Principles of Shared Care Agreements

Introduction

Good organisation of care across the interface between primary and secondary/tertiary care is crucial in ensuring that patients receive safe and high quality care – and in making the best use of clinical time and NHS resources in all care. Good professional practice requires care for patients to be seamless; patients should never be placed in a position where they are unable to obtain the medicines they need, when they need them. Lack of communication between primary and secondary/tertiary care and misunderstandings around the responsibilities of the professionals involved are often cited as reasons for patients not being able to get their medicines in a timely manner, despite effective collaborative working and communication being an important part of patient-centred professionalism.

1. Criteria for Classifying Drugs as Suitable for Shared Care

a. It is in the best interests of the patient for a primary care prescriber to take over prescribing, however, specialist involvement is required for:

- initiation of treatment
- on-going specialist monitoring and/or
- assessment to enable effectiveness and /or
- reducing risk of toxicity.

and/or

b. Medicines that are specifically suggested as suitable for shared care by the DH or NICE.

2. Shared Care Agreements

a. Treatment should be initiated by a specialist (which could include consultant, suitably trained specialist non-medical prescriber or GP with specialist interest within a secondary, tertiary, or primary care clinic). Clinical and prescribing responsibility should be transferred to primary care only when the patient's clinical condition is stable or predictable. This does not mean that the patient is discharged from specialist care.

NHSE guidance states that patients can be discharged, but need a fast track referral route in certain circumstances e.g. Adult ADHD.

As the CCG is not responsible for agreeing tertiary care shared care, there may be a need to consider treatment on a case by case basis.

The GP should agree in writing for each individual case and the secondary/tertiary provider must continue to provide prescriptions until successful transfer of responsibilities. Specialist advice should be available to primary care prescribers i.e. not requiring referral back to specialist as such.

b. The legal responsibility for prescribing lies with the doctor or health professional who signs the prescription and it is the responsibility of the individual prescriber to prescribe within their own level of competence. This includes responsibilities with supplying or administering the prescribed medicine and instructions to others.

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c. Patients should be at the centre of the shared care agreement however where patients do not have the mental capacity to make healthcare decisions involvement of carers and/or attorneys (holding the Lasting Power of Attorney for health and welfare) should be considered prior to decisions around shared care.

d. Shared care must be in accordance to the Shared Care template (Appendix 1). Communication between the specialist and the primary care prescriber should include the letters of request and agreement/refusal (Appendix 2).

e. For medicines which are prescribed under a share care arrangement, primary care prescribers should have sufficient knowledge and experience to monitor, stop, or alter the dosage of the medicine **in appropriate circumstances and have access to specialist advice to support them** (details should be made available within Share Care Agreements i.e. not requiring referral back to specialist as such). The degree of control, which they have over this prescribing, and 'a route of return' to specialist care will form part of the shared care agreement.

f. Agreements for shared care must not be used nor declined for cost shifting purposes.

g. It is the responsibility of the Joint Prescribing Committee (JPC) to ensure that adequate support, education and information is made available to primary care prescribers who "share care" of patients with a specialist in order for treatment to be managed safely in primary care.

h. GP/Primary care prescribers must seek further support from the referring specialist or CCG rather than decline shared care on the basis of lack of competence as default.

i. Explicit criteria for review need for monitoring and discontinuation of the medicine should be included; this should also be communicated to the patient.

j. Patients should never be used as a conduit for informing the GP that prescribing is to be transferred nor to inform the specialist that shared care has been declined. They should never be placed in a position where they are unable to obtain the medicines they need because of lack of communication between primary and secondary/ tertiary care.

3. Circumstances where shared care is not appropriate

In some situations the use of shared care is not appropriate and in these cases the hospital/specialist should retain responsibility for prescribing. Whilst the situations may be broad and diverse the following would be examples:

a. Patients receiving the majority of ongoing care, including monitoring, from the specialist service.

b. Where the primary care prescriber does not feel competent in taking on clinical responsibility for the prescribing of the medicine despite taking steps (as stated in point 2e above) to seek further support from the specialist.

c. Where a drug requires specialist intervention, stabilisation and monitoring on an ongoing basis.

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d. Where patients have declined the shared care option following informed discussions with the specialist prescriber.

e. Where insufficient information has been provided to proceed with shared care and/or no Shared Care Agreement or protocol exists.

f. Unlicensed medicines unsuitable for use in primary care or being used 'off-label' for an indication with no established evidence base.

g. Where drugs are being used as part of a hospital-initiated clinical trial.

h. Where the drug is new, only available through hospitals or has not been approved for addition to the current primary care formulary.

i. The indication for prescribing is contrary to NICE guidance and the use of the drug has not been approved on an 'exceptional basis'.

j. A medicine for which the JPC considers there to be poor evidence base or lack of cost effectiveness compared to alternative commissioned treatments.

k. Black Triangle Medicines (unless there is a large body of evidence supporting use e.g. BNF, NICE).

l. There is a NICE recommendation that the medicine should not be prescribed on the NHS for the condition specified.

m. Medicines subject to High-tech Hospital at Home guidance (EL (95)5).

n. All other treatments funded by NHS England unless specifically agreed to be provided through a shared care prescribing agreement, or other process as agreed by the JPC.

o. There is a clear NHSE/I Specialised Commissioning or JPC decision to not routinely fund usage of the medicine or NHSE considers the drug not suitable for shared care.

p. Shared care should not be approved with non-NHS funded providers as no guarantee patients will continue to fund themselves.

4. Funding Issues

a. Each shared care protocol submission must include an estimate of the number of patients affected.

b. Commissioners should take account of the operational and resource implications of shared care, and of the fact that this should also extend to the requirements and sustainability of hospitals in situations where shared care is not accepted.

c. If the treatment is likely to produce significant cost pressures (i.e. it cannot be managed within the existing prescribing budget), then agreement needs to be reached with JPC and if supported, appropriate funds identified.

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d. All appropriate monitoring requirements (e.g. phlebotomy, ECG, height/weight checks) must be fulfilled. The person delivering that aspect of the shared care agreement should ensure that the resources to do this are in place in the clinical setting in which they are delivered (for example within a Primary Care Network (PCN)).

e. The requirement for the appropriate resource will need to be considered by commissioners, based on the likely workload implications of the transfer of care i.e. from secondary/tertiary to primary care.

5. Approval and Review of Shared Care protocols

a. Consultation with primary/secondary/tertiary care prescribers must be sought when developing or reviewing a shared care protocol or supporting prescribing guideline.

b. The JPC must recommend the approval of all shared care protocols before they can be distributed for use between primary and secondary care.

c. A shared care protocol or supporting prescribing guideline will usually be approved for two years after which time an up-dated version should be submitted by the author for re-approval. Any major changes in national guidance or any significant issue that arises should prompt a review of the shared care protocol or supporting prescribing guideline at an earlier date.

References

- Responsibility for Prescribing between Primary and Secondary/Tertiary Care. NHS England. Jan 2018.
- SPS - Shared Care Guidance - A Standard Approach - Regional Medicines Optimisation Committee (RMOC) October 2019 V2
- Good Practice in Prescribing and Managing Medicines and Medical Devices. General Medical Council Guidance. 2013.

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Appendix 1 Shared Care Protocol

Methylphenidate, Lisdexamfetamine, Dexamfetamine, Guanfacine & Atomoxetine for Attention Deficit Hyperactivity Disorder in patients over 18 years of age

AREAS OF RESPONSIBILITY FOR SHARED CARE

This shared care agreement outlines suggested ways in which the responsibilities for managing the prescribing of **Methylphenidate, Lisdexamfetamine▼, Dexamfetamine▼ Guanfacine & Atomoxetine for Attention Deficit Hyperactivity Disorder in patients over 18 years of age** can be shared between the specialist and general practitioner (GP). GPs are invited to participate. If the GP is not confident to undertake these roles, then he or she is under no obligation to do so *(please refer to Principles of Shared Care Agreements in point 2h)*. In such an event, the total clinical responsibility for the patient for the diagnosed condition remains with the specialist. Refer to Principles of Shared Care document for full details, in summary:

- Transfer of monitoring and prescribing to Primary care is normally after the patient is on regular dose and with satisfactory investigation results for at least 12 weeks.
- The duration of treatment will be determined by the specialist based on clinical response and tolerability.
- All dose or formulation adjustments will be the responsibility of the initiating specialist unless directions have been discussed and agreed with the GP/primary care clinician.
- Termination of treatment will be the responsibility of the specialist.

PRESCRIBING INFORMATION

1. Background

This guidance has been reviewed in line with the updated NICE guidance NG87 issued in September 2019 on the diagnosis and management of Attention deficit hyperactivity disorder which states; 'After titration and dose stabilisation, prescribing and monitoring of ADHD medication should be carried out under Shared Care Protocol arrangements with primary care'. Clear guidelines are therefore necessary to clarify the roles of primary and secondary care providers when using more specialist medicines.

Psychiatry UK is the Kent and Medway commissioned service provider for the assessment and diagnosis of adult ADHD patients. They are commissioned to initiate and titrate patients on appropriate drug treatment as specified by NICE and the Kent and Medway formulary. They will undertake remote assessments.
A small number of patients who need to be seen face to face will be managed by a sub contract to Psicon. GP management and specialist contact information will be provided in the Psicon to GP letter. Psicon will operate under these shared care arrangements.
Children transitioning to the adult services will be referred direct to Psychiatry UK/ Psicon by NELFT.

Once the patient has been stabilised on their medication regime by Psychiatry UK or Psicon the patient's care will be transferred to the GP's care under the terms of the pathway in appendix 1.

Medication will usually be offered if ADHD symptoms are still causing a significant impairment after environmental modifications have been implemented and reviewed. Lisdexamfetamine or

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methylphenidate are usually offered first-line, with dexamfetamine or atomoxetine as possible alternatives if lisdexamfetamine and/or methylphenidate are contraindicated, not tolerated, or ineffective. For transitioning children it may be appropriate to continue with existing successful treatments.

Non-pharmacological treatment in combination with medication may be considered for adults with ADHD who have benefited from medication but whose symptoms are still causing significant impairment. This can include a structured supportive psychological intervention focused on ADHD, regular follow-up either in person or by phone, and/or elements of or a full course of CBT.

2. Indications (*Please state whether licensed or unlicensed)*

- Attention-deficit hyperactivity disorder is defined by core signs of an excess of inattention, hyperactivity and impulsiveness. These are normal personality traits, so it is important to establish that they are present to a greater extent than would normally be expected, that they cause impairment (commonly in social or academic domains) and that they are pervasive across a range of situations.
- NICE clinical guidelines for the Management of ADHD (NG 87) state that the treatment strategies for ADHD in adults are essentially similar to those used in childhood. It also very importantly states that "it remains an anomaly that many medicines that are considered to be safe and effective in children and adolescents are not licensed for use in adults".
- Pharmacological treatment should be the first line treatment for ADHD, unless the person prefers psychological treatment. Medication should be prescribed as part of a comprehensive treatment programme addressing psychological, behavioural and educational or occupational needs.
- Historically, ADHD was considered a childhood disorder and patients were expected to grow out of this condition by their late teens. However, it is now widely recognised that in up to 70% - 80% of patients, the condition continues into adulthood, and continues to cause impairment of functioning in a large proportion of these patients.
- British Association of Psychopharmacology (BAP) Guidelines state: "Although controlled evidence for prescribing in adults is not extensive, this consensus statement can be considered to meet the criteria for adequate evidence and experience when prescribing standard medications to adults with ADHD, when done in the context or with support of specialist psychiatric services".

All medication for ADHD should only be initiated by a healthcare professional with training and expertise in diagnosing and managing ADHD.

- Offer lisdexamfetamine or methylphenidate as first-line pharmacological treatment for adults with ADHD.
- Consider switching to lisdexamfetamine for adults who have had a 6-week trial of methylphenidate at an adequate dose but have not derived enough benefit in terms of reduced ADHD symptoms and associated impairment.
- Consider switching to methylphenidate for adults who have had a 6-week trial of lisdexamfetamine at an adequate dose but have not derived enough benefit in terms of reduced ADHD symptoms and associated impairment.
- Consider dexamfetamine for adults whose ADHD symptoms are responding to lisdexamfetamine but who cannot tolerate the longer effect profile.
- Offer atomoxetine to adults if:
    - they cannot tolerate lisdexamfetamine or methylphenidate or
    - their symptoms have not responded to separate 6-week trials of lisdexamfetamine and methylphenidate, having considered alternative preparations and adequate doses.

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Please see NICE's information on prescribing medicines.

3. Pharmaceutical aspects

Refer to most current BNF for https://bnf.nice.org.uk/drug/

For a full list, see manufacturer's Summary of Product Characteristics (SPC) (on www.medicines.org.uk/emc

4. Exclusions or contraindications

Please note this does not replace the Summary of Product Characteristics (SPC) and should be read in conjunction with it.

- Patients not registered with a GP in the Kent and Medway CCG area
- Patients unwilling or likely to be unable to be compliant with the service
- Non-NHS patients
- Patients where a written request for shared care has not been received.

Refer to current BNF https://bnf.nice.org.uk/drug/ and SPC www.medicines.org.uk/emc for contraindications.

5. Initiation and ongoing dose regime (by specialist) ***Note***

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- *Transfer of monitoring and prescribing to Primary care is normally **after the patient is stable on a regular dose** and with satisfactory investigation results for period of time as agreed by the specialist. This is usually 12 weeks.*
- *Specialist to specify the length of treatment supplied to the patient in order to indicate to primary care when new supply will be required for forward planning.*
- *All dose or formulation adjustments will be the responsibility of the initiating specialist unless directions have been discussed and agreed with the primary care clinician*
- *Termination of treatment will be the responsibility of the specialist.*

All medication for ADHD should only be initiated by a healthcare professional with training and expertise in diagnosing and managing ADHD.

6. Specialist responsibilities for monitoring (including frequency)

- When patient is on a stable dose of ADHD medication, Psychiatry UK or Psicon to request shared care with General Practice. This is usually after 12 weeks.
- Send the completed ***'Request to share care form' (appendix 1) together with a clinic letter which includes other relevant information*** to the GP.
- Psychiatry UK/ Psicon to obtain consent from patient if unlicensed medication prescribed – confirmation to be provided in patient/ GP letter.
- 1 month supply of medicine to be provided by Psychiatry UK / Psicon with the transfer of care, and following any change in medication by Psychiatry UK or Psicon.
- Clear written communication from Psychiatry UK or Psicon to GP and patient regarding the patient's treatment plan
- Psychiatry UK / Psicon to ensure patients are educated about taking responsibility for organising monitoring every 6 months and annual review with GP practice.

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- Psychiatry UK / Psicon to ensure patients understand that if they do not attend for monitoring prescriptions will not continue to be issued. GP should contact Psychiatry UK/ Psicon for advice on stopping the patient's prescription. (Patients with recurrent issues are not suitable for this pathway and will need to be reviewed with support from Psychiatry UK/ Psicon).

7. GP responsibility

- Return the completed ***'Shared care agreement form***' (appendix 1) to the specialist within **2 weeks** of receipt of request to share.
- GP to inform specialist about termination of shared care if specialist review letter/email is not available when re-authorisation of script is required.
- Patient to make appointment to see health care assistant for BP, pulse and weight check every 6 months or to arrange for remote monitoring to be undertaken.
- Standard thresholds for BP and pulse to trigger an alert to the GP.
- 28 day prescription is issued if there is evidence of monitoring BP, pulse and weight not more than 7 months old.
- Methylphenidate, lisdexamfetamine and dexamfetamine are CDs, so prescriptions should be limited to 30 days' supply (and are only valid for 28 days from the date of signature). Sustained release methylphenidate preparations need to be prescribed by brand as they are NOT interchangeable (they have different release profiles).
- If there is any concern regarding patient management, the GP should contact Psychiatry UK/ Psicon – see contact details below.
- Changes in dose will usually be actioned by Psychiatry UK/ Psicon, however they may be actioned by the GP where they are in agreement to do so and are adequately supported by the specialist.
- Changes in drug will always be actioned by Psychiatry UK/ Psicon.

Patient annual review

Patient to have an annual ADHD review with an appropriately trained prescribing clinician within the practice. This review can be undertaken remotely if the clinician and patient are in agreement.

Annual review to include the following (see review template – appendix 1):

- Ongoing clinical benefit of medication
- Side effects
- Worsening of agitation & tension
- BP, pulse and weight trends
- General wellbeing of the patient
- Medication concordance/ potential diversion of the drug
- Illicit drug use
- Seek Psychiatry UK /Psicon input if required - see contact details below for fast track advice / referral

8. Dose Management (by primary care)

- Changes in dose will usually be actioned by Psychiatry UK/ Psicon, however they may be actioned by the GP where they are in agreement to do so and are adequately supported by the specialist.

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9. Summary of Key Clinical Information for Drugs Prescribed in Adult ADHD – *prescriber must consider interactions with any and all repeat medication the patient is taking at the time of initiation*

Refer to the current BNF https://bnf.nice.org.uk/drug/ and SPC: www.medicines.org.uk/emc for full prescribing information

	METHYLPHENIDATE	ATOMOXETINE	LISDEXAMFETAMINE	DEXAMFETAMINE	Guanfacine
Licensed in adults	**Xaggitin XL, Concerta XL, Matoride XL** (yes if started as a child) **Medikinet XL** – yes - new patients require careful dose titration **Equasym XL and immediate release preparations** – no **Xenidate XL** –– yes (if started as a child). NICE recommends.	Yes	Yes	No - but recommended by NICE NG87	No – For patients transitioning from children to adult services, it may be appropriate to continue with existing successful treatments.
Dose Range	**Methylphenidate immediate release**: 10 – 100mg daily in 2-3 doses **Xaggitin XL** 18-108mg daily **Concerta XL**: 18 – 108mg daily **Matoride XL:** 18 – 108mg daily **Medikinet XL**: 10 – 80mg daily **Equasym XL:** 10 – 100mg daily **Xenidate XL**: 18 – 108mg	**<70kg** – 500mcg - 1.8mg/kg/day – om or 2 divided doses (last dose early evening) **>70kg** – 40mg - 120mg daily - om or 2 divided doses (last dose early evening)	30-70mg daily	10 – 60mg daily in 2- 4 divided doses	1mg to 7mg once a day.

Withdrawal	Careful supervision is required during drug withdrawal, since this may unmask depression as well as chronic over-activity. Some patients may require long- term follow up.	Abrupt withdrawal can be implemented if necessary	Withdrawal symptoms after abrupt cessation following prolonged high-dosage administration of CNS stimulants include extreme fatigue and depression.	Careful supervision is required during drug withdrawal, since this may unmask depression as well as chronic over- activity. Some patients may require long-term follow up.	Patients/caregivers should be instructed not to discontinue guanfacine without consulting their physician. When stopping treatment, the dose must be tapered with decrements of no more than 1 mg every 3 to 7 days, and blood pressure and pulse should be monitored in order to minimise potential withdrawal effects.
Contra indications	**See SPCs – severe CVD or cerebrovascular disease**				Hypersensitivity to the active substance or to any of the excipients.
Dose in renal impairment	Not renally excreted but no data	No dose reduction needed	e GFR 15-30ml/min reduce to a maximum of 50mg daily	No data - caution	Dose reduction may be required in patients with severe renal impairment (GFR 29-15 ml/min) and an end stage renal disease (GFR<15 ml/min) or requiring dialysis. No data – caution.
Dose in hepatic impairment	No data - caution	Reduce dose by 25-50%	No data - caution	No data - caution	No data – caution.
Key Side effects	Insomnia, Nervousness, headache, palpitations, appetite loss, increase in BP & pulse, weight loss, fatigue & somnolence, increase in aggression & anxiety, verbal & physical tics, seizures	Increase in BP & pulse, weight loss, fatigue & somnolence ,	Increase in BP & pulse, weight loss, fatigue & somnolence, increase in aggression & anxiety, verbal & physical tics, seizures, visual disturbances	Increase in BP & pulse, weight loss, fatigue & somnolence, increase in aggression & anxiety, verbal & physical tics, seizures	Hypotension, weight increase, bradycardia, syncope, somnolence, headache, fatigue, upper abdominal pain and sedation.
Key Interactions	MAOIs, Antihypertensives, drugs that elevate BP, antipsychotics, clonidine	MAOIs, fluoxetine, paroxetine, QT interval prolongating drugs	MAOIs, serotonergic drugs, opiates	MAOIs, Antihypertensives, drugs that elevate BP, antipsychotics, clonidine	Valproic acid, Antihypertensive drugs, CNS depressant drugs. Guanfacine should not be administered with high fat meals due to increased exposure.

10. Adverse effect management

Specialist to detail action to be taken upon occurrence of a particular adverse event as appropriate. Most serious toxicity is seen with long-term use and may therefore present first to GPs.

Cardiac function and blood pressure

- Monitor heart rate and blood pressure before and after each dose change, and every 6 months.
- If there is an increase of heart rate 20 beats per minute over normal or 15-20 mm Hg increase in systolic blood pressure measured on two occasions contact ADHD specialist for advice. This does not preclude that smaller increases may be significant for individual patients.
- When BP remains high and the patient wants to continue taking ADHD medication, an antihypertensive is recommended. The first choice should be the one recommended by NICE.
- When the patient remains tachycardic, an ECG or 24hr ECG should be performed to exclude any arrhythmias. If tachycardia persists then the advice is to reduce the medication and if there is no change to switch to an alternative medication in liaison with the ADHD specialist.

Weight

- Monitor every 6 months
- In adults, the amount of weight loss that will raise concern will depend on how significant it is for an individual i.e. a small percentage loss in someone who is already underweight is more significant than the same weight loss in someone who has a normal BMI or is 'overweight'. Generally unexplained weight loss of more than 5% over 6 months would warrant a referral back to the specialist service.
- ADHD medication can be implicated in causing weight loss. Refer to the Specialist ADHD service to consider changing the drug if weight loss persists. It is the downward trend that is significant.
- Strategies to reduce weight loss:
    - Taking medication either with or after food, rather than before meals
    - Eating additional meals or snacks early morning or late evening when stimulant effects have worn off
    - Obtaining dietary advice and eating high-calorie foods of good nutritional value

Insomnia

- Insomnia is **not** a common side effect when ADHD medication is taken at the correct times.
- If there is disruption in sleep the advice would be to take the slow release earlier if possible or with the immediate release formulation to take the last dose earlier (patients shouldn't take the medication after 4.30 pm). In the case of ongoing issues seek advice from ADHD specialist.

Depression / Anxiety

- Consider seeking advice from the ADHD specialist if patients become depressed or more anxious.
- SSRIs are first line treatment for patients prescribed methylphenidate. There is a small increased risk of seizures.

- Antidepressant interactions with atomoxetine are more complex so it is recommended to seek advice from the ADHD specialist ○ Citalopram, escitalopram, fluoxetine and possible sertraline may increase the QT interval.
  ○ Fluoxetine and paroxetine may increase serum levels of atomoxetine ○ Mirtazapine and venlafaxine may have a synergistic effect on noradrenaline

Nausea /vomiting

- Nausea/vomiting is more common with atomoxetine but quite rare with the stimulants. Many of the anti-emetics can cause QT interval prolongation and therefore should not be prescribed with atomoxetine because of the risk of ventricular arrhythmias. Seek advice from specialist for patients prescribed atomoxetine with nausea/ vomiting.

Increased risk of convulsions

- Both stimulant and non-stimulant ADHD medication can increase the risk of convulsions in people who are not taking anticonvulsants, and are prone to seizures**.** In clinical practice it is recommended that when someone has a comorbid epilepsy, they should be closely monitored and in the event of increased seizure frequency to contact ADHD specialist or their neurologist. Often a small adjustment in their medication is enough to resolve the problem.

11. Advice to patients and carers

The specialist will counsel the patient with regard to the benefits and risks of treatment and will provide the patient with any relevant information and advice

- Before shared care is put in place the patient must be fully informed of the plan and must be in agreement with it.
- The patient should report to the specialist or GP if he or she does not have a clear understanding of the treatment or has any concerns relating to the treatment.
- Attend appropriate specialist, GP and other follow up appointments and co-operate with assessments.
- Attend review appointments at the primary care clinician practice for clinical monitoring as outlined in the original transfer of prescribing letter by the initiating specialist (e.g. blood pressure, pulse, height and weight).
- Inform the specialist or the GP of any other medication being taken, including herbal and over the counter products.
- Take medicines as prescribed and agreed.
- Read the patient information leaflet included with your medication, be aware of side effects including palpitations, exertional chest pain, unexplained fainting, and shortness of breath, development of new or worsening of pre-existing psychiatric symptoms. Report any adverse effects, wanting symptoms or concerns to your primary care clinician or initiating specialist.
- Seek help urgently if side effects are suspected, or are otherwise unwell.

12. Pregnancy and breast feeding

It is the responsibility of the specialist to provide advice on the need for contraception to female patients on initiation and at each review but the ongoing responsibility for providing this advice rests with both the GP and the specialist.

For advice on pregnancy and breastfeeding refer to current BNF https://bnf.nice.org.uk/drug/ and SPC: www.medicines.org.uk/emc .

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These drugs should only be used in pregnancy and breast feeding on the advice of a specialist.

13. Specialist contact information Psychiatry UK ADHD clinic

033 0124 1980 Mon - Fri 8am to 8pm
p-uk.kent.adultadhdservice@nhs.net

Psicon ADHD Clinic
kmccg.psicon.adults@nhs.net
01227 379099

14. Additional information

- There are several organisations that support people with ADHD:

  - ✓ The ADHD Foundation
  - ✓ The national Attention Deficit Disorder Information & Support Service Website ADDISS
  - ✓ The UK adult ADHD network
  - ✓ The UK ADHD Partnership
  - ✓ Adult Attention Deficit Disorder UK AADDUK - www.aadduk.org.
  - ✓ Mind www.mind.org.uk.

- Healthcare professionals or carers should monitor changes in the potential for stimulant misuse and diversion, which may come with changes in circumstances and age.

15. References

1. Attention deficit hyperactivity disorder: diagnosis and management. NICE guideline [NG87]. https://www.nice.org.uk/guidance/ng87
2. Summary of product characteristics. www.medicines.org.uk/emc
3. British National Formulary. https://bnf.nice.org.uk/drug/

Appendix 1

REQUEST TO SHARE CARE AND AGREEMENT FORM

Methylphenidate, Lisdexamfetamine, Dexamfetamin e, Guanfacine & Atomoxetine for Attention Deficit Hyperactivity Disorder in patients over 18 years of age

REQUEST TO SHARE CARE FORM

**The expectation is that this information, along with the full shared care protocol, provides sufficient information to enable GP* to be confident to take on clinical and legal responsibility for prescribing and monitoring. GP* to review and must respond to provider trust request to share care within 2 weeks, using form provided. ***This may be any primary care prescribing clinician.*

For completion by specialist (with shared care agreement form) - alternatively discharge letter to be provided containing this information.	
Patient name	
DOB	
NHS Number	
Patient weight (kg) – Date monitored	
Patient's BP / pulse – date monitored	
Drug (s) Dose, frequency, and route at handover	
Diagnosis (please indicate if unlicensed or "off-label"	
Date of first prescription by specialist	
Date of the next monitoring review	
Estimated date for prescribing responsibility to be with GP*	
Special prescribing advice for this patient	

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SHARED CARE AGREEMENT FORM

This form is used to agree shared care between specialist, patient and GP*.

Specialist and patient agreement By signing below we accept:

- The Kent and Medway CCG shared care principles
- The requirements and responsibility defined in this drug specific shared care protocol
- To provide medication for the transition period (at least 28 days)

Specialist name:	Patient name:
Designation:	DOB:
Provider Trust:	NHS number:
Direct telephone number:	
Email:	
Specialist signature:	Patient signature:
Date:	Date:

GP* response to shared care request

Please return to specialist within **2 weeks** of receipt of request to share.

This form is to be completed by the GP* who is requested to share care.

I agree to accept shared care as set out in this shared care protocol and KMCCG shared care principles. ☐

I have not received adequate support to take over prescribing therefore I do not accept shared care for this patient. ☐

My reasons for not accepting are:

Please note that GP agreement is voluntary, with the right to decline to share care if for any reason you do not feel confident in accepting clinical responsibility.

GP* name	
Designation	
Direct telephone number	
Email	
Practice address	
GP* signature	
Date	

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Specialist to retain a copy in the patients' hospital notes
Copy to be given to patient
GP* to retain a copy in primary care notes

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