Southern Health
NHS Foundation Trust

SH CP 249

Physical Health Monitoring for Psychotropic Medication

Version: 3

Summary	Guidelines for the physical health monitoring of adult patients on antipsychotics medicines	
Keywords	Antipsychotics, psychotropic, physical health, valproate, lithium, adult, olanzapine, venlafaxine, lamotrigine	
Target audience	All clinical staff	
Date issued	February 2023	
Approved & Ratified by	Medicines Management Committee	**Date of meeting:** 25/1/2023
Next review date	February 2026	
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Version Control

Change Record

Date	Author	Version	Page	Reason for Change
Sep 2019	J Wells	New Policy	Throughout	Updated around latest Valproate PPP risks. Removed SSRI & TCAs. Updated agreed guidance, to include proforma. Clarified that does not include Clozapine & HDAT.
Nov 2019	J Wells		4	Amendments to clarify Olanzapine
Dec 2019	J Wells		4	Clarify for APC that pharmacists should check Lithium levels as part of the supply process. Re-arranged order of columns
June 2020		1		Previously published on CCG websites, updated and transferred onto trust template
24/9/20		1	5	Corrected a typo in bullet 6
17/5/21	P. Abeywardana	2	4 5	Added Duloxetine and Pulse to table. Added A to valproate and annually to the definition of A Added pregnancy to bullet 9
June 2021	S. Masterson	2	4	Added reminder to record in results in the Lithium booklet, under the Li subheading in the table
Aug/ Nov 2021	J. Wells M. Webb	2 2	4 4, 5	Lithium blue box – Na added to 4th bullet. C, added frequency. Valproate purple box – hot link for PPP added. New reference included, SPS monitoring. Initial (blue) line reviewed to include specifics around individuals and CLDT patients. Bullet 14 added to repeat this.
January 2023	V Lawrence	3	4	Add weekly weights for 6 weeks for antipsychotics as per NICE depression guideline update June 2022. Risk groups updated as per NICE bipolar guidelines. Clarified when lithium levels are needed during dose titration. Removed annually line for lithium as this is included in 6monthly monitoring. Valproate box reworded and updated - Change pregnancy protection plan to pregnancy prevention programme. Add ARAF. ARAF must be completed before start of treatment. Duloxetine/venlafaxine blood pressure recommendations updated as per SmPCs.

Reviewers/contributors

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Contents

Key

Abbreviation	Meaning
CMHT	Community Mental Health Team
CLDT	Community Learning Disability Team
HDAT	High Dose Antipsychotic Therapy
Ca	Calcium
OPD	Outpatient Department

Physical Health Monitoring for Psychotropic Medication

Not for High Dose Antipsychotic Therapy (HDAT) or Clozapine

The Annual Health Check is recommended. Responsibility for medication monitoring and physical health checks lies with secondary care (CMHTs), where a patient has been under their care for 1 year or less, or their condition has not yet been stabilised, except where the patient is open to a CLDT or on a patient case by case need. For Clozapine and High Dose Antipsychotic Therapy (HDAT), the majority of monitoring remains in secondary care (see separate guidelines).

Medication	Frequency	BMI / weight	TFTs	U&Es/ eGFR	Ca	ECG	Lithium levels	FBC	HbA_{1c} Glucose	LFTs	Prolactin	BP Pulse	Lipids
	Secondary care												
Lithium* (record all levels and results in the patient's Lithium booklet)	Baseline	✓	✓	✓	✓	✓	1 week after every dose change and weekly until stable						
	Dose Change												
	3 monthly						for 1st year or in Risk Groups*						
	6 monthly	✓	✓	✓	✓	B	✓ after 1st year						
Valproate**	Baseline; PPP and Annual Risk Form	A						C		A			
Lamotrigine	Baseline; skin reaction advice							C					
Venlafaxine/ Duloxetine	Baseline	✓										✓	
	During initiation and post dose increases											✓	
	Periodically											✓	
Antipsychotics (for the most recent info check SPC for the specific drug)	Baseline & CV risk	✓		✓		✓		✓	✓	✓	✓	✓	✓
	During titration	Weekly for first 6/52										✓	
	After 1 month	✓							olanzapine				
	3 months	✓							▲ olanzapine				✓
	6 months	olanzapine							✓		✓		olanzapine
	9 months	olanzapine											olanzapine
	Annually & CV risk	✓		✓		B		✓	✓	✓	✓	✓	✓

A = before therapy and during first six months thereafter annually, include prothrombin. Check prior to surgery.

B = only if CVD suspected, risk factors or existing cardiac problem, or haloperidol.

C = before therapy & during first six months, thereafter annually. Recognise signs of blood disorders: anaemia/bruising – provide information for patients. Check prior to surgery.

PPP = Pregnancy Prevention Plan.

CV risk = Cardiovascular risk assessment required e.g. current Q-risk tool.

SPC = summary of product characteristics.

▲ **Olanzapine requires monitoring every 4 – 6 months thereafter.**

* Risk Groups with Lithium Therapy

Require increased monitoring: -

- Older people
- Concurrent interacting drugs e.g. NSAIDs, ACEIs, diuretics
- At risk of renal or thyroid dysfunction, raised calcium or other complications
- Significant disease or change in fluid/food/sodium intake
- Poor adherence or symptom control
- Last level greater than 0.8mmol/L

** Valproate Risks in Pregnancy

For all women/girls of child bearing potential: –

- An annual risk acknowledgement form (ARAF) must be completed by a specialist with the patient BEFORE start of treatment
- Valproate must NOT be prescribed until: risks have been explained, written information given to patient/responsible person, it has been established that patient is not pregnant, a Pregnancy Prevention Programme (PPP) is in place, patient has agreed to conditions of PPP including using highly effective contraception for the duration of treatment unless there are compelling reasons to indicate no risk of pregnancy.
- Patient must be reviewed annually by secondary care and a new ARAF completed

SH CP 249 Physical Health Monitoring for Psychotropic Medication.
Created by SHFT NHS Agreed by all clinical commissioning groups across Hampshire, Southampton & IOW.
Version: 3
February 2023

Physical Health Monitoring for Psychotropic Medication (not HDAT/ Clozapine)

General Principles

This guidance has been developed using the current BNF no. 82, Summary of Product Characteristics 2021 and SPS Drug Monitoring guidance. The guidance is a minimum recommendation only and clinical need should override decisions on monitoring. In the interests of patient care, where systems are currently in place (and working to meet the minimum monitoring requirements), these should not be changed.

1. Clinicians should use medications that are both clinically and cost effective.
2. Monitoring involves advising patients where to get their bloods done, depending on local phlebotomy arrangements, arranging ECGs and acting on the results. Inform the patient and their GP as appropriate.
3. If a medication is recommended by a clinician in an outpatient clinic, a FP10 prescription will be for a minimum of 2 weeks' supply unless clinical risk dictates otherwise. The GP should be informed promptly of this (OPD letters to be transmitted within 7 days to ensure compliance with the NHS standard contract) and the patient given a proforma to deliver to the GP surgery. Even then patients may wait a week to get new supplies.
4. Secondary care will continue the monitoring until the patient is stable.
5. Ongoing prescriptions may be issued by primary care when the patient is appropriately stabilised on a dosage and the GP has been informed and has agreed to take over prescribing.
6. After discharge from secondary care, patients should receive advice on required ongoing monitoring; dosage alterations where appropriate; how to access secondary care services again.
7. Re-refer to the appropriate secondary care service if required.
8. ECGs are only required when clinically indicated (see guide) and are the responsibility of the prescriber.
9. Where there are comorbid physical health issues or pregnancy (or planning for pregnancy), key specialists should be involved in the monitoring and the information shared, as appropriate.
10. The frequency of physical monitoring may need to be increased if you have clinical concerns.
11. Clozapine is a secondary care medication (red drug). Primary care needs to be aware that their patients are on it and of potential adverse effects and interactions. Clozapine should be added to the primary care record and SCR, where prescribed. See separate guidance.
12. Current shared care arrangements for Lithium will continue.
13. Care of a patient prescribed HDAT (>100% of BNF recommended doses of one or a combination of antipsychotics) is to remain under secondary care unless specifically agreed and this should be appropriately highlighted on the patient's GP record.
14. Specific arrangements may be needed for individual patients on a case-by-case basis, such as patients who are open to CLDTs.

3. Document review

The document will be reviewed every three years, or sooner if changes in legislation occur or new best practice evidence becomes available.

4. Associated Trust documents

- SH CP 111- Antipsychotics Guidelines
- SH CP 113 - Shared Care Guidelines for Prescribing Lithium
- SH CP 189 - Antisocial and Borderline Personality Disorder Guidelines the Pharmacological Treatment

5. Supporting references (always check latest versions)

- Current BNF https://bnf.nice.org.uk/
- Current SPC https://www.medicines.org.uk/
- www.sps.nhs.uk/home/guidance/drug-monitoring/