

## Surrey Heartlands Integrated Care System Area Prescribing Committee (APC)

**AMBER** shared care protocol:

**Guanfacine** To treat symptoms of ADHD in children aged 6 and over in “Cohort 2” (See Appendix 4), who have a concurrent mental health or neurodevelopmental condition requiring specialist care or where their condition is not considered to be sufficiently stable for discharge to primary care, and where the primary care provider is participating in the Locally Commissioned Service (LCS) for ADHD. This agreement is not to be used in the first year of treatment as the 3 monthly monitoring requirement is undertaken by the specialist service.

Review date – May 2027

### Specialist responsibilities

- Assess the patient and provide diagnosis; ensure that this diagnosis is within scope of this shared care protocol ([section 2](#)) and communicated to primary care.
- Use a shared decision-making approach; discuss the benefits and risks of the treatment with the patient and provide the appropriate counselling (see [section 11](#)) to enable the patient to reach an informed decision. Obtain and document patient consent. Provide an appropriate patient information leaflet.
- Assess for contraindications and cautions (see [section 4](#)) and interactions (see [section 7](#)).
- Conduct required baseline investigations and initial monitoring during the first 12 months of treatment (see [section 8](#)).
- Initiate and optimise treatment as outlined in [section 5](#).
- Transfer to primary care is normally after the patient has been treated at maintenance dose **for 12 months** and with satisfactory investigation results for at **least 4 weeks**. Prescribe sufficient medication (one month’s supply) to enable transfer to primary care, including where there are unforeseen delays to transfer of care.
- Once treatment is optimised, complete the shared care documentation and send to patient’s GP practice detailing the diagnosis, current and ongoing dose, baseline and most recent test results, confirm the monitoring schedule and when the next monitoring is required. Include contact information ([section 13](#)).
- Conduct the required monitoring in [section 8](#) and communicate the results to primary care. After each review, advise primary care whether treatment should be continued, confirm the ongoing dose, and whether the ongoing monitoring outlined in [section 9](#) remains appropriate.

- Give advice to primary care on continuing treatment if a person taking guanfacine becomes, or wishes to become, pregnant or breastfeed.
- Reassume prescribing responsibilities if the patient develops a concurrent mental health or neurodevelopmental condition requiring specialist care where their ADHD is best managed by the specialist service
- Provide advice to primary care on the management of adverse effects if required.
- Advise primary care if treatment should be discontinued. Trial discontinuations can be supported by the specialist.

### Primary care responsibilities

- Respond to the request from the specialist for shared care in writing. It is asked that this be undertaken within 14 days of the request being made, where possible.
- If accepted, prescribe ongoing treatment as detailed in the specialists request and as per [section 5](#) taking into any account potential drug interactions in [section 7](#).
- Adjust the dose of guanfacine prescribed as advised by the specialist.
- Conduct the required monitoring as outlined in [section 9](#).
- Assess for possible interactions with guanfacine when starting new medicines (see [section 7](#)).
- Manage any adverse effects as detailed in [section 10](#) and discuss with specialist team when required.
- Stop guanfacine and discuss urgently with the specialist if bone marrow suppression is suspected.
- Discuss other adverse effects with the specialist team as clinically appropriate (see [section 10](#)).
- Contact the specialist team for advice if the patient becomes or plans to become pregnant.
- Stop treatment as advised by the specialist. Trial discontinuations should be managed by the specialist.

### Patient and/or carer responsibilities

- Take guanfacine as prescribed and do not stop taking it without speaking to their primary care prescriber or specialist.
- Tell anyone who prescribes them a medicine that they are taking guanfacine
- Attend regularly for monitoring and review appointments with primary care and specialist. Be aware that medicines may be stopped if they do not attend appointments.
- Report adverse effects to their primary care prescriber. Seek immediate medical attention if they develop any symptoms as detailed in [section 11](#).

- Report the use of any over the counter medications to their prescriber and be aware they should discuss the use of azathioprine or mercaptopurine with their pharmacist before purchasing any OTC medicines.
- Inform the specialist or primary care prescriber as soon as possible if they become pregnant or wish to become pregnant.

## 1. Background

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Guanfacine is a centrally acting adrenergic medicine indicated for the treatment of attention deficit hyperactivity disorder (ADHD) in children and adolescents. Use in adults is off-label and should only be considered on the advice of a tertiary ADHD service. It may be recommended for children aged 5 years and over and young people if:

- they cannot tolerate methylphenidate or lisdexamfetamine or their symptoms have not responded to separate 6-week trials of lisdexamfetamine and methylphenidate, having considered alternative preparations and adequate doses (see NICE Guidance NG87 Attention deficit hyperactivity disorder: diagnosis and management).

NICE recommends that people with ADHD have a comprehensive, holistic shared treatment plan that addresses psychological, behavioural and occupational or educational needs.

Guanfacine should be used as part of a comprehensive treatment programme, typically including psychological, educational and social measures.

Where a person with ADHD is treated by a Child and Adolescent Mental Health Service (CAMHS) but is approaching their 18th birthday, it is expected that CAMHS will refer to the appropriate adult service if need for ongoing treatment is anticipated. NICE Guidance NG43 Transition from children to adults' services for young people using health or social care services should be followed.

Long-term usefulness of guanfacine for extended periods (over 12 months) should be periodically re-evaluated for the individual patient. Consider trial periods of stopping medication or reducing the dose when assessment of the overall balance of benefits and harms suggests this may be appropriate

## 2. Indications

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- Attention deficit hyperactivity disorder (ADHD) in children aged 6 years and over when response to previous methylphenidate or lisdexamfetamine treatment is considered clinically inadequate, or not tolerated.

### 3. Locally agreed off-label use

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The Surrey Heartlands Integrated Care System Area Prescribing Committee recommended the use of this document for the indications as outlined above.

The following information should be provided in correspondence to support prescribing in line with this shared care.

- Dosing specific to the indication
- Relevant interaction information
- Any additional monitoring requirements over and above the shared care.
- Duration of treatment
- Frequency of review.
- Specific features of adverse effects or deterioration pertinent to the specific indication for which it is used

### 4. Contraindications and cautions

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This information does not replace the Summary of Product Characteristics (SPC) and should be read in conjunction with it. Please see [BNF](#) & [SPC](#) for comprehensive information.

#### **Contraindications:**

- Hypersensitivity to guanfacine or to any of the excipients
- Hereditary problems of galactose intolerance, total lactase deficiency or glucose-galactose malabsorption.

#### **Cautions:**

- Risk factors for torsades de pointes: bradycardia, heart block, hypokalaemia, history of QT interval prolongation, concomitant use of other medicines which may prolong the QT interval.
- History of cardiovascular disease, hypotension, orthostatic hypotension, or syncope.
- Family history of cardiac or unexplained death.
- Dehydration (may increase risk of syncope).
- Alcohol consumption (not recommended during treatment).
- Concomitant treatment with centrally acting depressants or antihypertensives (see [section 7](#)).
- Suicidal ideation or behaviour.

Prescribing in the elderly is potentially inappropriate. See [BNF information on prescribing in the elderly](#).

## 5. Initiation and ongoing dose regimen

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- Transfer of prescribing to primary care is normally after at least 8 weeks, and when the patient's dose has been optimised and with satisfactory investigation results for at least 4 weeks.
- The duration of treatment & frequency of review 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 primary care clinician.
- Termination of treatment will be the responsibility of the specialist.

### **Initial stabilisation:**

1 mg once daily, adjusted in increments of not more than 1 mg every week, if necessary and tolerated.

**The initial stabilisation period must be prescribed by the initiating specialist.**

### **Maintenance dose (following initial stabilisation):**

0.05-0.12 mg/kg/day. Maximum dose 7 mg daily.

**The initial maintenance dose must be prescribed by the initiating specialist.**

Adults who have shown clear benefit from guanfacine in childhood or adolescence may continue treatment into adulthood at the same daily dose.

### **Conditions requiring dose adjustment:**

#### Hepatic or renal insufficiency:

Dose reduction may be required in patients with hepatic impairment, severe renal impairment (GFR 29-15 mL/min), end stage renal disease (GFR <15 mL/min) or in patients requiring dialysis.

#### Patients taking CYP3A inhibitors or inducers:

A 50% reduction in guanfacine dose is recommended, and further dose titration may be required.

## 6. Pharmaceutical aspects

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Route of administration:	Oral
Formulation:	Guanfacine hydrochloride (Intuniv®▼) Prolonged-release tablets: 1 mg, 2 mg, 3 mg, 4 mg
Administration details:	<p>Guanfacine can be taken with or without food but should not be given with high fat meals due to increased exposure.</p> <p>Tablets should be swallowed whole and not split, crushed or chewed.</p> <p>Guanfacine should be taken once daily in the morning or evening.</p> <p>If a dose is missed, then the next scheduled dose should be taken as usual; <u>a double dose should not be taken to make up for a missed dose</u>. If two or more consecutive doses are missed, re-titration is recommended, a lower starting dose may be required based on the patient's tolerance to guanfacine. Discuss with the specialist team or HCP with expertise in ADHD who conducts the annual review for advice on re-titrating guanfacine.</p>
Other important information:	<p>Grapefruit juice should be avoided during treatment with guanfacine.</p> <p>Due to risk of blood pressure increase upon discontinuation, guanfacine should be gradually tapered at a rate of no more than 1 mg every 3 to 7 days. Blood pressure and pulse should be monitored when discontinuing treatment.</p> <p>Discontinuation should be managed by the specialist team or HCP with expertise in ADHD who conducts the annual review.</p>

## 7. Significant medicine interactions

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The following list is not exhaustive. Please see [BNF](#) or [SPC](#) for comprehensive information and recommended management.

- Drugs which prolong the QT interval. Concomitant use with guanfacine is not recommended.
- **CYP3A4 and CYP3A5 inhibitors**, e.g. ketoconazole, clarithromycin, erythromycin, ciprofloxacin, diltiazem, fluconazole, verapamil, grapefruit juice, ritonavir: increased exposure to guanfacine. Dose reduction may be required, see [section 5](#).
- **CYP3A4 inducers**, e.g. carbamazepine, modafinil, phenytoin, rifampicin, St John's wort: reduced exposure to guanfacine. Dose increase may be required.

- **Valproic acid:** concomitant use may increase concentrations of valproic acid
- **Antihypertensive medicines:** risk of additive effects, e.g. hypotension, syncope
- **CNS depressants**, e.g. alcohol, sedatives, hypnotics, benzodiazepines, barbiturates, antipsychotics: risk of additive effects, e.g. sedation, somnolence
- **Administration with high fat meals:** increased exposure to guanfacine.

## 8. Baseline investigations, initial monitoring and ongoing monitoring to be undertaken by specialist

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Monitoring at baseline and during initiation is the responsibility of the specialist; only once the patient is optimised on the chosen medication with no anticipated further changes expected in immediate future will prescribing and monitoring be transferred to primary care.

- A full assessment, as recommended by [NICE guidance for ADHD](#). This should include a medical history and cardiovascular assessment, considering conditions that may be contraindications for guanfacine, and to ensure the patient meets the criteria for ADHD and that pharmacological treatment is required.
- Weight and height (using centiles)
- Blood pressure (BP) and heart rate.
- Electrocardiogram (ECG) and cardiology opinion are recommended if the patient has any of the following:
  - history of congenital heart disease or previous cardiac surgery
  - sudden death in a first-degree relative under 40 years suggesting a cardiac disease
  - shortness of breath on exertion compared with peers
  - fainting on exertion or in response to fright or noise, palpitations
  - chest pain suggestive of cardiac origin
  - signs of heart failure, heart murmur or hypertension
- ECG is recommended if the patient has a co-existing condition treated with a medicine that may increase cardiac risk.

### **Initial monitoring:**

- Weekly monitoring for signs and symptoms of somnolence, sedation, hypotension and bradycardia during dose titration and stabilisation.
- Weight and height (using centiles)
- Assessment of symptom improvement. Discontinue if no improvement is observed after one month.

### **Ongoing monitoring:**

Every three months if <10 years old

- Weight

Every 6 months

- Blood pressure and heart rate, and assessment for cardiovascular signs or symptoms
- Height and weight using centiles and appetite
- Assessment for new or worsening psychiatric and neurological signs or symptoms including Suicidal ideation or behaviour
- Assessment for any indication of abuse, misuse, or diversion
- In people of child-bearing potential, assess whether there is a risk of pregnancy. Consider pregnancy testing where appropriate

Maintenance:

- Annually

Review of ADHD medication, including preferences of the patient, their family or carer, benefits, adverse effects, and ongoing clinical need. Consider trial period off medication

Ensure the patient receives a review at least annually with a healthcare professional with training and expertise in managing ADHD. This may be in primary or secondary care, depending on local arrangements, and should include a review of ADHD medication, including patient preferences, benefits, adverse effects, and ongoing clinical need. Consider trial periods of stopping medication or reducing the dose when assessment of the overall balance of benefits and harms suggests this may be appropriate. If continuing medication, document the reasons why.

Review outcomes should be communicated to the primary care prescriber in writing, with any urgent changes also communicated by telephone. After each review, advise primary care whether treatment should be continued, confirm the ongoing dose, and whether the ongoing monitoring outlined in [section 9](#) remains appropriate.



## 9. Ongoing monitoring requirements to be undertaken by primary care

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See [section 10](#) for further guidance on management of adverse effects/responding to monitoring results.

Monitoring and actions	Frequency
<ul style="list-style-type: none"> <li>Blood pressure and heart rate</li> <li>Somnolence and sedation</li> <li>Weight and appetite</li> <li>Signs or symptoms of cardiovascular adverse effects, e.g. syncope, bradycardia</li> </ul> <p>Suicidal ideation or behaviour</p>	<p>Every 6 months <i>Specialist Clinician until Primary Care Prescriber has agreed to take on prescribing. At this point the GP is requested to carry out the 6-monthly review and the specialist clinician will carry out the annual review</i></p> <p>More frequent monitoring is recommended following dose adjustment, which may be done in primary care if directions have been discussed and agreed with the specialist service.</p>
<ul style="list-style-type: none"> <li>Assessment of adherence</li> </ul>	<p>As required, based on the patient's needs and individual circumstances</p>
<ul style="list-style-type: none"> <li>Review to ensure patient has been offered and attended an annual review with a healthcare professional with expertise in ADHD</li> </ul>	<p>Annually</p>

**(If relevant) If monitoring results are forwarded to the specialist team, please include clear clinical information on the reason for sending, to inform action to be taken by secondary care.**

## 10. Adverse effects and other management

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**Any serious adverse reactions should be reported to the MHRA via the Yellow Card scheme. Visit [www.mhra.gov.uk/yellowcard](http://www.mhra.gov.uk/yellowcard)**

For information on incidence of ADRs see relevant summaries of product characteristics

Result	Action for primary care
<p><b>As well as responding to absolute values in laboratory tests, a rapid change or a consistent trend in any value should prompt caution and extra vigilance</b></p>	

<b>Cardiovascular</b>	Symptoms such as palpitations, exertional chest pain, unexplained syncope, dyspnoea or other signs or symptoms suggestive of cardiac disease	Refer for urgent specialist cardiac evaluation
	Marked decrease from baseline in heart rate	Discuss with specialist team; dose reduction or cardiac evaluation may be required
	Hypotension or orthostatic hypotension	Give lifestyle advice (e.g. drinking plenty of fluids, getting up slowly from standing or sitting) and repeat monitoring. If blood pressure decreases markedly from baseline, reduce dose by 1mg and discuss with specialist team.
<b>Weight or BMI</b>	Outside healthy range	Provide appropriate support on multicomponent interventions to increase physical activity levels, improve eating behaviour and quality of diet. Discuss with specialist if difficulty persists; dose reduction, or treatment break, or change of medicine may be required.
<b>Psychiatric disorders</b>	Suicidal ideation or behaviour	Review patient and exclude other causes. Refer urgently for psychiatric assessment and notify the ADHD specialist team. Consider discontinuing guanfacine.
<b>Nervous system disorders</b>	Sedation and somnolence	Sedation and somnolence typically occur during the start of treatment and with dose increases. Review timing of dose; guanfacine may be taken in the morning or evening. Review lifestyle factors and reinforce that alcohol

		should be avoided. Seek specialist advice if sedation persists. Dose reduction or discontinuation may be indicated.
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## 11. Advice to patients and carers

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The specialist will counsel the patient about the benefits and risks of treatment and will provide the patient with any relevant information and advice, including patient information leaflets on individual medicines.

### **The patient should be advised to report any of the following signs or symptoms to their primary care prescriber without delay:**

- New or worsening psychiatric symptoms, such as suicidal ideation or behaviour
- Signs and symptoms of bradycardia or hypotension, e.g. fatigue, dizziness, palpitations, feeling faint or fainting

### **The patient should be advised:**

- To drink plenty of fluids; dehydration can increase the risk of falls or fainting.
- Not to drive, cycle, or operate machines if guanfacine affects their ability to do so safely, e.g. by causing dizziness or drowsiness, and to inform the DVLA if their ability to drive safely is affected. See <https://www.gov.uk/adhd-and-driving>.
- Avoid alcohol while taking guanfacine, as it may make side effects worse.
- Avoid grapefruit juice while taking guanfacine.
- Not to stop taking guanfacine without talking to their doctor. Due to risk of side effects, it is important to gradually reduce the dose of guanfacine under medical supervision.

### **Patient Information**

- NHS – attention deficit hyperactivity disorder. <https://www.nhs.uk/conditions/attention-deficit-hyperactivity-disorder-adhd/>
- Choice and medication
  - <https://www.choiceandmedication.org/sabp/condition/attention-deficit-hyperactivity-disorder/>
  - <https://www.choiceandmedication.org/sabp/medication/guanfacine/>

## 12. Pregnancy, paternal exposure and breast feeding

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

### **Pregnancy:**

Guanfacine is not recommended for use during pregnancy. There are no or limited data from the use of guanfacine in pregnant women, and animal studies have shown reproductive toxicity. Patients who become pregnant while taking guanfacine, or who plan a pregnancy, should be referred to the specialist team for review.

### **Breastfeeding:**

There is no published evidence on the safety of guanfacine in breastfeeding. Decisions on whether to use while breastfeeding should be made on a case-by-case basis with specialist input e.g. [UKTIS](#), taking into account the risks to the infant and benefits of therapy. The long half-life increases the risk of accumulation in breastfed infants. It may interfere with lactation, as guanfacine decreases prolactin levels in the mother. Infants should be monitored for decreased appetite/weight gain, sleep disturbances, gastrointestinal symptoms (e.g. pain, vomiting, constipation), although some of these may be difficult to detect.

Healthcare professional information on the principles of medicines use in breast feeding, and sources of information is available from: [Advising on medicines during breastfeeding – SPS - Specialist Pharmacy Service – The first stop for professional medicines advice](#)

### **Paternal exposure:**

No evidence regarding adverse outcomes following paternal exposure was identified

## 13. Specialist contact information

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Email address: [neurodevworkrequests@sabp.nhs.uk](mailto:neurodevworkrequests@sabp.nhs.uk) (Response within 72 hours)

To contact the specialist on the following telephone number if urgent advice needed: 01372 216555

Alternative contacts

Specialist Pharmacy Services Medicines Advice - on 0300 770 8564 or via email at [asksp.nhs@sps.direct](mailto:asksp.nhs@sps.direct) (Service operates Monday to Friday 9am-5pm)

SABP Pharmacy Service - [pharmacy@sabp.nhs.uk](mailto:pharmacy@sabp.nhs.uk), 01483 443717

Out of hours contact details: No SABP service providing this level of care for ADHD. Consider emergency services

Families and carers can contact the specialist service on the following telephone number 01372 216555 (Monday - Friday, 9-12.30pm) or email [neurodevworkrequests@sabp.nhs.uk](mailto:neurodevworkrequests@sabp.nhs.uk) for urgent advice and guidance related to their ADHD treatment.

A free out-of-hours phone line - 0300 222 5755 (5pm -11pm, 365 days a year) provides advice to parents and carers who are struggling with behaviours or difficulties which could be related to neurodevelopmental need, such as autism or ADHD.

In addition, advice for the young person and their family or carer can be accessed through:

<https://www.mindworks-surrey.org/our-services/access-and-advice>

If a patient requires additional support, which is not related to their ADHD treatment, then referral via a health, education or social care practitioner, would normally be required.

## 14. Additional information

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Where patient care is transferred from one specialist service or GP practice to another, a new shared care agreement must be completed. Ensure that the specialist is informed in writing of any changes to the patient's GP or their contact details.

## 15. References

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- eBNF. Guanfacine. Accessed via <https://bnf.nice.org.uk/drug/guanfacine.html> on 01/09/2021
- Guanfacine hydrochloride 1 mg prolonged-release tablets (Intuniv®). Date of revision of the text 25/06/20. Accessed via <https://www.medicines.org.uk/emc/product/5099> on 03/06/2021
- NICE NG87: Attention deficit hyperactivity disorder: diagnosis and management. Last updated September 2019. Accessed via <https://www.nice.org.uk/guidance/ng87/> on 04/06/2021
- NICE NG43: Transition from children to adults' services for young people using health or social care services. Last updated February 2016. Accessed via <https://www.nice.org.uk/guidance/ng43/> on 01/09/21
- Guanfacine risk minimisation materials. Updated November 2017. Accessed via [intuniv-checklist-for-the-on-going-monitoring-and-management-of-patients-during-guanfacine-treatment.pdf](https://www.intuniv.com/~/media/Intuniv/Checklist-for-the-on-going-monitoring-and-management-of-patients-during-guanfacine-treatment.pdf) on 03/06/21.
- Specialist Pharmacy Service. Safety in Lactation: Drugs for ADHD. Last updated October 2020. Accessed via <https://www.sps.nhs.uk/articles/safety-in-lactation-drugs-for-adhd/> on 26/05/2021 [Not currently available]

Specialist Pharmacy Service. Guanfacine Lactation Safety Information. Last updated January 2018. Accessed via <https://www.sps.nhs.uk/medicines/guanfacine/> on 03/06/2021 [Not currently available]

## 16. Other relevant national guidance

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- Shared Care for Medicines Guidance – A Standard Approach (RMOC). Available from <https://www.sps.nhs.uk/articles/rmoc-shared-care-guidance/> [Not currently available]
  - NHSE guidance – Responsibility for prescribing between primary & secondary/tertiary care. Available from <https://www.england.nhs.uk/publication/responsibility-for-prescribing-between-primary-and-secondary-tertiary-care/>
  - General Medical Council. Good practice in prescribing and managing medicines and devices. Shared care. Available from <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-practice-in-prescribing-and-managing-medicines-and-devices/shared-care>
- NICE NG197: Shared decision making. Last updated June 2021.  
<https://www.nice.org.uk/guidance/ng197/>.

## 17. Local arrangements for referral

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Define the referral procedure from hospital to primary care prescriber & route of return should the patient's condition change.

**See section 13 for details of advice relating to management of ADHD for an individual continuing with shared care**

**Where a second mental health or neurodevelopmental condition has emerged:**

1. and the primary need remains related to their ADHD, and the person may need to be transferred to cohort 3 with the cessation of shared care - access SABP care via email - [neurodevworkrequests@sabp.nhs.uk](mailto:neurodevworkrequests@sabp.nhs.uk)
2. and the primary need is NOT related to their ADHD (ie, concerns regarding emotional wellbeing or other mental health needs), please refer as usual to Access and Advice (AAT) which is available from 8am to 8pm, Monday to Friday and 9am to 12pm, Saturday. Tel.: 0300 222 5755

APC board date:  
Last updated:

# Appendix 1: Shared Care Request letter (Specialist to Primary Care Prescriber)

Dear *[insert Primary Care Prescriber's name]*

Patient name: *[insert patient's name]*

Date of birth: *[insert date of birth]*

NHS Number: *[insert NHS Number]*

Diagnosis: *[insert diagnosis]*

As per the agreed *[insert APC name]* shared care protocol for *[insert medicine name]* for the treatment of *[insert indication]*, this patient is now suitable for prescribing to move to primary care.

The patient fulfils criteria for shared care, and I am therefore requesting your agreement to participate in shared care. Where baseline investigations are set out in the shared care protocol, I have carried these out.

I can confirm that the following has happened about this treatment:

	Specialist to complete
<i>The patient has been initiated on this therapy and has been on an optimised dose for the following period of time:</i>	
<i>Baseline investigation and monitoring as set out in the shared care documents have been completed and were satisfactory</i>	Yes / No
<i>The condition being treated has a predictable course of progression and the patient can be suitably maintained by primary care</i>	Yes / No
<i>The risks and benefits of treatment have been explained to the patient</i>	Yes / No
<i>The roles of the specialist/specialist team/ Primary Care Prescriber / Patient and pharmacist have been explained and agreed</i>	Yes / No
<i>The patient has agreed to this shared care arrangement, understands the need for ongoing monitoring, and has agreed to attend all necessary appointments</i>	Yes / No
<i>I have enclosed a copy of the shared care protocol which covers this treatment/the SCP can be found here (insert electronic/ web link)</i>	Yes / No
<i>I have included with the letter copies of the information the patient has received</i>	Yes / No
<i>I have provided the patient with sufficient medication to last until</i>	
<i>I have arranged a follow up with this patient in the following timescale</i>	

Treatment was started on *[insert date started]* and the current dose is *[insert dose and frequency]*.

If you agree, please undertake monitoring and treatment from *[insert date]* NB: date must be at least 1 month from initiation of treatment.

The next blood monitoring is due on *[insert date]* and should be continued in line with the shared care guideline.

Please respond to this request for shared care, in writing, within 14 days of the request being made where possible.

# Appendix 2: Shared Care Agreement Letter (Primary Care Prescriber to Specialist)

## Primary Care Prescriber Response

Dear *[insert Doctor's name]*  
Patient *[insert Patient's name]*  
NHS Number *[insert NHS Number]*  
Identifier *[insert patient's date of birth and/or address]*

Thank you for your request for me to accept prescribing responsibility for this patient under a shared care agreement and to provide the following treatment

Medicine	Route	Dose & frequency

I can confirm that I am willing to take on this responsibility from *[insert date]* and will complete the monitoring as set out in the shared care protocol for this medicine/condition.

Primary Care Prescriber signature: \_\_\_\_\_ Date:  
\_\_\_\_\_

Primary Care Prescriber address/practice stamp



## Appendix 3: Shared Care Refusal Letter (Primary Care Prescriber to Specialist)

**Re:**

Patient *[insert Patient's name]*  
 NHS Number *[insert NHS Number]*  
 Identifier *[insert patient's date of birth and/or address]*

Thank you for your request for me to accept prescribing responsibility for this patient.

In the interest of patient safety NHS *[insert CCG name]*, in conjunction with local acute trusts have classified *[insert medicine name]* as a Shared Care drug and requires a number of conditions to be met before transfer can be made to primary care.

**I regret to inform you that in this instance I am unable to take on responsibility due to the following:**

		Tick which applies
1.	<p><b>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</b></p> <p>As the patient's primary care prescriber, I do not feel clinically confident to manage this patient's condition because <i>[insert reason]</i>. 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.</p> <p><b>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.</b></p>	
2.	<p><b>The medicine or condition does not fall within the criteria defining suitability for inclusion in a shared care arrangement</b></p> <p>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.</p> <p><b>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</b></p>	

3.	<p><b>A minimum duration of supply by the initiating clinician</b></p> <p>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 to provide them with the medication that you have recommended.</p> <p><b><i>Until the patient has had the appropriate length of supply the responsibility for providing the patient with their medication remains with you.</i></b></p>	
4.	<p><b>Initiation and optimisation by the initiating specialist</b></p> <p>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 to provide them with the medication that you have recommended.</p> <p><b><i>Until the patient is optimised on this medication the responsibility for providing the patient with their medication remains with you.</i></b></p>	
5.	<p><b>Shared Care Protocol not received</b></p> <p>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.</p> <p>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 to provide them with the medication that you have recommended.</p> <p><b><i>Until I receive the appropriate SCP, responsibility for providing the patient with their medication remains with you.</i></b></p>	
6.	<p><b>Other (Primary Care Prescriber to complete if there are other reasons why shared care cannot be accepted)</b></p>	

I would be willing to consider prescribing for this patient once the above criteria have been met for this treatment.

NHS England 'Responsibility for prescribing between Primary & Secondary/Tertiary care' guidance (2018) states that "when decisions are made to transfer clinical and prescribing responsibility for a patient between care settings, it is of the utmost importance that the GP feels clinically competent to prescribe the necessary medicines. It is therefore essential that a transfer involving medicines with which GPs would not normally be familiar should not take place without full local agreement, and

the dissemination of sufficient, up-to-date information to individual GPs.” In this case we would also see the term GP being interchangeable with the term Primary Care Prescriber.

Please do not hesitate to contact me if you wish to discuss any aspect of my letter in more detail and I hope to receive more information regarding this shared care agreement as soon as possible

Yours sincerely

**Primary Care Prescriber signature:** \_\_\_\_\_  
**Date:** \_\_\_\_\_

**Primary Care Prescriber address/practice stamp**

### Appendix 4

NHS Surrey Heartlands has worked with its Mental Health provider (Surrey and Borders Partnership NHS Foundation Trust [SABP]) to define cohorts of children who have been diagnosed with ADHD to support effective management across the primary care / specialist service interface.

These cohorts have been defined as follows:

	<b>Cohort 1</b>	<p>Children and young people who are <b>stable</b>:</p> <ul style="list-style-type: none"> <li>• Fully stabilised dose (i.e., titrated dose of medication which has not been changed in the recent six-month period)</li> <li>• uncomplicated by co-morbidities (i.e., currently not receiving specialist treatment for other mental health or neurodevelopmental conditions)</li> <li>• suitable for ongoing treatment and six-monthly reviews in primary care</li> </ul>
	<b>Cohort 2</b>	<p>Children and young people who have ADHD and are currently receiving specialist treatment for other mental health or neurological comorbidities. However, are easily stabilised with small changes but are perhaps seen more frequently by specialist services. These CYPs may be suitable for shared care.</p>
	<b>Cohort 3</b>	<p>Children who have <b>co-morbidities and/or have complex needs due to risk</b> (mental health / safeguarding / physical health), may be on other forms of medication and doses of medications are frequently changed hence need regular review by the specialist service. These CYPs are not suitable for shared care and prescribing responsibility should stay within the specialist service.</p>