Safe transfer of prescribing guidance

TEWV Prescriber Summary – see Formulary

Application required before prescribing

Products requiring an application, before prescribing, using the single application form

- Unlicensed drugs / off-label prescribing not prior-approved in Trust guidance – see appendix
- Restricted drugs (formulary, but subject to approval before prescribing)
- Non-formulary drugs

Not suitable for transfer to primary care

Unlicensed drugs / off label prescribing
The Guidance on Unlicensed and Off-Label Use of Medicines prior-approved list includes some treatments as unsuitable for transfer

Red drugs
These drugs should only be prescribed in secondary care.
e.g. clozapine

Not approved
Can only be prescribed if approved by a TEWV panel.
e.g. lurasidone (off-label),
oral paliperidone,

Suitable for transfer to primary care when specified criteria are met

Unlicensed drugs / off label prescribing
It is often possible to transfer prescribing if there is supporting national guidelines (e.g. NICE). The transfer requires individual GP agreement and should not be assumed.

Amber: Shared Care
Shared care guidance (SCG) must be followed. Transfer can occur when specified in SCG.
e.g. ADHD drugs, depot antipsychotics, lithium & melatonin

Amber: Specialist initiation
Specialist initiation – see individual drug / drug groups in this guidance for specific criteria.
e.g. antipsychotics must be monitored by TEWV until 12 months and prescribed for 3 months or until stable (whichever is longest).

Usually suitable for transfer

Green
Suitable for initiation in primary or secondary care. If seen by a TEWV prescriber it is usually appropriate to provide the first prescription to give time for GP to add to the system. Where the patient has not been seen (advice only) or there are other individual considerations the first prescription can be provided by the GP.

Successful Transfer of Prescribing – Key Points

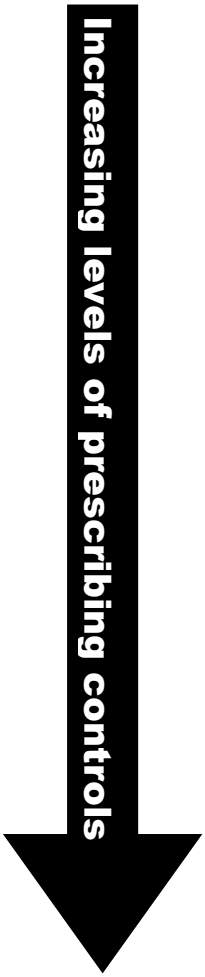
Good communication is essential. Full guidance on what to include in the letter is provided on page 4 & 5 of this guidance. The aim of the letter should be to politely request that the GP takes over prescribing. The language should not be demanding and should reflect that there is an option not to take 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.

Most 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 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
Amber: Specialist Initiation	● Specialist initiation. Can be initiated by a specialist and transferred to the GP 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: Shared Care	⇄ These are specialist drugs which must be initiated by the specialist, but with the potential to transfer to the patients GP 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
Not Approved	✕ Drugs that have been considered by the APC or other approved body (e.g. NICE, NTAG) and are not approved for prescribing (i.e. cannot be initiated, but can be continued if already established) within TEWV.
Not Reviewed	⊘ Drugs that haven't been reviewed by the APC 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 Appendix 2 according to the classifications noted above.

Specialist Initiation includes TEWV prescribers working in primary care settings e.g. Community hubs, PCN practitioners, GP aligned services

The Formulary, with RAG list information, can be accessed online at http://joint-formulary.tees.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.

Contents

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

TEWV	**NY & Y**
Green	Green
Amber: Specialist Initiation	Amber
Amber: Shared Care	Amber (SCG)
Red	Red
Purple	**Black**
Grey	Grey

Transfer of prescribing procedure

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. As appropriate, 28 days treatment should be supplied to enable primary care to update their records and provide further prescriptions (if applicable).

Transfer of prescribing responsibility for amber specialist medication 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

AMBER: Specialist Initiation classified drugs should be transferred, as above. Note: added requirements for antipsychotics and antimanic medication.
Patients are regarded as stabilised on antipsychotics or antimanic medication, 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, to explain the rationale for treatment, may facilitate such transfer

AMBER: Shared Care ⇄ 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.

Note: where the patient uses a monitored dosage system, extra care needs to be taken during the transfer process. A discussion is recommended to ensure the most appropriate route of supply is made to maximise patient safety.

Suspension of primary care prescribing arrangements

Prescribing in primary care should be suspended and revert to secondary care when patients are being seen intensively by secondary care necessitating medication changes.

Where patients default from attending secondary care reviews, the risk/benefit of continued prescribing 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**
- there is 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.

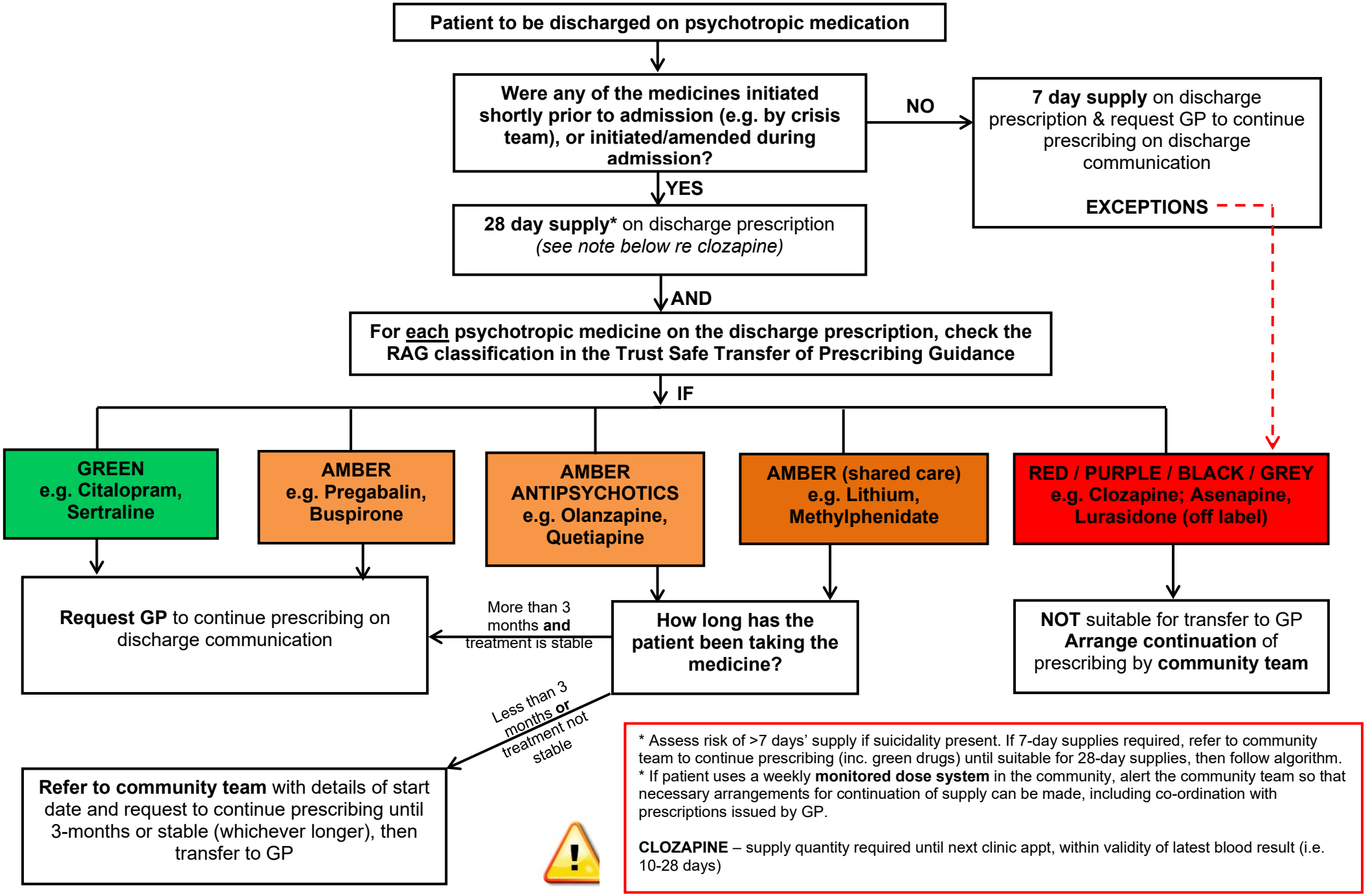
It is advised that the discharge care planning arrangements specifically highlight requirements for on-going physical health monitoring.

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: Discharge on psychotropic medication from in-patient units



Appendix 2: List of formulary status applicable for initiation by TEWV prescribers

GREEN ●	GREEN O	AMBER: Specialist Initiation ✚	AMBER: Shared Care ⇄	RED !	PURPLE X or other
4.1.1 Hypnotics					
Temazepam	Promethazine		Melatonin (Circadin) & liquid identified in Shared Care	Melatonin (non-Circadin)	Melatonin (Colonis Pharma brand)
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	Lorazepam	Pregabalin			Meprobamate
		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)	Promazine
		Chlorpromazine			
		Haloperidol			
		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 (oral)
		Aripiprazole			Lurasidone (all other indications)
		Lurasidone (Schizophrenia)			
		Olanzapine			
		Quetiapine			
		Risperidone			
4.2.2 Antipsychotic depots & long-acting injections (Responsibility for prescribing & administration not split) ⇄ Follow shared care protocol when transferring prescribing					

GREEN ●	GREEN O	AMBER: Specialist Initiation ✚	AMBER: Shared Care ⇄	RED !	PURPLE X or other
NOTE: If the transfer of care was made prior to 11/7/2019 then these drugs were considered as “amber specialist initiation” (except paliperidone and aripiprazole which have always been amber shared care) and therefore patients’ do not need to be referred back by primary care to establish shared care. A shared care agreement is required for any transfer from 11/7/2019 onwards.					
			Aripiprazole	Olanzapine	
			Flupentixol Decanoate		
			Haloperidol Decanoate		
			Paliperidone		
			Risperidone		
			Zuclopenthixol Decanoate		
4.2.3 Antimanic drugs ✚ Initiation by specialist; Prescribing follows Bipolar Disorder Medication 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 & Valproate ⇄ Follow shared care protocol when transferring prescribing					
		Olanzapine	Lithium Carbonate (Priadel)		Asenapine
		Quetiapine			
		Risperidone	Lithium Citrate (specify brand name)		
		Carbamazepine			
		Lamotrigine	*In girls and women of child bearing potential:* Sodium valproate Valproic acid		
		Sodium valproate			
		Valproic acid			
		Aripirazole			
		Haloperidol			
4.3.1 Tricyclic and related antidepressants Prescribing follows Depression Medication Pathway for Adults					
Amitriptyline	Clomipramine				Dosulepin
Trazodone	Imipramine				Trimipramine
	Lofepramine				
	Nortriptyline				

GREEN ●	GREEN O	AMBER: Specialist Initiation ✚	AMBER: Shared Care ⇄	RED !	PURPLE X or other
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			Tranylcypromine
		Phenelzine			Isocarboxazid
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					Paroxetine Fluvoxamine (only used for existing patients and patients moving into the area already stabilised on paroxetine or fluvoxamine)
Escitalopram					
Fluoxetine					
Sertraline					
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	Vortioxetine	Venlafaxine > 225mg		Agomelatine	
Venlafaxine	Duloxetine	Reboxetine		Bupropion	
4.4 CNS Stimulants & drugs used for ADHD ⇄ Follow shared care protocol when transferring prescribing					
			Atomoxetine		
			Dexamfetamine		
			Guanfacine		
			Lisdexamfetamine		
			Methylphenidate		
4.6 Drugs used in nausea and vertigo					
Hyoscine hydrobromide					

GREEN ●	GREEN O	AMBER: Specialist Initiation ✚	AMBER: Shared Care ⇄	RED !	PURPLE X or other
4.8.2 Drugs used in status epilepticus					
Diazepam	Lorazepam				
Midazolam					
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	
				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			
		Galantamine			
		Memantine			
		Rivastigamine			

Appendix 3: Transfer of Prescribing Checklist

BEFORE TRYING TO TRANSFER PRESCRIBING: CHECKING IT'S APPROPRIATE

- ☐ I have reviewed the formulary status of the medication and it is appropriate to transfer
- ☐ The medication and patient's mental health is stable (i.e the patient has completed their response to medication and there are no recognised problems with compliance or significant acute risks of harm to self or to others).
- ☐ There has been consideration of STOMP (if applicable)
- ☐ The patient has completed at least one month of treatment (or 3 months for antipsychotics) and is suitable for 28 day prescriptions
- ☐ A minimum of one month's notice has been provided to the GP to ensure adequate time to add the prescription to the GP system

AMBER SHARED CARE: FOLLOWING THE SHARED CARE PROTOCOL

- ☐ There is a shared care protocol available to use (NOTE: if there isn't one available, then it the medication is not shared care and shouldn't be referred to as such)
- ☐ The patient & medication meets all of the criteria defined within the shared care protocol
- ☐ A clear letter has been written to the GP and a copy of the shared care protocol has been sent
- ☐ Arrangements have been made to continue prescribing until the GP agrees to shared care being established for this patient
- ☐ Arrangements have been made for the necessary secondary care responsibilities to be carried out (as defined in the protocol)

UNLICENSED / OFF-LABEL MEDICATION: ASK FIRST

- ☐ The medication has been supported for prescribing in TEWV (is on pre-approved list or has had an application approved)
- ☐ The patient has been informed of the licensing status of the drug
- ☐ It is reasonable to ask a non-specialist to takeover prescribing with appropriate secondary care input
- ☐ The transfer has been discussed by phone or letter with the GP and they have agreed to the transfer
- ☐ A clinic letter has been sent which provides the GP with an appropriate management plan to support prescribing

DISCHARGE FROM SECONDARY CARE SERVICES ON ANTIPSYCHOTICS OR ANTIMANIC MEDICATION: WHAT NEEDS TO BE CONSIDERED

- ☐ The medication is NOT amber shared care, red or purple
- ☐ No active treatment is being provided by TEWV specialist services
- ☐ There has been at least one annual review, by secondary care
- ☐ The patient has been stable on, and concordant with, treatment for a minimum of 6 months
- ☐ The patient is not receiving section 117 after care
- ☐ Discharge communication clearly outline a medication treatment plan including expected length of treatment and criteria for review

Appendix 4: Transfer of Prescribing Issues

WHAT TO DO IF THE GP HAS QUERIED OR NOT ACCEPTED THE TRANSFER REQUEST:

SELF CHECK

- ☐ Have you followed all of the guidance within this document?
- ☐ Can you provide any supporting information to enable a successful transfer?
- ☐ Would a phone call to the GP help?
- ☐ Is it reasonable for the GP not to accept this transfer?

PEER SUPPORT

- ☐ Discuss the case with someone in your team. Can they provide any additional guidance? (NOTE: Ensure it's a peer that understands this document)
- ☐ Ask a colleague to review your transfer request letter and provide any helpful suggestions
- ☐ Consider trying again (best with a phone call) if the peer support has provided some different insight

LOCALITY SUPPORT

- ☐ Is this a persistent problem in a locality, or with a GP practice or an individual GP?
- ☐ Is the request definitely within the boundaries of this guidance?
- ☐ Discuss in an appropriate forum and seek advice
- ☐ Escalate to specialty governance group if there is a theme

PHARMACY SUPPORT

- ☐ If there is a pattern / theme were transfer is not being accepted, but is considered acceptable according to this guidance then consider discussion / email with Christopher.williams@nhs.net or Richard.morris2@nhs.net
- ☐ Pharmacy may not be able to resolve the specific issue, but it can help to shape future guidance and raise concerns through the Area Prescribing Committee

Document changes:

August 2023	V9.3	Review date extended to 1st April 2024
November 2022	V9.3	Minor change – page 12. Removed GP advisor (role no longer available) and amended QuAG to governance group
February 2022	V9.2	Updated wording throughout to specific better between secondary care, primary care, GP and specialist (recognising embedded mental health specialist practitioners). Definition to include this added to page 2. Removed reference on page 2 to quick reference guides (which no longer exist). All hyperlinks updated. Lurasidone now amber SI for licensed indication & duloxetine is green.
July 2020	V9.1	Minor amendments / clarity in green drugs box on page 1
May 2020	V9.0	RAG formulary status amended to match new APC format (green+ now amber specialist initiation/recommendation). Green and amber specialist initiation box separated in narrative. Additional comment added re: MDS. Appendix 1 added – guide to discharge from inpatients on psychotropic medication Appendix 2: Drug lists updated throughout to match formulary: Hyperlinks added and updated. Colour added to table to define differences. 4.1.1 – melatonin (colonis pharma) added as purple 4.1.2 – chlordiazepoxide deleted. Meprobamate added as purple. 4.2.1 – promazine added as purple 4.2.2 – all depots / LAIs (except olanzapine) now amber shared care 4.3.1 – added nortriptyline as green. Dosulepin and trimipramine added as purple. 4.3.2 – tranylcypromine and isocarboxazid added as purple 4.3.3 – fluvoxamine removed. Paroxetine added as purple. 4.3.4 – reboxetine moved from green to amber specialist initiation Section 4.8.1 (antiepileptics) removed as TEWV prescribers will not normally initiate 4.8.2 – clonazepam, phenobarbital and phenytoin removed Appendix 3: new checklist added Appendix 4: new checklist for transfer of prescribing challenges
21st June 2019	V8.1	Hyperlinks corrected throughout. Formulary hyperlink added to first page.
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.
2nd June 2017	V7.1	Lisdexamfetamine now amber (was red) and clarification added re: antipsychotics on page 3. Hyperlinks to website updated.