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| **Agenda item: 9**<br>**Paper no: PCCC iC 31-18** |

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| **Title of Report:** | Attention Deficit Hyperactivity Disorder (ADHD) in children 6-17 years old - 12 monthly review monitoring for CNS stimulants, atomoxetine, guanfacine and melatonin (Circadin®): update | |
| **Status:** | **To approve** | |
| **Committee:** | Primary Care Commissioning Committees in Common | **Date**: 9/11/18 |
| **Venue:** | NWS CCG 58 Church St, Weybridge, Surrey, KT13 8DP | |

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| **Presented by:** | Linda Honey | |
| **Executive Lead sign off:** | Karen Thorburn MD, NWS CCG<br>Vicky Stobbart MD GW CCG<br>Colin Thompson MD SD CCG | Date: 2/11/18 |
| **Author(s):** | Linda Honey; Associate Director Medicines Optimisation NWS CCG | |

**Governance:**

| | | |
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| **Conflict of Interest:**<br>The Author considers: | **CONFLICT(S) NOTED**<br>Name(s) of individuals with conflict: Locality GPs<br>Mitigating Action(s):<br>• Interest noted, non-voting so can participate in discussion but has no role in decision making | ✓ |
| **Previous Reporting:**<br>(relevant committees/ forums this paper has previously been presented to) | The LCS has been approved previously by PCOG / PCCC for NWS CCG. It has been updated with the addition of a new drug, guanfacine, following approval of the shared care by the Surrey wide Prescribing Clinical Network and the NWS Clinical Executive.<br>The LCS is also being extended to be delivered in G&W CCG and SD CCG and has been discussed at each PCOG<br>This has also been discussed at GW Clinical Commissioning Committee | |
| **Freedom of Information:**<br>The Author considers: | Open – no exemption applies | ✓ |

**Executive Summary:**

Attention Deficit Hyperactivity Disorder (ADHD) in children 6-17 years old - 12 monthly review monitoring for CNS stimulants, atomoxetine, guanfacine and melatonin (Circadin®): has been updated as follows:

- To include guanfacine alongside the CNS stimulants / atomoxetine and melatonin (CIrcadin)
- To include up to date contact details / emails for SABPT for all 3 CCGs
- The shared care documents have been updated and are going to the Surrey wide PCN for final approval 7th Nov 2018

There are currently capacity issues with the CAMHs service at SABPT and this LCS helps generate capacity by enabling patients to be reviewed annually in primary care.
There are currently 2800 children under the care of SABPT across Surrey who are on these medications and would be appropriate for this LCS.

| Age: | 0-17 year olds | 0-17 %age of total |
|---|---|---|
| NHS East Surrey CCG | 40432 | 15.48% |
| NHS Guildford and Waverley CCG | 45278 | 17.33% |
| NHS North East Hampshire and Farnham CCG | 10374 | 3.97% |
| NHS North West Surrey CCG | 79958 | 30.61% |
| NHS Surrey Downs CCG | 65403 | 25.04% |
| NHS Surrey Heath CCG | 19762 | 7.57% |
| **Grand Total** | **261207** | |

Using the above table, it is estimated that for G&W CCG this equates to 485 patients (17.33% of 2800) and for SD CCG this equates to 701 patients.

Attention Deficit Hyperactivity Disorder (ADHD) in children 6-17 years old - 12 monthly review monitoring includes the following drugs

- The CNS stimulants, atomoxetine, guanfacine and melatonin (Circadin)
- The ADHD LCS enables patients to be seen by the specialist service annually for a full review (which is in line with NICE quality standards). The LCS allows for patients to be seen annually by their General Practice for a physical medication review (the annual reviews by the specialist / GPs alternate so that the patient is seen 6 monthly) which is line with SPCs for these medications.
- The primary care review includes height / weight / pulse / BP
- The LCS has contact details for the specialist service to allow for good communication between the GP and the specialist service

Feedback has been received in relation to the LCS when discussed at previous meetings and these points are being worked through:

- *Review to be called an ADHD review instead of physical medication review* – the LCS has been updated accordingly
- *Specification to state the age range 6-18 years old* – the LCS has been updated to state the licence range 6-17years
- *Process for referral back to SABP to include timescales (as raised at Guildford and Waverley PCOG) when CAMHS will respond to referral and intervene in particular for the following issues*
    - *A. Query at GP ADHD Review,*
    - *B. DNA "child not brought" as potential safeguarding*
    - *C. If there is any issues/changes with the child falling outside the timescales of the GP and SABP ADHD review - confirmation that the family should contact CAMHS and not the GP and through what process, when they have a query, crisis.*

- *Noted in PCOG that interest in GP buddying system for this LCS, but at present to be considered post one year into this LCS when IT systems are in place to facilitate* – the LCS has been updated accordingly
- *Training by CAMHS for GPs to complete the ADHD review; this will ideally need to take place in Jan* – this will be arranged locally
- *"Delay in sexual development" – to clarify this is part of the specialist role and not to be undertaken by primary care* – this has been clarified and is going for sign off at the PCN 7th Nov
- *Specification to be shared with Surrey Downs GP Locality meetings and brought back to Surrey Downs PCOG.*

**Implications:**

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|---|---|
| What is the **health impact/ outcome** and is this in line with the **CCG's strategic objectives**? | • Achieving a sustainable system<br>• Development of collaborative working<br>• Primary Care development<br>• Safe, effective care providing the best possible health and care outcomes and patient experience<br>• Commissioning a safe and sustainable Children's service |
| What is the **financial/ resource** required? | Limited impact anticipated for NWS – LCS already in place for other drugs<br>If all 485 children estimated were included in the LCS the cost for delivery of the LCS in G&W is approx. £25k/annum<br>If all 701 children estimated were included in the LCS the cost for delivery of the LCS in G&W is approx. £35k/annum |
| What **legislation, policy or other guidance** is relevant? | NICE guidance in relation to the medication included in the LCS |
| Is an **Equality Analysis** required? | Not completed not a new LCS |
| Any **Patient and Public Engagement**/ consultation required? | No additional engagement required as LCS already operational |
| Potential **risk(s)**? (including reputational) | |

**Recommendation(s):**

- Approve the updated LCS for NWS CCG
- Approve the LCS for roll-out to SD and G&W CCGs following updates as requested by PCOG

**Next Steps:**

- Communication to practices via locality meeting
- To be sent to all practices for sign up due to amendment in LCS
- Updated shared care documents to go on the Prescribing Advisory Database

North West Surrey CCG

**Locally Commissioned Service LCS007 - ADHD (SABPT version)**

**Service Specification**

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|---|---|
| **Service Ref:** | LCS007 – ADHD (SABPT Version) |
| **Service:** | Attention Deficit Hyperactivity Disorder (ADHD) in children 6-17 years old - 12 monthly review monitoring for CNS stimulants, atomoxetine, guanfacine and melatonin (Circadin®) |
| **Commissioning Lead:** | North West Surrey Clinical Commissioning Group |
| **Provider Lead:** | GP practice as stated on page 3 of the NHS Standard contract 2017/18 – NWSLCS2017/18. |
| **Start date:** | 1st December 2018 - TBC |
| **Frequency of service review:** | Annual / Bi-annual review of service |
| **Date of last review undertaken:** | Nov 2018 |
| **End date:** | 31st March 2021 |

## 1. Population Needs

**National/local context and evidence base**

ADHD is defined by the core signs of inattention, hyperactivity and impulsiveness. Estimates of the prevalence of ADHD vary widely within and between countries. It is estimated that around 5% of school-aged children and adolescents would meet the DSM-IV diagnostic criteria for ADHD, equivalent to 366,000 children and adolescents in England and Wales, but not all of these children and adolescents would require treatment. Current treatments for ADHD include a range of social, psychological and behavioural interventions. These are mainly aimed at the child, but sometimes involve parents and/or guardians and teachers. Dietary interventions are often used when particular foods aggravate hyperactivity. The central nervous system (CNS) stimulants methylphenidate, dexamfetamine, lisdexamfetamine and atomoxetine / guanfacine (non-stimulant) are used in the treatment of ADHD. Treatment should be initiated as part of a comprehensive treatment programme for ADHD under specialist supervision by an appropriately qualified healthcare professional with expertise in ADHD where remedial measures alone prove insufficient. Ongoing prescribing and monitoring of drug therapy should be performed under shared care arrangements – shared care documents can be found on the Prescribing Advisory Database (PAD) http://pad.res360.net/PAD/Search

Sleep disorders in children and young people with ADHD can be managed using melatonin the licensed product Circadin® should be used off-label providing other causes of insomnia (eg bedtime resistance, sleep disordered breathing, side effects of medication – if on methylphenidate the dose can be reduced or switched to atomoxetine) and sleep hygiene measures (including use of a sleep diary) have failed. Treatment should be initiated as part of a comprehensive treatment programme for ADHD under specialist supervision by an appropriately qualified healthcare professional with expertise in ADHD. Ongoing prescribing and monitoring of drug therapy should be performed under shared care arrangements – shared care documents can be found on the Prescribing Advisory Database (PAD) http://pad.res360.net/PAD/Search

Melatonin is a naturally occurring hormone produced by the pineal gland in the brain. It is involved in coordinating the body's sleep-wake cycle and helping to regulate sleep. The Prescribing Clinical Network supported the use of Circadin® for the treatment of Delayed Sleep Phase Syndrome in children with neuro-developmental disorders in February 2014. The PCN noted the NICE ESUOM2

review of melatonin for this indication which concluded that melatonin appears to be well tolerated in the available randomized controlled trials in the short and medium term with only mild and transient adverse effects e.g. headache or dizziness (this included data from children treated for a range of 1-57months).

## 2. Outcomes

NHS Outcomes Framework Domains & Indictors

| | | |
|---|---|---|
| Domain 1 | Preventing people from dying prematurely | |
| Domain 2 | Enhancing quality of life for people with long-term conditions | |
| Domain 3 | Helping people to recover from episodes or following injury | X |
| Domain 4 | Ensuring people have a positive experience of care | |
| Domain 5 | Treating and caring for people in a d=safe environment and protecting them from avoidable harm | X |

### Locally defined outcomes

All children who receive a CNS stimulant / atomoxetine / guanfacine in line with NICE guidance for ADHD are recommended to receive a 6 monthly physical medication review to ensure treatment is continued only when safe and appropriate to do so (**note** children receiving guanfacine are not appropriate for entering into the LCS for the first year of treatment as during this time period three monthly reviews are required to be undertaken by the specialist). The agreed shared care documents stipulate the responsibility for on-going management of patients (note: the 6 monthly review will alternate between the specialist service who initiated treatment and the GP)

All children who receive melatonin for sleep disorders should be reviewed 6 month to ensure treatment is continued only when safe and appropriate to do so. The agreed share care document stipulates the responsibility for on-going management of patients (note: the 6 monthly review will alternate between the specialist service who initiated treatment and the GP)

If a patient does not regularly attend their six monthly review (either in primary or secondary care) the GP should immediately refer the patient back to the specialist service who will be responsible for managing their on-going care including prescribing if appropriate. Shared care is not appropriate for patients who do not regularly attend their six monthly reviews.

## 3. Scope

### 3.1 General Practices in North West Surrey Clinical Commissioning Group

### 3.2 Population covered

Children initiated on CNS stimulants/atomoxetine +/- melatonin for ADHD by the specialists at SABP NHS Trust and are being managed by their GP under a shared care agreement

### 3.3 Service description/care pathway

The agreed shared care documents are embedded below and are available on the PAD
http://pad.res360.net/PAD/Search


DRAFT Atomoxetine Amber Shared care gı


DRAFT Dexamphetamine Aml


Draft Guanfacine Amber shared care gı


DRAFT Lisdexamfetamine Am


Melatonin shared care NWS for ADHD L


DRAFT Methylphenidicate An

### 3.4 Interdependence with other services/providers

As per shared care patient monitored in conjunction with specialist at SABP NHS Trust

### 3.5 Aims & Objectives of service

Children should be initiated on CNS stimulants / atomoxetine / guanfacine for ADHD by a specialist in line with NICE NG87. Ongoing prescribing and monitoring of drug therapy should be performed under shared care arrangements in line with the documents embedded in this LCS / on the PAD http://pad.res360.net/PAD/Search

Children should be initiated on melatonin for sleep disorders in line with the flow chart on the PAD http://pad.res360.net/Content/Documents/Melatonin%20Sleep%20Disorders%20-%20flow%20chart%20PCN%20-%20May%202014.pdf Ongoing prescribing and monitoring of drug therapy should be performed under shared care arrangements in line with the document embedded in this LCS / on the PAD http://pad.res360.net/PAD/Search

When a GP practice agrees to take over shared care of a child initiated on a CNS stimulant / atomoxetine / guanfacine for ADHD +/- melatonin for sleep disorders by the specialists at SABPT the GP practice are required to undertake a 12 monthly physical medication review monitoring for that patient in-line with the shared care documents and this locally commissioned service. Details of the requirements in relation to this are documented below:

To carry out a physical medication review monitoring the following on a 12 monthly basis (the patient will be reviewed 6 monthly in line with the product license with reviews alternating between GP 12 month review and specialist 12 month review):

- Height, weight, appetite, sleep pattern
- Blood pressure and pulse

Assess the continued need for melatonin (if taking) and consider stopping melatonin if sleep disorder resolved (e.g. 14 day break).

Results of the above tests should be communicated to the specialist service for reviewing and collating in the patient's records: to support this process an email/fax back template is available as an appendix to the shared care documents and embedded below.


Monitoring form NWS.docx

After reviewing the monitoring results the specialist will advise the GP of any required actions. The specialist will complete the bottom part of the template and return the completed template to the practice after each GP physical medication review.

The practice should communicate to the specialist after every physical medication review. This will also enable the specialist to know if the patient is not attending the required GP follow ups which may highlight a safeguarding concern for example.

To inform the consultant via email / fax number below if the patient does not attend their 6 monthly physical medication review for advice in particular in relation to appropriate continued prescription.

- Fax: 01932 722563
- email: RXX.SABPCAMHSNW@nhs.net

If a patient does not regularly attend their six monthly review (either in primary or secondary care) the GP should immediately refer the patient back to SABPT who will be responsible for managing their on-going care including prescribing if appropriate. Shared care is not appropriate for patients who do not regularly attend their six monthly reviews.

To contact the specialist on the following telephone number if urgent advice needed: 0300 2225755

Providers must have the following in place:

I. **A register**. Providers should be able to produce and maintain an up-to-date register of all children receiving a CNS stimulant / atomoxetine / guanfacine +/- melatonin for ADHD. Practices should note those patients whose treatment is complete and discontinue them from future clinical audits.

i. **Call and recall**. There must be evidence of a robust, systematic and responsive recall system to ensure that children receive their GP physical medication review at 12 monthly intervals. In addition the Provider must have mechanisms in place to deal with non- attendees of monitoring appointments linking with secondary care for advice.

ii. **Professional links**. To work together with specialists at SABP Mindsight Surrey CAMHS team to ensure patients are appropriately managed in line with the agreed shared care documents and as outlined in this specification. Any health professionals involved in the care of patients in the programme should be appropriately trained.

iii. **Referral policies**. Where appropriate to refer patients promptly to the specialists at SABP Mindsight Surrey CAMHS team or liaise with them for advice

iv. **Record keeping**. To maintain adequate records of the service provided, incorporating all known information relating to any significant events e.g. hospital admissions, death of which the provider has been notified;

v. **Training**. Each provider must ensure that all staff involved in providing any aspect of care under this scheme have the necessary training and skills to do so (this is in relation to the staff conducting the physical medication review e.g. taking BP / pulse)

## 4. Applicable service standards

### Applicable national standards

- Attention deficit hyperactivity disorder: diagnosis and management March 2018 NG87
- Methylphenidate, atomoxetine and dexamfetamine for attention deficit hyperactivity disorder in children and adolescents (2006) NICE technology appraisal guidance 98
- Sleep disorders in children and young people with attention deficit hyperactivity disorder:melatonin NICE ESUOM2 Jan 2013

### Applicable Quality Requirements

Patients must be monitored in line with the agreed shared care documents for the individual drugs and as outlined in this specification.

## 5. Applicable quality requirements & CQUIN Goals

Not applicable for this LCS.

## 6. Location of service providers premises & Home visiting services

### 6.1 Providers premises

GP practice as stated on page 3 of the NHS Standard contract 2017/18 – NWSLCS2017/18.

### 6.2 – Home visiting services

This locally commissioned service should be provided to all eligible patients as defines within the service specification. This includes any registered patients who are considered to be housebound and requiring treatment.

The provider will receive the agreed LCS payment under the scheme and in addition, can claim the sum for attending a patient's home to provide treatment. Please refer to schedule 3 of the NHS Standard contract ref: NWSLCS2017/18 for the detail of all applicable payments.

The "housebound payment" is in recognition of the additional resources required to deliver to this cohort of patients. Claims should be made via the quarterly claim form corresponding to the date range within which the original activity is delivered under the scheme.

## 7. Payments & Claims

### 7.1 Payment schedule

Please refer to schedule 3 of the NHS Standard contract ref: NWSLCS2017/18 for full pricing arrangements under the terms of the contract and individual LCS specification.

Providers will receive a fee for completing a 12 monthly physical medication review monitoring as outlined in this specification and the shared care documents on the PAD for the CNS stimulants / atomoxetine, guanfacine and melatonin (Circadin®) for treating ADHD in children.

### 7.2 Claiming method & timescale

All claims are to be made by the provider at the close of the quarter within which services have been delivered. Claims should be made via the individual quarterly claims form as provided by the lead commissioner.

Only claims submitted with the required evidence and within the applicable payment time from will be processed.
Claims received after the end of the financial year within which services were delivered will be processed for payment at the discretion of the lead commissioner.

### 7.3 EMIS Search & Report

As part of North West Surrey's ongoing commitment to data quality & reducing the workload for practices, when reporting activity surrounding Locally Commissioned Services, the CCG will be extracting LCS activity data using EMIS Enterprise Search and Reports. Enterprise Search and Reports allows the CCG to run reports for the practices, removing the need to submit claim forms.

As effective and accurate reporting relies on consistent read coding, it is essential that when recording activity relating to this LCS you following the guidelines.
To support this, the CCG have provided EMIS clinical resource, however if you would prefer to enter this information manually please refer to the Read Code guidance document to ensure consistent recording takes place.

## 8. Buddy arrangements & Sub contracting

### 8.1 Buddy arrangements

***Please state if this service is not eligible for Buddy or sub-contracting arrangements.***

This service **NOT** currently available for the provision of services to patients other than the providing practice own registered population. There are intentions to review this position when IT systems are in place to facilitate this.

All requirements as outlined in the service specification must be maintained and delivered in a consistent way when providing services to patients other than the providing practices own registered population.

Claims should be made via the quarterly claim form. An additional fee will be payable to the provider for the additional administration and governance arrangements required to provide the buddy arrangements.

Full details of the treatment provided to patients under the terms of agreement must be documented and the patients registered GP must be notified of any treatment and outcomes of any tests provided. The provider remains responsible for all histology, call & recall and follow up requirements.

Full details of any complaints and/or Serious Incidents must be reported to the lead commissioner for this service.

PLEASE NOTE – Acceptance of the requirement to deliver services under the "buddy arrangements" must be indicated on the signature sheet for each separate service delivered under the contract.

### 8.2 Sub-Contracting

The Provider may wish to sub-contract the provision of certain elements or services commissioned under a Local Commissioned Services.
When deciding to appoint a sub-contractor the provider must:

- submit details of their accreditation process, which Commissioners will review and seek to agree in order to ensure the method is robust;
- Following any accreditation process undertaken by the Provider, the Commissioner will have the authority to veto the decision should the Commissioner be sufficiently concerned by the accreditation process and any material received as part of that process;
- The Commissioner may support the evaluation of any new sub-contracted party the Provider wishes to award a contract with.
- The commissioner will not be party to the sub contract arrangement and will therefore cannot be responsible any element of the commercial agreement.

The provider entering into the sub-contracting agreement retains responsibility for the delivery of the commissioned service(s) and is responsible for managing and overseeing the service provisions and ensuring that all requirements of the contract and service specification are being adhered to.

## 9. Post Payment Verification (PPV)

NW Surrey CCG as lead commissioners has responsibility to ensure all services provide value for money and deliver safe quality care. The lead commissioner may request evidence to ensure

payments made to providers under this agreement are in line with the contractual requirements outlined in the specification and valid as per the claim criteria and time frames specified.

The commissioner may request at any time, evidence to support any claims made or details of any sub-contracting arrangement, details must be provided within the requested timescale.

Where possible the lead commissioner will use tools available to validate expenditure and activity using available existing data i.e. audits and returns by providers and will aim to prevent repeat requests.

## 10. Termination period

Either party can terminate the service outlined in this specification by providing 3 months notice in writing.

Termination of a single or multiple LCS service(s) does not affect all services listed within the NHS Standard contract ref: NWSLCS2017/18, unless specified. Individual service termination is required for each commissioned service and will need to be clearly specified.

Upon termination of a service the provider will remain responsible for managing the closure of clinics and advertising the service change to their registered population and stakeholders. This will include cancelling any booked clinics and assisting in the re direction to alternative providers.

At the end of the termination period the provider must make all activity claims as per the quarterly process as defined in section 8.2. Any payment applications for claims made after a service has expired will be reviewed by the lead commissioner on an individual basis and payment will be discretional.

North West Surrey CCG

**Agreement:**

| | |
|---|---|
| Practice Name: | |
| Practice Address: | |
| Practice H Code: | |

By signing and returning this document you AGREE to the terms and conditions of providing the Locally Commissioned Service LCS007 - ADHD (SABPT version with guanfacine).

*THIS LCS IS NOT AVAILABLE UNDER THE BUDDY AGREEMENT*

Signed by Partner of the practice:

| | |
|---|---|
| Signature: | |
| Print Name: | |
| Date: | |

Please return completed forms to:
**Email:** nwsccg.primarycare@nhs.net

(Electronic copies are acceptable but must be signed.)

**Post:**
Primary Care Contracting, North West Surrey CCG, 58 Church Street, Weybridge, Surrey, KT13 8DP

Surrey Downs CCG

**Locally Commissioned Service LCS007 - ADHD (SABPT version)**

**Service Specification**

| | |
|---|---|
| **Service Ref:** | LCS007 – ADHD (SABPT Version) |
| **Service:** | Attention Deficit Hyperactivity Disorder (ADHD) in children 6-17 years old - 12 monthly review monitoring for CNS stimulants, atomoxetine, guanfacine and melatonin (Circadin®) |
| **Commissioning Lead:** | Surrey Downs Clinical Commissioning Group |
| **Provider Lead:** | GP practice as stated on page 3 of the NHS Standard contract 2017/18 – NWSLCS2017/18. |
| **Start date:** | 1st Jan 2019 - TBC |
| **Frequency of service review:** | Annual / Bi-annual review of service |
| **Date of last review undertaken:** | Nov 2018 |
| **End date:** | XXXXX |

## 1. Population Needs

**National/local context and evidence base**

ADHD is defined by the core signs of inattention, hyperactivity and impulsiveness. Estimates of the prevalence of ADHD vary widely within and between countries. It is estimated that around 5% of school-aged children and adolescents would meet the DSM-IV diagnostic criteria for ADHD, equivalent to 366,000 children and adolescents in England and Wales, but not all of these children and adolescents would require treatment. Current treatments for ADHD include a range of social, psychological and behavioural interventions. These are mainly aimed at the child, but sometimes involve parents and/or guardians and teachers. Dietary interventions are often used when particular foods aggravate hyperactivity. The central nervous system (CNS) stimulants methylphenidate, dexamfetamine, lisdexamfetamine and atomoxetine / guanfacine (non-stimulant) are used in the treatment of ADHD. Treatment should be initiated as part of a comprehensive treatment programme for ADHD under specialist supervision by an appropriately qualified healthcare professional with expertise in ADHD where remedial measures alone prove insufficient. Ongoing prescribing and monitoring of drug therapy should be performed under shared care arrangements – shared care documents can be found on the Prescribing Advisory Database (PAD) http://pad.res360.net/PAD/Search

Sleep disorders in children and young people with ADHD can be managed using melatonin the licensed product Circadin® should be used off-label providing other causes of insomnia (eg bedtime resistance, sleep disordered breathing, side effects of medication – if on methylphenidate the dose can be reduced or switched to atomoxetine) and sleep hygiene measures (including use of a sleep diary) have failed. Treatment should be initiated as part of a comprehensive treatment programme for ADHD under specialist supervision by an appropriately qualified healthcare professional with expertise in ADHD. Ongoing prescribing and monitoring of drug therapy should be performed under shared care arrangements – shared care documents can be found on the Prescribing Advisory Database (PAD) http://pad.res360.net/PAD/Search

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children with neuro-developmental disorders in February 2014. The PCN noted the NICE ESUOM2 review of melatonin for this indication which concluded that melatonin appears to be well tolerated in the available randomized controlled trials in the short and medium term with only mild and transient adverse effects e.g. headache or dizziness (this included data from children treated for a range of 1-57months).

## 2. Outcomes

NHS Outcomes Framework Domains & Indictors

| | | |
|---|---|---|
| Domain 1 | Preventing people from dying prematurely | |
| Domain 2 | Enhancing quality of life for people with long-term conditions | |
| Domain 3 | Helping people to recover from episodes or following injury | X |
| Domain 4 | Ensuring people have a positive experience of care | |
| Domain 5 | Treating and caring for people in a d=safe environment and protecting them from avoidable harm | X |

### Locally defined outcomes

All children who receive a CNS stimulant / atomoxetine / guanfacine in line with NICE guidance for ADHD are recommended to receive a 6 monthly physical medication review to ensure treatment is continued only when safe and appropriate to do so (**note** children receiving guanfacine are not appropriate for entering into the LCS for the first year of treatment as during this time period three monthly reviews are required to be undertaken by the specialist). The agreed shared care documents stipulate the responsibility for on-going management of patients (note: the 6 monthly review will alternate between the specialist service who initiated treatment and the GP)

All children who receive melatonin for sleep disorders should be reviewed 6 month to ensure treatment is continued only when safe and appropriate to do so. The agreed share care document stipulates the responsibility for on-going management of patients (note: the 6 monthly review will alternate between the specialist service who initiated treatment and the GP)

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## 3. Scope

### 3.1 General Practices in Surrey Downs Clinical Commissioning Group

### 3.2 Population covered

Children initiated on CNS stimulants/atomoxetine +/- melatonin for ADHD by the specialists at SABP NHS Trust and are being managed by their GP under a shared care agreement

### 3.3 Service description/care pathway

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DRAFT Atomoxetine Amber Shared care gı


DRAFT Dexamphetamine Amber


Draft Guanfacine Amber shared care gı


DRAFT Lisdexamfetamine Amber


Melatonin shared care SD for ADHD LCS


DRAFT Methylphenidicate Amber

### 3.4 Interdependence with other services/providers

As per shared care patient monitored in conjunction with specialist at SABP NHS Trust

### 3.5 Aims & Objectives of service

Children should be initiated on CNS stimulants / atomoxetine / guanfacine for ADHD by a specialist in line with NICE NG87. Ongoing prescribing and monitoring of drug therapy should be performed under shared care arrangements in line with the documents embedded in this LCS / on the PAD http://pad.res360.net/PAD/Search

Children should be initiated on melatonin for sleep disorders in line with the flow chart on the PAD http://pad.res360.net/Content/Documents/Melatonin%20Sleep%20Disorders%20-%20flow%20chart%20PCN%20-%20May%202014.pdf Ongoing prescribing and monitoring of drug therapy should be performed under shared care arrangements in line with the document embedded in this LCS / on the PAD http://pad.res360.net/PAD/Search

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To carry out a physical medication review monitoring the following on a 12 monthly basis (the patient will be reviewed 6 monthly in line with the product license with reviews alternating between GP 12 month review and specialist 12 month review):

- Height, weight, appetite, sleep pattern
- Blood pressure and pulse

Assess the continued need for melatonin (if taking) and consider stopping melatonin if sleep disorder resolved (e.g. 14 day break).

Results of the above tests should be communicated to the specialist service for reviewing and collating in the patient's records: to support this process an email/fax back template is available as an appendix to the shared care documents and embedded below.


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To inform the consultant via email / fax number below if the patient does not attend their 6 monthly physical medication review for advice in particular in relation to appropriate continued prescription.

- Fax: 01372 204125
- Email: RXX.SABPCAMHSNE@nhs.net

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To contact the specialist on the following telephone number if urgent advice needed: 0300 2225755

Providers must have the following in place:

I. **A register**. Providers should be able to produce and maintain an up-to-date register of all children receiving a CNS stimulant / atomoxetine / guanfacine +/- melatonin for ADHD. Practices should note those patients whose treatment is complete and discontinue them from future clinical audits.

i. **Call and recall**. There must be evidence of a robust, systematic and responsive recall system to ensure that children receive their GP physical medication review at 12 monthly intervals. In addition the Provider must have mechanisms in place to deal with non- attendees of monitoring appointments linking with secondary care for advice.

ii. **Professional links**. To work together with specialists at SABP Mindsight Surrey CAMHS team to ensure patients are appropriately managed in line with the agreed shared care documents and as outlined in this specification. Any health professionals involved in the care of patients in the programme should be appropriately trained.

iii. **Referral policies**. Where appropriate to refer patients promptly to the specialists at SABP Mindsight Surrey CAMHS team or liaise with them for advice

iv. **Record keeping**. To maintain adequate records of the service provided, incorporating all known information relating to any significant events e.g. hospital admissions, death of which the provider has been notified;

v. **Training**. Each provider must ensure that all staff involved in providing any aspect of care under this scheme have the necessary training and skills to do so (this is in relation to the staff conducting the physical medication review e.g. taking BP / pulse)

## 4. Applicable service standards

### Applicable national standards

- Attention deficit hyperactivity disorder: diagnosis and management March 2018 NG87
- Methylphenidate, atomoxetine and dexamfetamine for attention deficit hyperactivity disorder in children and adolescents (2006) NICE technology appraisal guidance 98
- Sleep disorders in children and young people with attention deficit hyperactivity disorder:melatonin NICE ESUOM2 Jan 2013

### Applicable Quality Requirements

Patients must be monitored in line with the agreed shared care documents for the individual drugs and as outlined in this specification.

## 5. Applicable quality requirements & CQUIN Goals

Not applicable for this LCS.

## 6. Location of service providers premises & Home visiting services

### 6.1 Providers premises

GP practice as stated on page 3 of the NHS Standard contract 2017/18 – NWSLCS2017/18.

### 6.2 – Home visiting services

This locally commissioned service should be provided to all eligible patients as defines within the service specification. This includes any registered patients who are considered to be housebound and requiring treatment.

The provider will receive the agreed LCS payment under the scheme and in addition, can claim the sum for attending a patient's home to provide treatment. Please refer to schedule 3 of the NHS Standard contract ref: NWSLCS2017/18 for the detail of all applicable payments.

The "housebound payment" is in recognition of the additional resources required to deliver to this cohort of patients. Claims should be made via the quarterly claim form corresponding to the date range within which the original activity is delivered under the scheme.

## 7. Payments & Claims

### 7.1 Payment schedule

Please refer to schedule 3 of the NHS Standard contract ref: NWSLCS2017/18 for full pricing arrangements under the terms of the contract and individual LCS specification.

Providers will receive a fee for completing a 12 monthly physical medication review monitoring as outlined in this specification and the shared care documents on the PAD for the CNS stimulants / atomoxetine, guanfacine and melatonin (Circadin®) for treating ADHD in children.

### 7.2 Claiming method & timescale

All claims are to be made by the provider at the close of the quarter within which services have been delivered. Claims should be made via the individual quarterly claims form as provided by the lead commissioner.

Only claims submitted with the required evidence and within the applicable payment time from will be processed.
Claims received after the end of the financial year within which services were delivered will be processed for payment at the discretion of the lead commissioner.

### 7.3 EMIS Search & Report

As part of Surrey Downs' ongoing commitment to data quality & reducing the workload for practices, when reporting activity surrounding Locally Commissioned Services, the CCG will be extracting LCS activity data using EMIS Enterprise Search and Reports. Enterprise Search and Reports allows the CCG to run reports for the practices, removing the need to submit claim forms.

As effective and accurate reporting relies on consistent read coding, it is essential that when recording activity relating to this LCS you following the guidelines.
To support this, the CCG have provided EMIS clinical resource, however if you would prefer to enter this information manually please refer to the Read Code guidance document to ensure consistent recording takes place.

## 8. Buddy arrangements & Sub contracting

### 8.1 Buddy arrangements

***Please state if this service is not eligible for Buddy or sub-contracting arrangements.***

This service **NOT** currently available for the provision of services to patients other than the providing practice own registered population. There are intentions to review this position when IT systems are in place to facilitate this.

All requirements as outlined in the service specification must be maintained and delivered in a consistent way when providing services to patients other than the providing practices own registered population.

Claims should be made via the quarterly claim form. An additional fee will be payable to the provider for the additional administration and governance arrangements required to provide the buddy arrangements.

Full details of the treatment provided to patients under the terms of agreement must be documented and the patients registered GP must be notified of any treatment and outcomes of any tests provided. The provider remains responsible for all histology, call & recall and follow up requirements.

Full details of any complaints and/or Serious Incidents must be reported to the lead commissioner for this service.

PLEASE NOTE – Acceptance of the requirement to deliver services under the "buddy arrangements" must be indicated on the signature sheet for each separate service delivered under the contract.

### 8.2 Sub-Contracting

The Provider may wish to sub-contract the provision of certain elements or services commissioned under a Local Commissioned Services.
When deciding to appoint a sub-contractor the provider must:

- submit details of their accreditation process, which Commissioners will review and seek to agree in order to ensure the method is robust;
- Following any accreditation process undertaken by the Provider, the Commissioner will have the authority to veto the decision should the Commissioner be sufficiently concerned by the accreditation process and any material received as part of that process;
- The Commissioner may support the evaluation of any new sub-contracted party the Provider wishes to award a contract with.
- The commissioner will not be party to the sub contract arrangement and will therefore cannot be responsible any element of the commercial agreement.

The provider entering into the sub-contracting agreement retains responsibility for the delivery of the commissioned service(s) and is responsible for managing and overseeing the service provisions and ensuring that all requirements of the contract and service specification are being adhered to.

## 9. Post Payment Verification (PPV)

Surrey Downs CCG as lead commissioners has responsibility to ensure all services provide value for money and deliver safe quality care. The lead commissioner may request evidence to ensure payments made to providers under this agreement are in line with the contractual requirements outlined in the specification and valid as per the claim criteria and time frames specified.

The commissioner may request at any time, evidence to support any claims made or details of any sub-contracting arrangement, details must be provided within the requested timescale.

Where possible the lead commissioner will use tools available to validate expenditure and activity using available existing data i.e. audits and returns by providers and will aim to prevent repeat requests.

**10. Termination period**

Either party can terminate the service outlined in this specification by providing 3 months notice in writing.

Termination of a single or multiple LCS service(s) does not affect all services listed within the NHS Standard contract ref: NWSLCS2017/18, unless specified. Individual service termination is required for each commissioned service and will need to be clearly specified.

Upon termination of a service the provider will remain responsible for managing the closure of clinics and advertising the service change to their registered population and stakeholders. This will include cancelling any booked clinics and assisting in the re direction to alternative providers.

At the end of the termination period the provider must make all activity claims as per the quarterly process as defined in section 8.2. Any payment applications for claims made after a service has expired will be reviewed by the lead commissioner on an individual basis and payment will be discretional.

**Locally Commissioned Service LCS007 - ADHD (SABPT version)**

**Agreement:**

| | |
|---|---|
| Practice Name: | |
| Practice Address: | |

Surrey Downs CCG

| | |
|---|---|
| Practice H Code: | |

By signing and returning this document you AGREE to the terms and conditions of providing the Locally Commissioned Service LCS007 - ADHD (SABPT version with guanfacine).

*THIS LCS IS NOT AVAILABLE UNDER THE BUDDY AGREEMENT*

Signed by Partner of the practice:

| | |
|---|---|
| Signature: | |
| Print Name: | |
| Date: | |

Please return completed forms to:
**Email:** nwsccg.primarycare@nhs.net

(Electronic copies are acceptable but must be signed.)

**Post:**
Primary Care Contracting, North West Surrey CCG, 58 Church Street, Weybridge, Surrey, KT13 8DP

Guildford & Waverley CCG

**Locally Commissioned Service LCS007 - ADHD (SABPT version)**

**Service Specification**

| | |
|---|---|
| **Service Ref:** | LCS007 – ADHD (SABPT Version) |
| **Service:** | Attention Deficit Hyperactivity Disorder (ADHD) in children 6-17 years old - 12 monthly review monitoring for CNS stimulants, atomoxetine, guanfacine and melatonin (Circadin®) |
| **Commissioning Lead:** | G&W Clinical Commissioning Group |
| **Provider Lead:** | GP practice as stated on page 3 of the NHS Standard contract 2017/18 – (*Contract reference to be inserted* ) |
| **Start date:** | **TBC** |
| **Frequency of service review:** | Annual / Bi-annual review of service |
| **Date of last review undertaken:** | N/a |
| **End date:** | 31st March 2021 |

## 1. Population Needs

**National/local context and evidence base**

ADHD is defined by the core signs of inattention, hyperactivity and impulsiveness. Estimates of the prevalence of ADHD vary widely within and between countries. It is estimated that around 5% of school-aged children and adolescents would meet the DSM-IV diagnostic criteria for ADHD, equivalent to 366,000 children and adolescents in England and Wales, but not all of these children and adolescents would require treatment. Current treatments for ADHD include a range of social, psychological and behavioural interventions. These are mainly aimed at the child, but sometimes involve parents and/or guardians and teachers. Dietary interventions are often used when particular foods aggravate hyperactivity. The central nervous system (CNS) stimulants methylphenidate, dexamfetamine, lisdexamfetamine and atomoxetine / guanfacine (non-stimulant) are used in the treatment of ADHD. Treatment should be initiated as part of a comprehensive treatment programme for ADHD under specialist supervision by an appropriately qualified healthcare professional with expertise in ADHD where remedial measures alone prove insufficient. Ongoing prescribing and monitoring of drug therapy should be performed under shared care arrangements – shared care documents can be found on the Prescribing Advisory Database (PAD) http://pad.res360.net/PAD/Search

Sleep disorders in children and young people with ADHD can be managed using melatonin the licensed product Circadin® should be used off-label providing other causes of insomnia (eg bedtime resistance, sleep disordered breathing, side effects of medication – if on methylphenidate the dose can be reduced or switched to atomoxetine) and sleep hygiene measures (including use of a sleep diary) have failed. Treatment should be initiated as part of a comprehensive treatment programme for ADHD under specialist supervision by an appropriately qualified healthcare professional with expertise in ADHD. Ongoing prescribing and monitoring of drug therapy should be performed under shared care arrangements – shared care documents can be found on the Prescribing Advisory Database (PAD) http://pad.res360.net/PAD/Search

Melatonin is a naturally occurring hormone produced by the pineal gland in the brain. It is involved in coordinating the body's sleep-wake cycle and helping to regulate sleep. The Prescribing Clinical Network supported the use of Circadin® for the treatment of Delayed Sleep Phase Syndrome in

children with neuro-developmental disorders in February 2014. The PCN noted the NICE ESUOM2 review of melatonin for this indication which concluded that melatonin appears to be well tolerated in the available randomized controlled trials in the short and medium term with only mild and transient adverse effects e.g. headache or dizziness (this included data from children treated for a range of 1-57months).

## 2. Outcomes

NHS Outcomes Framework Domains & Indictors

| | | |
|---|---|---|
| Domain 1 | Preventing people from dying prematurely | |
| Domain 2 | Enhancing quality of life for people with long-term conditions | |
| Domain 3 | Helping people to recover from episodes or following injury | X |
| Domain 4 | Ensuring people have a positive experience of care | |
| Domain 5 | Treating and caring for people in a d=safe environment and protecting them from avoidable harm | X |

### Locally defined outcomes

All children who receive a CNS stimulant / atomoxetine / guanfacine in line with NICE guidance for ADHD are recommended to receive a 6 monthly physical medication review to ensure treatment is continued only when safe and appropriate to do so (**note** children receiving guanfacine are not appropriate for entering into the LCS for the first year of treatment as during this time period three monthly reviews are required to be undertaken by the specialist). The agreed shared care documents stipulate the responsibility for on-going management of patients (note: the 6 monthly review will alternate between the specialist service who initiated treatment and the GP)

All children who receive melatonin for sleep disorders should be reviewed 6 month to ensure treatment is continued only when safe and appropriate to do so. The agreed share care document stipulates the responsibility for on-going management of patients (note: the 6 monthly review will alternate between the specialist service who initiated treatment and the GP)

If a patient does not regularly attend their six monthly review (either in primary or secondary care) the GP should immediately refer the patient back to the specialist service who will be responsible for managing their on-going care including prescribing if appropriate. Shared care is not appropriate for patients who do not regularly attend their six monthly reviews.

## 3. Scope

### 3.1 General Practices in G&W Clinical Commissioning Group

### 3.2 Population covered

Children initiated on CNS stimulants/atomoxetine +/- melatonin for ADHD by the specialists at SABP NHS Trust and are being managed by their GP under a shared care agreement

### 3.3 Service description/care pathway

The agreed shared care documents are embedded below and are available on the PAD
http://pad.res360.net/PAD/Search

DRAFT Atomoxetine Amber Shared care gı DRAFT Dexamphetamine Ami Draft Guanfacine Amber shared care gı DRAFT Lisdexamfetamine Arr Melatonin shared care GW for ADHD LC

DRAFT Methylphenidicate An

### 3.4 Interdependence with other services/providers

As per shared care patient monitored in conjunction with specialist at SABP NHS Trust

### 3.5 Aims & Objectives of service

Children should be initiated on CNS stimulants / atomoxetine / guanfacine for ADHD by a specialist in line with NICE NG87. Ongoing prescribing and monitoring of drug therapy should be performed under shared care arrangements in line with the documents embedded in this LCS / on the PAD http://pad.res360.net/PAD/Search

Children should be initiated on melatonin for sleep disorders in line with the flow chart on the PAD http://pad.res360.net/Content/Documents/Melatonin%20Sleep%20Disorders%20-%20flow%20chart%20PCN%20-%20May%202014.pdf Ongoing prescribing and monitoring of drug therapy should be performed under shared care arrangements in line with the document embedded in this LCS / on the PAD http://pad.res360.net/PAD/Search

When a GP practice agrees to take over shared care of a child initiated on a CNS stimulant / atomoxetine / guanfacine for ADHD +/- melatonin for sleep disorders by the specialists at SABPT the GP practice are required to undertake a 12 monthly physical medication review monitoring for that patient in-line with the shared care documents and this locally commissioned service. Details of the requirements in relation to this are documented below:

To carry out a physical medication review monitoring the following on a 12 monthly basis (the patient will be reviewed 6 monthly in line with the product license with reviews alternating between GP 12 month review and specialist 12 month review):

- Height, weight, appetite, sleep pattern
- Blood pressure and pulse

Assess the continued need for melatonin (if taking) and consider stopping melatonin if sleep disorder resolved (e.g. 14 day break).

Results of the above tests should be communicated to the specialist service for reviewing and collating in the patient's records: to support this process an email/fax back template is available as an appendix to the shared care documents and embedded below.

Monitoring form .docx

After reviewing the monitoring results the specialist will advise the GP of any required actions. The specialist will complete the bottom part of the template and return the completed template to the practice after each GP physical medication review.

The practice should communicate to the specialist after every physical medication review. This will also enable the specialist to know if the patient is not attending the required GP follow ups which may highlight a safeguarding concern for example.

To inform the consultant via email / fax number below if the patient does not attend their 6 monthly physical medication review for advice in particular in relation to appropriate continued prescription.

- Email: RXX.SABPCAMHSSW@nhs.net
- Fax: 01483 443770

If a patient does not regularly attend their six monthly review (either in primary or secondary care) the GP should immediately refer the patient back to SABPT who will be responsible for managing their on-going care including prescribing if appropriate. Shared care is not appropriate for patients who do not regularly attend their six monthly reviews.

To contact the specialist on the following telephone number if urgent advice needed: 0300 2225755

Providers must have the following in place:

I. **A register**. Providers should be able to produce and maintain an up-to-date register of all children receiving a CNS stimulant / atomoxetine / guanfacine +/- melatonin for ADHD. Practices should note those patients whose treatment is complete and discontinue them from future clinical audits.

i. **Call and recall**. There must be evidence of a robust, systematic and responsive recall system to ensure that children receive their GP physical medication review at 12 monthly intervals. In addition the Provider must have mechanisms in place to deal with non- attendees of monitoring appointments linking with secondary care for advice.

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**Locally Commissioned Service LCS007 - ADHD (SABPT version)**

**Agreement:**

| | |
|---|---|
| Practice Name: | |
| Practice Address: | |

Guildford & Waverley CCG

| | |
|---|---|
| Practice H Code: | |

By signing and returning this document you AGREE to the terms and conditions of providing the Locally Commissioned Service LCS007 - ADHD (SABPT version with guanfacine).

*THIS LCS IS NOT AVAILABLE UNDER THE BUDDY AGREEMENT*

Signed by Partner of the practice:

| | |
|---|---|
| Signature: | |
| Print Name: | |
| Date: | |

Please return completed forms to:
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(Electronic copies are acceptable but must be signed.)

**Post:**
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