NHS
Hertfordshire and West Essex
Integrated Care Board

Guidance for the safe implementation of medicine switches in GP practices

Introduction

The cost of various brands of the same medicine (or generic versions of the same medicine) can vary widely depending on the manufacturer. This variation in cost does not reflect the clinical efficacy of the medicine. NICE support the use of medicines with the 'lowest acquisition cost' when cost variations do not affect clinical efficacy.[1]

This presents the potential for significant financial savings to the local NHS. Herts and west Essex Integrated Care Board (HWE ICB) have therefore commissioned the use of ScriptSwitch (an interactive software tool at the point of prescribing), which is used in GP practices to promote clinically equivalent switches to medicines with the lowest acquisition cost.

The HWE ICB Medicines Optimisation Delivery and Implementation Group (MODIG) have identified the need to publish implementation guidance to assist clinicians to safely manage switches. This guidance stratifies the levels of risk associated with medicine switches and appropriate action to mitigate adverse outcome to the patient. This guidance will focus on the following:

- Types of switches
- Summary of potential risks and process to categorise risk for individual switches
- Summary of possible mitigations and process to safely implement individual switches
- Summary of governance to minimise risks associated with switch implementation

Types of switches

There are 2 main types of switch methods that can be used by clinicians to make changes to a patient's medicine. The type of switch selected can depend on various factors, for example, the risks associated with the medicine being switched and clinician resources in terms of time commitment.

1. **Opportunistic switch:**
   This is a switch that is carried out by the prescriber when a decision to prescribe is made at any time without specific planning to carry out the switch. A ScriptSwitch message pops up at the point of prescribing and the clinician then has the choice to accept the switch to the preferred ICB choice of the medication. The patient may or may not be present when the switch is made
2. **Proactive switches:**
   These are switches that are carried out in a systematic way. A search of all patients within the GP practice is initially carried out to select the most suitable patients eligible for a switch. Proactive switches can be split into 2 types:
   a. **Individual patient medication review** – where there is a need to establish individual patient factors that may inform appropriateness or otherwise of a switch. The patient may or may not be present when the switch is made

   a. **Bulk switch** – simple focused piece of work, identifying suitable patients to be switched to the preferred alternative and making the changes for all the eligible patients within a set timeframe. There is no requirement for a medication review as

individual patient factors do not impact the suitability of the switch. The patient would not usually be present when the switch is made
Types of potential risks and process to categorise risk for individual switches
In general, there is potential risk of miscommunication/patient misunderstanding whenever a medicines switch is introduced. The implementation guidance will stratify the risks associated with individual switches and provide mitigation strategies to manage the various levels of risks identified (i.e. seriousness of potential adverse outcome in a patient to whom the change is made), thus supporting safe implementation. The levels of risks identified include: **High risk:** These medicine switches may present the **potential** for a serious adverse clinical outcome if not safely implemented. Examples include the following: • **Difference in bioavailability:** Some medicines have a narrow margin of safety (narrow therapeutic index), small changes can therefore potentially lead to the patient receiving a subtherapeutic or toxic dose. The margin of safety can be affected by a change in formulation or brand. An example includes phenytoin.[2] • **Changes in formulation:** Some formulation switches may require a change in dosing regime and therefore a potential for error if the dose change is not communicated effectively to the patient. An example includes a switch from once daily quetiapine XL tablets to twice daily quetiapine standard release tablets.[2] • **Changes in device technique:** Where technique is an important component of drug delivery, changing devices may constitute a potential for error if this is not communicated to the patient effectively, and appropriate counselling/training provided. An example includes a switch from a salbutamol pressurised metered dose inhaler (pMDI) e.g. Ventolin to Salbutamol Easyhaler, a dry powder inhaler (DPI).[2] **Medium risk:** These medicine switches may constitute a moderate clinical risk to the recipient/patient if not safely implemented. Examples include: • Brand to generic (and vice versa) switches of complex classes of medicines: o Mental health treatments with wide therapeutic indices, e.g. methylphenidate, antidepressants. The complexity of these switches is due to the potential vulnerabilities of the patient group o Controlled drugs excluding fentanyl (as fentanyl is a potent opioid, therefore switches are considered high risk due to the potential for toxicity in overdose).[4] Controlled drugs in general are considered medium risk due to the risk of inadvertent under or overdosing, which may result in either under-treatment or potentially serious adverse effects o Switches where differences in excipients may have the potential to cause allergic reactions, e.g. inclusion of sunset yellow or peanut oil o Antiepileptic drugs that have been categorised by the Commission on Human Medicines (CHM) as category 2 or 3, i.e. being suitable to be switched with respect to formulations and brands, but clinicians are advised to consider patient perceptions &/or co-morbidities.[3] **Low risk:** These medicine switches represent simple formulation or like-for-like switches and dose optimisation changes (i.e. no change in dosage, but a rationalisation in strength/number of

tablets/capsules used for each dose) with no anticipated impact on clinical outcome.[5] examples of simple switches which include:

- Tablets to capsules and vice versa
- Solutions to suspensions and vice versa
- Dose optimisation, e.g. pregabalin 75mg capsules to pregabalin 150mg capsules. Both strengths cost the same (per capsule) and by using the higher strength for a patient on 150mg twice daily the cost is halved and pill burden reduced
- Changes in size of dressings to ensure use of the most cost-effective sizes and lengths of bandages where this is appropriate (when supported by the tissue viability nurse [TVN] recommendations)
- No clinical difference in excipients, e.g. inclusions of potential allergens

Mitigation strategies for the safe implementation of switches

When the level of risk for a particular switch has been identified, potential mitigations will be identified, and a recommendation made to the MODIG committee for the safe implementation of the switch. These may include the following (the examples given below are not exhaustive and are intended as a guide to the MODIG committee):

- The type of switch proposed to support safe implementation e.g. opportunistic &/or proactive
- Whether direct patient contact is required as part of the switch process (to ensure that the information has been received and understood) versus written communication only (letter or text message)
- Proposed resources to support the switch e.g. patient letters &/or text message wording to support clear communication (it is proposed that patient letters are developed for all switches)
- Specific patient counselling points identified as essential for safe communication of the switch, e.g. the presence of an excipient that may have the potential for allergy (once agreed, these would be included in the ScriptSwitch message)
- Addition of flags to prescriptions to enable community pharmacists to counsel patients on the change to their medication. For example, this could be included in the **dosage directions** and/or on the right-hand side of repeat prescriptions.

In addition, it is proposed that the following are undertaken to minimise the risk of all medicine switches:

- ICB staff work with GP practice staff (who are involved in prescription generation) to reinforce that when switches are implemented, the original medicine should not be added back to repeat prescriptions (i.e. to prevent possibility of patients taking both the original & new version of their medicine)
- Patients are advised to finish taking the remaining medicine before starting on the new switch
- GP practice staff to be encouraged to use the feedback function within ScriptSwitch to inform the ICB of issues/concerns related with specific switches, or to contact the ICB Pharmacy and Medicines Optimisation Team directly on hweicbhv.medicinesoptimisationteam@nhs.net
- If possible, GP practice staff to liaise with local community pharmacies regarding plans to implement new switches (i.e. for proactive switches, and/or a practice decision to start to

action opportunistic switches where anticipated number of switches is moderate/high). This is to inform stock holding and support improved communication between GP practice, community pharmacist and patients.

Governance – Process & Summary

The MODIG committee has responsibility and accountability for developing appropriate strategies to minimise risk associated with switch proposals in HWE ICB. As such, all switch proposals (excluding simple switches, which are taken to MODIG for noting only to avoid delay and maximise efficiency) [5] must be approved by MODIG, who will review the appropriateness of the switch with respect to the risk categorisation and proposed implementation strategy. Relevant sections will therefore be included in MODIG switch proposal papers to outline the proposed risk categorisation (with reasons), and suggested risk mitigations. This will include information on:

- Type of switch proposed e.g. opportunistic &/or proactive
- Potential risk(s) and proposed risk level identified
- Proposed action(s) to mitigate the risk(s) identified
- Proposed resources and advice to be made available to GP practices to support implementation of the switch

The MODIG committee will be required to discuss and agree the above as part of the switch approval process.

Information regarding risk minimisation strategies to be included in ICB Pharmacy Medicines Optimisation Team newsletters to both practices and community pharmacists (when new switches are agreed by MODIG) and within switch messages on ScriptSwitch.

References:

1. NICE on cost acquisition: NG28 Visual summary on choosing medicines for type 2 diabetes in adults (nice.org.uk)
2. Guidance for Appropriate Prescribing of Generic and Branded Medicines (being updated)
3. MHRA – Antiepileptics: https://www.gov.uk/drug-safety-update/antiepileptic-drugs-updated-advice-on-switching-between-different-manufacturers-products
4. Serious and fatal overdose of fentanyl patches - GOV.UK (www.gov.uk)
5. Simple switches: Process guidance for the prior addition of simple switches to ScriptSwitch to improve efficiency

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