Safe Transfer of Prescribing Guidance

journey to change

NHS Tees, Esk and Wear Valleys NHS Foundation Trust

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Further guidance

Links to the trust intranet can be found using the Medicines Optimisation – Interactive Guide

A shortened version of the interactive guide, with website links, is available for primary care here

Medications

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Quick Reference Guide

Formularies & RAG — Links to the formularies & explains what RAG status mean and describes some general principles.

The summary explains when a drug is suitable for transfer & gives top tips for successful transfer. — Summary for Prescribers

Communication — The key aspects of communication with GPs & broad rules of transfer of green & green + drugs

What is shared care & how to initiate shared care arrangements + off label prescribing (inc. CAMHS) — Shared Care & Off-label

Discharge — How and when to discharge patients (unless on shared care or red drug) and referral back.

To find out more detail on specific medications, use Ctrl+F and type in the drug name, click blue links on this page or click this button to scroll through. — Medications

In-patient Discharge — How to transfer prescribing when patients have been initiated on psychotropic medication as an in-patient.

Troubleshooting / advice — Checklist (to make sure you're following the process); How to approach Challenges

Title	Safe Transfer of Prescribing Guidance		
Approved by	Drug & Therapeutics Committee	Date of Approval	25 July 2024
Protocol Number	PHARM-0023-V10.0	Date of Review	31 July 2027

Overview

Prescribing Formulary

Formularies outline the preferred medicines and include the RAG (Red / Amber / Green) status which define where prescribing and monitoring of medication should occur:

DTV&F Care Group

- North East and North Cumbria (NENC) Formulary

NYY&S Care Group

- North Yorkshire & York Formulary
- Harrogate & Rural District Formulary

RAG Status

- The RAG status is subtly different across each formulary. The main difference is that GREEN+ in NENC has the same definition as AMBER in NYY. This guide refers to GREEN+ as a standard to avoid confusion.
- A summary description of each RAG status is included in this page. A full description is in appendix 5
- Some drugs have a different RAG status between the two areas.

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

RAG Status: Summary

GREEN: Can be initiated by a GP or in all other care settings. If initiated in TEWV it can be discontinued by primary care without recourse to secondary care.

GREEN+ (DTV&F)

AMBER (NYY&S)

Drugs normally recommended or initiated by a specialist. There may be a further restriction for use outlined in the formulary and the provision of additional information may be required for the GP.

AMBER SHARED CARE: Drugs initiated by secondary care specialist, but where continuing treatment by GPs may be appropriate under a shared care arrangement.

RED: Drugs for secondary care use only. The responsibility for initiation and monitoring treatment should rest with an appropriate secondary care clinician and the drug should be supplied via secondary care prescriptions throughout the duration of treatment.

BLACK: NOT APPROVED - Drugs that have been considered and are not approved for prescribing.

GREY / BROWN / NR: Descriptors applied to drugs that are under review or haven't yet been reviewed for inclusion in the formulary.

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TEWV Prescriber Summary

Application required prior to prescribing

- using the single application form

Unlicensed drugs / off-label prescribing

Application needed if not on prior-approval list in Trust guidance – see appendix 2

Restricted drugs – formulary, but subject to approval before prescribing (e.g. paliperidone & aripiprazole LAIs)

Non-formulary drugs (black / grey / NR / brown)

Not usually 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 that would be considered "red"

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

Non-formulary drugs
Can only be prescribed if approved by a TEWV panel.
e.g. lurasidone (off-label), oral paliperidone, cariprazine

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

Green+
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).

Suitable for transfer in most circumstances

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 the following pages 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 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.

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Transfer of Prescribing Procedure: Communication, Green, Green+, Off-Label Transfer

Communication with the GP

The following communication standards should be used for all initiated, stopped or changed medication – this is regardless of RAG status:

Details of the medication prescribed

- Including drug, indication, form, dose and quantity

Rationale for the decision

- Include key factors in decision making

Patient information provided

- Describe the level of shared decision making and note information provided to the patient / family / carer – include any significant discussion points

Treatment plan

- Describe plans for review, monitoring of effectiveness, physical health monitoring and planned next steps (including duration of treatment)

For further details including a list of key aspects to consider before prescribing (described in section 3) and a guide to recording in the electronic patient record (appendix 3) see the Prescribing and initiation of treatment procedure
A summary is also available in Medication Safety Series 26: Prescribing – Record Keeping & Communication Expectations.

Monitored Dosage Systems (MDS) / Compliance Aid

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.

GREEN classified drugs should be transferred by:

- Notifying the GP via the regular clinic letter.
- 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).

GREEN+ 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 product license or NICE recommendations.
- The stipulations related to specific drugs are met
- *For the transfer of prescribing context, patients are regarded as stabilised on antipsychotic or antimanic medication 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) and be suitable for 28-day prescriptions.

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Transfer of Prescribing Procedure: Off-label, CAMHS & Shared Care

OFF-LABEL / OFF-LICENSE

See: Guidance on Unlicensed and Off-Label Use of Medicines

Drugs prescribed at doses above BNF limits, in combinations (except where the combination is for Adverse Drug Reaction control) or for unlicensed indications not recommended by NICE cannot be transferred using this standard process.

They may 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.

PRESCRIBING FOR CHILDREN

The RAG status of a medicine does not always apply in CAMHS. Where there is a substantial body of evidence to support the use of an unlicensed medicine or a licensed medicine outside of its licence for example in paediatrics the GP may be asked to prescribe. However the GP must be fully informed and made aware of the licensing status. The GP should refer to the Children's BNF as a guide for prescribing of unlicensed medicines / licensed medicines outside of licence. The full agreement of the GP concerned must be obtained before prescribing is transferred.

Prescribers may wish to access the GMC guidance on prescribing off-label or unlicensed medications:
http://www.gmcuk.org/guidance/ethical_guidance/14327.asp

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Shared Care is a terminology that is applied inconsistently and sometimes used inappropriately

- In formulary terms it only applies to a drug that has a developed shared care protocol
- It is not a term that should be used for general transfer of specialist medicines
- In TEWV only the following groups of medicines have a shared care status: ADHD medicines, depot antipsychotics, lithium, melatonin and valproate in those of child-bearing potential.
- Drugs for dementia and oral antipsychotics are **not** shared care. These are examples of green / green+ medicines. Referring to these as shared care causes confusion and can sometimes lead to transfer of prescribing being rejected.
- Each shared care document outlines the responsibility of both primary care and TEWV.
- Most shared care arrangements require an annual review by the specialist.
- A new shared care document is not usually be required for dose optimisation (i.e. dose increase or decrease) unless the patients condition is no longer stable, necessitating cessation and then reinitiating shared care.
- A copy of the shared care guidance must be sent to the GP on transfer and should be stored in the TEWV electronic care record.

AMBER SHARED CARE classified drugs can only be transferred if:

- Prescribing is in line with the parameters of the agreed shared care guideline
- A copy of the applicable shared care guidance is sent with the clinic letter
- The GP provides positive acceptance of the shared care request

RED, **BLACK** and **BLUE** / **BROWN** / **GREY** drugs are not normally considered appropriate for transfer.

Transfer of Prescribing Procedure: Secondary Care Advice, Discharge & Quick Referral Back

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 request.

Discharge communication

- Must clearly outline a medication treatment plan including expected length of treatment and criteria for review. Example review criteria could include:
    - Increasing age (impacting on appropriate doses)
    - Patient / carer request
    - Change in physical health impacting mental health medication
- Where this is not clear, the GP should request clarity.

Discharging patients on antipsychotic or antimanic medication

Consideration may be given to discharging patients from secondary care services where no active interventions (over and above the medication – unless shared care or red) are being provided by specialist services and the patient has:

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

This should only occur with:

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

Discharge arrangements

- 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, disengages with monitoring 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 12 months of discharge, be referred directly to the discharging team.

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Appendix 1: Medication in BNF Chapter 4 initiated in TEWV

- Drugs listed in this section are featured alphabetical order. This does not indicate a clinical order of preference. Please refer to individual clinical guidelines.
- Hyperlinks are directly to the TEWV website as this is a guideline that primary care is likely to refer to.
- Links to the trust intranet can be found using the Medicines Optimisation – Interactive Guide
- A shortened version of the interactive guide, with website links, is available for primary care here

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Antipsychotics - Oral

GREEN+

- Amisulpride
- Aripiprazole
- Benperidol
- Chlorpromazine
- Flupentixol
- Haloperidol
- Lurasidone (Schizophrenia only)
- Olanzapine
- Quetiapine
- Risperidone
- Sulpiride
- Trifluoperazine
- Zuclopenthixol

- Initiation by specialist
- Prescribing follows appropriate clinical guidelines
- After initiation secondary care will retain responsibility for monitoring antipsychotics for 12 months
- Prescribing can be transferred when stabilised on treatment or prescribed for 3 months (whichever is longest)
- When switching antipsychotics prescribing can be transferred when stabilised on treatment or prescribed for 3 months (whichever is longest). The responsibility for 12 months monitoring does not restart (monitoring required at 3 months and then overall 12-month review following antipsychotic initiation).
- Minimum of one month's notice before transfer
- Annual review of medication by specialist services whilst actively involved in providing treatment
- If considering discharge from services see discharge guidance for antipsychotics

Monitoring Guide

RED

- Clozapine

- No transfer of prescribing
- See Processes for prescribing, dispensing, supply and monitoring
- On initiation send Primary Care Information Sheet – GP to add to medication records noting prescribing and supply from TEWV.

Associated Guidance

- Psychotropic Medication Monitoring Guide
- Lurasidone – prescribing support document (PSS1) including formulary status & NTAG criteria for use in schizophrenia
- Anxiety medication pathway – adults
- Bipolar medication pathway – adults & children
- Depression medication pathway – adults
- Management of QTc Prolongation

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BLACK / GREY

- Asenapine
- Cariprazine
- Lurasidone (indications other than schizophrenia)
- Paliperidone
- Promazine

- These medications have no formulary status and would not normally be suitable for transfer to primary care
- Prescribing is by exception only. Each of these require a panel decision with an application required using the single application form

Associated Deprescribing Guidance

- Deprescribing guidance for: Promazine
- Quetiapine XL: IR in preference to XL formulations (pg.10)
- STOMP Medication Review Pathway: Stopping over Medication, of People with a Learning Disability, Autism or both, with psychotropic medicines

Antipsychotics - Injections

AMBER SHARED CARE
Antipsychotic Depots / Long Acting Injections (LAI)

- Aripiprazole* – shared care
- Flupentixol Decanoate – shared care
- Haloperidol Decanoate – shared care
- Paliperidone* – shared care
- Risperidone* – shared care
- Zuclopenthixol Decanoate – shared care

- Initiation and stabilisation under specialist
- *application required, before prescribing, using the single application form
- Prescribing follows appropriate clinical guidelines
- Secondary care will retain responsibility for monitoring for 12 months
- Prescribing and administration can be transferred under the agreed shared care guidelines when stabilised on treatment or prescribed for 3 months (whichever is longest).
- When switching antipsychotics prescribing can be transferred when stabilised on treatment or prescribed for 3 months (whichever is longest). The responsibility for 12 months monitoring does not restart.
- Minimum of one month's notice before transfer
- Annual review of medication by specialist services
- NOTE: If the transfer of care was made prior to 11/7/2019 then these drugs were considered as "green+" (except paliperidone and aripiprazole which have always been amber shared care) and therefore patients' do not need to be re-referred to establish shared care. A shared care agreement was required for any transfer from 11/7/2019 onwards.

RED

- Olanzapine LAI*
- Zuclopenthixol Acetate (Acuphase)

- No transfer of prescribing
- *application required, before prescribing, using the single application form
- See guidelines for prescribing and administration of olanzapine long-acting injection
- See guidelines for the safe use of Clopixol Acuphase

BLACK / GREY

- Clozapine Injection

- Unlicensed product – import only
- Prescribing is by exception only. Individual patient approval required by Drug & Therapeutics Committee approval with an application required using the single application form

Associated Guidance

- Paliperidone LAI: prescribing support document (PSS2)
- Psychotropic Medication Monitoring Guide
- Management of QTc Prolongation

Monitoring Guide

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Antimanic drugs

GREEN+
- Carbamazepine
- Lamotrigine
- Valproate (except in child-bearing potential)

AMBER SHARED CARE
- Lithium – shared care
- Valproate (in those of child-bearing potential) – shared care

- Initiation by specialist
- Prescribing follows appropriate clinical guidelines
- Prescribing can be transferred when stabilised on treatment (if not shared care) or as specified in shared care guidelines – annual review required by TEWV specialist
- Minimum of one month's notice before transfer
- If considering discharge from services see discharge guidance for antimanic drugs

Associated Guidance
- Anxiety medication pathway – adults
- Bipolar medication pathway – adults & children
- Depression medication pathway – adults
- Psychotropic Medication Monitoring Guide
- Management of QTc Prolongation

Associated Deprescribing Guidance
- STOMP Medication Review Pathway: Stopping over Medication, of People with a Learning Disability, Autism or both, with psychotropic medicines

Monitoring Guide

VALPROATE
- Sodium Valproate
- Valproic Acid
- All prescribing must follow Valproate Safety Measures
- Prescribing in people of child bearing potential can only be transferred under shared care

BLACK / GREY
- Asenapine

- These medications have no formulary status and would not normally be suitable for transfer to primary care
- Prescribing is by exception only. Each of these require a panel decision with an application required using the single application form

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Antidepressants

GREEN

- Amitriptyline
- Citalopram
- Clomipramine (G+)
- Duloxetine (G+)
- Escitalopram
- Fluoxetine
- Imipramine
- Lofepramine
- Mirtazapine
- Nortriptyline
- Sertraline
- Trazodone
- Venlafaxine
- Vortioxetine

- Suitable for GP prescribing
- See pathway for order of preference and place in therapy
- If recommended by TEWV prescriber then either transfer with one month's supply or ask GP to initiate if not urgent (i.e. does not need to be started within 14 days)

GREEN+

- Agomelatine – transfer leaflet
- Bupropion (TBC)
- Moclobemide
- Phenelzine
- Reboxetine
- Venlafaxine (doses >225mg)

- Initiation by specialist
- Prescribing follows appropriate clinical guidelines
- Minimum of one month's notice before transfer

Associated Guidance

- Anxiety medication pathway – adults
- Bipolar medication pathway – adults & children
- Depression medication pathway – adults & children
- Psychotropic Medication Monitoring Guide
- Management of QTc Prolongation

Associated Deprescribing Guidance

- Deprescribing guidance for: Dosulepin & Trimipramine
- Contained in depression medication pathway – adults
- STOMP Medication Review Pathway: Stopping over Medication, of People with a Learning Disability, Autism or both, with psychotropic medicines

BLACK / GREY

- Dosulepin
- Fluvoxamine*
- Isocarboxazid
- Paroxetine*
- Tranylcypromine
- Trimipramine

- These medications have no formulary status and would not normally be suitable for transfer to primary care
- Prescribing is by exception only. Each of these require a panel decision with an application required using the single application form
- *Can be continued for existing patients including those moving into the area

Monitoring Guide

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Hypnotics & Anxiolytics

GREEN
- Diazepam
- Lorazepam
- Promethazine
- Temazepam
- Zopiclone
- Zolpidem

- Suitable for GP prescribing but may not be appropriate
- Usually short term use only (less than 2 weeks)
- If recommended by TEWV prescriber then either transfer with one month's supply or ask GP to initiate if not urgent (i.e. does not need to be started within 14 days)
- Use for > 4 weeks requires robust plan for review including rationale.

GREEN+
- Buspirone
- Gabapentin
- Pregabalin

- Initiation by specialist
- Prescribing follows appropriate clinical guidelines
- Minimum of one month's notice before transfer

Associated Guidance
- Anxiety medication pathway – adults
- Bipolar medication pathway – adults & children
- Depression medication pathway – adults & children
- Psychotropic Medication Monitoring Guide
- Management of QTc Prolongation

AMBER SHARED CARE
- Melatonin (see shared care for approved products)

- Prescribing must be in line with shared care guidance
- Maintenance dose to be achieved prior to transfer – minimum one month's notice before transfer.
- Minimum annual specialist review
- Commissioning arrangements are different in DTV&F and NYY&S: two separate shared care guidelines exist.

RED
- Melatonin (brands other than those endorsed in the shared care guidance)

- Use of alternative brands is not encouraged, but if prescribed, would be considered red.
- Not usually suitable for transfer of prescribing. Consider switch to product supported in shared care guidance.

BLACK / GREY
- Melatonin (Colonis Pharma Brand)
- Meprobamate

- These medications have no formulary status and would not normally be suitable for transfer to primary care
- Prescribing is by exception only. Each of these require a panel decision with an application required using the single application form

Associated Deprescribing Guidance
- STOMP Medication Review Pathway: Stopping over Medication, of People with a Learning Disability, Autism or both, with psychotropic medicines

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Drugs for dementia

GREEN+
- Donepezil
- Galantamine
- Memantine
- Rivastigmine

- Initiation by specialist (see pathway for details)
- Prescribing follows Dementia Care Pathway
- Minimum of one month's notice before transfer

Associated Guidance
- Psychotropic Medication Monitoring Guide
- Management of QTc Prolongation

Miscellaneous

GREEN

Drugs used in status epilepticus:
- Diazepam
- Midazolam
- Lorazepam

Drugs used for hypersalivation:
- Hyoscine hydrobromide

GREEN+

Antimuscarinic drugs used in Parkinsonism:
- Orphenadrine
- Procyclidine
- Trihexyphenidyl

Monitoring Guide

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CNS Stimulants & drugs used for ADHD

AMBER SHARED CARE

- Atomoxetine – shared care
- Dexamfetamine – shared care
- Guanfacine – shared care
- Lisdexamfetamine – shared care
- Methylphenidate – shared care

- Initiation by specialist – see shared care for responsibilities
- Dose stabilised with minimum 3 months prescribing in secondary care
- Prescribing follows ADHD prescribing guidelines for Adults and Children & Young People
- Minimum of one month's notice before transfer
- Minimum annual review required by specialist

Associated Guidance

- Psychotropic Medication Monitoring Guide
- Management of QTc Prolongation

Drugs for dependence

RED – alcohol dependence

- Acamprosate
- Chlordiazepoxide
- Disulfiram
- Nalmefene
- Naltrexone

RED – opioid dependence

- Buprenorphine
- Lofexidine
- Methadone
- Naltrexone
- Suboxone

- Initiation and continuation by specialist commissioned service
- Prescribing in TEWV only for continuation of established treatments (except in-patient use of chlordiazepoxide – or oxazepam as alternative - for alcohol detox)
- Prescribing to be transferred back to specialist service on discharge

GREEN – nicotine dependence

- Nicotine Replacement Therapy (NRT)

Associated Guidance

- Alcohol detoxification: inpatient clinical algorithm
- Medicines and Smoking Guidance
- Methadone & Buprenorphine inpatient prescribing guideline
- Psychotropic Medication Monitoring Guide
- Management of QTc Prolongation

Monitoring Guide

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Appendix 2: Discharge on psychotropic medication from in-patient units

Patient to be discharged on psychotropic medication

Were any of the medicines initiated shortly prior to admission (e.g. by crisis team), or initiated / amended during admission?

No → **7 day supply** on discharge prescription & request GP to continue prescribing on discharge communication

EXCEPTIONS

Yes → **28 day supply*** on discharge prescription
(see note below re clozapine)

For <u>each</u> psychotropic medicine on the discharge prescription, check the RAG classification in the Safe Transfer of Prescribing Guidance

GREEN	GREEN+	GREEN+ ANTIPSYCHOTICS	AMBER SHARED CARE	RED / BLACK / GREY / BLUE
e.g. Citalopram, Sertraline	e.g. Pregabalin, Buspirone	e.g. Olanzapine, Quetiapine	e.g. Lithium, ADHD	e.g. Clozapine; Asenapine, Lurasidone (off label)

Request GP to continue prescribing on discharge communication

More than 3 months **AND** treatment is stable

How long has the patient been taking the medicine?

Less than 3 months **OR** treatment not stable

Refer to community team with details of start date and request to continue prescribing until 3-months or stable (whichever longer), then transfer to GP

NOT suitable for transfer to GP **Arrange continuation** of prescribing by **community team**

* Assess risk of >7 days' supply if suicidality present. If 7-day supplies required, refer to community team to continue prescribing (inc. green drugs) until suitable for 28-day supplies, then follow algorithm.

* If patient uses a weekly **monitored dose system** in the community, alert the community team so that necessary arrangements for continuation of supply can be made, including co-ordination with prescriptions issued by GP.

CLOZAPINE – supply quantity required until next clinic appt, within validity of latest blood result (i.e. 10-28 days)

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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

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

Amber shared care:
Following the shared care guidance

- ❑ There is a shared care guidance 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 the criteria defined within the shared care guidance
- ❑ A clear letter has been written to the GP and a copy of the shared care guidance 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 guidance)

Discharge from secondary care services on antipsychotics or antimanic medication: what needs to be considered

- ❑ The medication is NOT amber shared care, red or black / grey / blue / brown
- ❑ No other 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

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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 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?

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

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

Pharmacy support

- ❑ If there is a pattern / theme where 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 medicines governance structures within the integrated care boards

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Appendix 5: Full RAG Status Definitions

RAG Status

- The RAG status is subtly different across each formulary.
- A summary description of each RAG status is included here.
- This page provides the full descriptions of equivalent RAG status for each formulary
- NENC = North East & North Cumbria
- NYY = North Yorkshire & York

GREEN

NENC

Drugs where prescribing by GPs is appropriate. Can be initiated and prescribed in all care settings, and if appropriate, discontinued without recourse to secondary care.

NYY

Medicines suitable for initiation and routine use within primary, secondary and tertiary care. Primary care prescribers take full responsibility for prescribing.

GREEN+ [AMBER]

NENC – GREEN+

Drugs normally recommended or initiated by a specialist (hospital or GP with an extended role https://www.rcgp.org.uk/gpwer) but can be safely maintained in primary care with very little or no monitoring required. In some cases, there may be a further restriction for use outlined - these will be defined in each case. Provision of additional information, or an information leaflet, may be appropriate in some cases to facilitate continuing treatment by GPs.

NYY

Medicines recommended by a specialist; this could offer a valuable alternative/addition to the patients' treatment. These are considered suitable for GP prescribing following specialist recommendation. Little or no monitoring is required. A brief prescribing guidance document may be available for these, but there is no requirement for full shared care guideline. No formal Shared Care Guideline is required.

Items initiated by a specialist where there is not a need for ongoing monitoring other than for general adverse effects (as listed in the BNF and SPC). These are considered suitable for GP prescribing following specialist initiation, including titration of dose and assessment of efficacy where appropriate. No formal Shared Care Guideline is required.

AMBER SHARED CARE

NENC – AMBER

Drugs initiated by hospital specialist, but where continuing treatment by GPs may be appropriate under a shared care arrangement. The specialist should send the GP a copy of the shared care agreement to sign. The GP should sign the shared care agreement or indicate they do not want to be part of such an agreement and return a copy back to the specialist. Shared care guidelines are available or are being developed for most of the drugs listed as Amber. If no shared care guideline is available, the hospital specialist should provide the patient's GP with sufficient information and support to allow treatment to be continued and managed safely in primary care.

NYY – AMBER SC

Medicines that should be initiated by a specialist in secondary/tertiary care, and which require significant monitoring on an ongoing basis. After a successful initiation period, including titration of dose and assessment of efficacy, a transition to primary care prescriber care can take place. Full agreement to undertake prescribing for each specific patient must be reached under the amber shared care agreement, and guidance must be provided to the primary care prescriber (available online). The amber shared care guidance will outline the specialist and primary care prescriber responsibilities (including monitoring requirements) and basic prescribing information

RED

NENC

Drugs for hospital use only. The responsibility for initiation and monitoring treatment should rest with an appropriate hospital clinician and the drug should be supplied through the hospital throughout the duration of treatment. In some very exceptional circumstances (e.g. due to distance from the hospital, storage, supply or mobility/transport problems) it may be appropriate for the GP to be asked to prescribe a Red drug. This should be negotiated on an individual patient basis and should only be done with the GP's prior informed agreement where the roles of the GP and hospital services are clearly defined and agreed. The GP should not feel under pressure to prescribe in these circumstances. For all RED drugs automatically added to the formulary in response to a positive NICE TA: Prescribers need to ensure that local Trust new drug governance procedures and pharmacy processes are followed before any prescribing.

NYY

Medicines for hospital use only. The responsibility for initiation and monitoring treatment should rest with an appropriate hospital clinician. The drug should be supplied by the hospital for the duration of the treatment course. Primary care prescriber initiation or continuation of treatment is not recommended.

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BLACK

NENC

NOT APPROVED: Drugs that have been considered by NTAG or the NENC ICB Medicines Subcommittee (or other approved body) and are not approved for prescribing.

NYY

Medicines which the North Yorkshire and York Area Prescribing Committee has reviewed and does not recommend for use at present based on a review of clinical and/or cost effectiveness data in either primary or secondary care.

GREY [BROWN / NR]

NENC – BROWN

UNDER REVIEW: drugs whose current formulary status or RAG status is currently under review.

NENC – NR

NOT REVIEWED: Drugs that haven not been reviewed yet. This usually means that an application is in progress. These drugs are not normally considered appropriate for prescribing in the North East and North Cumbria until such time that a decision is taken on their formulary status.

NYY – GREY

Medicines which the North Yorkshire and York Area Prescribing Committee have not yet reviewed. Initiation by primary or secondary care for grey listed drugs is not supported and request to use should come via NY&Y APC.

Document Changes

Ver.	Date of change	Details of change
7.1	2/6/17	Lisdexamfetamine now amber (was red) and clarification added re: antipsychotics on page 3. Hyperlinks to website updated.
8.0	19/6/18	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.
8.1	21/6/18	Hyperlinks corrected throughout. Formulary hyperlink added to first page.
9.0	May 2020	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
9.1	July 2020	Minor amendments / clarity in green drugs box on page 1
9.2	February 2022	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.
10.0	25/7/24	• New format and full refresh • Language and terminology updated throughout to reflect organisational and NHS changes • RAG status updated throughout to reflect formulary status. Additional drugs added to black / grey sections.

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