

26 February 2024

Information Rights & Compliance Team  
99 Waverley Road  
St Albans  
Hertfordshire  
AL3 5TL

Tel: 01727 804227  
Email: [Hpkt.foi@nhs.net](mailto:Hpkt.foi@nhs.net)

Our Ref: FOI/04945

Thank you for your request concerning shortage of Methylphenidate.

Your request has been considered and processed in accordance with the requirements of the Freedom of Information (FOI) Act 2000.

**1. Did your Trust receive the above NatPSA? If so, on what date was it received?**

Yes on 28/09/2023.

**2. Assuming that the answer to the first part of question 1 is yes, was the NatPSA forwarded to relevant specialist teams within your Trust? Which specialist teams was the NatPSA forwarded to?**

Adult Community Mental Health services, CAMHs Services, LD&F – Clinical Leads And Practice Governance Leads for onward dissemination.

**3. The NatPSA states that ‘prescribers should not initiate new patients on products affected by this shortage until the supply issues resolve.’ Have any new patients under your care who would ordinarily have been prescribed the affected products not been given prescriptions because of this required action? If so, how many?**

This information is not recorded in a reportable format. This would be recorded in the electronic patient record (EPR) as a clinical note and these notes cannot be interrogated in the database.

**4. Where appropriate did specialist teams within your Trust ‘identify all patients currently prescribed these products’, as required by the NatPSA? If so, how many patients were identified and by what date was this action carried out?**

Notification sent to all teams to identify patients alongside management advice on 10/10/2023.

The affected ADHD medications would mostly be issued by prescription written in community clinics. They then would be sent onto community pharmacists for dispensing, rather than coming through the pharmacy team within the hospital. We do not have a way of identifying numbers of patients from our pharmacy computer system.

5. **Where appropriate did specialist teams within your Trust ‘make early contact with patients to establish how much supply they have remaining’, as required by the NatPSA? If so, how many patients did you attempt to contact? How many patients were successfully contacted?**

**CAMHS and ACMHS**

We did not make contact with all patients on ADHD medication affected by shortage to establish how much they had as that would have been a very difficult task due to the numbers and the lack of capacity for clinicians to do that extra work . We only actively contacted those on Guanfacine (intuniv) due to the risk of stopping it abruptly.

6. **Assuming that the answer to the first part of question 5 is ‘yes’, and that some patients were successfully contacted, how many patients were identified as having insufficient supplies to last until the re-supply date?**

**CAMHS and ACMHS**

The number of patients on Guanfacine are small. We do not have data about this as each clinician contacted a few under their caseload to advise them with regards to sudden stopping of Guanfacine and agree a plan.

7. **The NatPSA states that healthcare professionals should ‘contact patient’s specialist team[s] for advice on management options’. Have any specialist teams within your Trust been contacted by other healthcare professionals seeking such advice? If so, what advice were specialist teams able to provide?**

There is guidance on the Trust intranet to help specialists advise primary care colleagues  
Memo - ADHD medication shortage 20231009.

8. **Have specialist teams within your Trust ‘[supported] primary care teams seeking advice for patients currently prescribed the affected products’, as required by the NatPSA? If so, how?**

Yes, ICS wide group was convened to provide a systems wide approach to management. The specialists have been provided with management advice as above in (7) to support primary care colleagues. Team contact details have been shared, template letters for patients and carers have been provided.

9. **Have specialist teams within your Trust provided individualised management plans, either to primary care teams or directly to patients? If so, how many?**

**CAMHS**

No individualised plan were offered. Care plans were updated when patients were reviewed routinely during the period of the shortage. Care plans were also updated for the small numbers on Guanfacine and for patients who contacted the clinic raising concerns and asking for advice.

**ACMHS**

There is no specialised ADHD provision in ACMHS, however, when service users were seen for review, if required an individualised management plan was agreed.

10. **Have specialist teams within your Trust recommended alternative products in line with NICE guidance, where appropriate? If so, how many such recommendations have been made?**

**CAMHS and ACMHS**

Advice was emailed to all consultants to communicate to doctors and clinicians working under their care with advice around alternative preparations that could be offered to patients. Data was not collected but the advice was circulated to clinicians to use it as they see fit.

11. **What policy, if any, exists within your Trust for ensuring compliance with National Patient Safety Alerts? If such a policy exists, please provide a copy of it.**

Please see attached our Cascading Alert Notices Policy v9. Please note we are in the process of reviewing and updating this policy.

Should you require further clarification, please do not hesitate to contact me.

Please find enclosed an information sheet regarding copyright protection and the Trust's complaints procedure in the event that you are not satisfied with the response.

Yours sincerely

*Sue Smith*

**Sue Smith  
Information Rights Officer**

Enc: Copyright Protection and Complaints Procedure Information Leaflet.

If you would like to complete a short survey in relation to your Freedom of Information request please scan the QR code below or click [here](#).

