist circumference	●			●
BP	●		●	●
FPG/HbA_{1c}	●		●	●
Lipid profile[2]	●		●	●

[1] Smoking, diet, physical activity, and alcohol. [2] A non-fasting sample is satisfactory

Behaviour change and pharmacological interventions

Specific behaviour change interventions should be discussed in a collaborative, supportive and encouraging way, taking into account the person's preferences, barriers they face, and need for reasonable adjustments. Support behaviour change using motivational interviewing as a brief intervention integrated into short consultations (e.g., www.bmj.com/content/340/bmj.c1900).

- **Nutritional counselling:** advise to avoid less healthy snacks, take-away/fried food and sugary drinks, reduce energy intake to prevent weight gain, increase fibre intake. (NHS Eat Well: www.nhs.uk/live-well/eat-well/).
- **Limit alcohol intake:** use low-risk drinking guidelines (UK Chief Medical Officers www.gov.uk/government/publications/alcohol-consumption-advice-on-low-risk-drinking).
- **Physical activity:** advise to increase physical activity to a minimum of 150 minutes of 'moderate-intensity' physical activity per week (e.g. 30 mins on 5 days/wk); minimise sedentary time: break-up periods of inactivity (UK Chief Medical Officers www.gov.uk/government/publications/physical-activity-guidelines-adults-and-older-adults.
- **Smoking cessation:** smoking can impact on the metabolism of psychotropic drugs. Change in smoking status may require prompt drug dose alteration of certain antipsychotics, especially clozapine with its potential for rapid and serious toxicity (within a week).

If the person has not successfully reached their targets within three months, offer relevant pharmacological interventions as adjuncts to behaviour change interventions if safe and appropriate to do so, and in collaboration with the GP:

Anti-hypertensive therapy: follow NICE guidance www.nice.org.uk/ng136.

Lipid lowering therapy: follow NICE guidance www.nice.org.uk/ng238.

Note: if total cholesterol >9, non-HDL chol >7.5 or TG>20 (mmol/l), refer to metabolic specialist.

Treatment of diabetes: follow NICE guidance www.nice.org.uk/ng28.

Treatment of those at high risk of diabetes: Follow NICE guidance (recommendation 19) – www.nice.org.uk/PH38:

- **Metformin modified release** may be offered as an adjunct to intensive lifestyle intervention if behaviour change has not prevented/slowed progression of hyperglycaemia, particularly for those with BMI >35 kg/m2
- Adhere to British National Formulary guidance on safe use (in particular ensure renal function is adequate).
- Start with a low dose e.g., 500mg once daily and build up, as tolerated, to 1500–2000mg daily.

Review of antipsychotic and mood stabiliser medication: discussions about medication should involve the person, carer if appropriate, psychiatrist and the GP.

Ensure appropriate discussions if evidence of:

- Rapid substantial weight gain particularly following new antipsychotic initiation (e.g., 3-4kg < 4 weeks).
- Worsening of cardiometabolic indices (abnormal lipids, BP, or glucose) at 3-month check-up.

The psychiatrist should proactively consider, and discuss with the person, the potential risks and benefits of switching antipsychotic drug, both on physical and psychiatric health.

- As a first step prescribed dosages should follow BNF recommendations; rationalise any polypharmacy.
- Changing antipsychotic medication requires careful clinical judgement to weigh any benefits against the risk of relapse of the psychosis.
- An effective trial of medication is considered to be the person taking the medication, at an optimum dosage, for a period of 4-6 weeks.
- If clinical judgment and the person's preference support continuing with the same treatment, then ensure appropriate further monitoring and clinical considerations are carried out regularly.

It is advised that all side effects to antipsychotic medication are regularly monitored especially when commencing a new antipsychotic medication (**GASS questionnaire** https://rightdecisions.scot.nhs.uk/media/2352/glasgow-antipsychotic-side-effect-scale-gass.pdf) and that any side effects, as well as rationale for continuing, changing or stopping medication is clearly recorded and discussed with the person.

The Psychiatrist should maintain responsibility for monitoring the person's physical health and the effects of anti-psychotic medication for at least the first 12 months or until the person's condition has stabilised, whichever is longer. Thereafter, the responsibility for this monitoring may be transferred to primary care under shared care arrangements.

Discuss any non-prescribed therapies (including complementary therapies) which the person wishes to use; discuss the safety and efficacy of the therapies, and possible interference with the therapeutic effects of prescribed medication and psychological treatments.

ADOLESCENT Positive Cardiometabolic Health Resource

An **intervention framework** for adolescents aged 14-17 yrs experiencing **psychosis**.

Smoking	Health Behaviours and Lifestyle changes		Body Mass Index (BMI) Weight	Blood Pressure		Glucose Regulation	Blood Lipids
				Age 14-15 yrs use centile charts (ESH guidance tables 1-3)	Age ≥16 yrs use Lester BP guidance for adults	For diagnosis, fasting blood glucose tests are preferred if achievable	Blood tests can be fasting or non-fasting
RED ZONE							
Current smoker (tobacco, vaping) – ask regularly	**Dietary concerns AND/OR Physical inactivity/ sedentariness**	**Harmful alcohol intake or other substance use**	**Rapid weight gain:** >5% within 4wks of new antipsychotic initiation **OR** BMI ≥91st centile (assess using RCPCH BMI charts)	**BP** persists ≥90th centile systolic and/or diastolic (ESH guidance table 1 > 95th= hypertension 90-95th= high-normal < 90th normal)		**Glucose or HbA1C threshold:** FPG ≥5.5 mmol/lORRPG ≥11.1 mmol/l HbA1C ≥42 mmol/mol (≥6%)	**Abnormal lipids:** use local laboratory reference range for adolescent assessment QRisk3 should not be used to assess CVD risk in adolescents (see appendix)
CARE SHOULD ALWAYS BE PERSON-CENTRED, PRIORITISE SHARED DECISION-MAKING, ASSESS CAPACITY/COMPETENCE, AND INVOLVE PARENTS/CARERS/IMPORTANT OTHERS							
INTERVENTIONS				Close primary/secondary care liaison: assessment and onward referral to appropriate specialist. *Note: Family history of diabetes and/or premature heart disease heightens cardiometabolic risk.*			
Follow NICE guidance on tobacco use and consult latest vaping evidence i. Offer brief intervention/ behavioural support ii. Offer combined NRT iii. Refer to Smoking Cessation service	**Offer personalised assessment to support structured daily routines in:** • Healthy eating • Physical activity • Screen use	**Promote positive health behaviours** – refer to guidance: Coexisting psychosis and substance misuse (including alcohol)	If rapid weight gain with new antipsychotic discuss risks and benefits of antipsychotic switching If BMI ≥91st centile **AND** • presence of cardiometabolic risk or weight-related co-morbidity (see appendix): refer to local weight management programme • absence of cardiometabolic risk or weight-related co-morbidity: counsel on healthy weight reduction strategies If BMI ≥ 98th centile: refer to local weight management programme	**Co-manage with GP:** i. If BP remains in 90-95th centile range: active follow-up ii. If BP remains >95thcentile: assess and refer onwards to appropriate specialist		**At High Risk of Diabetes** FPG 5.5 - 6.9 mmol/l HbA1c 42-47 mmol/mol (6.0% - 6.4%) **Co-manage with GP:** i. Offer referral to a local evidence based lifestyle change programme ii. If ineffective: reassess and refer onwards to appropriate specialist	**Diabetes** Follow NICE guidance FPG ≥7.0 mmol/l RPG ≥11.1 mmol/l HbA1c≥48 mmol/mol (≥6.5%) At diagnosis refer those with suspected type 2 diabetes to a multidisciplinary paediatric diabetes team	**Co-manage with GP:** i. Offer referral to a local evidence based, lifestyle change programme ii. If lipid levels remain abnormal: assessment and onward referral to appropriate specialist iii. Refer as priority if possibility of familial hypercholesterolaemia
TARGET							
Smoking cessation AND Anticipate impact on antipsychotic drug metabolism; alter dose appropriately Promote smoking/vaping prevention in non-smokers	**Healthy diet** **Physical activity** ≥60 mins/day **Safer screen use** (e.g. frequent active breaks)	**Prevention and harm reduction for alcohol intake and drug misuse**	**Mitigate rapid weight gain** after new antipsychotic initiation Manage weight as part of a CVD risk-reducing approach	**BP** <90th centile systolic and/or diastolic **Manage BP** as part of CVD risk-reducing approach		**Prevent or delay onset of diabetes** * FPG <5.5 mmol/l HbA1c<42 mmol/mol(<6%)	**Target HbA1c** ≤48 mmol/mol (≤6.5%) to minimise risk of long-term complications	**Manage dyslipidaemia** as part of a CVD risk-reducing approach

Considerations for young people aged 14-17 years

Proactive cardiometabolic screening is recommended by NICE for this young population with psychosis (NICE CG155). This should be offered 6 monthly as a minimum when their condition is stable. When abnormalities or increased risk are identified, onward referral for further assessment and intervention is appropriate. Whilst many aspects of risk identification and management apply irrespective of age, some specific considerations for young people are necessary:

Developmentally appropriate: physical development varies greatly in adolescence related to growth and stage of puberty. Thus, differing developmental trajectories preclude the use of rigid age boundaries to assess cardiometabolic risk and rely more on clinical judgement and experience. For example, 16–18 year olds sit between adolescent and adult guidance in terms of risk identification and management (adult ranges vs centile charts).

Capacity: the Mental Capacity Act (MCA) applies to young people aged 16-17 years, who clinicians should assume have capacity to make decisions unless proven otherwise. For under-16s, the MCA does not apply and Gillick competence should instead be considered to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Shared decision making should underpin physical health screening and management in partnership with the young person, their family/carers, and include consultation with other key stakeholders (e.g. GP, Children and Young People's Mental Health services practitioner, Paediatrician).

Involve parents/carers/important others: encouraging and incorporating their unique perspectives, insight and observations empowers their active role in a young person's treatment plan and recovery.

Consider the particular needs of disabled young people, autistic young people, those with a learning disability or SEND: they are more likely to experience inequitable care and practitioners must make reasonable adjustments (Equality Act 2010) to ensure they can access effective care.

Looked After Children: monitoring should be an integral part of statutory annual health assessments.

Safeguarding: practitioners should bear in mind principles of safeguarding in all consultations with children and young people.

Ethnicity: BMI and BP centile charts provided were developed for CYP for White ethnicities. Currently a higher index of clinical suspicion will be required for all other ethnic groups.

Collaborative working: proactive management of cardiometabolic risk in this age group depends on mental health services (usually Early Intervention in Psychosis services or Children and Young People's Mental Health services) and primary care aligning aspects of monitoring and risk identification (e.g. use of centile charts rather than adult ranges for BP and BMI).

- Whilst antipsychotic initiation and proactive identification of potential cardiometabolic risk remain key functions of mental health services, the context for collaboration with primary care may be different. For instance, General Practitioners (GPs) are less familiar with psychosis in younger people (typically seeing a new case under age 16 every five years).
- Whilst GPs usually feel able to manage physical comorbidities in older people, they may not feel confident in assessing or initiating treatment of a physical health problem in an under-18 with psychosis.

Inequalities in core determinants of health (e.g. affordability of healthy foods, access to physical activities); consider how social prescribing and signposting to local services could help overcome these.

Local commissioners: should consider how young people with psychosis, as a vulnerable group for severe health inequalities, can access local evidence based lifestyle change programmes, that address key modifiable CVD risks (e.g. smoking cessation, weight management, nutrition and physical activity).

Complications of Excess Weight (CEW) Clinics: commissioned by NHSE at a national level as a tertiary referral service for children and young people organised by postcode in England https://www.england.nhs.uk/get-involved/cyp/specialist-clinics-for-children-and-young-people-living-with-obesity/

Polypharmacy: Where psychotropic polypharmacy is present, additional monitoring and supervision may be required to minimise the risk of physical health complications.

While this adolescent supplement focuses on protecting the cardiometabolic health of young people with psychosis, the principles can be applied to young people taking antipsychotic medication for other non-psychotic psychiatric disorders.

Appendix

BODY MASS INDEX (BMI) – see RCPCH BMI charts. A BMI ≥91st centile suggests overweight. A child ≥98th centile suggests clinically obese. Values for adolescents based on the RCPCH BMI centile charts are shown in Fig 1.

Fig. 1

Age (years)	Girls (BMI kg/m2)		Boys (BMI kg/m2)	
	91st centile	98th centile	91st centile	98th centile
14	23.5	26.5	22.5	25.2
15	24	27	23	26
16	24.7	27.7	24	26.7
17	25	28.2	24.5	27.5

- **If BMI ≥91st centile: offer referral** to local weight management services if:
  - i) assessed to have **hypertension, glucose or lipid disturbance** or
  - ii) evaluated to have **co-morbidities related to excess weight**. These include:
    - **Obstructive sleep apnoea** (OSA): typically restless sleep with snoring, stop/start breathing accompanied by morning headaches. OSA is more frequent in those with psychosis and increases the risk of CVD and diabetes and poorer mental and physical outcomes.
    - **Polycystic ovary syndrome** (PCOS): amenorrhoea, irregular periods, acne and hirsutism. PCOS can also arise from antipsychotic-induced hyperprolactinaemia (prolactin level needed).
    - **Non-alcohol related fatty liver disease** (NAFLD): asymptomatic, detect by liver function tests.
    - **Idiopathic intracranial hypertension:** typically, excess weight accompanied by regular night-time and morning headache.
- **If BMI ≥98th centile: offer referral** to local weight management services

BLOOD PRESSURE – see 2016 European Society of Hypertension guidelines for the management of high blood pressure in children and adolescents. Hypertension in children is defined as systolic blood pressure (SBP) and/or diastolic blood pressure (DBP) persistently **at least 95th percentile** for sex, age and height measured on at least three separate occasions.

- **For adolescents aged 15 years and under:** refer to the following ESH centile charts:
  - **ESH TABLE 2.** Blood pressure for boys by age and height percentiles
  - **ESH TABLE 3.** Blood pressure for girls by age and height percentiles
- **For adolescents aged 16 years and over:** follow the Lester BP guidance for adults with its threshold for the diagnosis of hypertension of **>140/90 mmHg.**

Monitoring: How often and what to do

	Baseline	Weekly for first 6 weeks	12 weeks	Every 6 months when stable
Personal/Family History	●			●
Lifestyle review[1]	●		●	●
Weight	●	●	●	●
Waist circumference	●			●
BP	●		●	●
FPG/HbA_{1c}	●		●	●
Lipid profile[2,3]	●		●	●

1. Smoking, diet, physical activity, alcohol and substance use.
2. A non-fasting sample is satisfactory.
3. While evidence supports the use of statins in adolescents with Familial Hyperlipidaemia, the evidence for lipid-lowering therapy in other groups is limited or lacking.
Monitoring table derived from NICE CG 155 supplementary information on baseline monitoring

Offer ECG: if physical examination has identified specific cardiovascular risk (e.g. hypertension); if there is a personal history of cardiovascular disease; if there is a family history of cardiovascular disease such as sudden cardiac death or prolonged QT interval; if specified in the SPC of the prescribed antipsychotic; or the child or young person is being admitted as an inpatient.

QRISK should not be used to assess CVD risk in adolescence.

The Lester Positive Cardiometabolic Health Resource was co-produced by NHS England and the National Clinical Audit of Psychosis Team (Adolescent supplement added in 2025.)

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The following organisations support the use of this resource:

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

RCGP Royal College of General Practitioners

Royal College of Physicians

Royal College of Surgeons of England ADVANCING SURGICAL CARE

Royal College of Nursing

HQIP Healthcare Quality Improvement Partnership

Equally Well UK

CENTRE FOR MENTAL HEALTH

BDA The Association of UK Dietitians

Rethink Mental Illness

CMHP College of Mental Health Pharmacy

British Cardiovascular Society

The British Cardiovascular Society (BCS) have reviewed and support the use of the adolescent supplement.