Oxfordshire
Clinical Commissioning Group

Oxford City Locality Commissioning Meeting

Date of Meeting: 14.6.18					**Paper No:** **9a**	
Title of Paper: **ADHD services- is there a better pathway?**						
Is this paper for	**Discussion**		**Decision**		**Information**	✓

Purpose of Paper:

To feed back to practices the discussions on ADHD which transpired from the City main Locality meeting in May.

Paper 9a covers the pathway
Paper 9b covers the ADHD adult self rating screening tool should practices require this
Paper 9c is a record of the table discussions which took place.

Action Required:

Not the paper, and that a meeting is taking place later in June to further these discussions with the provider.

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ADHD services- is there a better pathway?

This discussion paper tries to make relevant points about previous AMHT services for ADHD and the "bare bones of how it might be re-arranged" BUT it is difficult to come up with an alternative pathway when we have no idea what the potential parameters/ restrictions are.....

Problems with adult ADHD in the population

Underdiagnosed especially in women. ?prevalence approx 1% by ICD10, 5% by DSM-IV.
ADHD is not regarded as being important, but diagnosis and treatment can make a massive difference to people's lives. ?economic case for adult diagnoses especially longer term. Maybe could reduce referrals for anxiety and depression, substance misuse, misdiagnosed BPD etc.
Students are left unable to access Government funding (DSA) for disability -related study support until they have achieved a diagnosis. Similarly may help people hold down jobs (reasonable adjustments – Equality Act).
Perception that arbitrary cut off on continuum/controversial diagnostic threshold (but this is true for many diagnoses). MH stigma, worries about overmedicating, worries about pathologising normality… but actually plenty of evidence that ADHD is major disease burden…

Problems with ADHD for (some) GPs

Pressure to prescribe stimulants without psych assessment (timing, provisional diagnosis from abroad, diagnosis years ago but managed without Rx before – especially students); existing 'shared care' monitoring not properly funded; variable awareness/compliance with share care protocols (GPs and Psych!); perceived disinterested approach from AMHT; GP workload cannot take another 'straw' on camel's back; frustration with commissioners- "Shouldn't the CCG be holding the OH to their contractual obligations rather than getting us to do the work?"

Planning a new service - principles

Most people supportive of an alternative pathway if expedite process for patients AND proper funding for extra work for GPs (involve LMC) -payment is important.
Best practice for patients vs what is affordable/can be delivered.
Need for pragmatism: need to reduce perception of risk/risk aversion (actually the drugs are not that dangerous if used properly), need to be flexible about formulary restrictions (actually already allows methylphenidate, lisdexamfetamine, dexamphetamine, and atomoxetine after specialist titration [amber], not guanfacine or modafinil- seems fair enough!); need to be supported in 'relaxing' guidelines (NICE or European guidelines)-will the CCG be happy to sign off a protocol that doesn't meet NICE guidelines
Clear about the remit for the service and the responsibilities of primary care and AMHT; clear guidelines and a named person in the AMHT to contact if we have a complex case or things are not working.
Need to involve all interested parties/build consensus: involve OH, Oxfed, GP champions, college nurses, OU counselling service, OU Disability Advisory Service, Brookes Uni, ?other educational bodies, Polly Branney… and of course PATIENTS.
Could we use this example to improve the relationship between University support services and NHS Mental Health services- more widely. But NB University counselling & disability services unable

to offer anything for adult ADHD assessment (currently) and also under severe increasing pressure- they cannot subsidise NHS more than they do already.
Managing those from abroad where the diagnosis may or may not be accepted- including whether we can allow the option of prescribing expensive drugs privately (by NHS GP but via OxFEd?- but NB private CDs need special form=FP10CDF).
Equity of service across the county (presumably some practices will not want to take on assessment or monitoring, especially if you are paying below market rate)

Planning a new service- practicalities

Referral process
should we use ASRS or similar to allow GPs to refer for assessment?

Diagnosis
DIVA2.0 usually takes Dr @1.5 hours to do a DIVA & another >15mins to sort out medication? Could this be reduced by a nurse specialist e.g. 2h nurse with Dr for 0.5h?
How much could be done in primary care by own GP/ GPSI in locality +/- nurse specialist?
How much is it feasible/desirable to simplify (dumb down?) assessment and management?
Use of ObTest*?
How do we get specialist support (e.g. email advice or other support for difficult cases, medication queries, service for those with dual/multiple diagnosis etc) and liaison with OH/2y care?
What about overlap with ASD assessment or other disorders (cluster B PD, anxiety etc.)- some common comorbidities./differentials fall outside AMHT interests. Who would do joint neurodevelopmental assessments instead of separate ADHD/ASD?

Treatment:
Titration -weekly consults (telephone contact?) to titrate, with monitoring P,BP, (Wt) after each dose change- maybe suitable for GPSI/nurse in locality?
Access to psychological Rx?
Consideration of environmental modifications, reasonable adjustments at work/study?

Maintenance
Monitoring every 6m at least
Annual 'specialist' review

Audit/review of service
?who ?how ?when

LBL 9/5/18 (slight revision 4/6/18)

*QbTest is a computer-based program that combines a test of attention ability with a movement analysis based on an infrared measurement system- costs+