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# Prescribing Hints & Tips

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## ADHD MEDICINES – PHASED RETURN TO ROUTINE PRESCRIBING

Following improvement in the national supply position, ADHD medicines are no longer considered to be in sustained national shortage, and prescribing is now moving through a phased return to bring it routine care in line with local ADHD shared care protocols and national guidance.
Generic prescribing of **12-hour prolonged-release methylphenidate tablets** was introduced across Nottingham & Nottinghamshire ICB as a temporary mitigation during national shortages and should now be gradually de-escalated.

- **New patients**, specialists will specify the intended brand when shared care is initiated.
- **Patients already under shared care**, blanket or bulk switching is not required; switching to a Nottingham & Nottinghamshire Preferred Prescribing List brand should will normally take place at routine specialist reviews. However, Primary Care prescribers do not need to wait for specialist reviews to move to brand prescribing where if they are clinically comfortable and the change is agreed with the patient, and Community pharmacies should supply the brand specified to avoid unintended switching.

Detailed information, including formulation- and product-specific requirements, and medicines that must always be prescribed by brand, is set out in the ADHD Medications Shortages – Post-Supply Recovery Guidance.

## FENTANYL OVERDOSE

Please see below details of serious harm caused due to opioid use, as highlighted in a recent Prevention of Future Deaths report (Regulation 28):

> Ms B was found deceased at home, where she was found to have two fentanyl patches on her body rather than the single patch prescribed by her GP. She had been prescribed fentanyl patches & codeine for chronic pain since 2011, following an accident and amputation of her arm. Post-mortem examination found that she had a toxic level of fentanyl in her system and codeine would have added to that toxicity.
>
> At the time of initial prescription in 2011, GP awareness of the complications of fentanyl was more limited, but in 2014/15 GPs at the practice had attempted to address her level of opioid use, although she was not in agreement. However, she had at least annual medication reviews, where no clear plans to address her opioid use was found after 2015, meaning there were missed opportunities over a 9 to 10-year period.
>
> There was also a missed opportunity for the hospital pain clinic to raise the fentanyl prescription with the practice in 2021. The court heard that oftentimes, opioid reduction/stoppage can be difficult, and Ms B had expressed objections. There is no positive evidence that she had used two patches to deliberately harm herself; it was also noted that she had fallen and injured her ankle just days before her death and she was probably experiencing increased pain because of that.

Ref: March 26 - MSATS - Medication Safety Officer - Futures (login needed) Accessed 29th May 2026

This unfortunate incident serves as an important reminder for all prescribers and clinical teams on the potential harm of high dose opioids and opioids in combination.

Points to raise within your practice and with your clinical teams:

- Do you have a policy in place for reviewing patients on long term high dose opioids? Patients should be reviewed regularly and at least 6 monthly.
- Do you routinely inform patients about the risks associated with high dose opioid use and document this clearly?

## APC AND INTERFACE UPDATE

The latest updates from APC can be found on their website here.

## MAILING LIST

If you wish to be added or removed from the Prescribing Hints and Tips mailing list, please email e.moncrieff@nhs.net