NHS
Nottingham and Nottinghamshire
Integrated Care Board

Guidance on the management of Shared Care prescribing requests

Following a self-funded assessment and diagnosis of ADHD

by a private clinician

This guidance was written for patients seeking private diagnosis for ADHD, recognising the significant waiting lists for NHS review for this cohort of patients. For patients seeking private/NHS shared care for other indications the following principal remains-

It is a fundamental principle of the NHS that 'there should be as clear a separation as possible between private and NHS care.' Guidance on NHS patients who wish to pay for additional private care.

Some private providers offer NHS services which can be accessed by patients following a GP referral under patient choice. In such cases the provider could be considered to be equitable to any other NHS provider, even if this NHS care is delivered by a private organisation.

This guidance is intended to support the process for agreeing on-going medication supply and monitoring for patients who have self-referred for PRIVATE care for ADHD and is intended to help practices to make a decision with the clinical elements all in one place, it is not intended to tell GPs they must accept shared care even if all boxes are ticked and practices may choose to have their own policy on this.

Patients electing to see a private specialist, should do so on the expectation that all recommended tests, procedures and prescribed medicines will be provided privately (not on the NHS). A recommendation from a private specialist for a medicine that is available on the NHS does not entitle the patient to NHS prescriptions for that medicine. Recommendations from specialists for ongoing prescribing on the NHS need to be made at an NHS consultation with an NHS specialist. A GP is therefore under no obligation to provide an NHS prescription to a patient based on the recommendation of a private specialist. However, patient safety is paramount when making any decisions and if a GP considers that ongoing prescribing of a medicine is appropriate on the NHS, it is recommended the GP does so based on the guidance provided in this document.

Furthermore, due to a significant increase in demand nationally, the available NHS services for assessment of patients with suspected ADHD have significantly long waiting lists. The result of which is the proportion of this patient cohort seeking private assessment is significantly greater than patients seeking assessment for other conditions.

Guidance from the British Medical Association Medical Ethics Committee (BMA, 2009) suggests that where the medicine is specialised in nature and not something GPs would generally prescribe, it is up to the individual GP to decide whether to accept clinical

responsibility for the prescribing decision recommended by another clinician. Locally ADHD prescribing and monitoring is expected to be under a shared care agreement between a specialist and GP.

Where a private clinic requests the patients' GP prescribe on-going medication under a shared care agreement the following should be satisfied before the GP considers accepting the request:

The private specialist making the recommendation must be an appropriately trained UK registered healthcare professional.

Diagnosis

As per NICE NG87:

A diagnosis of ADHD **should only** be made by a specialist psychiatrist, paediatrician or other appropriately qualified healthcare professional with training and expertise in the diagnosis of ADHD, on the basis of:

- a full clinical and psychosocial assessment of the person; this should include discussion about behaviour and symptoms in the different domains and settings of the person's everyday life **and**
- a full developmental and psychiatric history **and**
- observer reports and assessment of the person's mental state.

A diagnosis of ADHD **should not** be made solely on the basis of rating scale or observational data. However, rating scales such as the Conners' rating scales and the Strengths and Difficulties Questionnaire are valuable adjuncts, and observations are useful when there is doubt about symptoms.

For a diagnosis of ADHD, symptoms of hyperactivity/impulsivity and/or inattention should:

- meet the diagnostic criteria in DSM-5 or ICD-11 (hyperkinetic disorder; but exclusion based on a pervasive developmental disorder, or an uncertain time of onset is not recommended) **and**
- cause at least moderate psychological, social and/or educational or occupational impairment based on interview and/or direct observation in multiple settings **and**
- be pervasive, occurring in 2 or more important settings including social, familial, educational and/or occupational settings.

As part of the diagnostic process, include an assessment of the person's needs, coexisting conditions, social, familial, and educational or occupational circumstances and physical health.

ADHD should be considered in all age groups, with symptom criteria adjusted for age-appropriate changes in behaviour.

Recommended medications.

Recommended treatment should follow NICE NG87. Where treatment recommendations are not in-line with NICE or the local joint formulary and shared care protocol, the specialist should provide clear clinical rationale to the GP. If the GP is not satisfied with this rationale, they should refuse to continue the prescribing:

Offer methylphenidate (either short or long acting) as the **first-line** pharmacological treatment for children aged 5 years and over and young people with ADHD. Offer methylphenidate or lisdexamfetamine as **first-line** pharmacological treatment for adults with ADHD.*

*This is an off-label use of lisdexamfetamine for adults with no ADHD symptoms in childhood.

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 switching to lisdexamfetamine for children aged 5 years and over, young people and 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 **dexamfetamine** for children aged 5 years and over, young people and adults whose ADHD symptoms are responding to lisdexamfetamine but who cannot tolerate the longer effect profile.

Dexamfetamine is only licensed to treat ADHD in children and young people aged 6 to 17 years when response to methylphenidate is clinically inadequate. It is not licensed for children and young people aged 5 to 17 years who have responded to but are intolerant of lisdexamfetamine

Offer **atomoxetine** to children aged 5 years and over, young people and 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.

This is an off-label use of atomoxetine for adults with no ADHD symptoms in childhood.

Shared care should be in line with the Nottingham Area Prescribing Committee shared care protocols. These may be provided by the GP to the private specialist and shared care may only be considered if both parties agree to follow these protocols.

On-going review by the private provider

As per NICE NG87:

A healthcare professional with training and expertise in managing ADHD should review ADHD medication at least once a year and discuss with the person with ADHD (and their families and carers as appropriate) whether medication should be continued. The review should include a comprehensive assessment of the:

• Patient with ADHD (and their family or carers as appropriate)

• benefits, including how well the current treatment is working throughout the day

• adverse effects of prescribed medication

• clinical need and whether medication has been optimised

• impact on education and employment

• effects of missed doses, planned dose reductions and periods of no treatment

• effect of medication on existing or new mental health, physical health or neurodevelopmental conditions

• need for support and type of support (for example, psychological, educational,

social) if medication has been optimised but ADHD symptoms continue to cause a significant impairment.

Where the robustness of follow up cannot be guaranteed or there is risk that follow up will not continue, the patient should be referred to an NHS provider. The NHS referral will be managed in the same way as other patients being referred for NHS services, ie there should

be no expectation that the patient will be managed any more urgently by an NHS provider than any other patient without a previous diagnosis. In the interim, prescribing should be maintained on a private basis from the private clinic.

Where the GP **is not satisfied** with the above principals, on-going prescribing of ADHD medication may be refused, and the patient referred back to obtain supplies from their private specialist. It may be mutually agreeable for the GP to make a referral under the NHS to an NHS provider, however the patient would be required to join the waiting list in the same way as any other referred patient.