WNL LMCs' ADHD position statement - sent to the members of the WNL ADHD Task and Finish Group – 29 July 2026

In advance of the ADHD task and finish group on August 4th, the combined LMCs of WNL thought that it would be useful to set out our position as to the future direction of primary care involvement in ADHD prescribing.

- We note the following:
    - That NICE mandate an annual review by 'a healthcare professional with training and expertise in managing ADHD' i.e. not the registered GP. This substantive review is separate to the review of pulse/BP/weight (and height in children), which is needed at least 6 monthly for those on ADHD medication.
    - That patients in WNL who were diagnosed by the NHS are largely not getting these substantive reviews as they are discharged after dose titration.
    - That NHSE guidance on shared care states that patients under shared care should be able to access review 'from the secondary care team in a timely manner without necessarily requiring a new referral' – this is not currently possible as discharged patients require a new referral back for any review.
    - That the twice-yearly pulse/BP/weight check is resourced via an LCS in Tower Hamlets, to the value of £39.75 per check (£79.50 per year) and is therefore not contractually core general practice. It is not resourced in WNL.
    - That an increasing number of requests for the NHS team to provide annual reviews and/or prescribe long-term is putting pressure on their ability to see new patients, and that even if funding were available, there are not enough psychiatrists to do all of this work.
    - That the current situation of GPs engaging in 'shared' care which is (a) unresourced and (b) not truly shared, as most patients are discharged from secondary care, is not tenable and cannot continue.
    - That refusing new shared care is the July 2026 collective action from the BMA and therefore the number of requests accepted is likely to drop further.
- We therefore believe that the only sustainable model for the provision of ADHD care is via a GP with extended role (GPwER) hub and we would propose the following model:
    - All referrals go via a single point of access. The most complex are routed to secondary care (e.g. where there are complex psychiatric co-morbidities or a dual diagnosis with addiction issues) and the rest go to the GPwER hub.
    - Assessments are done by the GPwERs, supported/mentored by consultant psychiatrists. The level of support and supervision needed will drop over time as GPwERs gain experience.
    - Patients remain under the care of the GPwER hub indefinitely and are proactively recalled for an annual review. The review is done by the most appropriate clinician – where it is the first or second review, or the patient wishes to discuss adverse effects or

other issues, this would usually be a GPwER. For patients who are on medication long-term with no problems, a NMP with training in ADHD may suffice.

- There are two possibilities for long-term prescribing:

    1) GPs who are willing to share care do the prescribing, under the terms of a funded LCS similar to the one in Tower Hamlets. For GPs who are not willing to share care, prescribing remains with the GPwER hub. Access to EPS to community pharmacies from the GPwER hub will be essential as most ADHD medications are controlled drugs and so a single prescription cannot be done for longer than one month.

    2) The GPwER hub retains all prescribing, if it is felt that this is more cost-effective than an LCS in general practice. Medications would be recorded on the GP notes as a hospital issue, as is currently done for biologics, anti-retrovirals and other long-term prescriptions held in secondary care.

- We note that ICB staff have previously raised concerns that GPwERs are too expensive compared to NMPs, but would suggest that the following be considered:

    - A GPwER will be able to take a holistic view of the patient, interpret any ECG that is needed and manage the ADHD in conjunction with any other co-morbidities or life stages (such as the menopause or plans for conception). An NMP is likely to reach the boundaries of their knowledge more quickly and need to refer to other secondary care teams, thus increasing cost and delay.

    - The cost of NMPs is often considered as their top-line salary and does not include (a) the cost of doctor supervision and (b) the proportion of patients who will go on to need a doctor review after seeing an NMP. When this is properly factored in, we think it unlikely that there will be any saving.

    - If a model where the registered GP shares care is continued, the registered GP is much less likely to be willing to do this if the care is entirely managed Dr Vicky Weeks – Medical Director for WNL/NCL LLMCs

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Dr Toni Hazell – Haringey LMC Chair/ representative for WNL LMCs

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