NHS Standard Contract - SCHEDULE 2 – THE SERVICES

Severe Mental Illness (SMI) Health Check LES

Service Specification No.	
Service	Severe Mental Illness (SMI) Health Check LES
Commissioner Lead/s	Dr Anand Barmade, Strategic Clinical Executive Kate Tufnell, Head of Adult Mental Health Commissioning
Provider Lead	As signed
Period	1 April 2020 to 31 March 20211 April 2021 to 31 March 2022
Date of Review	End of contract period or as necessary

1. Population Needs

1.1 National context

People living with severe mental illness (SMI) have a life expectancy of 15-20 years lower than the general population. The disparity in these health outcomes is partly due to this cohort of patients not being offered appropriate or timely physical health assessments.

SMI is a medical disorder and should be managed like any other serious long-term illness, including prompt diagnosis, regular monitoring, undertaking regular health checks, ensuring people with SMI attend screening programs, referral to appropriate clinical support services, advising on preventive actions, advanced decision making and contingency planning, and signposting people to local information and advice & support services.

1.2 Local context

Around 2389 people in Rotherham are estimated to have a serious mental illness (SMI). The Five Year Forward View for Mental Health has committed that by 2020/21, 280,000 people living with severe mental illness (SMI) would have their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention each year.

This specification aims to achieve, by the end of 2020/21/22, 60% of the population with SMI on the GP register receive an annual physical health check and any associated interventions. 50% of these checks should be undertaken in a primary care setting, with 10% taking place in secondary care.

Commissioning of improved physical health care for people with an SMI within a primary care setting further builds on work to ensure parity of esteem between mental and physical health by giving equal attention to the physical health of people with mental health problems as is given to the general population.

Regular physical health checks, which include lifestyle and family medical history and routine tests such as weight, blood pressure, glucose and fats or lipids, can identify potential problems before they develop into serious conditions.

CCGs have a delegated responsibility to improve physical healthcare for people with SMI in line with their legislative duties for addressing equalities and health inequalities. In accordance with the Public Sector Equality Duty, section 149 (1) of the Equality Act 2010 and the Health and Social Care 2012, CCGs alongside other bodies have duties regarding:

- eliminating unlawful discrimination under the Equality Act 2010;
- advancing equality of opportunity;
- fostering good relations;
- reducing health inequalities in access to health and health outcomes; and

- improving services and developing more integrated services.

Primary Care currently carry out some of the above through the Quality and Outcomes Framework (QOF). Under the SMI clinical domain, practices undertake the following work:

- Care Plan development
- Blood pressure monitoring
- Smoking Status
- Record of BMI

This LES is an enhancement of the above work and has been designed to further improve the health outcomes of people living with SMI, and includes:

- Completion of recommended physical health assessments
- Follow-up: delivery of or referral to appropriate NICE-recommended interventions
- Follow-up: personalised care planning, engagement and psychosocial support

This service should be provided in conjunction with the Shared Care Protocol (Appendix One) and the Physical health check and follow-up interventions for people with severe mental illness Technical Guidance (Appendix Two).

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	✓
Domain 2	Enhancing quality of life for people with long-term conditions	✓
Domain 3	Helping people to recover from episodes of ill-health or following injury	N/A
Domain 4	Ensuring people have a positive experience of care	✓
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	✓

3. Scope

3.1 Aims

Primary care teams are responsible for carrying out annual physical health assessments and follow-up care for:

- Patients with SMI who are not in contact with secondary mental health services, including both:
  - those whose care has always been solely in primary care, and
  - those who have been discharged from secondary care back to primary care; and

- Patients with SMI who have been in contact with secondary care mental health teams (with shared care arrangements in place) for more than 12 months and / or whose condition has stabilised.

Secondary care teams are responsible for carrying out annual physical health assessments and follow-up care for:

- patients with SMI under care of mental health team for less than 12 months and / or whose condition has not yet stabilised
- inpatients

This specification looks to provide focus and address the below six areas.

- Ensuring clarity about the required elements of a physical health assessment for someone with an SMI
- Ensuring provision of follow-up interventions to address identified health risks such as a lack of physical exercise
- Ensuring sufficient capacity in primary care to develop and deliver personalised support plans and provide navigation to ensure that people have access to the right resources and services
- Clarifying roles and responsibilities across primary and secondary care teams in relation to the physical health of people with SMI
- Improving communications and collaboration between primary and secondary care
- Developing confidence and competence within the primary care workforce to deliver good physical healthcare for people with SMI

The provider will ensure that they advertise this service to their patients. Services need to be accessible, appropriate and sensitive to the needs of all service users. No-one should be excluded or experience difficulty in accessing and effectively using the service due to their race, gender, disability, sexual orientation, religion and/or age.

3.2 Objectives

Providers of the service will be required to:

- Ensure people with SMI receive the same level of care among all GP practices in Rotherham
- Ensure each practice has a Lead Clinician for SMI
- Enhance physical health care and health promotion advice for all people with SMI
- Follow-up all people with SMI via delivery of or referral to appropriate interventions, and implement personalised care planning, engagement and psychosocial support.

3.3 Service Description

The requirements for participation in this contract are as follows:

- The Provider shall ensure their SMI register is up to date by sharing and receiving information (in the form of an SMI register) from and to the secondary care mental health provider (Rotherham, Doncaster and South Humber NHS Foundation Trust - RDaSH) on a quarterly basis.
- The Provider will communicate, via the most suitable means, with those patients on their SMI register to inform them of the annual physical health check invite and any follow up invites.
- The Provider shall complete an annual physical health check for those patients on the SMI Register aged 18 years and over (except in first 12 months of treatment under secondary care). The national target for patients receiving a comprehensive physical health check is 60%.
- The physical health check is to include delivery of or referral to appropriate NICE-recommended interventions, follow-up personalised care planning, engagement and psychosocial support.
- The Provider shall use the Bradford Electronic Template to complete and record the annual physical health check.
- The Provider shall report on to the CCG a quarterly basis the total number of people on the GP SMI register
- The Provider shall report on to the CCG a quarterly basis the total number of people on the GP SMI register who have received a full comprehensive physical health check (within the last 12 months) in a primary care setting.

3.4 Target population and eligibility criteria

All patients who are registered with a Rotherham GP and who have a diagnosis of SMI.

3.5 Training

It is recommended that clinicians undertake the online training resource (Physical healthcare for people with SMI) accredited by the Royal College of General Practitioners which can be accessed through https://portal.e-lfh.org.uk/ . A Mental Health Core Skills Framework has also been developed in collaboration with Skills for Health, which identifies the learning outcomes to be achieved by individuals when addressing the physical health care needs of people with SMI - http://www.skillsforhealth.org.uk/services/item/146-core-skills-training-framework

All providers are required to carry out the following:

- Have a named Lead Clinician for SMI who will ensure that a SMI update will be included as part of their appraisal process.
- The named Lead Clinician will provide active mentorship and supervision of GPs using the pathway to ensure that diagnosis, treatment and/or referral is appropriate.
- Ensure all staff undertaking the physical health checks:
    - understand what SMI is and how it might be experienced
    - understand the risks of poor physical health and how to support people with SMI to engage and access appropriate physical health care
    - feel confident to talk about health holistically including mental health, healthy lifestyles, risk reduction and physical health
    - have technical skills and expertise in relation to carrying out physical health assessments and obtaining and communicating the results

3.6 Quality requirements

The Provider shall:

- Maintain adequate records of the performance and results of the service provided.
- Maintain full records of all physical health checks and follow up procedures in such a way that aggregated data and details of individual patients are readily accessible.

3.7 Monitoring and evaluation

The Provider must provide NHS Rotherham CCG with such information as may be reasonably required to demonstrate that it has robust systems in place to deliver the Local Enhanced Service.

Providers will be required to provide evidence of the requirements and the specific numbers of people supported under the agreement.

SMI registers will be monitored in order to triangulate the payment process and to ensure appropriate payment.

3.8 Patient satisfaction

In order to ensure patients are satisfied with the SMI Physical Health Check service, the CCG will undertake a rolling survey monkey to monitor patient satisfaction. Providers will provide the patient with the appropriate link for completion.

3.9 Read codes

The SMI primary care disease register is made up of patients who have the following codes:

- Schizophrenia Eu20

• Schizotypal personality	Eu21
• Persistent delusional Disorder	Eu22
• Acute/Transient psychotic disorders	Eu23
• Induced delusional disorder	Eu24
• Schizoaffective disorders	Eu25
• Manic Episodes	Eu30
• Bipolar Disorder	Eu31
• Severe Depression with Psychosis	Eu323
• Non organic Psychosis	E1 (and all subsets)

Other diagnoses, including diagnoses of personality disorder (other than schizotypal personality disorder), substance misuse disorders without co-morbid psychosis, eating disorders or recurrent depression are not currently included in the definition.

This does not mean that these diagnoses are not 'serious' or do not carry physical health risk but the SMI definition is aligned to current evidence base for physical health checks which is driven by cardio metabolic risks associated with anti-psychotic medications. It also aligns with current QoF register definition.

If national guidance changes regarding these definitions, the service specification will be updated to reflect these changes.

3.10 Remuneration

A total sum of £91.35 per patient per annum is available to practices. Payment will be made to practices for each complete health check undertaken within each quarter.

	Technical Guidance section
• a measurement of weight (BMI **OR** BMI + Waist circumference)	Part 1
• a blood pressure (diastolic and systolic BP recording **OR** diastolic and systolic BP recording and recording of pulse rate)	Part 1
• a full blood lipid profile including cholesterol test **OR** QRISK Assessment	Part 1
• a fasting blood glucose test **OR** HbA1c test	Part 1
• an assessment of alcohol consumption	Part 1
• an assessment of smoking status	Part 1
• an assessment of nutritional status or diet and level of physical activity	Part 3
• an assessment of use of illicit substance / non prescribed drugs	Part 3
• support access to relevant national screenings , including: o Cervical Cancer o Breast Cancer o Bowel Cancer	Part 5

In line with NHS England guidance document Improving physical healthcare for people living with severe mental illness in primary care, the following additional elements should also be provided for people with SMI as part of a comprehensive health check in line with clinical evidence and consensus:

	Technical Guidance section
• Medicines reconciliation and review	Part 3

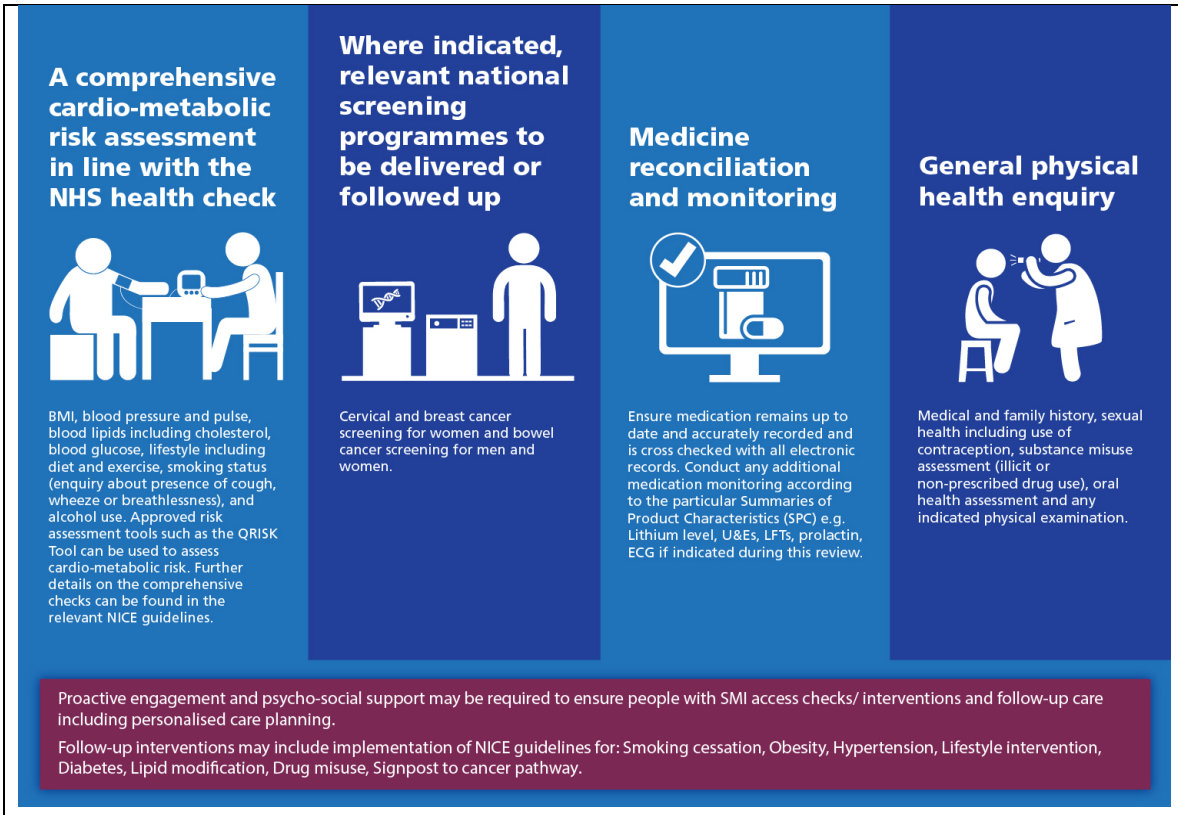
- Follow-up interventions, including: Part 4
    - Weight management – advice/referral
    - Blood pressure – lifestyle and dietary interventions
    - Blood pressure – pharmacological interventions
    - Blood glucose – high risk/pre-diabetic interventions
    - Blood glucose – diabetic interventions
    - Alcohol consumption – advice/referral
    - Smoking – advice/referral
    - Substance misuse intervention – referral to CGL/Shared Care
    - Lifestyle interventions in relation to blood lipid measurements and nutritional status, diet and physical activity
    - Pharmacological interventions relating to blood lipids including cholesterol
- Sexual health and contraceptive advice – including general contraceptive advice, advice about risks of unprotected sexual intercourse and evaluation of risk of sexual abuse and/or exploitation
- Oral health advice – including general advice regarding oral health, provision of a toothbrush and an information leaflet regarding oral health and how to register with a dentist.
- Prolactin if patient symptomatic as per GASS – refer to shared care protocol for details

For the purpose of claim reimbursement a person is counted as having had a comprehensive physical health assessment if they have received all of the component parts listed above within a twelve month period.

If an element of the health check is offered and a patient refuses e.g. blood tests, the practice should exception code this as appropriate. These health checks will also be eligible for payment under the LES. However, there is an expectation that patients will receive the full health check and use of exception coding should be minimal. Where an exception code is not available, the practice should document refusal in the patient notes.

As per Section 3.7, if there are high numbers claims for incomplete health checks the CCG reserves the right to request an audit of these claims and supporting information to be submitted.

Practices will not be able to claim for health checks which have not been completed by the practice where this is not due to patients refusing any of the component parts.



Consequences for late submission of activity data:

- 1 – 7 days: 5% of payment
- 8 – 14 days: 10% of payment and payment won't be released until the next payment run
- 15 – 21 days: 50% of payment and payment won't be released until the next payment run
- Submissions received after 21 days (3 weeks) will receive no payment.

A reminder by email will be sent out at least one week prior to submission date. It is the responsibility of the practice to ensure that any changes to contact details for the Practice lead/ practice manager are notified to the GP Commissioning team.

In the event of unforeseen exceptional circumstances e.g. unplanned admission to hospital, there is scope for the CCG to process a payment without precedent. It is however a practice responsibility to put in place sufficient contingency arrangements to ensure activity is submitted by the date specified.

If the CCG makes a payment to a practice under the LES and :

a) The practice was not entitled to receive all or part thereof, whether because it did not meet the entitlement conditions for the payment **or because the payment was calculated incorrectly** (including where a payment on account overestimates the amount that is to fall due);or

b) the CCG was entitled to withhold all or part of the payment because of a breach of a condition attached to the payment, but is unable to do so because the money is already been paid,

then the CCG is entitled to repayment of all or part of the money paid.

Any suspicions of fraud will be referred to the CCG's Counter Fraud Specialist for further

investigation. It is important to recognise that claiming for procedures that do not fall within the service specification may constitute fraud and will be referred to the CCGs Counter Fraud Specialist for further investigation.

3.11 Termination of Agreement

This service forms part of the basket of enhanced services of the Rotherham Quality Contract, and is therefore subject to the terms outlined in the Quality Contract.

Following the recent publication of the 'Investment and Evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan' the CCG acknowledges that further guidance may influence the future delivery of Local Enhanced Services.

All Local Enhanced Services will be subject to regular review in line with the development of Primary Care Networks (PCNs). Three months' notice will be given to Providers if services are to transfer to PCN delivery and/or payment.

The Practice and/or CCG may give three months written notice to terminate the service for reasons other than those outlined above.

Rotherham Doncaster and South Humber NHS Foundation Trust

DRAFT Shared Care Protocol

Physical Healthcare Assessments and Follow Up Care

DOCUMENT CONTROL:	
Version:	1
Ratified by:	
Date ratified:	
Name of originator/author:	Doncaster – David Smith Rotherham – Julie Hunter North Lincolnshire – Claire Coppens GP Primary Care Leads
Name of responsible committee/individual:	Physical Health and Wellbeing
Date issued:	
Review date:	
Target Audience	Primary Care/Secondary Care Teams

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1. Introduction

This protocol sets out guidelines for Primary Care and Secondary Care responsibilities for carrying out annual physical health assessments and follow up care. This supports the national guidelines outlined in the Quality Outcome Framework:

PRIMARY CARE

Primary care teams are responsible for carrying out annual physical health assessments and follow-up care for:

1. Patients with SMI who are not in contact with secondary mental health services, including both:

a. those whose care has always been solely in primary care, and

b. those who have been discharged from secondary care back to primary care; and

2. Patients with SMI who have been in contact with secondary care mental health teams (with shared care arrangements in place for Physical Health) for more than 12 months and / or whose condition has stabilised.

SECONDARY CARE

Secondary care teams are responsible for carrying out annual physical health assessments and follow-up care for:

1. Patients with SMI under care of mental health team for less than 12 months and / or whose condition has not yet stabilised

2. Inpatients

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2. Background and Rationale

Rationale for monitoring the cohort of patients with Serious Mental Illness (SMI):

People with severe mental illness (SMI) are at increased risk of poor physical health, and their life-expectancy is reduced by an average of 15–20 years mainly due to preventable physical illness. Two thirds of these deaths are from avoidable physical illnesses including heart disease and cancer, mainly caused by smoking. There is also a lack of access to physical healthcare for people with mental health problems – less than a third of people with schizophrenia in hospital receive the recommended assessment of cardiovascular risk in the previous 12 months. People with SMI are three times more likely to attend A&E with an urgent physical health need and almost five times more likely to be admitted as an emergency, suggesting deficiencies in the primary physical healthcare they are receiving.

With over 490,000 people with SMI registered with a GP, it is important to ensure a stronger emphasis on collaboration and communication between primary and secondary care. This is necessary given that in the longer term and certainly following discharge from secondary care, people with SMI should be supported to manage their health within primary care.

Appropriate sharing and exchanging of information between practitioners about diagnosed physical and mental health conditions is essential for safe practice.

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3. Collaboration with Primary Care Clinicians

This protocol will support the delivery of shared care between secondary care provider and primary care regarding physical health checks for people with SMI and the appropriate follow up.

This should include information on:

- Roles and responsibilities, including frequency of follow up annual physical health checks.

- Sharing and exchanging information regarding physical health of people with SMI, via electronic patient records across secondary and primary interfaces.

The rationale for this protocol is to ensure essential information needed for safe and effective care of patients who are also seen by secondary care mental health services is communicated to primary care professionals.

Building on the developments made across England to improve communications between primary and secondary care, responsibilities for conducting physical health checks and the ongoing management of physical healthcare should be clearly identified and formalised locally. Electronic systems and infrastructure should continue to evolve to support the transfer of accurate and up to date patient records, making information accessible.

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4. Shared Care Arrangements

4.1 Aspects for which Secondary Care Team is responsible

- Identifying patients who meet the Serious Mental Illness (SMI) criteria and diagnosis. 'SMI' refers to all individuals who have received a diagnosis of schizophrenia or bipolar affective disorder, or who have experienced an episode of non-organic psychosis *(Improving PH for people with SMI [3], NHS England).*
- Maintain and share quarterly with Primary Care an SMI register; to include and identify patients being supported under shared care for physical health.
- Offer an annual physical health check (for those patients who meet the criteria above and are not managed under shared care).
- Providing physical healthcare checks in line with Cardio-Metabolic Assessment and the following cardio metabolic parameters (previously included in the 2017-19 CQUIN):
    - Smoking status;
    - Lifestyle (including exercise, diet alcohol and drugs);
    - Body Mass Index and/or waist circumference;
    - Blood pressure;
    - Glucose regulation (preferably HbA1c or fasting plasma glucose. Random plasma glucose as appropriate);
    - Blood lipids;
    - Consider use of Glasgow Anti-psychotic Side-effect Scale (GASS).
- Complete and update appropriate Health Action Plan/Care Plan.
- Ensure patient is fully informed of, and engaged with the treatment detailed within the Health Action Plan:
        - That the patient/carer is clear what is being monitored and by whom
        - Following review share with the GP the Health Action Plan/Care Plan
- Provision of an accessible advisory service to the GP in regard to individual patient clinical queries raised:
    - For the Adult Mental Health service the preferred method of communication for routine (Monday to Friday) queries is by telephone to the principal managing team. A record of the advice will be recorded on SystmOne. A copy of the advice given by the RDaSH Clinician will be sent to GPs on the EMIS clinical system. RDaSH will aim to respond to these queries within 24hrs via email or telephone accordingly. If

the GP requires a more urgent response they must specify this and their rational at the point of first contact.

Email queries can also be sent to rdash.rotherhampsychiatristadvice@nhs.net . Receipt of emails are acknowledged within 48hours, prioritized and forwarded to the relevant team. RDASH will aim to respond to the query within 5 working days.

- If the patient lacks mental capacity in this area then ensure that information is shared, if this is deemed to be in the best interests of the patient (Mental Capacity Act 2005)
- Ensure that Trust policy regarding informed consent is followed
- RDaSH will be responsible for any referrals to Cardiology/Cardiac Services when an abnormal ECG is taken.

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4.2 Aspects for which Primary Care Team is responsible

- Offer an annual physical health check for patients with a shared care agreement
- Providing physical healthcare checks in line with Cardio-Metabolic Assessment and the following cardio metabolic parameters (previously included in the 2017-19 CQUIN):
    - Smoking status;
    - Lifestyle (including exercise, diet alcohol and drugs);
    - Body Mass Index and/or waist circumference;
    - Blood pressure;
    - Glucose regulation (preferably HbA1c or fasting plasma glucose. Random plasma glucose as appropriate);
    - Blood lipids;
    - Consider use of Glasgow Anti-psychotic Side-effect Scale (GASS).
- Complete and update appropriate Health Action Plan/Care Plan.
- Ensure patient is fully informed of, and engaged with the treatment detailed within the Health Action Plan:
    - That the patient/carer is clear what is being monitored and by whom
    - Following review share with RDaSH. For practices using SystmOne, a task will be sent to the RDaSH advising that a letter has been added to the patient record. For EMIS practices, a letter will be sent to the RDaSH team either via email or hard copy.
- Management of any physical health concerns and ongoing health management as identified by RDaSH (above and beyond low level advice) through the PHC excluding ECGs.

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4.3 Patient (or Carers) Responsibilities

- Attend and participate in the monitoring of their physical health
- Share any concerns they have in relation to their physical health
- Report to the specialist or GP if they do not have a clear understanding of their condition and/or treatment
- Report any adverse effects of treatment to their specialist or GP

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5. Procedure for Adopting Shared Care

Patients must be considered stable prior to RDaSH making a Shared Care request

A stable patient is considered to be someone who for a minimum of 3 months has not undergone active upward dose titration, changed medication type or actively been involved with acute services for symptom management (e.g. assertive outreach/home treatment teams or inpatient care) where medication changes are likely.

Individuals who have achieved a sufficient reduction in symptoms to not require additional acute services may wish to explore medication dose reduction. An individual's condition would still be considered stable despite down titration of medication. Similar adjustments to refine medication regimes should not exclude these individuals from accessing physical health checks and interventions in primary care.

It is anticipated that once responsibility for monitoring has been transferred to primary care under a shared care arrangement after the first year or first period of stabilisation that primary care would continue to monitor physical health even if there are subsequent relapses or deterioration in symptoms.

RDASH will offer an annual Physical health check prior to requesting shared care.

RDaSH will submit a formal (letter/e-mail) request to the GP requesting shared care of the patient's physical health

It will be assumed that shared care is accepted unless formally declined (in writing) to RDaSH within 6 weeks of receipt of request.

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6. References:

1. NHS England, (2018). CQUIN Indicator Specification 2017-2019. [online] Available at: https://www.england.nhs.uk/publication/cquin-indicator-specification/

2. NHS England, (2014). Lester Tool. [online] Available at: https://www.england.nhs.uk/2014/06/lester-tool/

3. NHS England, (2018). Improving physical healthcare for people living with severe mental illness (SMI) in primary care. [online] Available at: https://www.england.nhs.uk/wp-content/uploads/2018/02/improving-physical-health-care-for-smi-in-primary-care.pdf

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7. Shared Care Development:

Written by:

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Primary Care:

Doncaster:

Rotherham:

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Reviewed by:

Approved by:

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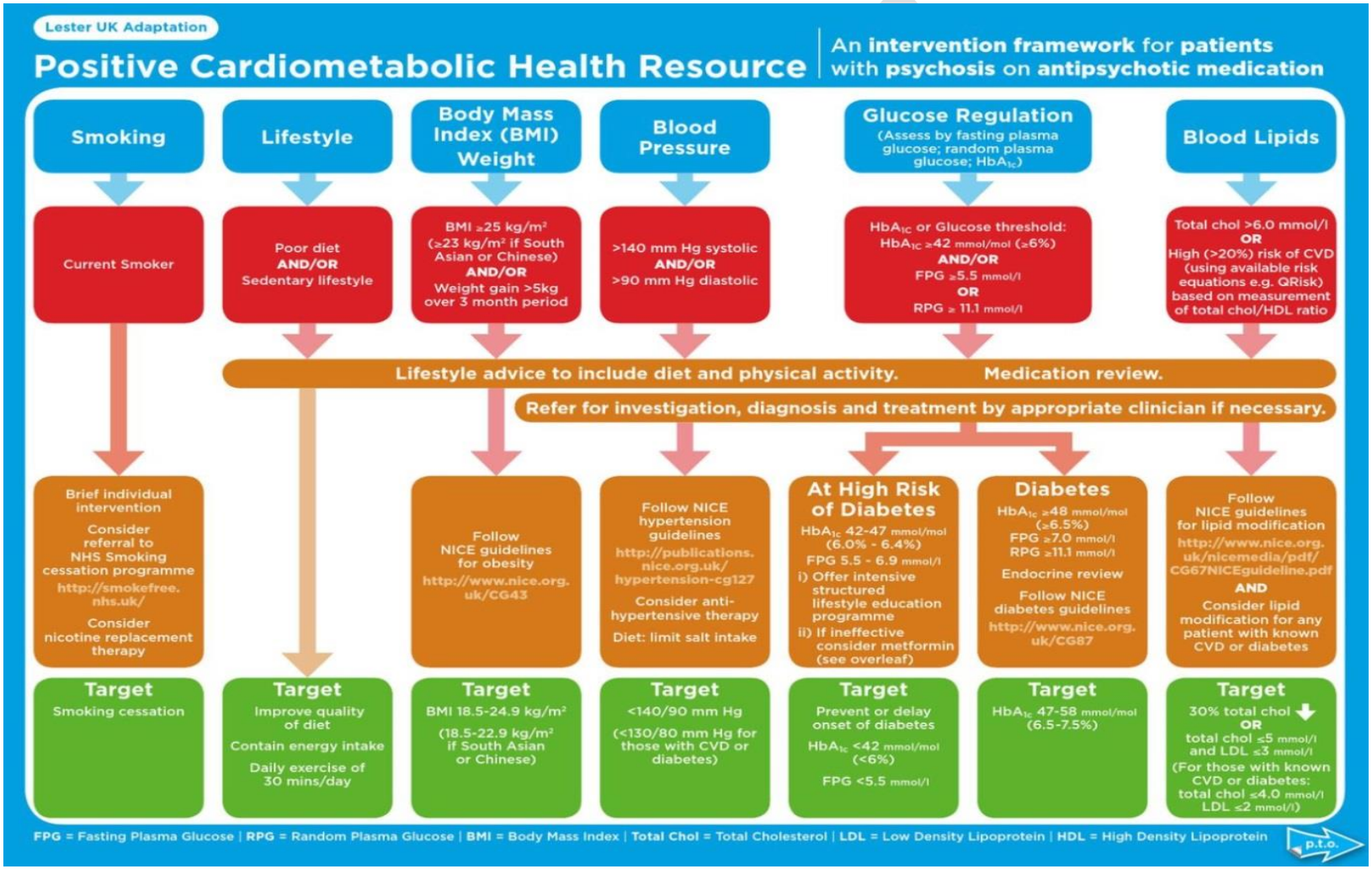
Appendix 1 – Lester Tool



Lester Tool [2], NHS England. https://www.england.nhs.uk/2014/06/lester-tool/

Appendix 2 – Glasgow Antipsychotic Side-effect Scale (GASS)

Glasgow Antipsychotic Side-effect Scale (GASS)

Name: **Age:** **Sex: M / F**

Please list current medication and total daily doses below:

This questionnaire is about how you have been recently. It is being used to determine if you are suffering from excessive side effects from your antipsychotic medication.

Please place a tick in the column which best indicates the degree to which you have experienced the following side effects.

Also tick the end or last box if you found that the side effect was distressing for you.

© *Waddell & Taylor, 2007*

Over the past week:	*Never*	*Once*	*A few times*	*Every day*	*Tick this box if distressing*
1. I felt sleepy during the day					
2. I felt drugged or like a zombie					
3. I felt dizzy when I stood up and/or have fainted					
4. I have felt my heart beating irregularly or unusually fast					
5. My muscles have been tense or jerky					
6. My hands or arms have been shaky					
7. My legs have felt restless and/or I couldn't sit still					
8. I have been drooling					

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9. My movements or walking have been slower than usual					
10. I have had uncontrollable movements of my face or body					
11. My vision has been blurry					
12. My mouth has been dry					
13. I have had difficulty passing urine					
14. I have felt like I am going to be sick or have vomited					
15. I have wet the bed					
16. I have been very thirsty and/or passing urine frequently					
17. The areas around my nipples have been sore and swollen					
18. I have noticed fluid coming from my nipples					
19. I have had problems enjoying sex					
20. **Men only:** I have had problems getting an erection					

Tick yes or no *for the* ***last three months***	*No*	*Yes*	*Tick this box if distressing*
21. **Women only**: I have noticed a change in my periods			
22. **Men and women**: I have been gaining weight			

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Staff Information (for interpreting GASS questionnaire)

1. Allow the patient to fill in the questionnaire themselves. All questions relate to the previous week.

2. Scoring for questions 1-20

Patient answer	Points
Never	0
Once	1
A few times	2
Every day	3

Scoring for questions 21-22

Patient answer	Points
No	0
Yes	3

Total for all questions=

3. For male and female patients a score of:
0-21 absent/mild side effects

22-42 moderate side effects

43-63 severe side effects

4. Side effects covered include:

Question	Parameter
1-2	sedation and CNS side effects
3-4	cardiovascular side effects
5-10	extra pyramidal side effects
11-13	anticholinergic side effects
14	gastro-intestinal side effects
15	genitourinary side effects

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16	screening question for diabetes mellitus
17-21	prolactinaemic side effects
22	weight gain

5. The column relating to the distress experienced with a particular side effect is not scored, but is intended to inform the clinician of the service user's views and condition.

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