Healthier Together
Improving health and care in Bristol,
North Somerset and South Gloucestershire

NHS
Bristol, North Somerset
and South Gloucestershire
Integrated Care Board

Reference: FOI.ICB-2526/086

Subject: Children and Young People (CYP) Attention-Deficit/Hyperactivity Disorder (ADHD) Service

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

QUESTION	RESPONSE
1. Please provide a list of all providers the ICB holds contracts with for this service. i. Please include both statutory NHS and Independent Sector providers ii. Please include any service that includes a CYP ADHD service (for example a broader ND service, or one that includes a combined ASD/ADHD pathway) 2. For each contracted provider listed in the answer to #1, please provide the following schedules as included in the contract the ICB holds: i. Schedule 2A or equivalent: Service Specification that describes the service (whether standalone or integrated in a broader Service Specification) ii. Schedule 3C or equivalent: Local Prices that apply to the services provided	1. BNSSG ICB holds contracts with the following providers of CYP ADHD and Autism services: • **NHS Provider (Children & Young People)** Sirona Care and Health, Badminton Road Office, 2nd Floor, Badminton Road, Yate, BS37 5AF https://sirona-cic.org.uk/contact-sirona/ • **Contracted Private Sector provider (CYP & Adults):** Clinical Partners Limited, Unit 6, Chaldicott Barns, Tokes Lane, Semley, Wiltshire, SP7 9AW https://www.clinical-partners.co.uk/contact We do not hold contracts with any other private sector ADHD and Autism providers, however, they may still see BNSSG patients under the national “Right to Choose” framework and will need to be contacted directly for the data they hold. 2. Service specifications attached i. ADHD: Document 01

	Autism: Document 02 Both service specifications under the Children's Community Health Partnership are currently under review. Local Accreditation: Document 03 ii. The ADHD services provided by Sirona form part of a wider block contract and as such individual service values are not available. Local accreditation pricing framework: Document 04

The information provided in this response is accurate as of 10 July 2025 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.

Service Specification: BNSSG Paediatrics in the Community March 2017

This specification must be read along with the overarching specification which applies to all services

1. Population Needs

1.1 Aims

To provide a consultant led, locality based paediatric service for children and young people who are vulnerable due to illness, disability and / or disadvantage.

To access traditionally 'hard to reach' groups of children and young people to ensure that they are able to receive the health input required.

To improve outcomes for children and young people as identified in national and local strategies.

To work towards an integrated approach to children's health and social care.

1.2 Policy Guidance

- National Service Framework for Children, Young People and Maternity Services (October 2004)
- Aiming High for Disabled Children (May 2007)
- Healthy Lives, Brighter Futures (Feb 2009)
- Joint Health and Wellbeing Strategies – Bristol and South Gloucestershire
- Children and Young People Plan/Partnership Strategies/Anti-poverty Strategies – Bristol and South Gloucestershire
- Working Together to Safeguard Children: A guide to Inter-agency working to safeguard and promote the welfare of children' HM Government 2015. http://www.workingtogetheronline.co.uk/index.html
- South West Safeguarding and Child Protection Procedures 2013 http://www.online-procedures.co.uk/swcpp/
- British Association of Community and Child Health guidelines. http://www.bacch.org.uk/policy/publishedguidelines.htm

1.3 General Overview

The Paediatrics in the Community service is to have two aspects:

- Delivery of a set of core community paediatric pathways for neurodevelopmental and neurodisabilities and associated conditions.
- Safeguarding, including child protection medical and clinical assessments for abuse and neglect and medical assessments of historical sexual abuse or potential current sexual abuse not requiring specialist forensic

assessments e.g. sexual assault. Assessing the health needs of looked after children and children undergoing the adoption process. Fulfilling the statutory responsibility for responding to unexpected child deaths.

Service Benefits

- Clinical leadership encompassing the most vulnerable groups with the objective of reducing health inequalities.
- Broad range of specialisms provided within the Service to ensure that complex health needs can be met.
- Strong, positive multi agency and multi-disciplinary planning and working relationships that ensure effective delivery of health services to vulnerable and disadvantaged children and young people.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

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

2.3 Expected Outcomes

- The Service will aim to meet the relevant overarching outcomes identified locally in relevant strategies described above.
- Children and young people who are thought to be harmed by abuse or neglect receive a consultant led child protection medical or clinical assessment in a timely fashion by medical staff or nurse consultants with the appropriate competencies
- Early diagnosis and intervention is optimised therefore reducing late/more intense treatment of conditions.
- The emotional needs of children are assessed and supported.
- Co-ordination and dissemination of information relating to specific

children is facilitated by appropriate attendance at multidisciplinary and multi-agency team meetings.

- Providing the CCG designated doctors for safeguarding children, Looked after Children and designated clinical officer for SEND on behalf of Bristol and South Gloucestershire CCGs.
- Services work in an integrated way to provide a holistic care approach to vulnerable children. This is facilitated by appropriate engagement or attendance at strategy and planning meetings.
- Health inequalities are reduced.
- Access to services by the most vulnerable families is improved.
- All training delivered is evaluated and of high quality.

The Service will also meet the relevant outcomes identified in the national strategy for children and young people's health 'Healthy lives, brighter futures' (February 2009).

3. Scope

3.1 Objectives of service

- To keep children safe from abuse, neglect, exploitation and accident.
- To promote access to education for all children.
- To promote child health and prevent disease.
- To provide early recognition and effective support to disabled children.
- To ensure the emotional and physical health and medical needs of Looked after children, and those being adopted, are met.
- To work in partnership with other agencies and disciplines in achieving the above.
- To research child health in a manner that supports the objectives of the service.
- To teach medical undergraduates and post graduates, as well as professionals from other agencies, to allow the objectives to be met.
- To work as part of a broad children's services network to provide high quality specialist child centred care.
- To improve equity and accessibility of service to the most vulnerable and hard to reach children.
- Provide appropriate support to increase the knowledge and skills of staff in other services who are responsible for providing health, social care and education to vulnerable children.
- To provide expert clinical paediatric leadership across the health system

and in partnership with the local authority and the Police for child protection, Child death reviews, Children in Care and Special Educational Needs and Disability, including Designated roles.

- To work with Commissioners to ensure high quality, effective and value for money services are delivered.
- To provide palliative and end of life care for children

3.2 Service Description

The Service will provide:

- General community paediatric clinical assessment and diagnosis of children identified as in need of the service.
- Assessment, diagnosis and follow up of children in need of protection, in the care of the local authority, or with special educational needs.
- 24 hr urgent medical assessments and clinical assessments for children who may have been abused or neglected by the on call child protection team
- Contribution to multi-agency assessment of neglect and emotional abuse for children referred with developmental or health issues.
- Medical examinations for allegations of historical sexual abuse, ongoing medical care and examination for current or suspected child sexual abuse (cases that do not require a forensic medical assessment)
- Providing reports for and attendance at Case Conferences for families known to the Community Paediatric service. 95% production of reports, contribution and 95% attendance when currently in receipt of services from the Paediatrics in the Community team .
- Provision of witness of fact medical reports and attendance at Court as a professional witness.
- Initial and review health assessments of children taken into the care of the local authority (see LAC service specification).
- To contribute to Education Health and Care Planning following local SEND procedures.
- Medical and clinical advice on care pathways and planning processes and assessment and management of children with emotional and behavioural difficulties.
- Detailed assessment reports to other agencies, including family and criminal justice processes. as professional witnesses for children under our care
- Advice on health concerns related to safeguarding, adoption and fostering (LA permanency panels), childhood accident prevention and other health promotion initiatives.
- Leadership and co-ordination of the team around the child. NHS services

supporting children and young people with complex Special Educational Needs in the community.

- A Named Doctor and Named Nurse for safeguarding children to lead on child protection within the organisation (see separate SLA for the detailed requirements of this role).
- CCG Designated Professionals as strategic health system wide leaders including a Designated Doctor for safeguarding children and Looked After Children and designated medical / clinical officer for SEND on behalf of Bristol and South Gloucestershire CCGs.
- Medical Advisor role for Adoption Panels.
- Medical and clinical advice to planning processes and provision of clinics for vulnerable adolescents.
- Evaluated and high quality training for other professionals/agencies as appropriate.
- Clinical advice to parents following the death of a child (including Sudden Infant Death) where appropriate.
- Joint examinations with the Forensic Medical Examiner (FME) for children below the age of 16 years who have been subjected to an acute sexual assault. 14 - 17 year olds there will be discussion re need for paediatrician to attend depending on the vulnerability of the child – see the Sexual Assault Referral Service below for detailed specification.

Out of area cover

The following service requirements are not included in the contract value and have separate funding mechanisms in place.

- A Designated Paediatrician to support the West of England Child Death Overview Panel and 24hr 365 day input for the Rapid Response process for unexpected death in children by the on call child protection team (Bristol, North Somerset and South Gloucestershire only). Costs of this activity will be reimbursed by the managing organisation for CDOP.
- Maintain a reciprocal arrangement with the Community Paediatrics Service in North Somerset for maintenance of an out of hours rota
- Undertake physical examinations for cases of suspected sexual abuse in North Somerset on a case by case basis as agreed and funded by the North Somerset service

3.3 Accessibility / acceptability

The Service will make provision to address any issues that are within its power to resolve to ensure that it is accessible to all families, children and young people for appropriate targeted support.

The Service will be provided according to agreed priorities. The service will work to agreed waiting time standards, which will be agreed with commissioners and available to the public. Such waiting times will not exceed the 18 week Referral to Treatment pathway as specified in the NHS

Constitution.

For appointment based services, the provider will need to ensure that systems are in place to effectively take bookings whilst offering choice to patients. Target and maximum waiting times to be agreed with the provider

Where possible the service will offer a second opinion to families who have concerns about the diagnosis given to their child. Where possible the service will offer a change of lead professional where relationships between the lead professional and a family have irrevocably broken down. A second opinion may also be offered where a school or setting disagrees with the service's formulation of a child's needs.

The service is expected to conform to all relevant currently published and future NICE guidance.

The service will provide clear and accessible information to families and referrers on its role and eligibility criteria. The service will engage in the Local Offer for SEND, and in signposting of families to appropriate services, both within the service and outside.

3.4 Whole System relationships

- Commissioner/provider contract management processes.
- Local Safeguarding Children's Boards in Bristol and South Gloucestershire.
- Health and Wellbeing Boards in Bristol and South Gloucestershire.
- Children's Trust Boards in Bristol and South Gloucestershire.
- Public Health in Bristol and South Gloucestershire
- Avon and Somerset Constabulary

3.5 Safeguarding

Please also refer to the overarching specification.

- The Service must ensure that policies and procedures relating to safeguarding are adhered to and that it seeks advice from the Named Professionals within the organisation and the CCG Designated Professionals as strategic health system wide leaders.
- All Staff must have undertaken training and possess the competencies at a level consummate to their role as set out in in the Safeguarding Children and Young People: Roles and Competences for Health Care Staff (RCPCH 2014) http://www.rcpch.ac.uk/sites/default/files/page/Safeguarding%20Children%20-%20Roles%20and%20Competences%20for%20Healthcare%20Staff%20

%2002%200%20%20%20%20(3)_0.pdf

- All staff must have the appropriate level of Disclosure and Barring Service (DBS) criminal record checks, community paediatrics in the community clinical staff are expected to have enhanced checks including children's and adults' barred list check(s).
- The Service should adhere to the safeguarding quality schedule and its references in the main body of the contract.
- In addition to the general requirements described above, and given the crucial role for the paediatrics in the community workforce in local child protection processes, the service will be a key partner in inter-agency planning processes for ensuring the safety and wellbeing of all children and young people.
- Monday to Friday daytime rota covering Bristol and South Gloucestershire. This will be appropriately staffed with medical and nurse specialists or nurse consultants working under full Consultant supervision. It provides clinical safeguarding expertise input into strategy discussions / meetings , clinical safeguarding expertise to the Multi Agency Safeguarding Hub (MASH) or equivalent and medical or clinical examinations when there are concerns about abuse or neglect.
- Out of hours rota supervision. Covering Bristol and South Gloucestershire.
- Consultant delivered medical consultation and clinical medical input for complex Child Protection cases admitted to Bristol Children's Hospital.
- Provide clinical safeguarding expertise and advice to Multi Agency Safeguarding Hubs (MASH) or equivalent, participating in strategy discussions / meetings as appropriate to ensure a multi-agency decision is made.

3.5 Interdependence with other services / providers

Please also refer to the overarching specification

The service will work alongside services in the Local Authorities, schools, Police, Multi Agency Safeguarding Hub (MASH) or equivalent, third sector providers and others in supporting individual children, young people and families. The service will maintain clear channels of communication and collaboration with other agencies. In particular the service will work to locally agreed protocols for the inter - agency management of safeguarding concerns, Education Health and Care Plan assessment, planning and review, and Single Assessment Framework Early Help - SAF(eh). In some areas the service may be co-located with Local Authority services, e.g. 0 - 25 Disability Service, other social care or preventative services

Relevant networks

The service will be involved in a wide range of multidisciplinary and multi -

agency networks based around its key network planning groups and professional leadership areas:

- Safeguarding and Child Protection
- Looked After Children
- Special Educational Needs and Disabilities Vulnerable adolescents
- Neurodevelopmental and neuro-disabilities and associated conditions
- Children with additional needs
- Undergraduate medical training
- Postgraduate medical training
- Continuing professional development

3.6 Service Model

The Service will be delivered generically by consultant led area and locality teams of paediatricians, nurse consultants and nurse specialists based in the community.

They will be expected to work closely with community therapists, community nurses and others to deliver an integrated clinically safe service.

Specialist consultant clinical leadership will be provided for each of the network planning areas identified

The service will specifically target vulnerable and disadvantaged children with complex health needs and will work closely with public health colleagues to plan appropriate services.

A consultant will take a lead role for ensuring that overall professional standards are set and maintained, that a cost effective in-service training programme is provided and that the service collects robust and effective activity information.

There will be adequate support from an administration service to assist the specialist functions.

3.7 Care Pathways

Clinical care pathways that are likely to be followed in this Service are for:

- Attention deficit hyperactivity disorder (ADHD)
- Impaired communication, including autistic spectrum disorders (ASD)
- Child protection

- Continence
- Complex neurodevelopmental disorders, developmental delay, complex congenital disorders, cerebral palsy, developmental coordination disorder, high risk neonates.
- Sensory impairment pathways
- Child deaths, including rapid response
- Health assessments of Looked After Children
- Epilepsy
- Down’s syndrome

3.8 Service Ethos

- Assessments and care plans will incorporate and evidence the voice of the child or young person.
- Assessments and care plans will incorporate and evidence the views of parents and carers.
- Children, young people, parents and carers will be actively involved in service development and monitoring.
- The service will support parents/carers in developing their capacity to reduce the health consequences of long term vulnerability in their children. This will include the appropriate provision of written materials and signposting to other support services.
- Early diagnosis and intervention is optimised thereby reducing late/more intense treatment requirements.
- The service supports the emotional and behavioural needs of children and young people, working alongside other services.
- The service considers the emotional wellbeing needs of children and young people with physical or sensory impairment, and makes appropriate linkages with other service to ensure these needs are met.

3.9 Referral Access and Acceptance Criteria

Geographic coverage/boundaries

The Service will be available to all families, children and young people who are registered with a GP in Bristol and South Gloucestershire.

Where cover is to be provided for North Somerset or any other area this will be set out and funded outside of the agreed contract value.

Location(s) of Service Delivery

The Service is locality and community focussed and therefore should be delivered from appropriate locations and within suitable settings, including schools, early years settings and the service user's home/place of residence when necessary in order to ensure an effective service to assessed children and young people. Young people should be offered choice to be seen in clinic or in another setting.

Teams will be co-located with Preventative Services / Social Care colleagues in community children's hubs in South Gloucestershire or other co-location bases within Bristol and South Gloucestershire.

In addition to appointment - based service delivery, multi-disciplinary meetings etc., the service will develop mechanisms for families, referrers and other professionals to seek community paediatric advice by means of telephone advice, email, online chats on specific topics etc.

Days / Hours of operation

The Service will operate flexibly within normal working hours for the majority of its services. However the Service will also provide some twilight clinics within each CCG area in order to facilitate access.

Rapid response services for sudden child deaths, urgent child protection medical advice and urgent assessment of children who may have been sexually abused will be covered by an on-call consultant led service 24 hours a day and 365 days per year.

Referral criteria & sources

The Service is available to children and young people where there are concerns about a child's health, development or educational progress.

The following general categories describe the children and young people who can be referred for specialist assessment and treatment:

- Impaired communication (including where Autistic Spectrum Disorder is suspected)
- Impaired motor function (e.g. Cerebral Palsy)
- Sensory impairment
- Impaired feeding
- Impaired sleep
- Impaired continence
- Impaired/restricted attention
- Developmental impairments or at significant risk of developmental impairment (e.g. high risk neonates)
- Learning difficulties restricting access to learning activities or participation in school

- Prolonged absence from school on health grounds (> 6 weeks)
- Epilepsy / possible seizures
- Chronic unexplained symptoms (e.g. pain, fatigue)
- Palliative care in life limiting conditions
- Children experiencing or at risk of abuse or neglect

Referral route

Referrals will be made by:

- GPs
- Health Visitors
- School Health Nurses
- Acute and community paediatric health services
- Schools and early years settings
- Children's Social Care and Preventative Services
- Police

Each Local Authority has a Single Point of Access for Local Authority children's services.

The Provider will work with each Local Authority to develop systems and protocols for access to community health services through these Single Point of Access (SPAs). Referrals will be initially be triaged by the community paediatric team. After triage it may be there is a need for further information which the team will lead on acquiring. Whilst awaiting assessment, First Point / First Response will consider access for parents to parenting support and/or education. For safeguarding through the Multi Agency Safeguarding Hub (MASH) or equivalent

Acceptance criteria

The service will see children from birth up to their eighteenth birthday. For children in certain categories (e.g. those in special schools) care will be provided until their nineteenth birthday.

Response time & detail and prioritisation

The Service will meet the following response times:

- Urgent child protection referral requiring medical assessment and immediate response to unexpected child death within 4 hrs
- Non urgent requests from Children's Social Care, Police or an Multi Agency Safeguarding Hub within 24hrs –
- Children in Care initial assessments – within 28 days from becoming

looked after by the local authority

- Assessment for SEN Education, Health and Care Plan – to be agreed with provider.
- Other referrals – within 8 weeks.
- Referral to treatment – within 18 weeks.

3.12 Equality and Diversity

Please refer to the overarching specification.

3.13 Sexual Abuse Referral Service Detailed Specification

The service will maintain and develop the existing child and family centred approach which is recognised as an area of good practice. The service will be supported by appropriately trained paediatricians, forensic medical examiners and support staff. The service will be seamless despite different criteria being applied to a variety of case presentations, so that the most appropriate professionals provide care for a variety of presentations in different settings. This will be ensured by development of a clear care pathway for children presenting with allegations of sexual abuse.

Current data indicates that approximately 24 children over 14 and under the age of 16 years, and a further xx 16 aged 17 - 18 years, received a forensic medical examination during 2014. However this number is very likely to be an underestimate and with increasing awareness of various aspects of sexual assault in the press and improved pathways this number is likely to increase significantly.

Scope of the service

The service will see all children under the age of 18 where appropriate (specific age related criteria will apply), working in partnership with other professionals and agencies to link into the wider holistic care pathways of sexual abuse services.

- **Acute victims** will be seen within the required forensic timescales, working alongside the Forensic Medical Service to provide appropriately skilled paediatric input to age appropriate examination, in order to support the health needs of the child and any criminal justice proceedings that might take place. The service will provide an appropriate extended hours service for 365 days a year.
- **Historical victims** –clinics for victims of historical abuse (outside the forensic window) or current victims not requiring a forensic examination will be provided at appropriate times. The service will support the emotional and physical health needs of the victim, signpost to other appropriate services and support any subsequent criminal justice proceedings.

Location of Service delivery

Examinations for both acute and historic cases will usually take place at the SARC or Bristol Royal Hospital for Children and must be in the most appropriate place for the victim's needs with adequate clinical support.

Examinations will be undertaken in forensically clean rooms using appropriate equipment e.g. video colposcopy. The appropriate storage of samples, images etc. will follow National Guidance (including Forensic Regulator Standards)

Workforce

The staff will be skilled to appropriate national standards. Opportunities to maintain skills should be explored through a developing network of peer review (linking into the wider South West peer review network) and through joint training sessions.

Interagency working

The service will maintain appropriate links with partner agencies particularly in respect of Children Safeguarding Procedures (Local/Regional/National) including sexual health services, Police, social services, mental health etc. to enhance the onward care and support for victims.

Data and reporting

The provider will work with the commissioner/co-commissioner to develop data and service reporting to the SARC Commissioning Board

Future service development

Future service developments will be made in collaboration with the commissioner/co-commissioner as part of the ongoing performance and monitoring process.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

4.3 Applicable local standards

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4 Parts [A-D])

5.2 Applicable CQUIN goals (See Schedule 4 Part [E])

Service Specification: BNSSG Paediatrics in the Community March 2017

Version 1: February 2016 Bid documentation
Version 2 March 2016 Agreed with Provider and commissioner amendment

NHS
Bristol, North Somerset
and South Gloucestershire
Clinical Commissioning Group

Service Specification: v0.8

Autistic Spectrum Disorder Assessment & Diagnosis Pathway 0 – 18 years

This specification must be read along with the overarching specification which applies to all services

The purpose of this document is to specify diagnostic pathways for children and young people with Autistic Spectrum Disorder. It describes the role, function and responsibilities of services. The expectation is to move away from traditional delivery that has resulted in significant waiting lists and times to a more flexible and responsive model.

1. Needs

1.1 Background

Autism was once thought to be an uncommon developmental disorder, but recent studies have reported increased prevalence and now the condition is thought to occur in at least 1% and probably nearer 2.5%of children. NICE recognises that individuals and groups prefer a variety of terms, including autism spectrum disorder, autistic spectrum condition, autistic spectrum difference and neuro-diversity. The ASD NICE quality standard recognises the important role that families and carers play in supporting their child and aims to improve the experience of not only the children and young people but also those who care for them.

- Without understanding, autistic people and families are at risk of being isolated and developing mental health problems
- Autism is much more common than many people think. There are around 700,000 people on the autism spectrum in the UK – that's more than 1 in 100. If you include their families, autism is a part of daily life for 2.8 million people
- Autism doesn't just affect children. Autistic children grow up to be autistic adults
- Autism is a hidden disability – you can't always tell if someone is autistic.
- The right support at the right time can make an enormous difference to people's lives.
- 34% of children on the autism spectrum say that the worst thing about being at school is being picked on
- 63% of children on the autism spectrum are not in the kind of school their parents believe would best support them
- 17% of autistic children have been suspended from school; 48% of these had been suspended three or more times; 4% had been excluded from one or more schools
- Seventy per cent of autistic adults say that they are not getting the help they need from social services.
- At least one in three autistic adults is experiencing severe mental health difficulties
- Only 16% of autistic adults in the UK are in full-time paid employment, and only 32% are in some kind of paid work
- Only 10% of autistic adults receive employment support but 53% say they want it

1.2 National and international context

Autism, according to the NHS Information Centre, is estimated to affect around 1% of the UK population which is around 700,000 people who live with the condition. Autism is a lifelong condition but skill and coping strategies learned as children have lifetime relevance and can make an enormous difference to their ability when they become adults with autism to make the most of their lives.

However recent studies from other countries point to a greater incidence than 1% of population. The Autism and Developmental Disabilities Monitoring Network in the USA looked at 8 year old children in 14 states in 2008, and found a prevalence rate of autism within those states overall of 1 in 88, with around five times as many boys as girls diagnosed (Autism and Developmental Disabilities Monitoring Network Surveillance Year 2008 Principal Investigators, 2012)
The National Center for Health Statistics in the USA published findings from telephone surveys of parents of children aged 6-17 undertaken in 2011-12. The report showed a prevalence rate for autism of 1 in 50 (Blumberg, S .J. et al, 2013)

A study of a 0-17 year olds resident in Stockholm between 2001-2007 found a prevalence rate of 11.5 in 1,000, very similar to the rate found other prevalence studies in Western Europe, (Idring et al , 2012)

A much higher prevalence rate of 2.64% was found in a study done in South Korea, where the researchers found two thirds of the people on the autism spectrum were in the mainstream school population, and had never been diagnosed before. (Kim et al, 2011).

Researchers comparing findings of prevalence studies from different parts of the world over the past few years have come up with a more conservative median estimate of prevalence of 62 in 10,000. They conclude that the both the increase in estimates over time and the variability between countries and regions are likely to be because of broadening diagnostic criteria, diagnostic switching, service availability and awareness of autism among professionals and the public, (Elsabbagh M. et al, 2012).

1.2 Local ASD data

Pupils with SEN and Primary need of ASD. (Jan 2018)
https://www.gov.uk/government/collections/statistics-special-educational-needs-sen

Area	Total pupils	Primary need: ASD
South West	**138265**	**1587**
Bristol City of	67161	953
North Somerset	31335	199
South Gloucestershire	39769	435
Grand Total	**138265**	**1587**

Children with Autism known to schools
https://fingertips.phe.org.uk/profile/learning-disabilities/data#page/0/gid/1938132702/pat/6/par/E12000009/ati/102/are/E06000023

	2015		2016		2017		2018	
Children with Autism known to schools	**1245**	**132785**	**1383**	**134998**	**1531**	**136682**	**1712**	**138265**
Bristol	665	62965	728	64677	858	66011	981	67161
North Somerset	197	30266	210	30723	217	30970	239	31335
South Gloucestershire	383	39554	445	39598	456	39701	492	39769
Grand Total	**1245**	**132785**	**1383**	**134998**	**1531**	**136682**	**1712**	**138265**

1.4 Local context

Comprehensive support for children and young people with social communication disorders is provided through a network of services, which include:

- Universal services such as early year's services, health visiting and primary care.
- Targeted services such as Specialist CAMHS, S&LT, Community Paediatrics, Occupational Therapy, LD team, primary mental health workers, educational psychologists and school and youth offending teams (when appropriate). Voluntary / third sector providers counselling (including social care and education).
- Specialist CAMHS teams.

These services are not provided exclusively by the NHS.

As children and young people's social communication challenges affect all aspects of their lives, no one service alone will be able to meet their needs. There is a duty of cooperation placed on services to work together to the benefit of children and young people. Agencies need to work together to meet the needs of the populations they serve and to achieve wider system efficiencies. Services should work together in integrated ways to ensure appropriate communication and transitions.

This specification is linked to other specifications within the local area including:

- Overarching Community Children's Health Services.
- Public Health Nursing.
- Community Paediatrics and therapies.
- Counselling.
- Specialist CAMHS
- CAMHS highly specialist services

- Acute Paediatrics.
- Accident and Emergency Services.
- Perinatal Mental Health Services.
- Adult Mental Health services.

It is important that children and young people, however they first present with difficulties, are supported by professionals to receive appropriate help and support as soon as possible. Interventions offered will be evidence-based, where there is a sufficient body of evidence, or reflect best practice. This specification details local integrated, multi-agency care pathways that enable the delivery of effective, accessible, holistic evidence-based care including assessment of need, and diagnostic assessment where families and / or young people wish it . A key principle should be that support should be provided to meet identified needs, whether or not a diagnostic assessment has been chosen by a family.

The Provider will ensure that children and young people will be treated, as far as possible, within their own community / close to home and in a timely manner.

It is essential that children, young people and parents / carers are involved in service design (as well as providing feedback to services). The Provider will actively consider how their service will respond to the needs of BNSSGs diverse population. This will include complying with relevant equalities legislation and best practice guidance. We will expect the service to make reasonable adjustments to ensure the service is open and accessible to the whole of our population.

Particular reference will be made to needs of people with disabilities, people from black and other ethnic minority communities, people who currently find it difficult to access current services or who are under-represented within those services.

There is a specific expectation that people with a learning disability will not be excluded from the services offered and that reasonable adjustments will be made to ensure an inclusive service delivery model.

The service will be delivered in line with the requirements of the national and local autism strategy to ensure people with autism have access to mainstream public services where ever possible and in doing so will be treated fairly as individuals.

People who are deaf will be enabled to access services through the provision of appropriate support.

People who require help with language, such as interpreting, in order to access services will be provided with appropriate support.

Transition arrangements into adult services must be in place, including transition arrangements to primary care if children / young people are not going to meet adult mental health services thresholds but still require some level of support.

1.6 What we have been told stakeholders want from ASD Diagnosis service

Children, young people and parents / carers have told us they want:

- Early identification
- A timely diagnostic pathway
- Better support pre and post diagnosis
- Better transition experience.

Other stakeholders have told us they want:

- Right service, right time including in partnership with local authority and voluntary sector services.
- Seamless with other services.
- Stepped pathway
- Shared goals with other agencies – (Think Family, Team around the family, key working - Requirement to attend Education, Health and Care Plan and Early Help meetings).
- Ensure good transition through 16-18 Transition pathway
- Flexible person centred service not just clinic based.
- If young people not engaging or clinically not appropriate for service, need support for family/ referrers.
- Clinical and administrative staff who can communicate well.
- Services that reflect and meet the need of a diverse population; age and gender appropriate, culturally competent.

2. Outcomes

Health outcomes for children, young people and parent carers in BNSSG are maximized through the timely assessments and management of interventions. Children, young people and other family members are enabled to cope with their diagnoses and receive sufficient help and support to reduce the impact of their ASD challenges

2.1 NHS Outcomes Framework Domains and Indicators

ASD support services contribute to a number of strategic outcomes that have been pre-defined both nationally and locally. The provision of good ASD support services will support improved outcomes across all five domains.

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

2.2 Local Area Strategic Outcomes

Strategic outcomes are determined and monitored by the Bristol SEND Partnership Board, the South Gloucestershire SEND Partnership Board and the North Somerset SEND Programme Board

2.2 Service Outcomes

- Addressing inequalities in access
- Better managed transitions to adult services.
- Increased awareness, clear pathways and joint working with other services including voluntary / third sector organisations who work with children and young people with ASD needs.
- The service will work with children, young people, families and partner agencies to support individual users to engage with services. This may include, where appropriate, contact in collaboration with other professionals, seeing children in an alternative setting, and flexibility about timing of appointments. The service will support partner agencies to hold and manage risk around the individual, through collaborative approaches.
- Increased flexibility and perseverance in engaging creatively with children and families who find services difficult to access.
- Choice and responsive service

- The service contributes to reducing the stigma of autism
- Increasing integrated delivery to ensure everybody has a shared vision of improving ASD support
- Engage as appropriate in Education, Health and Care Assessment and Plan development
- Ensure good joint working and flexible transition through 16 - 18 years transition to adulthood pathway and developed protocols.

3. Scope

3.1 Aim

To provide an ASD Diagnostic pathway that is accessible, high quality and timely.

3.2 Objectives

The Provider must:

- ensure that services for children and young people place them and their parents/carers at the heart of everything they do
- Work with children and young people and parents / carers in co-designing and reviewing ASD care pathways.
- Work with all relevant agencies to ensure that services for children and young people with ASD challenges are coordinated and address their individual needs, providing a holistic approach.
- Ensure that children, young people and their parents / carers are treated with compassion, respect and dignity, without stigma or judgment.
- Ensure that children and young people's physical health, mental health, learning and social needs are considered alongside their social communication needs.
- Ensure that children and young people who access the service are seen in a timely manner.
- Provide a clinically led service with professional leadership arrangements in place. There will be a clear and accountable management structure.
- Provide initial and follow-up assessments that are written and shared with the child, young person and / or parent / carer. Any technical terms in these assessments/ care plans should be defined.
- Seek and use a range of service monitoring, evaluation & feedback including the collection of quantitative, qualitative data and complaints.
- Ensure the impact of trauma, abuse or neglect in the lives of children and young people is properly considered when identifying need and making diagnostic decisions and formulations Ensure that any additional vulnerability or inequality suffered by children and young people (e.g. learning disability, victim of child sexual exploitation, homelessness) is properly considered when identifying need and making diagnostic decisions and formulations.
- Agree the aim and goal of assessment with the child / young person or parent / carer,
- Provide information at all stages of the pathway about interventions or treatment options to enable children, young people and parents / carers to make informed decisions about their care appropriate to their competence and capacity; this information needs to be clear, easy to understand and jargon free.

- Provide written information to the child / young person and parent / carer about the care plan and how to access services (both routinely and in a crisis); this information needs to be clear, easy to understand and jargon free.
- Provide written assessments, care plans, etc. that are easy to understand and jargon free; any technical terms in these assessments / care plans should be defined.
- Provide information about how the services commissioned will increase opportunities for social value and social capital in line with the Social Value Act 2012.
- Ensure that children and young people leaving the service have an agreed and documented discharge plan that supports self-management where possible and explains how to access help if this becomes necessary. Where a young person is moving to another service, whether to adult mental health services or to a different service, the Provider will ensure that the agreed transition protocol is followed.
- Ensure that the service is accessible and provided in an appropriate setting that creates a safe physical environment.
- Ensure that the service provides relevant Continuing Professional Development (CPD), appropriate supervision to support risk management delivering best outcomes. The service should provide regular appraisal to staff, and has a clear workforce plan that takes account of the changing mental health needs of the local population.
- Maintain an accurate data set and provide accurate and timely reporting to commissioners (local, regional and national) and national organisations when requested.
- Work collaboratively with other agencies in the health, social care system and voluntary sector to ensure regular case reviews to ensure effective progress through the care pathway.
- Participate as appropriate in the development and delivery of SEND Education, Health and Care plans.
- Ensure that the technology in place includes effective integrated embedded technology to support and underpin practice in a clinically meaningful way.
- Ensure that management information is readily accessible and regularly used for service improvement.
- Ensure that clear communication pathways and information sharing mechanisms are in place so that children, young people and, where appropriate, their parents / carers experience a smooth journey through the care pathway.
- Work together in a collaborative way with relevant agencies in health, social services and education to ensure that children and young people have appropriate advice and support throughout their care:
    - Including using locally agreed systems to support joint agency working (including in-reaching into Early Help, using Single Assessment. Framework, Team Around the Family), meeting safeguarding standards

    - and providing clear protocols on information sharing.
    - Consent will be asked for[1] from children, young people and parent / carers regarding information sharing with other agencies (rather than a blanket decision not to share health information with such agencies).
    - Including information about non-attendance, to mitigate against the risks inherent in the fact that children and young people are often dependent on others to access care.

- Address health inequalities, by providing an ASD service acceptable to vulnerable groups. Vulnerable groups will be targeted with the aim of equity of outcome through flexible, intense, strength based joint working.

3.2 Legal and Regulatory Framework

The service must operate according to relevant legislation and guidance, with particular reference to:

Autism Diagnosis in Children and Young People: Recognition, referral and diagnosis of children and young people on the autistic spectrum **(NICE Clinical Guideline 128, January 2014).**

The National Service Framework for Children, Young People's and Maternity Services (Department of Health, 2004) articulated the need for specialist services for children with Autism Spectrum Disorders to be provided in a seamless fashion as close to the child's locality as possible (Standard 9). It stressed the importance of multidisciplinary and inter-agency working in order to meet the child's needs effectively and without undue delay, and emphasised that universal services have a clear role to play in child mental health, though some children and young people also need ready access to appropriately skilled specialist mental health professionals.

Children and Families Act 2014

The Special Educational Needs and Disability Code of Practice: 0-25 years was published in June 2014 jointly by the Department of Health and the Department for Education and provides statutory guidance on duties policies and procedures relating to Part 3 of the Children and Families Act 2014. Organisations who are bound by this statutory guidance includes local authorities (education, social care and relevant housing and employment and other services), clinical commissioning groups, NHS Trusts and NHS Foundation Trusts.

The Special Educational Needs and Disability Code of Practice (2014) main changes from the SEN Code of Practice (2001) are:

- The code of practice (2014) covers the 0-25years age range.
- There is a clearer focus on the views of children and young people and on their role in decision making
- It includes guidance on the joint planning and commissioning of services to ensure close cooperation between education, health services and social care.

- For children and young people with more complex needs a coordinated assessment process and the new Education, Health and Care Plan(EHC Plan) replace statements and Learning Difficulty Assessments(LDAs).There is new guidance on the support pupils and students should receive in education and training settings.
- There is a greater focus on support that enables those with SEND to succeed in their education and make a successful transition to adulthood.

3.3 Service description

3.3.1 The Provider is required to:

- Be registered with the Care Quality Commission.
- Ensure that all professionals will remain compliant with their relevant professional standards and bodies and be revalidated as required.
- Have an indemnity scheme.
- Have robust clinical and corporate governance systems to manage and learn from complaints and incidents and to meet the training and supervision needs of its staff.
- Ensure services are available to all children and young people without regard to disability, gender, sexuality, religion, ethnicity, social, or cultural determinants. However, where it is deemed clinically appropriate, alternative services may be established that meet the specific needs of one or more groups within a community. Such services will enhance rather than detract from the existing provision.
- Where the consequences of not immediately meeting clinical need are assessed to be similar, services will prioritise children and young people who are likely to have the poorest long term life outcomes. Breakdown of their school, home or care situation has the highest priority.
- Offer children, young people and parents / carers age and format-appropriate information about their condition and care.
- Ensure that services have age-appropriate physical settings.
- Ensure that the rationale for diagnosis, evidence considered and decisions made will be fully documented. This will be shared with the child / young person and parent / carer in writing as appropriate.
- Ensure that initial and continuous care planning involves all members of the team providing care, the child / young person and their parents / carers.
- Ensure that informed consent issues around both sharing of information within the family and with other agencies and around treatment are clearly explained and documented.
- Ensure that all service developments and / or redesigns are undertaken using co-production.
- Ensure any cross-charging arrangements for cross-boundary children / young people are included.
- Contribute to other parts of agreed multi-agency care pathways.

- Relationships will be built with Local Authority and Voluntary Community services for children and young people to enable increasing integration of delivery, key working models and a team flexible approach across organisations. This will include working with adult services regarding vulnerable 16/17 olds and having a presence in settings such as organisations providing supported accommodation to provide consultation and sign posting

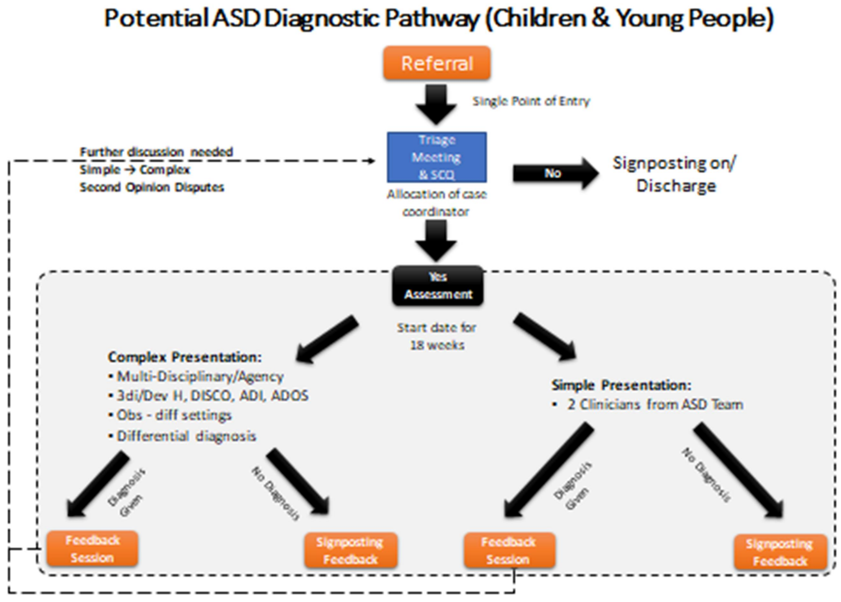
3.3.2 Service Description

A minimum service offer to improve access and assessment for children and young people with ASD.

The key areas of the service delivery are:

- To implement a high quality ASD diagnostic pathway
- Achieve a referral to diagnosis target of 18 weeks
- Eradicate waiting lists for diagnostic assessment
- To engage with children, families and carers to gain knowledge of what they feel would be the best way to support them through the pre and post diagnosis pathway

3.3.2.1 Bristol & South Gloucestershire pathway



1. Referral from professionals or parents or young person via web-based Single Point of Entry (SPE) form together with completed supporting information forms from parents, educational setting and young person (as applicable) with clear indication that an ASD diagnostic assessment is requested. If incomplete information is received, the remaining items will be requested before the referral is processed.

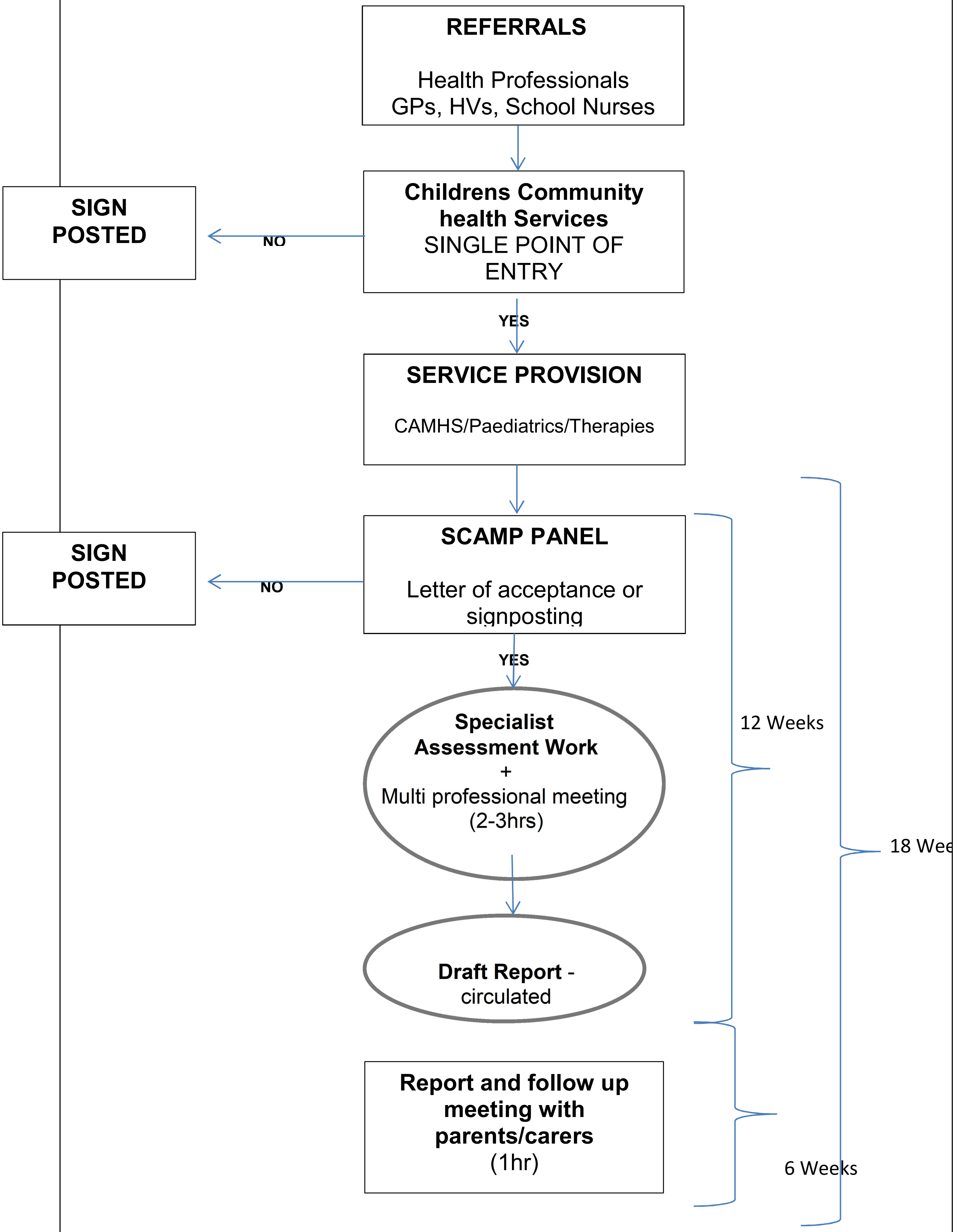
2. Referral information passed to ASD diagnostic assessment team manager / coordinator. Triage form to be populated with this information for review by multi professional representatives focussing on school aged / preschool aged in a weekly triage meeting. At this meeting the outcome will be
   - Referral accepted; professionals who should be involved in the assessment will be identified, the element of assessment needed will be identified. This information recorded on triage form and coordinator or team will subsequently schedule the assessment.
   - Referral not accepted for diagnostic assessment, but passed to another professional for a new appointment to determine what approach is appropriate. Referral passed to SPE to send to professional for triage and booking.

Referrer and parents and GP will be informed of outcome

3. Assessment will be scheduled, where possible as a ‘one stop shop’ at school or clinic, including the diagnostic meeting and the feedback meeting to parents. If a more complex case, some additional assessments may be needed before the one stop shop is held. Preschool children may be allocated to a SEESAW group and community paediatric appointment will be scheduled alongside the group work. Initial appointments with community paediatric team, including specialist nurses, may be indicated where they are not known to any CCHP service already – these will be scheduled before the one stop shop.
4. If at the end of the diagnostic assessment, it is felt that the case is complex and more assessment is needed, information will be returned to the triage meeting to review and agree next steps.
5. After the end of the diagnostic assessment, if an ASD diagnosis is made, there will be a 6-8 week follow up appointment with a member of the team
6. At the end of the completed diagnostic assessment the child or young person will be discharged from the ASD diagnostic assessment service pathway. If they have ongoing medical needs e.g. monitoring ADHD medication, they will remain open to the relevant service and continue their follow up
7. Children and young people who have a diagnosis of ASD will have access to a responsive, drop in style approach for further advice.

3.3.2 North Somerset pathway

Autistic Spectrum Disorder Pathway



Social Communication & Autism Multiagency Pathway (SCAMP) is the multi-professional service and is staffed with professionals from SCCS teams.

There are 3 streamlined the pathways according to the assessed need:

a) Early Years SCAMP Assessment (preschool children)

These are children who are known to SLT, known to Community Paediatrics and possibly other services - a minimum of 2 services. Since August 2018, children who come into this pathway are assessed and diagnosed before beginning school.

The minimum number of hours to complete this pathway is approximately 33 hours per child.

b) Standard SCAMP Assessment (school aged children)

These are children referred to SCAMP from any of our services who require further assessment for ASD. The number of services involved is generally a minimum of 3.

The minimum number of hours to complete this pathway is approximately 33.5 per child.

The Community Paediatric nurses have developed a pre-SCAMP Nurse led pathway, ensuring that all referrals have gathered as much evidence as possible to inform the assessment panel.

c) Enhanced SCAMP Assessment (comorbidities)

Again, these are children referred to SCAMP from any of our services who require further assessment for ASD. The number of services involved is generally a minimum of 4.

The minimum number of hours to complete this pathway is approximately 62 hours per child. These are children that present with high complexity and therefore will require additional assessments particularly from CAMHS clinicians.

3.4 Acceptance criteria

The service has defined acceptance criteria for ASD Assessment that will be available to referrers, children, young people, their parent carers and other agencies.

The Provider will:

- Accept referrals for children and young people aged up to 18 years registered with a GP in Bristol, South Gloucestershire or North Somerset where there is a reasonable description that suggests that the child / young person may have an ASD
- Accept referrals from schools, health professionals and self-referral, via a single point of access which will be developed with each local authority.
- In cases where referrals are found to be inappropriate, with consent, refer or signpost the child / young person and their family / carers to other services through the single point of access.

- Provide locally available, age- and developmentally appropriate, co-produced information for children / young people, parents / carers and referrers about the services provided and how they are accessed.
- Support and ensure inter-agency working.
- Support and ensure discharge or transition planning.
- If the service concludes that the needs of child / young people or parents are better met by other agencies and not covered within this specification. It will facilitate access to those services.
- Ensure that the referrer is clear as to whether the service has accepted the referral and, if not, in line with agreed information-sharing protocols, provide the rationale for this and written suggestions to what the services will do: for example, whether the service will refer on or signpost or expect the referrer to do so.
- Gather the agreed range of information at the point of referral noting information sharing protocols

3.5 Exclusion criteria

Children and young people may *not* be eligible for the service provided on the basis of:

- Age if over 18 years.
- Where a more clinically appropriate service has been commissioned from an alternative provider
- Children in court proceedings where intervention is not advised under Home Office guidelines.
- Court assessments, unless specifically contracted.

3.6 Outputs

The Provider will:

- Triage referrals within 10 working days
- Carry out ASD assessment within 18 weeks of acceptance of referral
- Maintain communication with referrer / family whilst waiting for and between appointments.
- Ensure that the staff undertaking the assessment are appropriately trained and experienced to undertake assessment, to identify strengths and difficulties including identification of ASD diagnosis where appropriate.
- Work in collaboration with the child / young person and, where possible, the parents / carers on the decision to refer for further assessment and / or treatment or to discharge and / or signpost, based on the combined assessment of their needs and risk.

3.6 Key Performance Indicators

3.6.1 **Workforce**
Target:
100% of staff (non – probationary) have had basic Autism training

3.6.2 **Referral**
Target:
95% ASD referrals are triaged within 10 working days

3.6.3 **Assessment**
Target:
95% Assessments started within 12 weeks following acceptance of referral and completed within 18 weeks.

3.6.4 **Post Diagnosis**
Target:
95% Assessment follow up offered within 8 weeks of diagnosis

3.7 Does Not Attend (DNA) / Re-engagement policy

When a service user does not attend, a risk assessment should be made and acted upon. A service should not close a case without informing the referrer that the service user has not attended. The service should make explicit re-engagement policies available to referrers, children / young people and parents / carers.

Teams will work assertively with children and families who have difficulty engaging with the service, and will explore creative means to ensure that interventions are offered in styles and settings which promote engagement with children / young people and their parent / carers.

3.9 Care transition protocols

The service will have protocols in place co-developed with service users, GPs and other services to ensure that transitions between services are robust and that, wherever possible, services work together with the service user and parents / carers to plan in advance for transition (this is especially critical in the transfer to adult mental health services and primary care or other services, e.g. voluntary / third sector).

3.10 Staffing arrangements, recruitment and training, supervision / appraisal requirements

The Provider will:

- Ensure the workforce including frontline staff has the necessary compassion, values and behaviours to provide person-centred, integrated care and enhance the quality of experience through education, training and regular continuing personal and professional development (CPPD) to enable positive relationships and instils respect for children / young people and parents / carers.

- Anticipate the numbers and capabilities of the workforce needed currently and for the future, ensuring an appropriate skill mix in teams to provide skilled supervision, enabling career progression and staff retention.
- The workforce will be able to deliver a range of recommended evidence-based assessment with a delivery model that best focuses the capacity of the service to the demands of the population.
- Ongoing workforce development in evidence based interventions will be in place.
- Ensure the workforce is educated to be responsive to changing service models, innovation and new technologies, with knowledge about effective practice and research that promotes adoption and dissemination of better quality service delivery.
- Ensure there is sufficient staff educated and trained with the required knowledge and skills within teams. The skill set required in the team may be subject to change according to changes in local needs.
- Ensure that there is compliance with the recommendations of the Francis Report (2013) and in particular the Code of Candour

Monitor caseloads for staff to ensure safe and effective delivery of services

3.11 Activity

Commissioners and Sirona will review actual activity levels as part of the on-going contract review arrangements. Where trends point towards a likely increase in overall activity exceeding the assumed levels, the commissioners and Sirona will agree jointly the actions to be taken. These could include, but are not restricted to, a reduction in overall service provision; a service redesign to meet the increasing demand or an increase in funding to acknowledge the increase.

The Provider will commit to alerting the commissioners as soon as information becomes available that indicates an upward trend and both parties agree that any corrective actions should be agreed within three months inclusive of commissioners and Sirona governance processes

3.12 Information Governance and Accountability

The Provider will comply with all relevant legislation and guidance to record information, in particular to comply with Data Protection acts, and comply with requirements to keep records for an appropriate period.

The Provider will develop information sharing protocols as appropriate with other agencies to enable integrated working.

3.13 Interdependence with other services / providers

3.13.1

Providers should ensure they have excellent links with services regularly used by young people providing a joined up accessible service supporting shared outcomes including improving access to education and healthy behaviours.

- General Practice.
- Schools and academies FE colleges and other education providers.
- Children centres and early year's settings
- Early Help providers.
- Health visitors.
- School health nurses
- Mental health services
- Voluntary sector providers.
- Independent providers.
- Inpatient or other highly specialist services.
- Youth services.
- Homelessness and Youth Housing agencies.
- Safeguarding – children and adults (Local Safeguarding Children's Board).
- Local authorities.
- Bristol Hospital Education Service/ South Gloucestershire Education Other Than at School Service (shared outcome of re-integration into school).
- Acute sector hospitals.
- Emergency departments.
- Community child health.
- Criminal justice system – including young offenders services.
- Addiction services.
- Local independent providers.

4. Applicable Service Standards

4.1 Applicable national standards

- Autism Act (2009)
- Autism Strategy (2010)
- Implementing Fulfilling and rewarding lives – statutory guidance for local authorities and NHS organisations to support implementation of the Autism

Strategy (2010)
- NICE guidance CG 128 (2011)
- Adult Autism NICE guidelines published (2012)
- Children and Young People Health Outcomes Strategy (2012)

4.4 Applicable local standards

Provision of transition focussed services.

5. Monitoring & Evaluation

5.1 Data recording

5.1.1 The following data must be collected and submitted monthly on CCHP SEND Data Dashboard

Workforce
- % of staff (non – probationary) with basic Autism training - content to be agreed annually at contract monitoring meetings

Referral
- Total number of referrals
- Age and gender of referrals
- Origin of referrals
- % of referrals triaged within 10 working days
- % of referrals leading to assessment

Assessment
- Number of assessments started within 12 weeks following acceptance of referral
- % of assessments started within 12 weeks following acceptance of referral

- Number of c&yp waiting between 12 – 24 weeks to start assessment and diagnosis process

- Number of c&yp waiting between 25 – 51 weeks to start assessment and diagnosis process

- Number of c&yp waiting more than 52 weeks to start assessment and diagnosis process

- % of assessments leading to diagnosis

Post Diagnosis
- % offered post diagnosis follow up meeting within 12 weeks when requested
- % of experiential feedback forms following discharge

6. Location of Provider Premises

6.1 The Provider's premises are located at:

A range of locations to respond flexibly to the needs and choices of children and families who, for reasons of access, culture or clinical presentation, have difficulty in engaging in clinic-based interventions. This will include seeing some children in their children centres, school, home, youth centre or other setting and some drop-in sessions in other services.

7. Service Delivery

The Provider will ensure that children and young people will be treated, as far as possible, within their own community / close to home and in a timely manner.

It is essential that children, young people and parents / carers are involved in service design (as well as providing feedback to services). The provider will actively consider how their service will respond to the needs of BNSSGs diverse population. This will include complying with relevant equalities legislation and best practice guidance. We will expect the service to make reasonable adjustments to ensure the service is open and accessible to the whole of our population.

Particular reference will be made to needs of people with disabilities, people from black and other ethnic minority communities, people who currently find it difficult to access current services or who are under-represented within those services.

There is a specific expectation that people with a learning disability will not be excluded from the services offered and that reasonable adjustments will be made to ensure an inclusive service delivery model.

The service will be delivered in line with the requirements of the national and local autism strategy to ensure people with autism have access to mainstream public services where ever possible and in doing so will be treated fairly as individuals.

People who are deaf will be enabled to access services through the provision of appropriate support.

People who require help with language, such as interpreting, in order to access services will be provided with appropriate support.

Transition arrangements into adult services must be in place, including transition arrangements to primary care if children / young people are not going to meet adult mental health services thresholds but still require some level of support.

Appendices

Appendix 1: "Learning disability and autism training for health and care staff" (Consultation – Feb. 2019)

Service Specification No.	**2A2**
Service	**BNSSG Attention Deficit Hyperactivity Disorder (ADHD) Service (Children and young people (<18 years)**
Commissioner Lead	**BNSSG ICB**
Provider Lead	
Period	**1st December 2024 – 31st March 2026**
Date of Last Review	**Quarter 4 2024**
Date of Next Review	**Quarter 4 2026**

1. Purpose

This service specification outlines BNSSG ICB's objectives, scope, pathway and principles of the Children's and Young People Attention Deficit Hyperactivity Disorder (ADHD) Service. Throughout this document, the term 'Service User' will refer to the child/young person and/or the parent/carer of the child or young person who is being assessed.

The Provider is commissioned to provide evidence-based ADHD diagnostic assessment and post diagnostic support for children and young people, led and undertaken by appropriately skilled health professionals. The service offer will be based on NICE guidelines and best practice associated with ADHD diagnosis.

1.1 National evidence base

NICE Attention Deficit Hyperactivity Disorder Definition | Background information | Attention deficit hyperactivity disorder | CKS | NICE outlines the existing principles for the identification, assessment, treatment and management of ADHD.

There are three subtypes of ADHD:

- The inattentive subtype accounts for 20% to 30% of cases
- The hyperactive-impulsive subtype accounts for around 15% of cases
- The combined subtype accounts for 50% to 75% of cases

The global prevalence of ADHD in children is estimated to be around 5%, although studies based on US populations (where rates of diagnosis and treatment tend to be highest) estimate the rate at between 8% and 10%. Prevalence | Background information | Attention deficit hyperactivity disorder | CKS | NICE

1.2 Right to Choose

Since 2014, in England under the NHS patients have a legal right to choose their healthcare provider and 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.

NHS Choice Framework - what choices are available to you in your NHS care
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 NHS 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.
- 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 or NHS England for the required service.
- Have a multi-disciplinary team including a paediatrician and/or child and adolescent psychiatrist.

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:

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.

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/

2. Service Scope

2.1 Aims

To provide an accessible, high quality and timely Children's and Young Person's ADHD diagnostic service, including 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, providers should offer Children and Young People with ADHD with a sufficient level of support to enable their continued independence and well-being.

2.1.1 Objectives

- To provide accurate diagnostic assessment, treatment including medication (if required) and a range of post diagnostic support.
- To provide a person-centred and flexible approach.
- To ensure that children, young people and their parents/carers are treated with compassion, respect and dignity, without stigma or judgment.
- To ensure that children and young people who access the service are seen in a timely manner.
- To ensure that the impact of trauma, abuse or neglect in the lives of children and young people is properly considered when identifying need and making diagnostic decisions and formulations.
- To ensure that any additional vulnerability or inequality suffered by children and young people (e.g. learning disability, victim of child sexual exploitation, homelessness) is properly considered when identifying need and making diagnostic decisions and formulations.
- To agree the aim and goal of assessment with the child/young person or parent/carer.
- 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.
- 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).

2.1.2 Service summary

The service is expected to conform to all relevant currently published and future NICE guidance.

The Provider is expected to ensure that they provide:

- Appropriate and accessible information to individuals about their service
- Appropriate and accessible information about timescales for assessment.
- Clear information to individuals about what will and may happen post diagnosis. Information about local signposting will be supplied to the provider by the lead Commissioner.
- 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.

2.2 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.

2.3 Referral Criteria

Children who are aged between 5 years and 17 years and 9 months and registered with a GP Practice within BNSSG.

Assessments of ADHD are restricted until children are over the age of 5.

If a young person is 17 years 9 months or older at the point of referral, or will reach this age while waiting for an assessment to be conducted, the Provider should either decline the referral or, if the Provider holds an NHS Standard Contract for Adult ADHD Assessment, the Provider may offer to transfer the patient to their adult ADHD Assessment service (the date of the original referral to children and young people ADHD services will be honoured). Transfer to an adult service should only be done with consent from the patient, in line with referral criteria for adult services; and in the case of young people who have already received a diagnosis of ADHD from children and young people ADHD services, if they are stable on medication.

2.4 Referral process and Waiting List

Children who are aged 5 and over can usually be assessed and referred by their school SENDCO. This is the preferred commissioned route in BNSSG and parents should initially raise concerns with schools if possible, rather than their GP. If a school referral is not available, a GP or other health care professional can make a referral.

The Provider must aim to triage BNSSG referrals within 5 working days of receipt (where possible). The Provider is expected to undertake waiting list reviews on a quarterly basis to ensure service user's clinical needs have not changed.

Prioritisation for assessment is not normally given, but certain patients may be prioritised depending on their circumstances at the discretion of the clinician e.g., those who are already diagnosed and/or clearly at risk from not being treated. 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.

It is expected diagnostic assessment should start within 12 weeks of referrals per NICE Guidance. The service will operate a waiting list if assessments are unable to be delivered within 12 weeks of referral.

2.5 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;

- The patient meets any of the nationally defined exceptions listed under "you do not have a legal right to choose if:" at https://www.nhs.uk/mental-health/social-care-and-your-rights/how-to-access-mental-health-services/#choice
- The patient meets any of the Provider's own exclusion criteria as set down in their policy at Appendix 2A2_2A4.

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.

2.6 Was Not Brought (Did Not Attend)

Any patient who does not attend their agreed appointment (new or follow up) may be discharged back to the care of their GP. Both the patient and GP will be notified in writing to ensure the referring GP is aware and can action further management of the patient if necessary. Exceptions to this are:

- When a clinical decision is taken that discharging the patient is contrary to the patient's clinical interests.
- Children of 18 years and under or vulnerable adults.
- When one of the following can be confirmed:
  - If the patient did not receive the letter/ digital notification of the appointment including the appointment being sent to incorrect patient address / contact number
  - The appointment was not offered with reasonable notice.
  - If reasonable adjustments or patients' needs have not been supported – for example, accessible communications, translation, transport needs.

Outside of these exceptions, it will be at the providers discretion as to whether a patient will be entitled to rebook an appointment after a first DNA without being discharged from the service. If a patient is offered another appointment and DNA after a second appointment is offered it is expected that the patient will be discharged back to the referrer.

When a service user is not brought to an appointment, a risk assessment should be made and acted upon. A service should not close a case without informing the referrer that the service user has not attended. The service should make explicit re-engagement policies available to referrers, children / young people and parents / carers.

In the event of a paediatric patient making multiple (more than one) cancellations, multiple changes or if they DNA on multiple occasions - in addition to the clinical review process and active engagement with the patient, the provider will write to the patient's GP following the second DNA to establish if there are any particular circumstances, including safeguarding concerns, why the patient might not be attending. It is not acceptable to refer patients back to their GP simply because they wish to delay their appointment or treatment. However, there are situations when referring a patient back to their GP is in their best clinical interests. Such decisions should be made by the treating clinician on a case-by-case basis and following discussion and agreement with the patient.

The Provider will make every effort to rebook appointments where cancellations are received within 24 hours of appointment time. Where a patient DNAs the appointment without prior notice, the Provider will charge BNSSG ICB in line with the agreed DNA fee in the BNSSG Pricing Framework and Payment schedule (schedule 3C – Local Prices) of this contract.

The Provider should follow a robust Access Policy which supports the safeguarding of children, as described in clause 3.2.1.

2.7 Assessment Outcomes

3 elements of service:

- Assessment
- Treatment (if applicable)
- Post diagnosis support
  - Support and liaison to local primary care, mental health and learning disability teams, in addition to social care and voluntary sector providers

2.7.1 Assessment

The assessment may be conducted over a number of appointments, tailored to the need of the service user. In accordance with NICE guidance, 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, on the basis of:

- A full clinical and psychosocial assessment of the person; this should include discussion about behaviour and symptoms in the different domains and settings of the person's everyday life **and**
- A full developmental psychiatric history **and**
- Observer reports and assessment of the person's mental state.

The Children's and Young People's ADHD Diagnostic Service will offer:
- Initial triage based on a balance of waiting time and clinical assessment of need (see section 2.4 of this specification).
- Diagnostic assessment including gathering of developmental history, observations from home and education settings using agreed tools and process.
- Post-diagnostic signposting to appropriate services local to BNSSG.
- Post diagnostic initiation of medication trial if recommended with appropriate monitoring and follow up.
- The service will be person centred, based on the needs of the service users and involvement of their carer / families (if appropriate).

2.7.2 Diagnostic Outcomes

Assessment may result in three possible outcomes:

1. An ADHD diagnosis is confirmed as present.
2. The diagnosis is confirmed as not present. In this instance, the service user's GP, and (with the appropriate agreement and consent) any relevant services/carers/families should be notified accordingly. The service user would be referred on to other services, depending upon needs and presentation.
3. A diagnosis of ADHD is uncertain or inconclusive. A recommendation may be made to access a second opinion or to complete a re-assessment following a period of time (at which point it may be possible to arrive at a conclusive finding).

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, including all relevant aspects of their assessment and treatment from the Provider. This will be communicated in written form to the service user and other relevant parties, e.g., the referring professional and/or the GP.

The Provider will ensure that, as part of their service offer and discharge processes, service users are well-informed about what to expect from the service. They should be given information and signposting to other community, voluntary and other services, including those local to BNSSG.

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 child at risk should be part of all stages of the process.

The service should be providing information to support the care of patients and signposting to other organisations including the voluntary sector.

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

2.7.3 Feedback

Service users will be provided with detailed feedback where the results of the assessment and the implications of this are discussed with them. If they have not been given a diagnosis, the feedback session would be an opportunity to better explain their presenting difficulties. There, strengths and needs will be identified. Service users will also be signposted and/or referred to appropriate services, as required.

2.7.4 Treatment

- A discussion with the patient and/or parent/carer must take place 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. For services that have been commissioned to be delivered virtually, the patient will be responsible for measuring and providing physical health monitoring information to the Provider. This should be conducted in line with NICE guidance Recommendations | Attention deficit hyperactivity disorder: diagnosis and management | Guidance | NICE which provides recommendations for the frequency of review for children prescribed ADHD medication.
- Liaison with the GP to ascertain whether the GP is willing to take over future prescribing, while recognizing 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.

2.7.5 Shared care arrangements

Providers must be aware that shared care for Children and Young People’s ADHD in BNSSG covers medication prescribing only and willingness to engage in shared care may vary between GPs. In all cases, responsibility for physical health monitoring and annual reviews will remain with the provider and the service will also be required to retain prescribing where this isn’t available in primary care. Early communication with the service user’s GP is essential to determine whether they are able to take prescribing once the patient is stable on medication and if a GP does not agree to undertake prescribing under a shared care agreement, they are under no obligation to do so.

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.

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 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.
- The provider understands that they will retain total clinical responsibility for the ongoing physical health checks and reviews (at the intervals recommended by NICE depending on the age of the child or young person).
- Discharge letters to be sent (either electronically or by post) to services users and copied to GPs/referrers within 10 working days of appointment.
- At the point of the implementation of a shared prescribing protocol, the service user (and/or their parent or carer) 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 responsibilities remain with the Provider until the service user is stable and GP agrees to shared-care.

A prescriber can choose not to accept 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 responsibility solely on grounds of cost. Distance is not a reason for requiring transfer of care.

Recommendations | Attention deficit hyperactivity disorder: diagnosis and management | Guidance | NICE

2.7.6 Advice and Information

Following diagnosis the individual (and their parent/carer) should be provided with one follow up support session to provide feedback, signposting and advice regarding medication options if recommended.

The session would be used as follows:

- To provide the service user with more time to discuss their individual diagnosis and what it means to them.
- In discussion with the individual, referrals to other agencies may be made including to Social Care for an assessment of need under the Care Act 2014.
- To provide signposting to support and advice services local to BNSSG to support individuals (and those who support them) to develop coping mechanisms in order to improve their mental, physical and emotional health and wellbeing.
- It is important at this stage that written confirmation by the Provider is sent to the GP / referrer to provide information regarding the outcome of the assessment and also the future plan for the individual.

2.7.7 Discharge processes

The service is primarily diagnostic with treatment if required. Hence service users with on-going needs will need to be referred to the appropriate service following assessment.

Service users will be discharged from the service in accordance with the Providers Discharge Policy and take into consideration:

- Discussion with the service user and
- GPs can contact the Provider if concerns arise post discharge.

See Other Local Arrangements, Policies and Procedures (schedule 2G4) for provider’s discharge policy/procedure.

2.8 Prescribing

NHS Prescription Issuance for Patients in Regions with NHS Cost Centre Setup
For patients within the Bristol, North Somerset, South Gloucestershire (BNSSG) area or other regions where the Provider has been allocated an NHS cost centre and NHS FP10 prescription pads by the Integrated Care Board (ICB), the Provider shall issue NHS prescriptions. These prescriptions will be sent to the patient's nominated pharmacy, in accordance with local formularies and in compliance with applicable NHS guidelines and regulations.

For patients in regions where the Provider has not been set up with an NHS cost centre and is therefore unable to issue NHS prescriptions, the Provider shall issue private prescriptions. These prescriptions will be processed through an online pharmacy, which will contact the patient to arrange delivery at a suitable time and location convenient to the patient. The online pharmacy will invoice the Provider directly for the cost of the medication, which in turn will be recharged to the referring ICB.

2.8.1 Medication

Medication titration as per NICE (2018) guidance and, for BNSSG patients, 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:

- For BNSSG patients, local BNSSG formulary Mental health disorders (Remedy BNSSG ICB) and
- NICE guidance NG87 Overview | Attention deficit hyperactivity disorder: diagnosis and management | Guidance | NICE

Please refer to the BNSSG Joint formulary and shared care protocols for BNSSG first line product. Please prescribe the first line brand of Methylphenidate product, unless there is a clinical reason not to.

2.8.2 Annual Reviews

- Annual reviews to be carried out in line with NICE Guideline NG87 Recommendations | Attention deficit hyperactivity disorder: diagnosis and management | Guidance | NICE
- Annual review to be undertaken by the Provider,
-

2.9 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).

A reporting schedule will be included in the NHS Standard Contract issued to the Provider. This will not be exhaustive.

Reporting should be submitted to the Commissioner quarterly. The Commissioner may make ad hoc requests for performance and quality data if required.

2.10 Days/Hours of Operation

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

2.11 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)

2.12 Relevant networks and screening programmes

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

2.13 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.

2.13.1 Staff Training and Development:

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.
- All staff must have the relevant safeguarding training according to role as set out in the Intercollegiate Document 2019 and Intercollegiate Document for Looked after Children 2020.

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) from which the service is provided.

2.13.2 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.

2.14 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 (in accordance with the Providers process for determining suitable remote/digital 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 including cognitive impairment, lack of capacity, hearing, oral or a learning disability in order to:

- Minimise clinical risk arising from inaccurate communication

- Support equitable access to healthcare for people whom English is not a first language
- 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.

2.15 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.

2.16 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.

The commissioner acknowledges that where a proportion of a Provider's workforce is comprised of subcontracted clinicians, these are exempt from the Governance schedule (schedule 5).

2.17 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

- Attention deficit hyperactivity disorder: diagnosis and management (2019) Overview | Attention deficit hyperactivity disorder: diagnosis and management | Guidance | NICE
- Attention Deficit Hyperactivity Disorder Quality standard [QS39] Overview | Attention deficit hyperactivity disorder | Quality standards | NICE
- Attention Deficit Hyperactivity Disorder Attention deficit hyperactivity disorder | Health topics A to Z | CKS | NICE
- Working together Working Together to Safeguard Children 2023 A guide to multi-agency working to help, protect and promote the welfare of children

- Safeguarding Looked after Children. Intercollegiate Role Framework: Looked after children: knowledge, skills and competences for health care staff (2020)
- Safeguarding children and young people. Intercollegiate Document: Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019)
- Protecting Children and Young People -The responsibilities of doctors, GMC Protecting children and young people (May 2018)
- Safeguarding Children and Young People: Roles and Competencies for Health Care Staff, Intercollegiate document (March 2019).

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

3.2.1 As part of this specification, a safeguarding children policy or all age safeguarding policy is required which links to the local standards and protocols below.

BASIC PRINCIPLES OF SAFEGUARDING CHILDREN

- This specification seeks to emphasise the following principles:
- The welfare of the child is paramount.
- It is the responsibility of all staff to safeguard and promote the welfare of unborn babies, children, young people, adults and their families as defined in Section 2.6 above.

All staff should adopt a child-centred approach which is fundamental to safeguarding and promoting the welfare of every child. A child centred approach means keeping the child in focus when making decisions about their lives and working in partnership with them and their families.

All staff, both clinical and non-clinical, should:

- Be aware of the signs and symptoms of potential and actual abuse.
- Understand how to respond to actual or suspected abuse of a child.
- Know who to contact for advice and support in relation to safeguarding and promoting the wellbeing of unborn babies, children and young people.
- Understand the need to share appropriate information in a timely way and in accordance with current legislation and guidance, including responding to information requests to safeguard a child.
- All staff should actively contribute to multi-agency working in safeguarding children from abuse, neglect or exploitation regardless of protected characteristics.
- Children and their families must be able to share concerns and complaints and there are mechanisms in place to ensure these are heard and acted upon. For further information see below:

Local Authority Safeguarding Reporting processes:
- Bristol: Welcome to the Keeping Bristol Safe Partnership website. (bristolsafeguarding.org)
- North Somerset: Threshold Document - Continuum of Help and Support (proceduresonline.com)
- South Gloucestershire: Category: Children | SafeguardingSouth Gloucestershire Safeguarding (southglos.gov.uk)

Reporting forms can be accessed via the relevant Local Authority website, above, or via remedy Referrals & Procedures (Remedy BNSSG ICB)

3.2.2 Care Quality Commission

The Provider must be registered with the Care Quality Commission.

3.3 Applicable Local Standards

The Provider will maintain compliance for staff training on Safeguarding and Equality and Diversity at a minimum of 85%.

3.4 Applicable Quality Requirements

A quality schedule will be included in the NHS Standard Contract issued to the Provider. The Provider must comply will all quality requirements. Please see clause 2.9 Reporting for details on data submissions.

4. Location of Provider Premises

The provider will provide the service virtually.

Face to face assessments will only be available following an incomplete/failed remote assessment where there is no other option and where the provider and BNSSG ICB agree that this is a reasonable adjustment. This will be discussed on a case by case basis and face to face assessments will take place at one of the providers existing clinics. Where the provider clinic is located outside of BNSSG, the patient must indicate their willingness to travel the distance before final approval can be granted.

Healthier Together
Improving health and care in Bristol,
North Somerset and South Gloucestershire

NHS
Bristol, North Somerset
and South Gloucestershire
Integrated Care Board

BNSSG ICB Autism pricing framework

ASD assessment (remote) Adults and CYP		
Expected activity included	**Expected length of appointment**	**Price**
Triage of Referral	Appointment length dictated by diagnostic tool used	**£1,780**
Administration costs		
Autism Diagnostic Assessment, feedback session and outcome report		
Discharge of patient, signposting and promotion of local and national resources		
Assessments to be carried out in line with section 2.7 of BNSSG Adult and CYP Autism Spectrum Disorder Service specifications		

Please read the following in conjunction with the pricing information:

- Any activity taking place outside of this pricing framework MUST be agreed with the responsible commissioner in advance.
- The provider is expected to deliver a remote only service and is commissioned on this basis.
- Face to face assessments will only be available in exceptional circumstances following an incomplete/failed remote assessment, where the provider is legally required to make a reasonable adjustment by delivering an in-person appointment. Please also see section 4 of the service specification(s)
- Face to face assessments must be agreed in advance by the responsible commissioner and patients must be willing to travel if the provider does not have premises locally. Any face to face assessments undertaken without prior agreement from the responsible commissioner will be at the providers own financial risk.
- The current local prices will be applicable at least until the end of the 25/26 financial year (31st March 2026). After this date, the ICB will consider an uplift to the local tariff, but this is not guaranteed.
- Any uplift to be considered will not be more than the maximum applicable NHS net inflationary uplift for the subject financial year. Net inflationary uplift means gross inflation as determined in the NHS planning guidance for that year, minus NHS mandatory efficiency factor.
- The contract activity will be payable on the basis of applicable NHS tariff for activity performed.
- Maximum agreed DNA payment is 50% of appointment fee.

Version control:

Version	Date	Updated by
1.0	November 2024	[redacted], Contract Manager
1.1	December 2024	[redacted], Contract Manager
1.2	May 2025	[redacted], Contract Manager