Reference: FOI.ICB-2425/177

Subject: Children and Adult ASD and ADHD Services

I can confirm that the ICB does hold some of the information requested; please see responses below:

QUESTION	RESPONSE
Please refer to requesters template enclosed. Clarification received: • I am referring to providers from **all sources** (commissioned, patient choice, other funding sources). • An independent company that has a contract with the NHS to provide NHS funded services would be regarded as "independent".	Please refer to requesters template enclosed. Also enclosed are the service specifications for: Adult 'BNSSG Autism Spectrum Disorder Service', and 'Attention Deficit Hyperactivity Disorder (ADHD) – Adults (18+ years)'. Links for children's services can be found in the requesters template.

The information provided in this response is accurate as of 12 September 2024 and has been approved for release by Sarah Truelove, Deputy Chief Executive and Chief Finance Officer for NHS Bristol, North Somerset and South Gloucestershire ICB.

Please complete all fields in light/dark grey. Please provide figures for the end of each financial year, where applicable.
ASD - autism spectrum disorder
ADHD - attention deficit hyperactivity disorder

Name of your organisation:	Bristol, North Somerset and South Gloucestershire Integrated Care Board

Clarification received:
•I am referring to providers from all sources (commissioned, patient choice, other funding sources).
•An independent company that has a contract with the NHS to provide NHS funded services would be regarded as "independent".

Questions | *Answers >>>*

1) Does your organisation **commission or provide** (please specify) referral, diagnosis or treatment services for the fol	Yes / no?	Commission or provide?
a. ASD in children	Yes	Commission
b. ASD in adults	Yes	Commission
c. ADHD in children	Yes	Commission
d. ADHD in adults	Yes	Commission

2) Please provide an overview of the current **digital and physical care pathways**, from referral for assessment to diagnosis and long-term treatment, for **each** of the following.	Overview of digital care pathway	Overview of physical care pathway
a. ASD in children	https://remedy.bnssg.icb.nhs.uk/children-young-people/special-educational-needs-disability-send/autism-spectrum-disorder-asd/	
b. ASD in adults	Service Spec enclosed	
c. ADHD in children	https://remedy.bnssg.icb.nhs.uk/bnssg-icb/development-area/obsolete-pathways/adhd-care-pathway-obsolete-june-2024/	
d. ADHD in adults	Service Spec enclosed	

3) Please provide each of the following, for **each of the following financial years** 2021/22, 2022/23 and 2023/24, **split by ASD in Children, ASD in adults, ADHD in children and ADHD in adults**.	2021/22				2022/23				2023/24			
	ASD in children	ASD in adults	ADHD in children	ADHD in adults	ASD in children	ASD in adults	ADHD in children	ADHD in adults	ASD in children	ASD in adults	ADHD in children	ADHD in adults
a. Number of:	-	-	-	-	-	-	-	-	-	-	-	-
i. People **referred** for diagnosis assessment	Not Held	Not Held - Held by AWP or Right to choose providers	Not Held	Not Held - Held by AWP or Right to choose providers	Not Held	Not Held - Held by AWP or Right to choose providers	Not Held	Not Held - Held by AWP or Right to choose providers	Not Held	Not Held - Held by AWP or Right to choose providers	Not Held	Not Held - Held by AWP or Right to choose providers
ii. People **screened/triaged** and **subsequently not assessed**	Not Held	Not Held - Held by AWP or Right to choose providers	Not Held	Not Held - Held by AWP or Right to choose providers	Not Held	Not Held - Held by AWP or Right to choose providers	Not Held	Not Held - Held by AWP or Right to choose providers	Not Held	Not Held - Held by AWP or Right to choose providers	Not Held	Not Held - Held by AWP or Right to choose providers
iii. Diagnosis **assessments** completed	Not Held	Not Held - Held by AWP or Right to choose providers	Not Held	Not Held - Held by AWP or Right to choose providers	Not Held	Not Held - Held by AWP or Right to choose providers	Not Held	Not Held - Held by AWP or Right to choose providers	Not Held	Not Held - Held by AWP or Right to choose providers	Not Held	Not Held - Held by AWP or Right to choose providers
iv. People subsequently **diagnosed** with the relevant condition	Not Held	Not Held - Held by AWP or Right to choose providers	Not Held	Not Held - Held by AWP or Right to choose providers	Not Held	Not Held - Held by AWP or Right to choose providers	Not Held	Not Held - Held by AWP or Right to choose providers	Not Held	Not Held - Held by AWP or Right to choose providers	Not Held	Not Held - Held by AWP or Right to choose providers
b. Average (mean) **waiting time** from referral to assessment (in weeks)	Not Held	Not Held - Held by AWP or Right to choose providers	Not Held	Not Held - Held by AWP or Right to choose providers	Not Held	Not Held - Held by AWP or Right to choose providers	Not Held	Not Held - Held by AWP or Right to choose providers	Not Held	Not Held - Held by AWP or Right to choose providers	Not Held	Not Held - Held by AWP or Right to choose providers

4) What was the **total expenditure** by your organisation on **mental health services**, for **each of the following financial years** 2021/22, 2022/23 and 2023/24?	2021/22		2022/23		2023/24	
	Children	Adult	Children	Adult	Children	Adult
Total mental health services expenditure (£):	£12.890m	£136.946m	£14.542m	£142.288m	£15.551m	£165.269m

5) Please provide each of the following **expenditures by your organisation**, for **each of the following financial years** 2021/22, 2022/23 and 2023/24, **split by ASD in Children, ASD in adults, ADHD in children and ADHD in adults**.	2021/22				2022/23				2023/24			
	ASD in children	ASD in adults	ADHD in children	ADHD in adults	ASD in children	ASD in adults	ADHD in children	ADHD in adults	ASD in children	ASD in adults	ADHD in children	ADHD in adults
a. **Total** expenditure: b. **Split** of expenditure: i. Screening/triage of referrals ii. Diagnosis assessments iii. Post-diagnosis treatment (incl. medication) iv. Post-diagnosis follow-up v. Other (please specify)	Expenditure is part of a block contract figure. The requested breakdown cannot be provided.	Expenditure is part of a block contract figure and right to choose budget. The requested breakdown cannot be provided.	Expenditure is part of a block contract figure. The requested breakdown cannot be provide	Expenditure is part of a block contract figure and right to choose budget. The requested breakdown cannot be provided.	Expenditure is part of a block contract figure. The requested breakdown cannot be provide	Expenditure is part of a block contract figure and right to choose budget. The requested breakdown cannot be provided.	Expenditure is part of a block contract figure. The requested breakdown cannot be provide	Expenditure is part of a block contract figure and right to choose budget. The requested breakdown cannot be provided.	Expenditure is part of a block contract figure. The requested breakdown cannot be provide	Expenditure is part of a block contract figure and right to choose budget. The requested breakdown cannot be provided.	Expenditure is part of a block contract figure. The requested breakdown cannot be provide	Expenditure is part of a block contract figure and right to choose budget. The requested breakdown cannot be provided.

6) For **all providers used since 2021/22** for the provision of ASD in Children, ASD in adults, ADHD in children or ADHD in adults services, please provide the following information.	a. Name of provider	b. NHS or independent provider		c. Categories of **patients served**				d. **Services provided** for your organisation					e. **Total expenditure by your organisation** on their services		
	Name	NHS	Independent	ASD in children	ASD in adults	ADHD in children	ADHD in adults	Screening/triage of referrals	Diagnosis assessments	Post-diagnosis treatment (incl. medication)	Post-diagnosis follow-up	Other (please specify)	2021/22	2022/23	2023/24
Provider 1	Sirona care and health	N	Y	Y	N	Y	N	Y	Y	Y	Y	Post-diagnosis follow up for children ADHD on medication only	Expenditure is part of a block contract figure. The requested breakdown cannot be provide	Expenditure is part of a block contract figure. The requested breakdown cannot be provide	Expenditure is part of a block contract figure. The requested breakdown cannot be provide
Provider 2	Avon and Wiltshire NHS Partnership Trust	Y	N	N	Y	N	Y	Y	Y	Y	Y	[other specified]	Expenditure is part of a block contract figure. The requested breakdown cannot be provide	Expenditure is part of a block contract figure. The requested breakdown cannot be provide	Expenditure is part of a block contract figure. The requested breakdown cannot be provide
Provider 3	ADHD360	N	Y	N	N	Y	Y	Y	Y	Y	N	[other specified]	£5,460	£89,310	£817,100
Provider 4	Clinical Partners	N	Y	Y	Y	N	Y	Y	Y	N	N	[other specified]	£16,719	£72,397	£173,136
Provider 5	Dr J & Colleagues	N	Y	N	Y	N	Y	Y	Y	Y	N	[other specified]	£0	£0	£5,630
Provider 6	ProblemShared	N	Y	N	Y	N	Y	Y	Y	Y	Y	[other specified]	£0	£0	£0
Provider 7	Psychiatry UK	N	Y	N	Y	N	Y	Y	Y	Y	N	[other specified]	£767,322	£1,920,243	£2,220,078
Provider 8	Axia ASD	N	Y	N	Y	N	N	Y	Y	N	N	[other specified]	£0	£1,500	£10,000
Provider 9	Mind Professionals	N	Y	N	Y	N	N	Y	Y	N	N	[other specified]	£0	£0	£1,380
Provider 10	Evolve Psychology	N	Y	Y	N	Y	N	Y	Y	N	N	[other specified]	£0	£2,800	£0
Provider 11	Psicon	N	Y	N	N	Y	N	Y	Y	Y	N	[other specified]	£0	£995	£0
Provider 12	Provide CiC	N	Y	Y	N	N	N	Y	Y	N	N	[other specified]	£0	£0	£7,100
Provider 13	PRIVATE PHARMACY GROUP (THE)	N	Y	N	N	Y	Y	N	N	N	N	Pharmacy provision	£471	£412	£0
Provider 14	H & AK FLETCHER LTD	N	Y	N	N	Y	Y	N	N	N	N	Pharmacy provision	£0	£8,628	£200,385
Provider 15	EXCELSIOR HEALTH LTD	N	Y	N	N	Y	Y	N	N	N	N	Pharmacy provision	£0	£264	£0

f. Number of people accessing their services commissioned by your organisation		
2021/22	2022/23	2023/24
The ICB does not hold this information	The ICB does not hold this information	The ICB does not hold this information
The ICB does not hold this information	The ICB does not hold this information	The ICB does not hold this information
The ICB does not hold this information - this information is held by ADHD 360	The ICB does not hold this information - this information is held by ADHD 360	The ICB does not hold this information - this information is held by ADHD 360
The ICB does not hold this information - this information is held by Clinical Partners	The ICB does not hold this information - this information is held by Clinical Partners	The ICB does not hold this information - this information is held by Clinical Partners
The ICB does not hold this information - this information is held by Dr J & Colleagues	The ICB does not hold this information - this information is held by Dr J & Colleagues	The ICB does not hold this information - this information is held by Dr J & Colleagues
The ICB does not hold this information - this information is held by ProblemShared	The ICB does not hold this information - this information is held by ProblemShared	The ICB does not hold this information - this information is held by ProblemShared
The ICB does not hold this information - this information is held by Psychiatry UK	The ICB does not hold this information - this information is held by Psychiatry UK	The ICB does not hold this information - this information is held by Psychiatry UK
The ICB does not hold this information - this information is held by Axia ASD	The ICB does not hold this information - this information is held by Axia ASD	The ICB does not hold this information - this information is held by Axia ASD
The ICB does not hold this information - this information is held by Mind Professionals	The ICB does not hold this information - this information is held by Mind Professionals	The ICB does not hold this information - this information is held by Mind Professionals
The ICB does not hold this information - this information is held by Evolve Psychology	The ICB does not hold this information - this information is held by Evolve Psychology	The ICB does not hold this information - this information is held by Evolve Psychology
The ICB does not hold this information - this information is held by Psicon	The ICB does not hold this information - this information is held by Psicon	The ICB does not hold this information - this information is held by Psicon
The ICB does not hold this information - this information is held by Provide CIC	The ICB does not hold this information - this information is held by Provide CIC	The ICB does not hold this information - this information is held by Provide CIC
The ICB does not hold this information - this information is held by H & PRIVATE PHARMACY GROUP (THE)	The ICB does not hold this information - this information is held by H & PRIVATE PHARMACY GROUP (THE)	The ICB does not hold this information - this information is held by H & PRIVATE PHARMACY GROUP (THE)
The ICB does not hold this information - this information is held by H & AK FLETCHER LTD	The ICB does not hold this information - this information is held by H & AK FLETCHER LTD	The ICB does not hold this information - this information is held by H & AK FLETCHER LTD
The ICB does not hold this information - this information is held by EXCELSIOR HEALTH LTD	The ICB does not hold this information - this information is held by EXCELSIOR HEALTH LTD	The ICB does not hold this information - this information is held by EXCELSIOR HEALTH LTD

Service Specification

Service Specification No.	**TBC**
Service	**BNSSG Autism Spectrum Disorder Service**
Commissioner Lead	**BNSSG Integrated Care Board (ICB)**
Provider Lead	**TBC (Right to Choose)**
Period	**1st April 2024**
Date of Review	**Quarter 4 2023-2024**
Date of Next Review	**Quarter 4 2025**

1. Purpose

This service specification outlines BNSSG ICB's objectives, scope, pathway and principles of the Adult Autism Service.

Please note BNSSG Integrated Care System (ICS) is undertaking a review of the children and young people autism pathway. The future model of care may impact the commissioning and pathway of the adult services commissioned in BNSSG.

Autism spectrum disorder (referred to as autism in the rest of this document) is the official name of a diagnosis within a broader category called neurodevelopmental disorders in the International Statistical Classification of Diseases, eleventh edition (ICD-11; 5).

Autism is a long-life neurodevelopmental condition that affects individuals from birth and lasts for their lifetime. Signs of autism might be noticed when an individual is very young, or not until later in life. It affects how individuals communicate, experience and interact with the world around them. Autism is a spectrum and autistic people may need little or no support, and the way that autism is expressed in individuals differs at different stages of life, in response to interventions, and with the presence of any co-existing conditions. Autism Spectrum Disorder is a life-long disorder; however, the prognosis can be improved by early diagnosis and assessment.

The core features of autism, as defined in ICD-11 and DSV-5 include:

- Persistent difficulties in initiating and sustaining social communication and reciprocal social interaction.
- Presence restricted, repetitive, and inflexible patterns of behaviour, interests, or activities that are clearly atypical or excessive.
- Onset in the developmental period.
- The symptoms result in significant impairment in personal, family, social, educational, occupational, or other important areas of functioning.

None of the individual autism diagnostic criteria are exclusive to autism and there is considerable overlap in diagnostic features of other communication, neurodevelopment and mental health conditions. In addition, autism commonly co-occurs with other conditions. This means that autism should not be assessed without also considering the possibility of differential or co-occurring diagnoses.

Common differential and co-occurring conditions include:

- Neurodevelopment disorders e.g., Attention Deficit Hyperactivity Disorder (ADHD),

global developmental delay
- Mood disorder
- Anxiety disorder
- Obsessive Compulsive Disorder (OCD)
- Attachment disorders
- Effect of early childhood trauma
- Psychosis

The Provider is commissioned to provide evidence-based autism diagnostic assessment and in agreement with Commissioners provide post diagnostic support led and undertaken by appropriately skilled health professionals. The service offer will be based on NICE guidelines and best practice associated with autism diagnosis and adapt procedures in relation to delivery and environment as highlighted in the following guidelines in section 1.1.

1.1 National evidence base

National strategy for autistic children, young people and adults: 2021 to 2026 is the government's national strategy for improving the lives of autistic people and their families and carers in England National strategy for autistic children, young people and adults: 2021 to 2026 - GOV.UK (www.gov.uk). The strategy has six main areas for improvements:

1. Helping people to understand autism.
2. Helping autistic children and young people at school.
3. Helping autistic people to find jobs.
4. Making health and care services equal for autistic people.
5. Making sure autistic people get help in their communities.
6. Help for autistic people in the justice system.

This strategy aligns with the existing statutory guidance on implementing the Autism Act for local authorities and NHS organisations to support implementation of the Adult Autism Strategy (2015).

There are an estimated 700,000 autistic adults and children in the UK, approximately 1% of the population. In addition, there are an estimated 3 million family members and carers of autistic people in the UK. At least one associated mental health disorder occurs in approximately 70% of people with ASD (NICE).

NICE Autism Spectrum Disorder in adults (2021) Overview | Autism spectrum disorder in adults: diagnosis and management | Guidance | NICE reviews the existing evidence base for the identification, assessment, interventions, treatment and management of adults with autism.

The key principles of care include:

- Specialist diagnostic and assessment services and specialist care and interventions.
- Advice and training to other health and social care professionals on the diagnosis, assessment, care and interventions for adults with autism.
- Support in accessing, and maintaining contact with, housing, educational and employment services.
- Work in partnership with autistic adults and support to families, partners and carers where appropriate.
- Care and interventions for adults with autism living in specialist residential accommodation.
- Training, support and consultation for staff who care for adults with autism in residential and community settings.

The Autism Act (2009) Autism Act 2009 (legislation.gov.uk) places a legal duty on statutory agencies (NHS bodies and Local Authorities) to provide a range of services for adults with autism.

1.2 Right to Choose

Since 2014, in England under the Right to Choose Guidance NHS patients have a legal right to choose their mental healthcare provider and their choice of mental healthcare team. If a patient decides the waiting time for their autism assessment is too long, then they can choose alternative providers. The provider must be commissioned for the service by an ICB in England in order to offer Right to Choose.

NHS Choice Framework - what choices are available to you in your NHS care - GOV.UK (www.gov.uk)

Patients have the Right to Choose when the following conditions are met:

- The provider is in England (different rules apply for Scotland, Wales and Northern Ireland).
- The General Practitioner has agreed to make clinically appropriate referral.

Certain restrictions apply and patients cannot exercise their Right to Choose if they are:

- Already receiving mental health care following an elective referral for the same condition.
- Referred to a service that is commissioned by a local authority, for example a drug and alcohol service (unless commissioned under a Section 75 agreement).
- Accessing urgent or emergency (crisis) care.
- Accessing services delivered through a primary care contract.
- In high secure psychiatric services.
- Detained under the Mental Health Act 1983.
- Detained in a secure setting. This includes people in or on temporary release from prisons, courts, secure children's homes, certain secure training centres, immigration removal centres or young offender institutions.
- Serving as a member of the armed forces (family members in England have the same rights as other residents of England).

There are restrictions on who the patient can direct their care to. Patients cannot refer to just any provider. The provider must:

- Have a commissioning contract with any ICB in England or NHS England for the required service.
- Have the service and team led by a consultant or a mental healthcare professional.

1.3 Local Context

BNSSG ICS aims

BNSSG's Strategy and Joint Forward Plan have been developed to align with, and support, the four aims of Integrated Care Systems (ICS):

1. Improve outcomes in population health and health care.
2. Tackle inequalities in outcomes, experience and access.
3. Enhance productivity and value for money.
4. Help the NHS support broader social and economic development.

BNSSG Joint Forward Plan Joint Forward Plan - BNSSG Healthier Together (published June 2023) sets out how BNSSG ICB will deliver on the national vision of high-quality healthcare for all, through equitable access, excellent experience, and optimal outcomes over the next five years. It aims to:

1. Improve the health and wellbeing of the population.
2. Provide high-quality services that are fair and accessible to everyone.
3. Improve the health and wellbeing of the population.
4. Provide high-quality services that are fair and accessible to everyone.

In 2024, BNSSG published a Mental Health Strategy, based on 1% estimate, approximately 6,131 people aged 18-64 years are autistic. The strategy has six ambitions.

1. Holistic Care
2. Prevention and early help
3. Quality treatment
4. Sustainable System
5. Advancing equalities
6. Great place to work

https://bnssghealthiertogether.org.uk/health-wellbeing/mental-health-strategy/

2. Service Scope

2.1 Aims

To provide an accessible adult autism diagnostic service, including in agreement with commissioners, provision of post-diagnostic support as indicated by NICE guidelines and in line with commissioning requirements. The Provider is required to develop an effective and efficient service model that incorporates national and local ICS wide requirements. In collaboration with a range of statutory and voluntary sector agencies, to provide service users with autism with a sufficient level of support to enable an individual's continued independence and well-being.

2.2 Objectives

- To provide accurate autism assessment.
- To provide a report following assessment which identifies the service user's needs so that individually tailored post diagnostic support where required can be discussed between the patient and their GP.
- To help service users access a range of mainstream social care and independent sector services to meet their needs, including employment support, NHS Talking Therapies, housing and welfare rights.
- To provide a person centred and flexible approach.
- To deliver a service informed by NICE guidance and NICE quality 8 statements.
- To promote active and full engagement of service users in their own homes.
- To provide a clinically effective and cost-effective service.
- To help service users make informed choices about their care and identified support needs, in partnership with their health and social care professionals.
- To offer support to other services and agencies regarding the management of adults in this group to improve the ability of mainstream providers to meet their complex needs and to improve outcomes for each service user.
- Improved quality of life, as identified by the service user and appropriate evidence-based measurement tools. This could include the patient satisfaction questionnaire (PSQ) and the Friends and Family Test (FFT)

2.3 Service summary

The service will be aligned to NICE guidance Overview | Autism spectrum disorder in adults: diagnosis and management | Guidance | NICE.

Autistic people, or people who suspect they are autistic may have certain characteristics which present them with challenges in the way they communicate with others and their ability to be in situations that require some degree of social interaction. The Provider is therefore expected to ensure that they provide:

1. Appropriate and accessible information to individuals about their service.
2. Appropriate and accessible information about timescales for assessment.
3. A suitable accessible and safe environment for individuals if the diagnosis is to take place in a clinical /other environment.
4. Flexibility as to the environment the service is delivered in, which considers risk and the needs of the service user.
5. Clear information to individuals about what will and may happen post diagnosis.
6. Additional support if the individual is unable to consent to assessment and/or interventions. It may be appropriate for the referrer and provider to consider the Mental Capacity Act, and the use of an advocacy service if necessary.

It should be recognised that with this specification, individuals who may require diagnosis/post diagnostic interventions may present with different levels of complexities and also at different times of their life as follows:

- Individuals who were in receipt of services in childhood but for whom an assessment for autism was not completed. This may have been for a number of reasons including 'diagnostic overshadowing' whereby difficulties displayed were attributed to an individual's learning disability or mental health or behavioural condition.
- Individuals who may have been 'coping' due to their family support or their own capabilities, those masking difficulties who have struggled through but find that in adulthood, without the structured environment of school, they are unable to cope.
- Individuals whose difficulties first present in adulthood.

2.4 Population covered

BNSSG ICB is commissioning this service on behalf of patients registered with a GP for which the ICB is responsible. Under Patient Choice rules, patients from outside of BNSSG ICB may choose to select the provider and in these circumstances an invoice for payment should be directed to the appropriate responsible ICB.

2.5 Referral Criteria and sources

Referral criteria for Diagnostic Assessment:

- Adults 18yrs +
- Registered with a BNSSG GP
- Evidence that an autism assessment is required

Referral criteria for Post Diagnostic support (where commissioned):

- Adults 18+
- Registered with BNSSG GP
- Evidence of historical diagnosis of Autism.

2.6 Referral process, triage, screening and waiting list

Individuals will be referred directly to the provider by their GP.

Referral routes for diagnostic assessment:

- GP

Referral Route for Post Diagnostic Support:

- GP

The Provider will undertake screening and triage of all referrals to ensure that an individual is on the correct pathway and that all eligibility criteria have been met. This step may include administrative staff as well as clinical input. Information on the referral may also direct next steps, for example that a referral should be expedited due to significant risk or need, or that the level of complexity may dictate a more nuanced approach to the assessment. The Provider must regularly undertake waiting list review to ensure service's user clinical needs have not changed.

Prioritisation for assessment is not normally given, but certain patients may be prioritised depending on their circumstances. A referral may be prioritised in cases where there is a significant risk of a delay in assessment causing:

1. A marked deterioration in the individual's mental health.
2. A significant increase in the individual's level of risk to self and/or others.
3. An increased likelihood of an individual losing their job and/or their accommodation leading to either of the above.

The service will operate a waiting list and it is expected that diagnostic assessment should start within 3 months of referral as per NICE Guidance Quality statements | Autism | Quality standards | NICE.

2.7 Any exclusion criteria

Anyone under 18 years of age.

The Provider will treat all service users in a safe and appropriate environment. The Provider is entitled to exclude certain groups of patients for reasons of clinical safety or complexity of support healthcare facilities normally required, which are not available. Any changes to the provider's exclusion and acceptance criteria must have previously been shared and agreed with the relevant commissioner(s).

Where it is felt the exclusion criteria should be applied, the Provider should make all reasonable attempts to discuss this with the service user and where appropriate, the service user's GP to ensure that the decision is informed, and evidence based.

The Provider should ensure that when the exclusion criteria is applied, the service user is informed by a member of staff with an understanding of the criteria and the evidence used to inform the decision. The service user should receive a full explanation of the reasons for exclusion and where requested, the evidence used to inform the decision and signposted to other support services.

It is important to note that in cases where a person's deteriorating mental health makes a valid diagnostic assessment difficult, professionals from the team can provide support and consultation to the service user's care team as required.

Provider exclusion list to be added post accreditation.

Commented [LC1]: TBC following accreditation

2.8 Do Not Attends (DNAs)

The Provider will not charge for any service user who does not attend their appointment.

2.9 Assessment

2.9.1 Clinical profession conduction assessments

To comply with clinical guidelines, assessments will be conducted by clinical professionals who are members of a multidisciplinary team; clinicians from certain professional disciplines (paediatricians, psychiatrists, clinical psychologists) may conduct single clinician assessments if they judge that a consensus decision is not required.

The clinical professionals conducting autism assessments should, together, have experience and expertise in assessment of neurodevelopmental (including intellectual disability), language and communication, and behavioural and mental health conditions, as these are commonly differential or co-occurring conditions.

Clinical professionals should all meet the qualification, regulation and current professional registration requirements to practice by their respective professional bodies.

The assessment should include a number of steps including screening and triage, autism assessment, formulating a view about diagnosis, assessment feedback, assessment report, post diagnostic support (where commissioned).

2.9.2 Adult autism assessment quality standards

1. Assessments should be performed by clinicians who have the relevant experience both in the assessment of autism and in its common comorbidities and differential diagnoses. Ideally, clinicians involved in assessments should have access to the expertise of a multidisciplinary team.
2. Prior to starting the assessment, ensure that the individual understands the purpose, potential benefits, and risks of the diagnosis.
3. The assessment must comprehensively cover the following areas: core features of autism, early developmental history, behavioural issues, functional abilities in different settings such as home, school, and work, and any current or past physical or mental health conditions.
4. Utilise structured clinical interviews to systematically gather information relevant to the diagnosis. These interviews should be based on established criteria (DSM-5 and ICD-11) and protocols to ensure consistency and reliability. This is distinct from an assessment with family/carers or conversations with siblings (for example, developmental history taking or asking for descriptions of current concerns). This is also distinct from semi-structured behavioural observation assessments that specifically focus on traits associated with autism (for example, the Autism Diagnostic Observation Schedule – 2; ADOS-2 (35)). The clinical interview is pivotal for putting into context scores obtained on standardised questionnaires that may be used for screening or triage, or scores on semi-structured assessment tools. This also helps to address the question as to whether the service user may have differential or co-occurring diagnoses; crucial for formulation and reaching clinical conclusions. Therefore, the clinical interview must include screening or assessment of common differential or co-occurring diagnoses, as part of the clinical interview conducted by a clinician with a medical background or a qualified mental health professional.
5. The assessment should also include information gathered from an informant. Early developmental information is an important part of an autism assessment and should be gathered from a person who knew the service user as a child where possible. This is not always possible when assessing adults. Wherever possible corroborative information should also be sought from family members, spouses, friends, carers, this is especially true if no early childhood informant is available. There will be circumstances where no corroborative information is available. Though this does not necessarily negate the possibility of an assessment, it should be factored into the formulation of the person. If no childhood informant is available information should be gathered from a person who knows the individual well currently.

6. Consider using validated assessment tools like the Autism Diagnostic Interview – Revised (ADI-R) and Autism Diagnostic Observation Schedule (ADOS-2). These tools should be tailored to individual needs and should complement, not replace, clinical judgement. The use of these tools is not mandatory but should be considered in complex cases.
7. Collect information on how the individual currently functions in various social and adaptive contexts. Observe and document behavioural patterns, communication abilities, and daily living skills. This may or may not include the use of standardised assessments for this purpose (for example the ADOS-2). If standardised assessments are used it is important that clinicians are appropriately trained in their use and that the scores are interpreted in the context of the information gathered during the clinical interview. Scores by themselves are not sufficient to indicate a positive or negative diagnosis.
8. A thorough assessment should evaluate the possibility of other neurodevelopmental conditions, mental disorders, physical disorders, and communication difficulties. It is essential to distinguish autism from other conditions that may have overlapping symptoms.
9. Assess potential risks such as tendencies for self-harm, breakdown of existing support systems, or rapid escalation of behavioural issues. Develop a risk management plan as a preventive measure, should these risks be significant. Document the risks and management plan in the report.
10. The assessment setting should be conducive for the individual being evaluated. It should be quiet, free from distractions, and physically comfortable to ensure accurate and reliable data collection.
11. Once the assessment is complete, provide clear and easily understandable feedback, both verbally and in writing. Discuss the diagnostic outcome and its implications and ensure that all of the individual's questions and concerns are addressed. The process and outcome of this discussion should be documented.
12. After the assessment, a recommendation should be developed and documented. This plan should be individualised, focusing on the person's unique strengths, weaknesses, and needs. It should also link the individual to post-diagnostic support services.
13. If a diagnosis of autism has been made, follow-up should be arranged in order to provide information about the diagnosis and allow an opportunity for questions by the service users or their carers/family members. This follow-up could be an individual appointment or happen as part of a group.

2.9.3 Enhanced autism assessment

When there are complexities in an autism assessment, for example the presence of complex mental health disorders, an assessment may include, in addition to the above, the use of standardised assessment tools, broader assessment of clinical presentation, liaison with other services and a multi-professional discussion about the diagnostic outcome. The assessment pathway should be flexible enough to accommodate such complex cases. It may be that these cases need multiple assessments over time.

2.9.4 Formulating a view about diagnosis

Formulation is based on the integration of information gathered from a clinical interview, behavioural observation, developmental and corroborative accounts, clinical and educational records and liaison with other professionals. It must be viewed as more than just the scores on any given screening questionnaires or assessment tools. Diagnosis is a clinical decision - made by clinicians on the basis of all available information and in light of their clinical experience. All health professionals involved in the assessment should contribute to the formulation. At times it may be appropriate to hold broader MDT meetings, which include clinicians that were not involved in the assessment, to assist in formulation. This is especially true when an individual's presentation is complex and there may be alternate explanations for an individual difficulties and/or where the specific expertise of a clinician would be useful in the formulation process, for example a speech and language therapist.

2.10 Outcome post assessment

Service users will be provided with detailed feedback where the results of the assessment and the implications of this are discussed with them.

If a diagnosis of autism has not been made, the feedback appointment(s) would be an opportunity to discuss other factors that may have contributed to their difficulties. Service users will also be signposted and/or referred to appropriate services, as required.

If a diagnosis has been made, the feedback appointment(s) should be used to describe why this decision was made as well as a review of the service user's strengths and needs. This should be used to develop person centred recommendations which are realistic and available to the person in their local area.

Feedback should be supported by the production of an assessment report which should echo what was discussed in the feedback appointment(s) as well as set out the parameters of the assessment that led to this conclusion. This should be produced in a timely fashion (10 working days) and be shared with the GP/referrer, in addition to being sent to the service user.

The Provider will ensure that, as part of their service offer and discharge processes, service users are well-informed about their condition. They should be given information and signposting about community, voluntary and other services which may be of help to them.

All service users should be made aware of the Provider's statutory duty to share any relevant information with other agencies when there is a safeguarding concern, or it is thought crime or disorder has possibly taken place. When there is a safeguarding concern the voice of the possible adult at risk should be part of all stages of the process.

Whilst providing care, support and treatment to patients, staff need to be mindful that a family member may be a carer, be able to support that individual to identify with the role and signpost them to support services that can provide information and undertake a carer's assessment if appropriate.

In complex cases, it is expected where a service user is known and accessing other services e.g. housing, social care that the provider will engage with other health professional as and when required.

2.11 Post diagnostic support

Upon diagnosis, the service user should be provided with some psycho educational support.

2.12 Prescribing

Not applicable as the service does not have a prescribing role.

2.13 Performance Reporting

As part of the Provider internal data completeness, cleansing and quality processes, the ICB expect the information provided by operational team(s) to be scrutinised and understood by performance management staff and the senior management teams before submission to commissioners. The senior management team will take full responsibility for the accuracy of data insofar as the current level of completeness, coverage and accuracy of data has been established, taking into account any reported overall or service-specific improvements during the contract year(s).

Service access will be monitored through monthly reports from the provider and through regular contract review meetings with BNSSG ICB.

2.14 Days/Hours of Operation

The service will operate Monday to Friday. The service does not operate an emergency service.

2.15 Interdependencies with other services/providers

The Provider has a responsibility for the interface and development of appropriate pathways with other services; ensuring services are communicated to potential referrers. The provider will be required to work in co-operation with (and not limited to):

- ICB Commissioners and Exceptional Funding Request service
- GPs, and any other ICB approved referrers.
- Commissioning Support Unit (CSU)
- Local mental health trust (AWP)
- Local primary and community teams and other interface services
- Social services
- Independent and third sector providers (voluntary sector)

2.16 Relevant networks and screening programmes

The service will work within the local area agreed referral pathway.

2.17 Training/ education/ research activities

It is expected that the staffing levels will be sufficiently resourced and have the appropriate skills mix to meet the defined needs of the service users and to provide the interventions. The service should ensure that they have the expertise to provide cultural awareness services.

2.17.1 Staff Training and Development:

Staff will be expected to work locally with GPs offering advice and information. It is the responsibility of the Provider to recruit/provide suitable personnel and as such the Provider will determine the exact person specification. However, the following guidelines will apply to all staff groups including temporary staff e.g. agency:

1. All staff will be required to satisfy appropriate DBS checks.
2. Staff will have the appropriate clinical and managerial qualifications for their role.
3. All staff shall be appropriately trained/qualified and registered to undertake their roles and responsibilities.
4. Professional accountability must be formulated within an agreed governance structure.
5. Appropriate supervision arrangements for all levels of staff will be in place, including induction and clinical supervision.
6. Staff will participate in regular personal performance reviews including the development of a personal development plan.
7. All staff will be required to attend relevant mandatory training.
8. Staff will be expected to work locally with GPs offering advice and information.

As set out by the Care Quality Commission (CQC), registration documentation will be held on record by the Provider for all medical staff and will be available for inspection. A certificate of registration will be prominently displayed by the Provider in all sites (if applicable) that the service is provided from.

2.17.2 Clinical or Managerial Supervision Arrangements:

Supervision is regular protected time within work to reflect on and discuss a range of issues which together contribute to maintaining standards and ensure that the service delivers the highest quality of care to service users and carers.

2.18 Equality of Access

The Provider shall ensure the premises (if applicable) from which the service is to be provided shall be fully compliant with the Disability Discrimination Act (2005), the Equality Act (2010) and any other statute or common law relevant to the provision of the service and relating to Equality and Discrimination.

The Provider will treat all service users in a safe and appropriate environment depending upon age and any existing medical conditions. The provider must ensure that services deliver consistent outcomes for patients regardless of;

1. Gender
2. Race
3. Age
4. Ethnicity
5. Income
6. Education
7. Disability
8. Sexual Orientation

The Provider shall provide appropriate assistance and make reasonable adjustments for patients and carers who do not speak, read or write English or who have communication difficulties including cognitive impairment, lack of capacity, hearing, oral or a learning disability in order to:

1. Minimise clinical risk arising from inaccurate communication.
2. Support equitable access to healthcare for people whom English is not a first language.
3. Support effectiveness of service in reducing health inequalities

An Interpreter, advocate or Independent Mental Capacity Advocate or contact with PALS should be provided if necessary. Translation and Interpreting services must meet the relevant standards.

2.19 Information Governance

All organisations that have access to NHS patient data must provide assurances that they are practising good information governance and use the Data Security and Protection Toolkit (DSPT) to evidence this.

The Data Security and Protection Toolkit is a Department of Health Policy delivery vehicle that the Health and Social Care Information Centre (HSCIC) is commissioned to develop and maintain. It draws together the legal rules and central guidance and presents them in a single standard as a set of information governance and data security assertions. The Provider is required to carry out self-assessments of their compliance against these assertions.

The Provider will identify an Information Governance lead.

The Provider must complete and provide evidence that they have achieved a satisfactory position for their organisation's Data Security and Protection Toolkit through meeting all the mandatory requirements https://www.dsptoolkit.nhs.uk/

Final publication assessment scores reported by organisations are used by the Care Quality Commission when identifying how well organisations are meeting the Fundamental Standards of quality and safety – the standards below which care must never fall.

The Provider shall comply with all relevant national information governance and best practice standards including NHS Security Management – NHS Code of Practice, NHS Confidentiality – NHS Code of Practice and the National Data Security Standards. The Provider will participate in additional Information Governance audits agreed with the Commissioner.

2.20 Subcontracting

The Provider shall ensure that no part of the services outlined in this specification may be subcontracted to any other party than the approved Provider without the prior agreement and approval of the Commissioner.

2.21 Notifying and agreeing changes to services.

Providers must ensure that they seek Commissioners' consent to planned service changes as proposed Variations under GC13. If changes are made without Commissioner agreement, the Commissioner may be entitled under the Contract to refuse to meet any increased costs which ensue.

3. Applicable Service Standards

3.1 Applicable national standards

- Autism spectrum disorder in adults: diagnosis and management (2021)
  Overview | Autism spectrum disorder in adults: diagnosis and management | Guidance | NICE
- Autism Quality standard [QS51]
  Overview | Autism | Quality standards | NICE
- Autism in adults (May 2020)
  Autism in adults | Health topics A to Z | CKS | NICE

3.2 Applicable standards set out in Guidance and/or issued by a competent body

- Royal College of Psychiatry CR 228, July 2020- The psychiatric management of autism in adults
  The psychiatric management of autism in adults (CR228) (rcpsych.ac.uk)

4. Location of Provider Premises

The provider will provide the service virtually.

SCHEDULE 2 – THE SERVICES

A. Service Specification

Service Specification No.	**2A1**
Service	**Attention Deficit Hyperactivity Disorder (ADHD) – Adults (18+ years)**
Commissioner Lead	**BNSSG Integrated Care Board (ICB)**
Provider Lead	
Period	**1st April 2024 – 31st March 2025**
Date Last Reviewed	**January 2024**
Date of Next Review	**Quarter 4 2025**

1. Purpose

This service specification outlines BNSSG ICB objectives, scope, pathway and principles of the Adult Attention Deficit Hyperactivity Disorder Service (ADHD).

1.1 Aims and objectives

1. To improve ADHD related outcomes for each service user:
   - ADHD related functional impairment as measured by the WEISS FI scale.
   - ADHD related quality of life as measured by the AAQoL.
   - Mental wellbeing measured by Warwick and Edinburgh Mental Wellbeing scale.
   - ADHD symptomology as measured by Barkley ADHD rating scales.
   - PROMS are measured at assessment, end of titration and at annual review.
2. To provide a quality service that ensures there is optimal patient safety, clinical effectiveness and a person-centred approach to care taken.
3. Provide accessible assessments and diagnosis either face to face or virtually with clear reasoning behind decision reached.
4. To offer advice specific to the individual to other services and agencies, to include primary mental health care, third sector provision, secondary and tertiary services; regarding the management of ADHD with an interagency and multidisciplinary approach.
5. Treatment plans will be devised collaboratively with reference to the service user's goals to meet psychological, behavioural and occupational needs. Environmental modifications will be considered and progress to pharmacological interventions considered only if ongoing impairment in one domain subsequent to this is present (NICE, 2018).

The adult ADHD service provided will be informed by the following guidance and good practice guidelines:

1. ADHD: diagnosis and management NICE guideline NG87, published 14 March 2018, last updated 13 Sep 2019. https://www.nice.org.uk/guidance/ng87#:~:text=In%20September%202019%2C%20we%20amended,that%20poses%20an%20increased%20cardiovascular
2. Royal College of Psychiatrists – ADHD in adults: good practice guidelines.

https://www.rcpsych.ac.uk/docs/default-source/members/divisions/scotland/adhd_in_adultsfinal_guidelines_june2017.pdf

3. British Journal of General Practice guidance – Assessments for adult ADHD: what makes them good enough? https://bjgp.org/content/73/735/473
4. British Association of Psychopharmacology's guidelines (Bolea-Alamañac et al, 2014) https://www.bap.org.uk/pdfs/BAP_Guidelines-AdultADHD.pdf and the European Consensus Statement (Kooij et al, 2010) https://pubmed.ncbi.nlm.nih.gov/30453134/
5. General Medical Council guidance 2021 on shared care and prescribing. https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-practice-in-prescribing-and-managing-medicines-and-devices/shared-care

The Provider will work under the following values:

1. Personalised care and sharing decision-making ('No decision about me without me') should be a governing principle in service design and delivery.
2. It is important that all clinicians working with adults with ADHD are able to adopt a 'trauma-informed' approach as is appropriate since there is evidence that people with ADHD are more likely than their peers to have experienced adverse childhood events (ACEs) (Brown et al, 2017).
3. Equal and timely access to appropriate services and evidence-based interventions.
4. Proactive, assertive engagement, particularly with service users at higher risk (e.g. young people at risk of offending/offenders or older people who are homeless).
5. Co-ordinated interventions planned around outcomes agreed by the user of the service, tailored to their individual needs, choices and preferences, with a holistic focus on building individual strengths and improving quality of life.
6. Culturally appropriate integrated approaches and interventions for neurodevelopmental disorders, co-existing mental health problems and co-existing alcohol and illicit drug use.
7. Early intervention and other evidence-based interventions, including those delivered by high-quality services along a stepped pathway of care from primary to secondary services.
8. In agreement with the service user, involvement of family, friends, partners and support networks and good, clear information to inform people's choices and decision-making.
9. Medication used in the treatment pathway must meet with commissioning organisation (BNSSG) requirements for an evidence based and cost-effective formulary, with clear governance arrangements for the use of unlicensed medicines.

1.2 National and local context and evidence base

Clear guidance on clinical practice to support healthcare in ADHD is spelled out in national clinical guidelines. NICE guidance is linked to each ICBs responsibility and legal duty to regard NICE quality standards and recommendations, secure high-quality services and ensure continual improvement in the quality of local NHS services (in addition to their legal duty to reduce health inequalities) as set out in the NHS Constitution and The National Health Service Act (2006), as amended by The Health and Social Care Act (2012).

Furthermore, it appears that courts are increasingly willing to acknowledge that national guidance may be relevant (in conjunction with clinical judgement) in setting standards of care because they are evidence based and reflect reasonable medical practice. This means ICBs and clinicians are potentially at risk of being challenged if they do not adopt and follow NICE Guidance and they should only not adopt if they have something better to offer and there is agreement from Commissioners.

The rights of people with ADHD in the UK are protected under the Human Rights Act 1998 (article 14: right to non-discrimination), and further under the UK Equality Act 2010, which protects people with a disability (including ADHD). People with ADHD also have rights under the Public Sector Equality Duty

in England, Scotland and Wales, which places an obligation on public authorities to positively promote equality, not merely to avoid discrimination.

1.2.1 Right to Choose

Since 2014, in England under the NHS, patients have a legal right to choose their mental healthcare provider and their choice of mental healthcare team. If a patient decides the waiting time for their ADHD assessment is too long, then they can choose alternative providers. The provider must be commissioned for the service by an ICB in order to offer Right to Choose.
https://www.england.nhs.uk/long-read/patient-choice-guidance/

NHS Choice Framework - what choices are available to you in your NHS care
https://www.gov.uk/government/publications/the-nhs-choice-framework/the-nhs-choice-framework-what-choices-are-available-to-me-in-the-nhs

Patients have the Right to Choose when the following conditions are met:

- The NHS practice is in England (different rules apply for Scotland, Wales and Northern Ireland).
- The General Practitioner (GP) has agreed to make a clinically appropriate referral.

Certain restrictions apply and patients cannot exercise their Right to Choose if they are:

- Already receiving mental health care following an elective referral for the same condition.
- Referred to a service that is commissioned by a local authority, for example a drug and alcohol service (unless commissioned under a Section 75 agreement).
- Accessing urgent or emergency (crisis) care.
- Already have a diagnosis of ADHD and are receiving treatment through a primary care contract.
- In high secure psychiatric services.
- Detained under the Mental Health Act 1983.
- Detained in a secure setting. This includes people in or on temporary release from prisons, courts, secure children's homes, certain secure training centres, immigration removal centres or young offender institutions.
- Serving as a member of the armed forces (family members in England have the same rights as other residents of England).

There are restrictions on who the patient can direct their care to. Patients cannot refer to just any provider. The provider must:

- Have a commissioning contract with any ICB in England or NHS England for the required service.

Furthermore, a diagnosis of ADHD should only be made by a specialist psychiatrist, paediatrician or other appropriately qualified healthcare professional with training and expertise in the diagnosis of ADHD, as per the NICE Guidelines.

1.2.2 Strategic context

1. Under the NHS Long Term plan, https://www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24 the formation of Primary Care Networks (PCNs) in combination with the establishment of NHS Integrated Care Systems (ICSs), represents an opportunity to establish new and effective working practices to enable consistent and accessible healthcare for all people with ADHD. The NHS Community Mental Health Framework, https://www.england.nhs.uk/mental-health/adults/cmhs also sets out a vision for

how community services should modernise to offer joined-up-care for those with mental health needs, within ICSs.

2. Recent guidance, stemming from professionals across primary, secondary, and tertiary care in the UK, has recommended the development of an ADHD specialism within primary care as part of a roadmap for improving access to treatment https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-022-04290-7
The evidence base outlined above, and current guidelines, highlight the key role primary care services have to play in the provision of healthcare for people with ADHD, and the potential for supporting an expansion of this role. Not only are primary care practitioners, such as GPs, often the gatekeepers through the referral system to secondary care services, such as adult mental health and specialist ADHD services, but NICE guidelines recommend that they also provide healthcare support such as routine monitoring and prescribing of medication under shared care agreements with secondary care services. Furthermore, primary care services have an increasing role to play in terms of providing mental health and well-being support to people with ADHD, with additional roles such as mental health workers and social prescribing link workers funded through PCNs.

Such joined up care is supported locally as follows: BNSSG's mission is *"Healthier together by working together."*

"People enjoying healthy and productive lives, supported by a fully integrated health and care system - providing personalised support close to home for everyone who needs it."

1.2.3 BNSSG ICS aims

BNSSG's Strategy and Joint Forward Plan have been developed to align with, and support, the four aims of Integrated Care Systems:

1. Improve outcomes in population health and health care.
2. Tackle inequalities in outcomes, experience and access.
3. Enhance productivity and value for money.
4. Help the NHS support broader social and economic development.

BNSSG's Joint Forward Plan https://bnssghealthiertogether.org.uk/library/joint-forward-plan/ (published June 2023) sets out how BNSSG ICB will deliver on the national vision of high-quality healthcare for all, through equitable access, excellent experience, and optimal outcomes over the next five years.

It aims to:

1. Improve the health and wellbeing of the population.
2. Provide high-quality services that are fair and accessible to everyone.

In 2024, BNSSG published a Mental Health Strategy. The strategy has six ambitions.

1. Holistic Care
2. Prevention and early help
3. Quality treatment
4. Sustainable System
5. Advancing equalities
6. Great place to work

https://bnssghealthiertogether.org.uk/health-wellbeing/mental-health-strategy/

The core reference for Adult ADHD provision:

National Institute for Health and Clinical Excellence (NICE) 2018: Attention Deficit Hyperactivity Disorder: diagnosis and management https://www.nice.org.uk/guidance/ng87

In BNSSG we have seen unprecedented demand for diagnosis and treatment of ADHD over the last few years. Demand exceeds locally commissioned services resulting in long waiting times and significant growth.

2. Service Scope

2.1 Attention Deficit Hyperactivity Disorder summary

ADHD is a common condition in adulthood with estimated prevalence rates of 3-4% (NICE 2018, 2023). Attention Deficit Hyperactivity Disorder (ADHD) is a neurodevelopmental disorder consisting of the core symptoms: inattention, hyperactivity and impulsivity.

There are three subtypes of ADHD accounting for variations in the symptom profile:

- Combined presentation (50-75%),
- Predominately inattentive (20% to 30%) and
- Predominately hyperactive/impulsive presentation (15%). (NICE 2018, 2023)

In childhood, ADHD is more commonly diagnosed in boys than in girls. In adults the prevalence of ADHD in men and women is more equal. ADHD is a highly heritable condition. Approximately 2/3 of young people with a childhood diagnosis continue to suffer disabling ADHD symptoms in adulthood. ADHD is frequently associated with other developmental disorders (Autism Spectrum Disorders, Dyspraxia, Dyslexia, Dyscalculia, Tics, specific learning disorders, sensory integration problems etc), psychiatric disorders, alcohol & substance use, oppositional and unlawful conduct and other difficulties.

The suicide risk is increased in people with ADHD but this is largely down to co-morbid psychiatric disorders. In addition, physical health problems such as obesity, sleep disorders, migraine, epilepsy, asthma and accidents are more common in people with ADHD. Many of the associated conditions do not respond to treatment well until ADHD is diagnosed and managed. Untreated ADHD can affect all aspects of a person's life and wellbeing, impact on families and communities, and result in increased health, societal and economic costs. Treatment for ADHD is effective, improves health outcomes, reduces risks, improves quality of life and benefits the (health) economy.

2.2 Service description

Function of the Adult ADHD Service

The Provider shall only be accredited via BNSSG ICB's accreditation process to provide those services for which they have been qualified. Providers will be required to submit evidence of the clinical pathways used for each specialty/service they intend accepting referrals for.

The Provider will provide specialist assessment and prescribing for Adults over the age of 18 years with Attention Deficit Hyperactivity Disorder and Attention Deficit Disorder.

All assessment, treatment, monitoring and review will be undertaken by the provider and reviewed within shared care protocols where applicable. The Provider must ensure that a diagnosis of ADHD is only made by a specialist psychiatrist, paediatrician or other appropriately qualified healthcare professional with training and expertise in the diagnosis of ADHD.

2.3 Population covered

BNSSG ICB is commissioning this service on behalf of patients registered with a GP for which the ICB is responsible. Under Patient Choice rules, patients from outside of BNSSG may choose to select the provider and in these circumstances an invoice for payment should be directed to the appropriate responsible ICB.

2.4 Care pathway

The Provider will provide an ADHD assessment, diagnosis, prescribing and titration service with post diagnostic follow up reviews through a multi-disciplinary diagnostic and intervention service to service users registered with a BNSSG GP practice.

The pathway for shared prescribing is outlined in this document in Section 2.12. GP Practices may choose not to enter into shared care with a provider.

BNSSG general practices also have the option to sign up to a local enhanced service where the practice will undertake the prescribing and annual review of the patient. This sign up is voluntary. Please see appendix 1 for specification details.

The service will support the self-management of Service Users.

2.5 Referral Criteria and sources

Once an individual has selected their chosen provider, they will be referred directly to the provider by their GP or by secondary mental health services for assessment, diagnosis and treatment (if applicable) when a service user has been assessed and found not to have a co-existing secondary mental health service need.

2.6 Referral processes and Waiting List

The Provider must triage the referral within 5 working days of receipt of the referral. The Provider must regularly undertake waiting list review to ensure service users' clinical needs have not changed. Prioritisation for assessment is not normally given, but certain patients may be prioritised depending on their circumstances e.g., those who are already diagnosed and/or clearly at risk from not being treated.

2.7 Any exclusion criteria

Individuals currently with co-existing mental health conditions receiving ADHD treatment as part of their secondary mental health services treatments and interventions.

The Provider will treat all service users in a safe and appropriate environment. The Provider is entitled to exclude certain groups of patients for reasons of clinical safety or complexity of support healthcare facilities normally required, which are not available. Any changes to the provider's exclusion and acceptance criteria must have previously been shared and agreed with the relevant commissioner(s).

The Provider shall reject any referred NHS patient for the following reasons; (to be agreed with provider post accreditation)
Where it is felt the exclusion criteria should be applied, the Provider should make all reasonable attempts to discuss this with the service user and where appropriate, the service user's GP to ensure that the decision is informed and evidence based.

The Provider should ensure that when the exclusion criteria is applied, the service user is informed by a member of staff with an understanding of the criteria and the evidence used to inform the decision. The service user should receive a full explanation of the reasons for exclusion and where requested, the evidence used to inform the decision and signposted to other support services.

Commented [LC1]: To be agreed between provider and commissioner

2.7.1 Referral accepted and assessment delayed

Alcohol and substance use that impacts on the current presentation in a way which renders the assessment invalid.

2.7.2 Do Not Attends (DNAs)

The Provider will not charge for any service user who does not attend their appointment.

2.8 Assessment standards

As detailed in and derived from the documentation referenced under section 1.1 Aims and objectives, the locally agreed assessment standards are referenced on REMEDY https://remedy.bnssg.icb.nhs.uk/adults/mental-health/adhd-adult/ and the Provider will comply as follows:

- A comprehensive clinical and psychiatric history, to include mental state and risk assessment.
- A detailed developmental history.
- An up-to-date physical health history (primary care summary can be informative).
- Verbal and/or written collateral history, including school/educational reports, references etc.
- A diagnostic framework (currently ICD-11, DSM-5) should be referred to.
- Evidence of a diagnostic interview, either by using an established diagnostic instrument such as the DIVA, ACE + etc. or detailing systematic exploration of current and childhood symptoms.
- Reference to pervasiveness of symptoms across at least two important settings.
- Impact of ADHD symptoms on psychological, social, educational/occupational aspects of the person's life (The use of a questionnaire such as the WEISS functional impairment scale can be useful).
- Consideration of co-morbidities and their impact on ADHD symptomatology and overall impairment.
- Reference to limitations with the assessment due to inaccessible information, restrictive environments etc.

The assessment must be written into a comprehensive report and in addition to the above, should include:

- Information about the professional(s) who undertook the assessment, their role title, professional registration, and that the person/people undertaking the assessment are consistent with adopting NICE guidance on the composition of assessment teams. A diagnosis of ADHD can be made by a single clinician with appropriate training and experience in ADHD assessment (e.g., Psychiatrist, Psychologist or another appropriate qualified professional).
- In those circumstances where (ADHD) medication has been initiated following an assessment, it is important that the rationale for the treatment be stated by the professional who initiated the treatment. Reference to the guidelines and clinical practice to be included.

With the above standards in place, assessments can be accepted at face value between ADHD services, including from the independent sector. Where these standards have **not** been met, service users wishing to transfer into the NHS Bristol Adult ADHD Clinic (Avon and Wiltshire Partnership NHS Trust) will require a referral to the Clinic for a more comprehensive assessment, with a longer waiting time.

2.9 Assessment outcomes

All assessments must have a recorded outcome. Possible outcomes are:

- Diagnosis of ADHD.
- Confirmation of a previous or childhood diagnosis of ADHD.
- Non-diagnosis of ADHD.

- Identification of other needs/conditions and signposting.
- Liaison with other services, if required.
- Acceptance into the service for necessary treatment and interventions.
- Shared care agreement with GP with appropriate advice and support.

Service users will not need to have a care plan; however, their agreement will be sought in reaching and documenting a full written record of their assessment and care, including all relevant aspects of their assessment and treatment from the Provider.

2.10 Communication of outcome https://bjgp.org/content/73/735/473

The Provider will provide:

- Detailed feedback, explanation, and psychoeducation about ADHD, in easily accessible language.
- A discussion about psychosocial issues, including education or occupation and driving.
- Time for the service user to reflect on the diagnosis and ask questions and have the option available to go back to the assessment provider to ask further questions.
- A written summary of the discussion. This will be shared with the service user and other relevant parties, e.g. the referring professional and the GP.

2.11 Treatment https://bjgp.org/content/73/735/473
https://www.nice.org.uk/guidance/ng87#:~:text=In%20September%202019%2C%20we%20amended,that%20poses%20an%20increased%20cardiovascular

- A discussion to allow shared decision making about available treatment options, consideration of contraindications, and reasons for preferring one treatment to others.
- Consideration of measurable treatment goals before starting treatment.
- Treatment options are provided alongside or as an alternative to medication pathways to educate the patient on their condition and the alternatives available to them.
- Physical monitoring for medication (clinical examination, blood pressure, pulse, and weight) at baseline and during treatment to be undertaken by the provider. Some physical monitoring by patients themselves.
- Liaison with the GP to ascertain whether the GP is willing to take over future prescribing, while recognising there may be different patterns of 'shared' care.
- Right to Choose providers to inform themselves on what NHS treatment provision is available locally in order to understand limits in provision and not raise patient expectations unreasonably.

2.12 Transfer to Shared care arrangement with Primary Care

Providers must be aware that some GPs in BNSSG are not undertaking shared care or Local Enhanced Services, so communication with the service user's GP is essential. If a GP does not agree to undertake prescribing and monitoring under a formal "Shared Care" agreement, they are under no obligation to do so. In such an event, the total clinical responsibility for the patient for the diagnosed condition remains with the specialist Provider.

The service will provide initiation of treatment, follow up appointments (including prescribing and associated physical monitoring) until treatment is stabilised as detailed in BNSSG approved shared care protocols https://remedy.bnssg.icb.nhs.uk/formulary-adult/scps/scps/ and https://remedy.bnssg.icb.nhs.uk/adults/mental-health/adhd-adult/

Shared care between the Provider and the patient's GP may be established according to the following principles:

- Shared care is with agreement of all parties i.e. specialist, GP and service user.

- The shared care protocol has been shared and agreed with the GP before the transfer of clinical and prescribing responsibility to the GP.
- The service user has undergone appropriate stabilisation period for a medicine, is on a stable dose and side effects treated before prescribing is handed over; duration determined by the shared care protocol e.g. 3 months.
- Discharge letters to be sent (either electronically or by post) to services users and copied to GPs/referrers within 10 days of appointment.
- At the point of the implementation of a shared prescribing protocol for Adult ADHD, the service user will be informed of the transition and shared ongoing care with the GP.
- There is a structure in place by the Provider for the GP to access on-going clinical advice and support, detailed in the shared care arrangement e.g. adverse effects, abnormal monitoring, advice during a medication shortage etc.

All prescribing and monitoring responsibilities remain with the Provider until the service user is stable and GP agrees to share care.

A prescriber can choose not to accept clinical responsibility because of lack of familiarity or competence in the use of a medicine or if it is used outside agreed guidance. Prescribers may not refuse clinical responsibility solely on grounds of cost. Distance is not a reason for requiring transfer of care.

2.13 Prescribing

Environmental Modifications

Environmental modifications and changes to the physical environment to minimise the impact of ADHD on day-to-day life should be discussed prior to medication treatment.

Non-pharmacological treatments consisting of structured supportive psychological interventions focused on ADHD, for example Cognitive Behavioural Therapy (CBT) and psycho education regarding ADHD should be discussed as treatment options and if offered be in line with NICE (2019) recommendations.

All prescribing should be within the agreed patient care pathway, and compliant with BNSSG Joint Formulary, with clear governance arrangements for the use of medicines, including any use of unlicensed medicines.

2.13.1 Medication

Medication titration as per NICE (2018) guidance and compliant with BNSSG Joint Formulary, with clear governance arrangements for the use of medicines, including any use of unlicensed medicines.

All prescribing for ADHD must be initiated by a healthcare professional with high quality training and expertise in diagnosing and managing ADHD and is expected to be in line with:

- Local BNSSG formulary https://remedy.bnssg.icb.nhs.uk/formulary-adult/chapters/4-central-nervous-system/42-mental-health-disorders/ and
- BNSSG shared care protocols https://remedy.bnssg.icb.nhs.uk/formulary-adult/scps/scps/ and
- NICE guidance NG87 Overview | Attention deficit hyperactivity disorder: diagnosis and management | Guidance | NICE

Any prescribing that is not in line with all of the above will not be considered suitable for shared care with GPs. Where the formulary specifies a first line brand of a medication, the expectation is that the provider will also choose this first line unless there is a justifiable clinical reason why this is not suitable.

First line treatments

- Methylphenidate modified-release and immediate-release.
- Lisdexamfetamine.

Second line treatments

- Atomoxetine (recommended only if methylphenidate and lisdexamfetamine have been trialled and are unsuitable).
- Dexamfetamine (recommended only for adults whose ADHD symptoms are responding to Lisdexamfetamine but who cannot tolerate the longer effect profile).

If medication is agreed to be appropriate via shared decision making between the clinician and the service user, the following steps should be followed:

- All physical health monitoring should be undertaken as per the BNSSG shared care protocol to prepare for medication initiation.
- Treatment should be initiated and titrated until stable.
- Shared care with GP can be sought if all principles listed in 2.12 are met.

2.13.2 Treatments not suitable for shared care

- Dual treatment of stimulants or stimulants with atomoxetine is non-formulary in BNSSG and therefore is not suitable for shared care.
- NICE NG87 advises not to offer guanfacine for adults without advice from a tertiary ADHD service. Therefore GPs will be advised not to accept shared care of Guanfacine from providers.

2.14 Annual Reviews

- Annual reviews to be carried out with NICE Guideline NG87 and BNSSG ICB Shared Care protocols for medicines for ADHD in Adults. They may be undertaken by the Provider or the GP, depending on local commissioning arrangements. The Provider will need to confirm with the GP they wish to share care with, whether they are signed up to the BNSSG ADHD Local Enhanced Service (LES).
- Annual reviews can be undertaken by GP practice if signed up to BNSSG ADHD LES.
- Annual review to be undertaken by the Provider, if the patient is registered at a practice that is not signed up to the LES.
- In consultation with the patient, consider trial periods of stopping medication or reducing the dose when assessment of the overall balance of benefits and harms suggests this may be appropriate. If the decision is made to continue medication, the reasons for this should be documented.

2.15 Days/ hours of operation

- The service will operate minimum Monday to Friday 5 days a week.
- The service does not operate an emergency service.

2.16 Response times

- The service should aim for maximum 18 week wait referral to treatment time.
- Service access will be monitored through monthly reports from the provider and through regular contract review meetings with BNSSG ICB.

2.17 Interdependencies with other services/providers

The Provider has a responsibility for the interface and development of appropriate pathways with other services; ensuring services are communicated to potential referrers. The provider will be required to work in co-operation with (and not limited to);

- ICB Commissioners and Exceptional Funding Request service.
- GPs, and any other ICB approved referrers.
- Commissioning Support Unit.
- Local mental health trust (AWP).
- Local primary and community teams and other interface services.
- Social services.
- Independent and third sector providers (voluntary sector).

2.18 Relevant networks and screening programmes

The service will work within the local area agreed referral pathway.

2.19 Training/ education/ research activities

It is expected that the staffing levels will be sufficiently resourced and have the appropriate skill mix to meet the defined needs of the service users and to provide the interventions. The service should ensure that they have the expertise to provide cultural awareness services.

2.19.1 Staff Training and Development

Staff will be expected to work locally with GPs offering advice and information.

It is the responsibility of the Provider to recruit/provide suitable personnel and as such the Provider will determine the exact person specification. However, the following guidelines will apply to all staff groups including temporary staff e.g. agency:

- All staff will be required to satisfy appropriate DBS checks.
- Staff will have the appropriate clinical and managerial qualifications for their role.
- All staff shall be appropriately trained/qualified and registered to undertake their roles and responsibilities.
- Professional accountability must be formulated within an agreed governance structure.
- Appropriate supervision arrangements for all levels of staff will be in place, including induction and clinical supervision.
- Staff will participate in regular personal performance reviews including the development of a personal development plan.
- All staff will be required to attend relevant mandatory training.
- Staff will be expected to work locally with GPs offering advice and information.

As set out by the Care Quality Commission (CQC), registration documentation will be held on record by the Provider for all medical staff and will be available for inspection. A certificate of registration will be prominently displayed by the Provider in all sites (if applicable) that the service is provided from.

2.19.2 Clinical or Managerial Supervision Arrangements

Supervision is regular protected time within work to reflect on and discuss a range of issues which together contribute to maintaining standards and ensure that the service delivers the highest quality of care to service users and carers.

2.20 Equality of Access

The Provider shall ensure the premises (if applicable), from which the service is to be provided, as well as any virtual provision shall be fully compliant with the Disability Discrimination Act (2005), the Equality Act (2010) and any other statute or common law relevant to the provision of the service and relating to Equality and Discrimination.

The Provider will treat all service users in a safe and appropriate environment depending upon age and any existing medical conditions. The provider must ensure that services deliver consistent outcomes for patients regardless of:

- Gender
- Race
- Age
- Ethnicity
- Income
- Education
- Disability
- Sexual Orientation.

The Provider shall provide appropriate assistance and make reasonable adjustments for patients and carers who do not speak, read or write English or who have communication difficulties, in order to:

- Minimise clinical risk arising from inaccurate communication.
- Support equitable access to healthcare for people for whom English is not a first language.
- Support effectiveness of service in reducing health inequalities.

2.21 Information Governance

All organisations that have access to NHS patient data must provide assurances that they are practising good information governance and use the Data Security and Protection Toolkit to evidence this.

The Data Security and Protection Toolkit is a Department of Health Policy delivery vehicle that the Health and Social Care Information Centre (HSCIC) is commissioned to develop and maintain. It draws together the legal rules and central guidance and presents them in a single standard as a set of information governance and data security assertions. The Provider is required to carry out self-assessments of their compliance against these assertions.

The Provider will identify an Information Governance lead.

The Provider must complete and provide evidence that they have achieved a satisfactory position for their organisation's Data Security and Protection Toolkit through meeting all the mandatory requirements: https://www.dsptoolkit.nhs.uk/

Final publication assessment scores reported by organisations are used by the Care Quality Commission when identifying how well organisations are meeting the Fundamental Standards of quality and safety - the standards below which care must never fall.

The Provider shall comply with all relevant national information governance and best practice standards including NHS Security Management – NHS Code of Practice, NHS Confidentiality – NHS Code of Practice and the National Data Security Standards. The Provider will participate in additional Information Governance audits agreed with the Commissioner.

2.22 Subcontracting

The Provider shall ensure that no part of the services outlined in this specification may be subcontracted to any other party than the approved Provider without the prior agreement and approval of the Commissioner.

2.23 Notifying and agreeing changes to services

Providers must ensure that they seek Commissioners' consent to planned service changes as proposed Variations under NHS Standard Contract condition GC13. If changes are made without Commissioner agreement, the Commissioner may be entitled under the Contract to refuse to meet any increased costs which ensue.

3. Applicable Service Standards

3.1 Applicable national standards (eg NICE)

The Provider will have robust processes for reviewing, assessing, implementing and monitoring NICE technology appraisals and guidance.

Any and all treatments undertaken by providers as part of the service must be robust, evidence based, clinically effective treatments and the Provider must be qualified and registered to provide these treatments.

3.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

The Provider must deliver services in accordance with current best practice in healthcare and the range of policy and clinical/operational practice guidance relating to these services, complying in all respects with the standards and recommendations.

4. Location of Provider's premises

The Provider will provide the service virtually.

Local Reporting (this will go into Section 6 of the contract which includes national reporting, it is detailed here for feedback)

Monthly reporting

Minimal dataset

- Number of referrals received by GP Practice
- Number of referrals accepted and rejected and reason for rejection
- Referrals by gender
- Referrals by age
- Total waiting list size for first appointment broken down by monthly time bands
- Total waiting list size for 12 month annual follow appointment and number overdue 12 months.
- Number of DNAs
- Number of first appointments (assessment)
- Number of patients waiting for titration
- Number of follow up appointments provided
- Number of patients waiting therapy (if applicable)
- Number of psychological interventions received (if applicable)
- Number and percentage of service users diagnosed with ADHD

- Number and percentage of service users diagnosed with ADHD who are then started on medication
- Shared Care Agreements accepted and not accepted by GP
- Number of patients discharged.

Schedule 6C – Service development and Improvement Plan (extracted here for review and sign off)

	Milestones	Timescales	Expected benefit
Engagement with locally commissioned NHS provider - Avon and Wiltshire Mental Health Partnership Trust (AWP)	Providers offering adult ADHD services to work in collaboration with AWP to support integration with BNSSG pathways to mitigate any variations for service users. This could be via a range of options including but not exhaustive to - Shared multi-disciplinary meetings - Shared CPD - Sharing best practice	During 2024-2025 – ongoing	Shared learning. Shared professional development. Reduction in variation for service users.