MEETING PREPARATION PACK

Creating and implementing a communication plan between Drug Health and GPs for people on the NSW Opioid Treatment Program

YOUR LIKELY CONTRIBUTION AS CNC GP LIAISON

You are likely expected to bring the clinical and operational bridge between Drug Health and general practice: what information must be exchanged, who communicates it, when communication occurs, how urgent concerns are escalated, and how the transfer is confirmed and monitored.

1. What you should understand before the meeting

The purpose of communication

- Prevent missed doses, duplicate prescribing, unsafe re-starts, medication errors and loss to follow-up.
- Ensure the GP, Drug Health prescriber, pharmacy and patient understand their responsibilities.
- Support stable patients to receive appropriate treatment in primary care while retaining specialist advice and re-entry pathways.
- Make sure risk, treatment goals and clinically important changes are communicated in time to affect care.
- Use a consistent, structured and documented handover process across settings.

The essential OTP transfer information

- Patient consent and up-to-date contact details.
- Current OAT medicine, formulation, verified dose and prescribing authority arrangements.
- Last supervised or administered dose, dosing point and number of take-away doses supplied or remaining.
- Missed doses, recent intoxication, withdrawal, overdose and non-prescribed substance use.
- Treatment history, current goals, progress and planned dose changes.
- Relevant physical health, mental health, pregnancy status, allergies and other medicines.
- Current risks such as sedative use, child safety, homelessness, self-harm, cognitive impairment or high-risk behaviour.
- Prescriber, pharmacy and Drug Health contacts, including who can provide advice when problems arise.
- Clear interim plan, next appointment, care owner and escalation/re-entry pathway.

Regulatory and safety points

- A receiving prescriber must agree to accept care before transfer is completed.
- The current authorised prescriber is responsible for supplying the clinical information needed for safe transfer.
- A patient must be exited from one prescriber's OTP authority before another prescriber can be authorised.
- Permanent dosing-point changes must be notified through the relevant NSW OTP process.
- SafeScript NSW is used to apply for and manage OTP authorities and dosing-point information.
- An intoxicated or markedly sedated patient should not be automatically dosed; clinical assessment and prescriber review are required.
- Transfers must not create a gap in treatment, prescription coverage or pharmacy supply.

CURRENT WSLHD ACCESS INFORMATION

The NSW Government WSLHD service page lists the Drug Health central intake line as (02) 8860 2565, Monday to Friday, 8:45 am to 4:45 pm, with an after-hours answering service. GP referral is preferred, although self-referral is accepted. Confirm whether the meeting communication plan will use central intake, a dedicated GP Liaison line/mailbox, or both.

2. What to have ready

BRING A DRAFT, NOT JUST QUESTIONS

A useful meeting contribution is a simple proposed pathway that the group can correct. Bring a one-page draft showing routine communication, urgent communication, transfer steps, responsible roles and closed-loop confirmation.

Documents and information to bring

☐ The meeting agenda and service model or position description.

☐ Current Drug Health-to-GP referral or transfer forms.

☐ Your focused AOD assessment, shared-care plan and revised ISBAR tools.

☐ Current WSLHD Drug Health intake and key service contact details.

☐ Known GP referral routes, HealthPathways and WentWest contacts.

☐ Current pharmacy transfer or communication forms, if used.

☐ A de-identified example of a successful transfer and a transfer that was delayed or unsafe.

☐ Any current KPI, transfer-volume or referral-quality data.

☐ The NSW OTP Transfer of Care Guide and GP transfer fact sheet.

☐ A list of known communication failures, duplication points and delays.

Draft minimum communication dataset

Information	At referral	At acceptance / transfer	When changed
Three approved identifiers and contact details	☐	☐	☐
Consent and information-sharing limits	☐	☐	☐
OAT medicine, dose, formulation and authority	☐	☐	☐
Last dose, missed doses and takeaways	☐	☐	☐
Prescriber and dosing pharmacy	☐	☐	☐
Substance use, intoxication and withdrawal	☐	☐	☐
Overdose history and naloxone	☐	☐	☐
Physical and mental health / other medicines	☐	☐	☐
Patient goals and shared-care plan	☐	☐	☐
Current risks and escalation plan	☐	☐	☐
Next appointment and interim care owner	☐	☐	☐
Receiving clinician acceptance	☐	☐	☐

Draft communication triggers

Trigger	Who initiates	Who must receive	Expected timeframe
New referral to Drug Health	_____	_____	_____
GP requests specialist advice	_____	_____	_____
Patient suitable for GP/shared care	_____	_____	_____
Receiving GP accepts or declines	_____	_____	_____

Dose or formulation changes	_____	_____	_____
Missed doses / non-attendance	_____	_____	_____
Intoxication, overdose or ED/hospital presentation	_____	_____	_____
Pharmacy or dosing-point change	_____	_____	_____
Pregnancy, new medical or mental health risk	_____	_____	_____
Patient disengages or care becomes unstable	_____	_____	_____
Transfer completed / first GP review	_____	_____	_____
Re-entry to specialist Drug Health care	_____	_____	_____

3. Questions to ask in the meeting

Scope and eligibility

☐ Which patients are suitable for transfer or shared care with a GP?
☐ Which clinical or social factors require continued specialist management?
☐ Is there a required period of stability before transfer?
☐ Can the plan cover methadone, sublingual buprenorphine and LAIB, or are pathways different?
☐ Does the pathway apply only to Blacktown LGA or all WSLHD catchments?
☐ How will patients without an existing GP be matched with a willing practice?

Communication route and response times

☐ What is the single preferred referral route: eReferral, secure email, fax, telephone or central intake?
☐ Will there be a dedicated GP Liaison phone number and monitored generic mailbox?
☐ Who monitors each channel, and what are the coverage arrangements during leave?
☐ What response time will be promised for routine advice, urgent advice and transfer requests?
☐ What information must be sent before a referral is considered complete?
☐ How will receipt, triage, acceptance and allocation be acknowledged?
☐ When must communication be verbal rather than electronic only?

Roles and responsibility

☐ Who remains clinically responsible while the transfer is being arranged?
☐ Who verifies the dose, last administration, missed doses and takeaways?
☐ Who confirms the pharmacy and prescription supply?
☐ Who completes OTP exit and authority actions?
☐ Who informs the patient and provides written contact information?
☐ Who follows up if the patient misses the first GP appointment?
☐ Who provides specialist advice after transfer, and for how long?
☐ Who coordinates transfer back to Drug Health if the patient destabilises?

Clinical escalation

☐ What should a GP do for intoxication, missed doses, precipitated withdrawal, overdose or suspected loss of tolerance?
☐ What is the same-day clinical advice route?
☐ What requires ED/000, central intake, Addiction Medicine or Mental Health escalation?
☐ What is the after-hours plan?
☐ How will hospital admission, discharge or custody release be communicated?
☐ Is there a rapid re-entry pathway for patients no longer suitable for GP management?

Documentation, privacy and governance

☐ Which approved template will be used for handover: ISBAR, referral form, shared-care plan or combined document?
☐ Where will telephone advice and agreed responsibility be documented?
☐ What consent wording and privacy rules apply to information exchange with GPs and pharmacies?
☐ How will version control, document review and staff education be managed?
☐ Which group owns the pathway and approves future changes?

Monitoring and evaluation

☐ What does success look like at 3, 6 and 12 months?
☐ Which measures will be collected, by whom and how often?

☐ Will GP and patient feedback be collected?

☐ How will incidents, delays, incomplete referrals and failed transfers be reviewed?

☐ What reporting will the CNC GP Liaison provide to Drug Health and service governance?

4. Proposed communication workflow for discussion

Step	Action	Responsible	Communication / document	Closed-loop check
1. Identify	Drug Health team identifies a potentially suitable patient and discusses GP/shared-care options with the patient.	Drug Health treating team	Clinical review and patient discussion	Patient preference and consent documented.
2. Prepare	Complete stability/risk review and minimum dataset. Confirm GP availability and likely suitability.	Drug Health clinician / CNC GP Liaison	Focused AOD assessment and shared-care checklist	Missing information resolved before contact.
3. Approach GP	Contact GP with concise case summary and request discussion/acceptance.	CNC GP Liaison / prescriber	Secure referral plus verbal discussion for complex cases	Named GP acknowledges and reviews request.
4. GP decision	GP considers patient/practice suitability, appointments, fees, access, complexity and support required.	Receiving GP	Acceptance/decline response and questions	Decision documented and communicated to patient and Drug Health.
5. Plan transfer	Agree prescribing, monitoring, pharmacy, pathology, review, escalation and specialist backup.	Drug Health prescriber + GP + pharmacy + patient	Shared-care plan and ISBAR	All parties understand actions and dates.
6. Regulatory actions	Complete exit/new authority and dosing-point requirements without breaking treatment continuity.	Current and receiving prescribers	SafeScript/OTP regulatory processes	Authority and prescription arrangements confirmed.
7. Handover	Send final verified clinical information and complete verbal handover when required.	Drug Health clinician / prescriber	ISBAR and transfer summary	Receiver repeats back key dose/risk/actions.
8. First GP review	Patient attends GP; treatment and monitoring plan are confirmed.	Receiving GP	GP clinical record and update to Drug Health	Attendance/outcome communicated.
9. Early follow-up	Check patient, GP and pharmacy experience and resolve gaps.	CNC GP Liaison	Telephone/secure message	Issues documented and assigned.
10. Ongoing shared care	Scheduled review, outcome monitoring and rapid specialist advice/re-entry if risk changes.	GP with Drug Health support	Shared-care review plan	Review dates and escalation criteria remain current.

5. Decisions the meeting should ideally produce

☐ A defined target patient group and suitability criteria.

☐ A single routine referral/transfer channel.

☐ A dedicated urgent clinical advice pathway.

☐ Named owners for phone, mailbox, referral triage and leave coverage.

☐ A minimum communication dataset and approved handover template.

☐ Agreed response times for routine, urgent and incomplete referrals.

☐ A clear statement of responsibility while transfer is pending.

☐ A procedure for GP acceptance, decline and escalation.

☐ A transfer checklist covering prescriber, pharmacy, authority, prescription and first appointment.

☐ A rapid re-entry pathway to Drug Health.

☐ A GP education and support plan.

☐ A pilot start date, participating practices and evaluation measures.

☐ A review date and governance owner.

Suggested pilot measures

Measure	Definition	Target / owner
Referral completeness	Percentage containing all mandatory information.	_____
Acknowledgement time	Time from referral receipt to acknowledgement.	_____
Clinical response time	Time to advice or transfer decision.	_____
Successful transfer	Patient attends first GP appointment with uninterrupted dosing.	_____
Medication safety	Missed-dose, duplicate-prescribing or authority incidents.	_____
GP experience	Confidence and satisfaction before and after support.	_____
Patient experience	Understanding, continuity, cultural safety and satisfaction.	_____
Rapid re-entry	Time from escalation request to specialist response.	_____

6. Your short opening contribution

SUGGESTED WORDING

“For this communication plan, I suggest we agree on five things today: who is suitable for GP/shared care, the minimum information that must be exchanged, the single communication route and response time, who owns care at every stage, and the escalation or rapid re-entry pathway. I have brought a draft workflow and minimum dataset so we can identify gaps and agree on a pilot.”

7. Your notes and agreed actions

Key decisions:

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My actions:

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Actions assigned to others:

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Next meeting / review date:

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Reference notes

Prepared using current NSW Health sources checked on 23 September 2026: Transfer of Care Guide - Opioid Treatment Program; Accepting transfer of patients being treated for opioid dependence (September 2024); NSW Clinical Guidelines: Treatment of Opioid Dependence; NSW OTP prescriber information; Clinical Handover of Patient Care PD2026_021; and the NSW Government WSLHD Drug Health service page. Always confirm local procedures and contact details before implementation.