DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE
SHARED CARE AGREEMENT

DRUGS USED IN THE MANAGEMENT OF ADHD IN CHILDREN OVER 5 YEARS AND ADULTS

1. REFERRAL CRITERIA

- Shared Care is only appropriate if it provides the optimum solution for the patient.
- Prescribing responsibility will only be transferred when it is agreed by the consultant and the patient's GP that the patient's condition is reasonably predictable and the treatment regime has been specified.
- Patients will only be referred to the GP once the GP has agreed in each individual case, subject to receiving the relevant clinical information.
- The patient will be given a supply of the relevant drug sufficient for 4 weeks maintenance therapy.

2. AREAS OF RESPONSIBILITY

GP responsibilities	Consultant/Specialist Service's responsibilities

• Initial referral to specialist raising possibility of ADHD
• Provide information re medical history and perform physical examination if requested.
• Reply to the request for shared care as soon as practicable.
• Prescribe by brand name for MR preparations
• Adjust the dose as advised by the specialist.
• Once dose has been stabilised, prescribe repeat prescriptions – maximum of 30 days recommended (NB.CD requirements for all except atomoxetine)
• Confirm adherence to treatment and support as appropriate. Monitor for signs of diversion and misuse (e.g. by checking prescribing intervals of prescriptions)
• Report to and seek advice from the specialist on any aspect of patient care that is of concern and may affect treatment.
• Refer patient to the specialist if his or her condition deteriorates.
• Stop treatment on the advice of the specialist or immediately if an urgent need to stop treatment arises.
• If informed by the consultant or specialist clinic that the patient has defaulted from attending clinic **do not** continue prescription unsupervised
• Report any adverse events to the referring specialist and MHRA yellow card scheme.
 	
Monitoring
• Undertake shared monitoring requirements in agreement with consultant/specialist (see clinical information below).
• Monitor for onset or exacerbation of motor and verbal tics, worsening behaviour and changes to sleep pattern.
• Monitor for the development or worsening of psychiatric disorders.
 	
Adults
• Monitor HR and BP. Liaise with specialist and reduce the dose if:
  ○ sustained tachycardia, arrhythmia or
  ○ a clinically significant increase in
	• Inform patient about unlicensed status (adults)
	• Discuss the benefits and side effects of treatment with the patient/carer and the importance of adherence. In particular ensure awareness of: how to recognise symptoms of hepatic disorder (stomach pain, nausea, dark urine, jaundice); need to report promptly suicidal thoughts & self-harming behaviour; possible teratogenicity in pregnancy (as appropriate).
	• Risk assess for diversion and misuse.
	• Assess full medical history including history of cardiac disease, convulsive disorders, thyroid disorders, mental health problems and current medication.
	• Initiate treatment taking into account contra-indications, cautions, side-effects, compliance/diversion issues and cost.
	• Initiate prescriptions, titrating the dose against symptoms and side effects until dose optimisation is achieved. Titrate cautiously where indicated e.g. in neurodevelopmental disorders, mental health conditions and physical health conditions such as epilepsy or cardiac disease.
	• Prescribe by brand name for MR preparations
	• Ask the GP whether he or she is willing to participate in shared care once the dose is stable (informing of unlicensed status where applicable). Do not continue to prescribe once responsibility is transferred without communication with the GP (risks of misuse-communicate to GP if a CD prescription has been issued to patient from secondary care).
	• Communicate promptly with the GP when treatment is changed or the patient defaults attending clinic.
	• Review patient regularly, with an annual review of medications. Communicate the results of the review to the GP and provide advice on stopping treatment as appropriate.
	• Agree monitoring schedule with GP for adults every 6 months and ensure sharing of these results.
	• Have a mechanism in place to receive rapid referral of a patient from the GP in the event of deteriorating clinical condition.
	• Report adverse events to the MHRA yellow card scheme.
	• Ensure that clear backup arrangements exist for GPs to obtain advice and support.
	• Provide a care plan.
	
	Monitoring & treatment adjustment
	Baseline
	• Height (under 18 only), weight, pulse and BP
	• Examination of cardiovascular system.
	Refer for specialist cardiac evaluation if there is
	  ○ a history of congenital heart disease or cardiac surgery
	  ○ history of sudden death in a first degree relative under 40 years
	  ○ undue breathlessness
	  ○ fainting on exertion or in response to fright or noise

systolic BP measured on two occasions. Atomoxetine • Monitor for sexual dysfunction with Atomoxetine and refer back to specialist if a problem. Guanfacine • If a person taking guanfacine has sustained orthostatic hypotension or fainting episodes reduce the dose and refer back to the specialist for review. **Switching brands of methylphenidate** Switching between brands is supported if bioequivalent and recommended by Derbyshire medicines management team. Patients may be changed in primary care to the preferred recommended brand by their GP for ongoing prescribing, providing they have been appropriately informed before the switch takes place. Currently the recommended brands are Delmosart SR and Xaggitin XL, which are both bioequivalent to the brand Concerta XL. .	○ palpitations that are rapid, regular and start and stop suddenly ○ chest pain suggesting cardiac origin ○ signs of heart failure ○ a murmur heard during cardiac exam ○ high blood pressure (adults only). • An ECG is not needed before starting stimulants, atomoxetine or guanfacine if cardiovascular history and examination are normal and the person is not on medicine that poses an increased cardiovascular risk' • Base line evaluation to identify patients at risk of sedation and somnolence before starting guanfacine. Ongoing • Monitor for onset or exacerbation of motor and verbal tics, worsening behaviour and changes to sleep pattern. • Monitor for the development or worsening of psychiatric disorders. • Reduce the dose and refer to an adult physician or paediatrician if there is sustained resting tachycardia, arrhythmia or systolic blood pressure greater than the 95th percentile or a clinically significant increase on two occasions • If a person develops new or worsening seizures review ADHD medication and stop any that may be contributing; after investigation cautiously reintroduce if found to be unlikely cause. Children and young people • Monitor BP/ HR/ weight and Height • Refer to paediatric hypertension specialist if BP is consistently above 95th centile for age and height in children and young people. Atomoxetine Monitor for sexual dysfunction with Atomoxetine Guanfacine • If a person taking guanfacine has sustained orthostatic hypotension or fainting episodes reduce the dose or switch to another medication
Patient/ carer responsibilities: • Report any adverse effects • Maintain handheld records • Complete any monitoring forms requested by the specialist • Order repeat prescriptions and supplies and store safely • Attend all medical / other appointments as necessary	

3. COMMUNICATION AND SUPPORT

i. Contacts	**ii. Out of hours:**
If necessary contact the consultant who is supervising care – refer to assessment letter for details. **Pharmacy departments:** Derbyshire Healthcare NHS Foundation Trust: 01332 623700 ext 33268 Royal Derby Hospital: 01332 340131 Pharmacy via switchboard Chesterfield Royal Hospital: 01246 512157	On call psychiatrist/paediatrician/CAMHS via CRH switchboard 01246 277271 On call psychiatrist/paediatrician/CAMHS via DHCFT switchboard 01332 623700 On call paediatrician RDH via switchboard 01332 340131

iii. Specialist support/resources available to GP including patient information

Information on treatment for ADHD is available at http://www.choiceandmedication.org/derbyshcft/
The local Parent Support Group contact is: FLARE, Derbyshire ADHD Support Service.
Telephone: 01246 569012 E-mail: flareadhd@aol.com

4. CLINICAL INFORMATION

See Summary table below

Cautions and contraindications in cardiac disorder, cerebrovascular disorder, glaucoma, phaeochromocytoma and hyperthyroidism.

Caution in patients whose underlying medical condition might be compromised by increases in blood pressure or heart rate. Caution in epilepsy or history of seizures.

Methylphenidate is contraindicated in patients with a diagnosis or history of severe depression, anorexia nervosa/anorexic disorders, suicidal tendencies, psychotic symptoms, severe mood disorders, mania, schizophrenia, and personality disorder.

For full prescribing information please see the relevant Summary of Product Characteristics.

Information Sources Used:

- NICE clinical guideline 87: Attention Deficit Hyperactivity Disorder – Diagnosis and Management of ADHD in children, young people and adults. March 2018 (accessed July 2018)
- SPCs accessed July 2018 at www.emc.medicines.org.uk
  - Ritalin, Equasym XL, Delmosart SR, Xaggitin SR and Medikinet XL
  - Strattera
  - Elvanse
  - Intuniv
- MHRA Drug Safety Update Volume 2 Issue 8 March 2009. Methylphenidate: Updated guidance on safe and effective use in ADHD. Atomoxetine: risk of psychotic or manic symptoms.
- MHRA Drug Safety Update Volume 5 Issue 6 January 2012 Atomoxetine (Strattera▼): increases in blood pressure and heart rate—new contraindications, warnings, and advice for monitoring
- BNF accessed on-line July 2018
- BNF for Children accessed on-line July 2018
- Stockley's Drug Interactions accessed July 2018 at www.new.medicinescomplete.com

Further information:

Evidence Based Guidelines for the Management of Attention Deficit Hyperactivity Disorder : Update on recommendations from the British Association of Psychopharmacology. (2014)
https://www.bap.org.uk/pdfs/BAP_Guidelines-AdultADHD.pdf

Clinical Knowledge Summaries. Attention deficit hyperactivity disorder. (https://cks.nice.org.uk/attention-deficit-hyperactivity-disorder)

Acknowledgement

Shared care ADHD guideline for children:	
Reviewed and Reformatted by:	Beverley Thompson Deputy Chief Pharmacist Derbyshire Healthcare NHS Foundation Trust Lisa Taylor Senior Pharmacist Derby Hospitals NHS Foundation Trust Dr Morton Consultant Paediatrician Derby Hospitals NHS Foundation Trust Dr J Thomas, Chesterfield hospital Dr S Banta, Derbyshire Healthcare NHS Foundation Trust Dr S Taylor, Derbyshire Healthcare NHS Foundation Trust
In consultation with:	The Shared Care Guidelines Group Derby Hospitals NHS Foundation Trust Child and Adolescent Mental Health Services (CAMHS) Derbyshire
Shared care ADHD guideline for adults:	
Written by: Simon Taylor, Consultant Psychiatrist, Derbyshire Mental Health Services NHS Trust Beverley Thompson, Pharmacist, Derbyshire Mental Health Services NHS Trust Updated by Sally Jordan, Pharmacist, Derbyshire Healthcare Foundation Trust May 2012	
Shared Care ADHD guideline for adults & children:	
Amalgamated and reviewed by:	Beverley Thompson, Pharmacist, Derbyshire Healthcare Foundation Trust
In consultation with:	Dr Walters, Chesterfield Royal Hospital Dr McIntyre, Derby Hospitals NHS Foundation Trust Drs Banta & Taylor, Derbyshire Healthcare Foundation Trust

This does not replace the SPC, which should be read in conjunction with it.
Reviewed: September 2018
Next Review Date: August 2021

	Methylphenidate	Methylphenidate modified release		
Brand name	Prescribe generically (brands include Ritalin, Medikinet)	**Delmosart SR** **Xaggitin XL** (Previously Matoride XL and Concerta XL were the preferred brands)	**Equasym XL**	**Medikinet XL**
Strength	5mg,10mg,20mg tablets	18mg, 27mg, 36mg, 54mg tablets	10mg, 20mg, 30mg capsules	5mg, 10mg, 20mg, 30mg, 40mg, 50mg, 60mg capsules
Indication	As part of a comprehensive treatment programme for ADHD in children aged 6 and over. Treatment of ADHD in adults is **unlicensed**. NICE: Offer medication for ADHD only if symptoms are still causing a persistent significant impairment in at least one domain after environmental modifications have been implemented and reviewed.			
Place in Therapy	**First line**	**First line,** if once daily dosing and 12-hour action is required, or there are concerns about diversion (22% immediate release and 78% extended)	**First line,** if once daily dosing and 8-hour action is required or there are concerns about diversion. (Equasym XL 30% immediate release and 70% extended; Medikinet XL 50% immediate release and 50% extended)	
Controlled Drug	**Yes**	**Yes**	**Yes**	**Yes**
Dose in children 6 years and over	5mg once or twice a day. Titrate by weekly increments of 5-10mg/day against symptoms and side effects. **Max:** 60mg/day in divided doses. **4-5 years(unlicensed):** 2.5mg twice a day, increased by 2.5mg at weekly intervals. **Max** 1.4mg/kg in 2-3 doses.	As per plain tablets, using an equivalent dose. Not usually for initiation of treatment- use 18mg in the morning if required. **Max:** 54mg once a day.	As per plain tablets, using an equivalent dose. Initiate treatment using 10mg capsules daily Equasym XL- before breakfast. Medikinet XL- with breakfast. **Max:** 60mg once a day	
Unlicensed dose in children	Can be increased to 2.1mg/kg daily in divided doses up to a maximum of 90mg under specialist supervision. Discontinue after 1 month if no response	Can be increased to 2.1mg/kg daily in divided doses up to a maximum of 108mg under specialist supervision. Discontinue after 1 month if no response **(Note BNFc only includes this under Concerta XL, not Delmosart or Xaggitin)**	Can be increased to 2.1mg/kg daily in divided doses up to a maximum of 90mg under specialist supervision. Discontinue after 1 month if no response	
Dose in adults (unlicensed)	5mg 2 or 3 times a day. Titrate against symptoms and side effects at weekly intervals. **Max**: 100mg/day in up to 4 divided doses.	As per plain tablets, using an equivalent dose. If initiating treatment use 18mg daily, adjusted at weekly intervals. Usually given once daily, but not more than twice daily **Max:** 108mg daily	As per plain tablets, using an equivalent dose. Initiate treatment using 10mg capsules daily. (Equasym XL- before breakfast. Medikinet XL- with breakfast) Usually given once daily, but not more than twice daily. **Max:** 100mg once a day	
Adult physical Monitoring by GP	**Agree monitoring schedule with GP and consultant/specialist** **Pulse & BP before and after dose changes and then every 6 months; Weight every 6 months.** **Reduce the dose and liaise with specialist if: sustained tachycardia, arrhythmia or a clinically significant increase in systolic BP measured on two occasions.**			
Monitoring in children by specialist	Monitor BP/ HR Monitor Weight: every 3 months in children aged 10 years and under; at 3 months & 6 months in young people and children over 10 years and every 6 months thereafter Monitor Height every 6 months for children and adolescents and recorded on growth chart			
Drug Interactions	Warfarin; Phenytoin; Valproate; Carbamazepine; MAOIs; Tricyclic antidepressants; SSRIs; Clonidine; Risperidone			
Side effects (common or significant)	At the beginning of treatment: Nervousness, insomnia, decreased appetite **CNS** – headache, drowsiness, dizziness, dyskinesia, psychomotor hyperactivity **Skin** – rash, pruritus, urticaria, arthralgia, hair loss. **GI** – abdominal pain, nausea/vomiting, dry mouth, weight loss, diarrhoea **Blood** – very rarely leucopenia, anaemia, thrombocytopenia **CVS** – tachycardia, palpitations, arrhythmias, changes in heart rate and BP(usually increase). **Heart disease: Symptoms require prompt specialist cardiac evaluation.** **Psychiatric disorders**: associated with causing or worsening e.g. depression, suicidal thoughts, hostility, anxiety, agitation, psychosis and mania. **Motor and verbal tics**: associated with exacerbation or onset. **Other** – fever, cough. **In children**- moderately reduced weight gain and growth retardation			

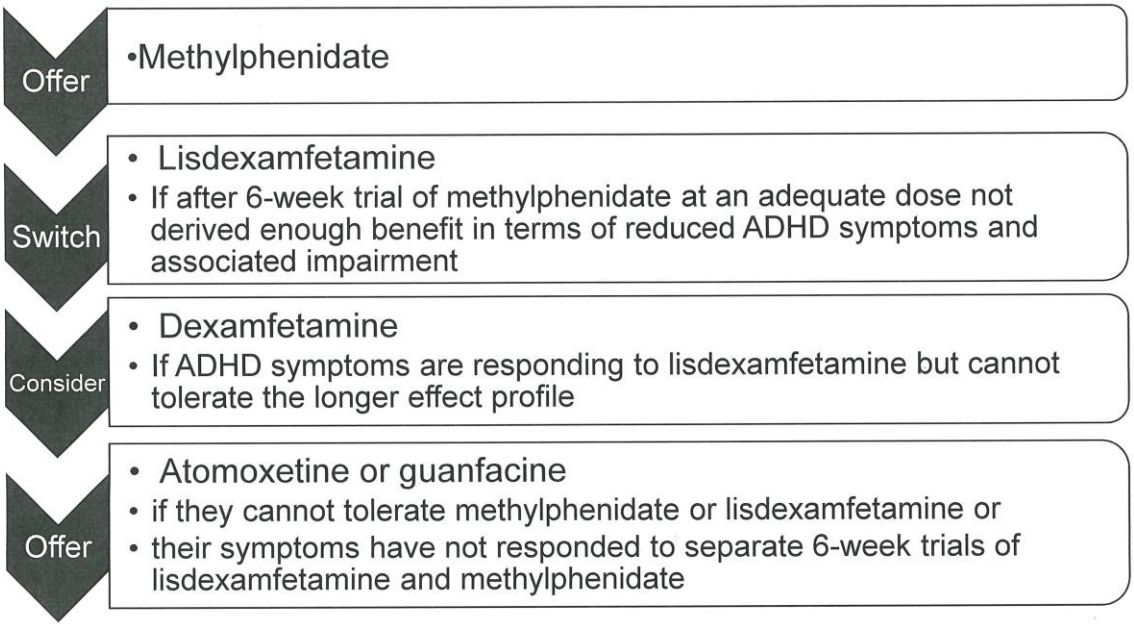
	Lisdexamfetamine	Dexamfetamine	Atomoxetine	Guanfacine
Brand name	Elvanse	Amfexa	Prescribe generically (this is supported by DHcFT – original brand Strattera)	Intuniv
Strength	20mg,30mg,40mg,50mg ,60mg 70mg caps. Adult: 30mg, 50mg, 70mg caps	5mg, 10mg, 20mg tablets	10mg,18mg,25mg,40mg,60mg caps and 4mg/ml oral solution	1mg, 2mg, 3mg,4mg prolonged release tablets
Indication	As part of a comprehensive treatment programme for ADHD in children aged 6 and over, when response to previous methylphenidate is considered clinically inadequate. Treatment of ADHD in adults.	Refractory hyperkinetic states under the supervision of a physician specialising in child psychiatry. Treatment of ADHD in adults **(unlicensed)**	As part of a comprehensive treatment programme for ADHD in children aged 6 and older, in adolescents and in adults.	As part of a comprehensive treatment programme for ADHD in children and adolescents 6-17 years old for whom stimulants are not suitable, not tolerated or have been shown to be ineffective.
Place in Therapy	**Second line** For those who have not derived enough benefit from an adequate (NICE suggest 6 weeks) trial of methylphenidate	**Third line** For those whose symptoms respond to lisdexamfetamine but who cannot tolerate the longer effect profile	**Third line** If methylphenidate and lisdexamfetamine have not been tolerated or if symptoms have not responded to adequate trials of each	**Third line for children aged 5 years and over and young adults** If methylphenidate and lisdexamfetamine have not been tolerated or if symptoms have not responded to adequate trials of each
Controlled Drug	**Yes**	**Yes**	**No**	**No**
Dose in children 6 years and over	30mg once daily in the morning or 20mg if appropriate. Titrate according to response/ tolerability. May be increased at weekly intervals by 10-20mg increments. **Max:** 70mg once a day	2.5mg 2 or 3 times a day, increasing if necessary by 5mg daily at weekly intervals up to 1mg/kg in 2-4 divided doses up to 20mg daily (40mg or more in some children).	**<70kg:** initially 0.5mg/kg/day minimum of 7 days, then titrated according to response and tolerability. Recommended maintenance dose is approx. 1.2mg/kg/day. **Unlicensed:** 1.8mg/kg/day (up to 120mg.) **>70kg**: initially 40mg/day minimum of 7 days titrated according to response and tolerability. Recommended maintenance dose is 80mg. Max dose 100mg **Unlicensed max**: 120mg. Once a day in the morning or 2 evenly divided doses (morning & late afternoon/ early evening) if not tolerated/inadequate response	1 mg once a day, adjusted in increments of not more than 1 mg per week then titrated according to response and tolerability. Recommended maintenance dose range is 0.05-0.12 mg/kg/day.
Dose in adults	30mg once daily in the morning. Titrate according to response/ tolerability. May be increased at weekly intervals by 20mg increments. **Max**: 70mg daily	Initial: 5mg twice a day. Titrate against symptoms and side effects, increasing at weekly intervals as required. **(Unlicensed)** **Max**: 60mg/day in 2 - 4 divided doses	40mg/day minimum of 7 days, then titrate as required. BNF- start at 0.5mg/Kg if <70kg Usual maintenance dose 80-100mg/day. **Unlicensed max** dose 120mg. Once a day in the morning or 2 evenly divided doses (morning & late afternoon/ early evening). if not tolerated/inadequate response	**Unlicensed** **NICE: do not offer guanfacine for adults without advice from a tertiary ADHD service**
Adult Physical Monitoring by GP	**Agree monitoring schedule with GP and consultant/specialist** **Pulse & BP before and after dose changes and then every 6 months; Weight every 6 months.** **Reduce the dose and liaise with specialist if: sustained tachycardia, arrhythmia or a clinically significant increase in systolic BP measured on two occasions.**			
Monitoring in children by specialist	Monitor BP/ HR Monitor Weight: every 3 months in children aged 10 years and under; at 3 months and 6 months in young people and children over 10 years and every 6 months thereafter Monitor Height every 6 months for children and adolescents and recorded on growth chart **Guanfacine**: weekly monitoring (for somnolence, sedation, hypotension and bradycardia) during dose titration; 3 monthly monitoring during first year of treatment			
Other monitoring			Monitor for sexual dysfunction with and refer back to specialist if a problem.	If orthostatic hypotention or fainting episodes reduce the dose and refer

				back to the specialist for review.
	Lisdexamfetamine & dexamfetamine		**Atomoxeine**	**Guanfacine**
Drug Interactions	MAOIs & Moclobemide Tricyclic antidepressants SSRIs SNRIs Lithium Haloperidol HIV protease inhibitors Opioids		CYP2D6 inhibitors eg Fluoxetine & Paroxetine Drugs that increase the QT interval. Drugs that lower the convulsive threshold. Drugs that cause electrolyte imbalance MAOIs Methadone, Tramadol	CYP3A4/5 inhibitors or inducers Drugs that increase the QT interval Grapefruit juice Clarithromycin, Erythromycin Tricyclic antidepressants Carbamazepine Valproate Phenytoin
Side effects (common or significant)	**CNS**- restlessness, irritability, tremor, dizziness, insomnia, headache. **GI** - dry mouth, anorexia, abdominal pain, nausea, vomiting, diarrhoea, weight loss. **CVS** - tachycardia, palpitations, and increased blood pressure **Psychiatric disorders**: Aggression, anxiety emotional lability, psychosis, euphoria **Motor and verbal tics**: associated with exacerbation or onset **Others**: dyspnoea, rash, fever.		**CNS** – headache, somnolence, dizziness, insomnia. **GI** - abdominal pain, nausea, vomiting, constipation, dyspepsia, dry mouth, weight loss **CVS**- increased BP and pulse rates, QT prolongation, orthostatic hypotension **Skin** – rash, dermatitis **Psychiatric disorders:** Rare - psychotic or manic symptoms, suicidal behaviour Common- Hostility, mood swings, irritability **Motor and verbal tics**: associated with exacerbation or onset. **Liver toxicity**: very rare. **Other**- decreased appetite, fatigue, lethargy, dysmenorrhoea, urinary retention, sexual dysfunction.	**CNS** – headache, somnolence, dizziness, insomnia, nightmares **GI** - abdominal pain/discomfort, nausea, vomiting, constipation, diarrhoea, dry mouth, decreased appetite **CVS**- bradycardia, hypotension **Skin** – rash, **Psychiatric disorders**: depression, anxiety, affect lability. **Others**: lethargy, fatigue, irritability sedation, enuresis,

Summary of NICE NG87 recommended on medication choice

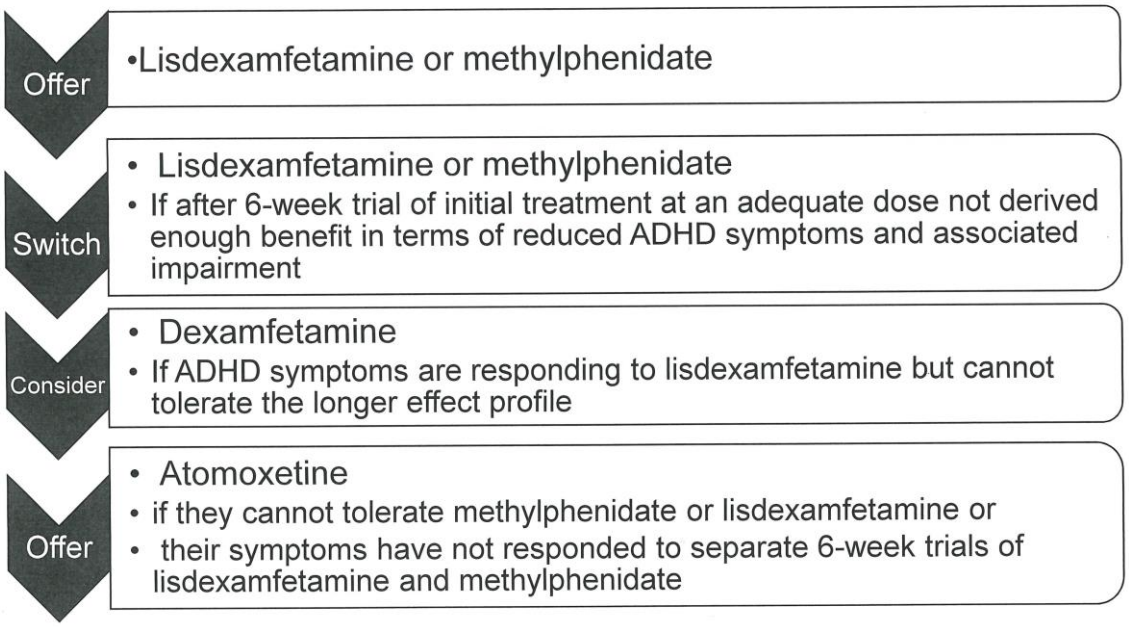
Medication choice - children aged 5 years and over and young people

Recommendations 1.7.7 to 1.7.10



Medication choice - adults

Recommendations 1.7.11 to 1.7.15



Sample Transfer Letter

Hospital No: «HOSPITAL_NUMBER»
NHS No: «NHS_NUMBER»

{Insert date}

PRIVATE & CONFIDENTIAL
«GP_TITLE» «GP_INITIALS» «GP_SURNAME»
«GP_ADDRESS_1»
«GP_ADDRESS_2»
«GP_ADDRESS_3»
«GP_ADDRESS_4»
«GP_POSTCODE»

DERBYSHIRE JAPC SHARED CARE AGREEMENT LETTER

Dear «GP_TITLE» «GP_SURNAME»

«FORENAME_1» «SURNAME» «DATE_OF_BIRTH»
«CURRENT_ADDRESS_1» «CURRENT_ADDRESS_2» «CURRENT_ADDRESS_3»
«CURRENT_ADDRESS_4» «CURRENT_POSTCODE»

Your patient was seen on ***{Insert date}*** with a diagnosis of ***{Insert diagnosis}***. Following out discussion of (date) and your agreement to continue the prescribing when we discharge him/her, I have initiated the following medication ***{Insert drug name}*** and am writing to ask you to participate in the shared care for this patient.

This medication has been accepted as suitable for shared care by the Derbyshire Joint Area Prescribing Committee (JAPC). I agree to the secondary care responsibilities set out in the shared care agreement for this medication (available from www.derbyshiremedicinesmanagement.nhs.uk/clinical_guidelines/shared_care_guidelines). I am therefore requesting your agreement to share the care of this patient. Where preliminary tests are set out in the agreement I have carried these out and results are below.

Dose Regimen	Date ***{Insert medicine name}*** started	Date for GP to start prescribing ***{Insert medicine name}*** from
The baseline test results are (if applicable): **See overleaf for initiation criteria.**		

I can confirm that the following has happened with regard to this treatment:

	Specialist to complete
The patient has been initiated on this therapy and has been on an optimised dose for the following period of time:	
Baseline investigation and monitoring as set out in the shared care documents have been completed and were satisfactory	*Yes / No*
The condition being treated has a predictable course of progression and the patient can be suitably maintained by primary care	*Yes / No*
The risks and benefits of treatment have been explained to the patient	*Yes / No*

The roles of the specialist/specialist team/ Primary Care Prescriber / Patient and pharmacist have been explained and agreed	*Yes / No*
The patient has agreed to this shared care arrangement, understands the need for ongoing monitoring, and has agreed to attend all necessary appointments	*Yes / No*
I have enclosed a copy of the shared care protocol which covers this treatment/the SCP can be found here (insert electronic/ web link)	*Yes / No*
I have included with the letter copies of the information the patient has received	*Yes / No*
I have provided the patient with sufficient medication to last until	
I have arranged a follow up with this patient in the following timescale	

I confirm I have explained to the patient: the risks and benefits of treatment and have given them the relevant patient information leaflet. The relevant baseline tests have been conducted and the need for monitoring, how monitoring will be arranged, and the roles of the consultant / nurse specialist, GP and the patient in shared care have been explained. I confirm the patient has understood and is satisfied with this shared care arrangement at this time.

If you do **NOT** wish to participate in shared care for this patient, usually under clinical grounds, please complete the attached form.

I will write to you prior to the discharge in 3 months with regards to continued prescribing.

Yours sincerely

{Consultant name}

GP RESPONSE TO SHARED CARE (only complete & send if **NOT** participating in shared care)

Shared care is produced by GPs and specialists knowledgeable in the field of that drug usage. The shared care has been approved by the JAPC. This allows a more convenient service to the patient and cost effective use of NHS resources.

Patient:	NHS No:
Consultant:	Medicine requested for shared care:

I will **NOT** be undertaking the GP responsibilities as described in the agreed shared care guideline. My clinical reasons for declining shared care for this patient are listed in the box below:

		Tick which apply
1.	**The prescriber does not feel clinically confident in managing this individual patient's condition, and there is a sound clinical basis for refusing to accept shared care** As the patients primary care prescriber I do not feel clinically confident to manage this patient's condition because *[insert reason]*. I have consulted with other primary care prescribers in my practice who support my decision. This is not an issue which would be resolved through adequate and appropriate training of prescribers within my practice. **I have discussed my decision with the patient and request that prescribing for this individual remain with you as the specialist, due to the sound clinical basis given above.**	
2.	**The medicine or condition does not fall within the criteria defining suitability for inclusion in a shared care arrangement** As the medicine requested to be prescribed is not included on the national list of shared care drugs as identified by RMOC or is not a locally agreed shared care medicine I am unable to accept clinical responsibility for prescribing this medication at this time. **Until this medicine is identified either nationally or locally as requiring shared care the responsibility for providing this patient with their medication remains with you**	
3.	**A minimum duration of supply by the initiating clinician** As the patient has not had the minimum supply of medication to be provided by the initiating specialist I am unable to take clinical responsibility for prescribing this medication at this time. Therefore can you please contact the patient as soon as possible in order to provide them with the medication that you have recommended. ***Until the patient has had the appropriate length of supply the responsibility for providing the patient with their medication remains with you.***	
4.	**Initiation and optimisation by the initiating specialist** As the patient has not been optimised on this medication I am unable to take clinical responsibility for prescribing this medication at this time. Therefore can you please contact the patient as soon as possible in order to provide them with the medication that you have recommended. ***Until the patient is optimised on this medication the responsibility for providing the patient with their medication remains with you.***	
5.	**Shared Care Protocol not received** As legal responsibility for clinical care lies with the clinician who signs the prescription, I need to ensure that I am in possession of sufficient clinical information for me to be confident to prescribe this treatment for my patient and it is clear where each of our responsibilities lie to ensure the patient is safely managed. For this reason I am unable to take clinical responsibility for prescribing this medication at this time, therefore would you please contact the patient as soon as possible in order to provide them with the medication that you have recommended. ***Until I receive the appropriate SCP, responsibility for providing the patient with their medication remains with you.***	

6.	**Other (Primary Care Prescriber to complete if there are other reasons why shared care cannot be accepted)**	

Yours sincerely

{GP name}
{Surgery}

Please send a copy of this response to:

1. The specialist/consultant requesting shared care
2. **AN ANONYMISED COPY OF THIS FORM ONLY** to the Medicines Management and Clinical Policies and Decisions Team, 1st Floor East Point, Cardinal Square, 10 Nottingham Road, Derby, DE1 3QT or E-MAIL: ddccg.medicinesmanagement@nhs.net

(Sending a copy of this form to the Medicines Management and Clinical Policies and Decisions Team will help to identify any inappropriate requests for shared care e.g. indication not covered, hospital monitoring requirements not fulfilled. It will also help to inform the CCG prescribing group of the reasons shared care is not being undertaken allowing for changes to be made in future updates to improve patient care).