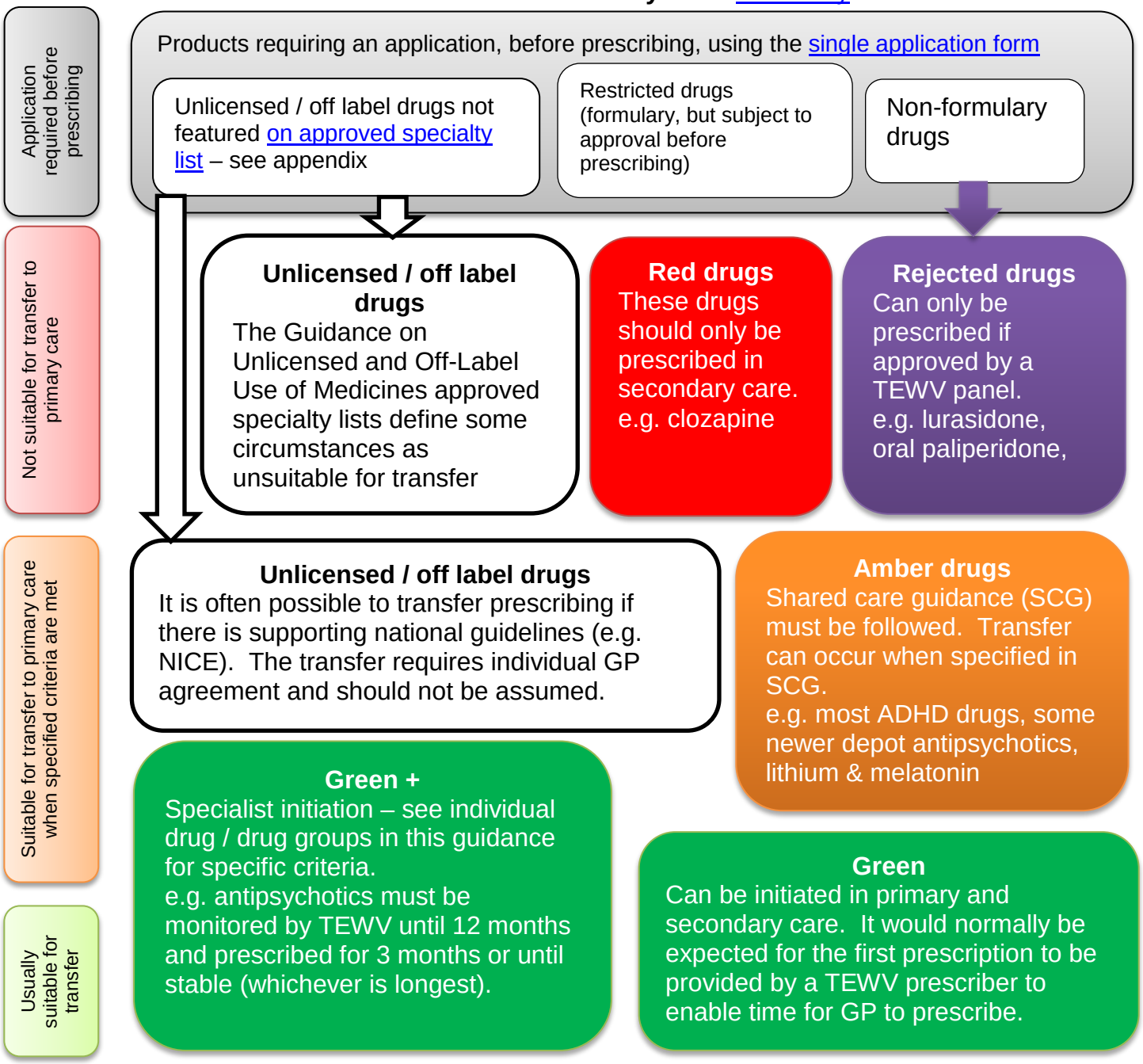
Safe transfer of prescribing guidance

TEWV Prescriber Summary – see Formulary



Successful Transfer of Prescribing – Key Points

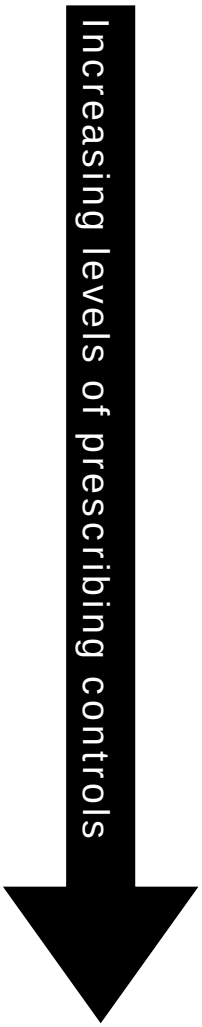
Good communication is essential. Full guidance on what to include in the letter is provided on page 4 & 5 of this guidance. The aim of the letter should be to politely request that the GP takes over prescribing. The language should not be demanding and should reflect that there is an option not to take over prescribing. You should look to include everything that will give the GP the confidence that their prescribing will be safe and reflective of best practice. If the drug is included in easily accessible local or national guidelines then the GP should be appropriately signposted. Always include a copy of shared care guidance if applicable. If prescribing is more complex, consider a direct phone call if appropriate or ask if the GP would accept transfer (once stabilised) before initiating.

The majority of medicines prescribed to treat mental health illnesses are covered by NICE guidance. Where prescribing follows NICE recommendations it is expected that prescribing responsibilities can be transferred from secondary to primary care services once patients are stabilised on treatment. This allows secondary care services to concentrate on the provision of specialist support and increases access to services. It also offers a much more convenient system for patients obtaining their medicines and allows primary care to provide comprehensive management of all of a patient's medication.

An underlying principle of this guidance is that prescribing and monitoring responsibilities must be clearly defined to ensure safe transfer of prescribing. Advice is available from the General Medical Council (GMC) on shared care prescribing and NHS England; Responsibilities for Prescribing between Primary and Secondary / Tertiary Care

All the drugs in Chapter 4 of the BNF which are prescribed by the Trust have been classified into categories which determine their prescribing status.

Green Drugs	● Can be initiated and prescribed in all care settings ○ Second line / alternative green drug
Green+ Drugs	✚ Specialist initiation / recommendation. Can be recommended by a specialist for initiation in primary care; or be initiated by a specialist and transferred to primary care once the patient is stabilised. In some cases there may be a further restriction for use outlined - these will be defined in each case.
Amber Drugs	▲ These are specialist drugs which must be initiated by the specialist, but with the potential to transfer to primary care within written and agreed shared care protocols and according to the agreed process for transfer of care
Red Drugs	◆ Drugs that should remain under the total responsibility of the specialist. Usually considered as "hospital only" drugs
Rejected	✕ Drugs that have been considered by the D&T or other approved body (e.g. NICE, NTAG) and are not approved for prescribing within TEWV.
Awaiting Review	⊘ Drugs that haven't been reviewed by the D&T yet. This usually means that an application is in progress. These drugs are not normally considered appropriate for prescribing in TEWV until such time that a decision is taken by the D&T & interface prescribing groups on their formulary status.



A full list of approved drugs is provided in Appendix1 according to the classifications noted above.

The Formulary, with RAG list information, can be accessed online at http://formulary.cdd.nhs.uk/. Note that the formulary is described as the County Durham & Darlington formulary, but it is for the whole of TEWV.

Copies of guidance and shared care can be found on the TEWV website here.

A quick reference guide for the formulary & safe transfer of prescribing aimed at TEWV prescribers is here. Localised versions for GPs are here (CDD, Tees, Hamb & Rich) and here (York, Scarborough, Harrogate)

Contents

Note local variations on the RAG status and equivalent TEWV RAG are stated below:

TEWV	**York & Scarborough**
Green	Green
Green Plus	Amber
Amber	**Amber (SCG)**
Red	Red
Purple	**Black**
Grey	Grey

Transfer of prescribing procedure

Transfer of prescribing responsibility may be considered when:

- The patient's mental state has been stabilised*
- The patient's dosage has been stabilised* and treatment is approved for transfer of prescribing.
- Prescribing is within NICE recommendations.
- The stipulations related to specific drugs are met

GREEN or GREEN ✚ classified drugs should be transferred, notifying the GP via the regular clinic letter. Include details of diagnosis (ICD-10), drug, dose and frequency; formulation (especially if a modified release, liquid or non-oral preparation is required); clinical indications if first line option not prescribed or non-standard formulation prescribed and list any discontinued drugs. The letter should also note a clear plan regarding review and planned duration of treatment.

*Patients are regarded as stabilised for the purpose of transfer of prescribing responsibility once they have completed their response to medication and there are no recognised problems with compliance or significant acute risks of harm to self or to others. They will usually have completed at least one month of treatment (or 3 months for antipsychotics - see appendix 1) and be suitable for 28 day prescriptions.

Drugs prescribed at doses above BNF limits, in combinations (except where the combination is for ADR control) or for unlicensed indications not recommended by NICE cannot be transferred using this standard process, but can be transferred in appropriate cases under individual agreement between specialist and GP. Communication in advance, including a phone call, may help to

AMBER ▲ classified drugs can only be transferred if the prescribing is in line with the parameters of the agreed shared care guideline. A copy of the applicable shared care guidance should be sent with the clinic letter. The GP must provide positive acceptance of the shared care request. All shared care guidelines can be found here.

RED, **PURPLE** and **GREY** drugs are not normally considered appropriate for transfer.

Suspension of primary care prescribing arrangements

Prescribing in primary care should be suspended and revert back to secondary care when:

- Patients are being seen intensively by secondary care necessitating medication changes

The risk of continued prescribing where patients default from attending secondary care reviews needs to be considered.

Triggers for referral back to secondary care services or need for specialist advice

These may include:

- Any spontaneous deterioration in mental state or increase in risk to self or others that cannot be managed by the GP
- Patient or carer request to review adverse side effects including the development of extra pyramidal side effects
- Non-concordance or lack of efficacy
- Specific prescribing circumstances e.g. pregnancy, breast feeding, initiation of concomitant therapy that may interact with the patient's therapy or mental state
- Increase in smoking, alcohol or drug use
- Deterioration or abnormalities in monitoring results

Access to services and specialist advice

Contact details for rapid access to services and advice will be provided in the GP letter/shared care prescribing transfer request.

Discharge of patients and quick referral back

Discharge communication must clearly outline a medication treatment plan including expected length of treatment and criteria for review. Where this is not clear, the GP should request clarity.

For patients on antipsychotic or antimanic medication, consideration may be given to discharging patients from secondary care services where no active treatment is being provided by specialist services and the patient has:

- had at least one annual review by secondary care services **and**
- been stable on and concordant with treatment for a minimum of 6 months **and**
- is not receiving aftercare under Section 117 **and**
- no other co-morbidity requiring consultant psychiatrist input

This should only occur with:

- explicit agreement from the GP **and**
- a formalised written agreement between secondary care and primary care **and**
- after discussion with the patient.

It is advised that the discharge care planning arrangements specifically highlight requirements for on-going physical health monitoring.

For patients who may not require lifelong treatment an indication of longer term review arrangements where discontinuation or review of treatment may be considered should be specified.

If after discharge a patient becomes mentally unstable or a slow deterioration in mental health is observed a referral from primary care would result in prompt action by secondary care.

Patients that have been discharged can, within 3 months of discharge, be referred back directly to the discharging team.

Appendix 1

GREEN ●	GREEN ○	GREEN PLUS ✚	AMBER ▲	RED ◆	PURPLE X
4.1.1 Hypnotics					
Temazepam	Promethazine		Melatonin (Circadin) Shared Care	Melatonin (non-Circadin)	
Zopiclone	Zolpidem				
4.1.2 Anxiolytics ✚ Initiation by specialist; Prescribing follows Anxiety Medication Pathway for Adults (only if SSRIs or SNRIs not tolerated); Stabilised on treatment; Minimum of one month supply on transfer					
Diazepam	Chlordiazepoxide	Pregabalin			
	Lorazepam	Buspirone			
4.2.1 First generation antipsychotics ✚ Initiation by specialist; Prescribing follows Psychosis Care Pathway; Secondary care will retain responsibility for monitoring for 12 months; Prescribing can be transferred when stabilised on treatment or prescribed for 3 months (whichever is longest); Minimum of one month's notice before transfer; Annual review of medication by specialist services whilst actively involved in providing treatment					
		Benperidol		Zuclopenthixol acetate (injection)	
		Haloperidol			
		Chlorpromazine			
		Promazine			
		Sulpiride			
		Trifluoperazine			
		Zuclopenthixol (oral)			
4.2.1 Second generation antipsychotics (oral) ✚ Initiation by specialist; Prescribing follows Psychosis Care Pathway; Secondary care will retain responsibility for monitoring for 12 months; Prescribing can be transferred when stabilised on treatment or prescribed for 3 months (whichever is longest); Minimum of one month's notice before transfer; Annual review of medication by specialist services whilst actively involved in providing treatment					
		Amisulpride		Clozapine	Paliperidone
		Aripiprazole			Lurasidone
		Olanzapine (specify clinical indication for orodispersible			

GREEN ●	GREEN ○	GREEN PLUS ✚	AMBER ▲	RED ◆	PURPLE X
		preparations)			
		Quetiapine (specify clinical indication for MR preparations)			
		Risperidone (specify clinical indication for orodispersible preparations)			
4.2.2 Antipsychotic depots & long-acting injections (Responsibility for prescribing & administration not split) ✚ Initiation by specialist; Prescribing follows Psychosis Care Pathway; Secondary care will retain responsibility for monitoring for 12 months; Prescribing can be transferred when stabilised on treatment or prescribed for 3 months (whichever is longest); GP practice agreement to administer depot; Minimum of one month's notice before transfer; Annual review of medication by specialist services whilst actively involved in providing treatment.					
		Flupentixol Decanoate	Paliperidone	Olanzapine	
		Haloperidol	Aripiprazole		
		Risperidone LA			
		Zuclopenthixol Decanoate			
4.2.3 Antimanic drugs ✚ Initiation by specialist; Prescribing follows Bipolar Care Pathway; Antipsychotics: Secondary care will retain responsibility for monitoring for 12 months; Prescribing can be transferred when stabilised on treatment or prescribed for 3 months (whichever is longest); Minimum of one month's notice before transfer; Annual review of medication by specialist services whilst actively involved in providing treatment Lithium ▲ Follow shared care protocol when transferring prescribing					
		Olanzapine (specify clinical indication for orodispersible preparations)	Lithium Carbonate (Priadel)		Asenapine
		Quetiapine (specify clinical indication for MR preparations)	Lithium Citrate (specify brand name)		
		Risperidone (specify clinical indication for orodispersible preparations)			
		Carbamazepine			
		Lamotrigine			
		Sodium valproate			
		Valproic acid			

GREEN ●	GREEN ○	GREEN PLUS ✚	AMBER ▲	RED ◆	PURPLE X
4.3.1 Tricyclic and related antidepressants Prescribing follows Depression Medication Pathway for Adults					
Amitriptyline	Clomipramine				
Trazodone	Imipramine				
	Lofepramine				
4.3.2 Monoamine-oxidase inhibitors ✚ Initiation by specialist; Prescribing follows Depression Medication Pathway for Adults & Anxiety Medication Pathway for Adults; Stabilised on treatment; Minimum of one month's supply on transfer					
		Moclobemide			
		Phenelzine			
4.3.3 Selective serotonin re-uptake inhibitors ✚ Initiation by specialist; Prescribing follows Depression Medication Pathway for Adults, Anxiety Medication Pathway for Adults & Depression Pathway CYP - guidance on pharmacological management; Stabilised on treatment; Minimum of one month's supply on transfer					
Citalopram	Fluvoxamine				
Fluoxetine					
Sertraline					
Escitalopram					
4.3.4 Other antidepressants ✚ Initiation by a specialist; Prescribing follows Depression Medication Pathway for Adults & Anxiety Medication Pathway for Adults; Stabilised on treatment; Minimum of one month's supply on transfer;					
Mirtazapine	Reboxetine	Venlafaxine > 225mg		Agomelatine	
Venlafaxine	Vortioxetine	Duloxetine		Bupropion	
4.4 CNS Stimulants & drugs used for ADHD ▲ Follow shared care protocol when transferring prescribing					
			Methylphenidate		
			Atomoxetine		
			Dexamfetamine		
			Lisdexamfetamine		
			Guanfacine		

GREEN ●	GREEN ○	GREEN PLUS ✚	AMBER ▲	RED ◆	PURPLE X
4.6 Drugs used in nausea and vertigo					
Hyoscine hydrobromide					
4.8.1 Antiepileptics ✚ Initiation by specialist; Prescribing follows NICE CG 137 Epilepsy ; Stabilised on treatment; Minimum of one month's supply on transfer					
Carbamazepine	Clobazam	Acetazolamide		Rufinamide	
Lamotrigine	Clonazepam	Ethosuximide			
Sodium Valproate	Gabapentin	Lacosamide			
	Phenytoin	Levetiracetam			
	Phenobarbital	Oxcarbazepine			
	Primidone	Perampanel			
	Tiagabine	Pregabalin			
		Retigabine			
		Stiripentol			
		Topiramate			
		Vigabatrin			
		Zonisamide			
4.8.2 Drugs used in status epilepticus					
Diazepam	Clonazepam				
Midazolam	Lorazepam				
	Phenobarbital				
	Phenytoin				
4.9.2 Antimuscarinic drugs use in Parkinsonism					
		Procyclidine			
		Orphenadrine			
		Trihexyphenidyl			
4.10.1 Alcohol dependence ◆ Initiation and continuation by specialist commissioned service; Prescribing follows NICE CG115 alcohol dependence and harmful alcohol use;					
				Acamprosate	

GREEN ●	GREEN ○	GREEN PLUS ✚	AMBER ▲	RED ◆	PURPLE X
				Chlordiazepoxide	
				Disulfiram	
				Nalmefene	
				Naltrexone	
4.10.2 Nicotine dependence Note: this section reflects TEWV prescribing guidelines and does not reflect primary care / local authority commissioning arrangements.					
Nicotine (NRT)					
4.10.3 Opioid dependence ◆ Initiation and continuation by specialist commissioned service					
				Buprenorphine	
				Lofexidine	
				Methadone	
				Naltrexone	
				Suboxone	
4.11 Drugs for dementia ✚ Initiation / recommendation by a specialist (see guidance); Prescribing follows Dementia Care Pathway					
		Donepezil (specify clinical indication for orodispersible preparations)			
		Galantamine			
		Memantine			
		Rivastigamine (specify clinical indication for patches)			

2nd June 2017	V7.1	Lisdexamfetamine now amber (was red) and clarification added re: antipsychotics on page 3. Hyperlinks to website updated.
19th June 2018	V8	Guanfacine moved to amber (was red). TEWV prescriber summary added to page 1. Fluphenazine decanoate removed as being discontinued. Page 3: shared care requires acceptance and comment added for combinations for ADR control. Hyperlinks amended and added throughout. Additional supportive text & signposting added throughout. Drugs for dementia amended in line with NICE.
21st June 2019	V8.1	Hyperlinks corrected throughout. Formulary hyperlink added to first page.