Reference: FOI.ICB-2526/350

Subject: Neurodevelopmental (Autism / ADHD) Contracts

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

QUESTION	RESPONSE
1. Contract list For all current neurodevelopmental service contracts (including diagnostic, waiting list initiatives, support services and Right to Choose arrangements) please provide a table with: a. Contract title / service name b. Brief service description (e.g. CYP autism diagnosis, adult ADHD, ND support service) c. Age group(s) covered d. Provider organisation name e. Contract start date f. Initial contract end date g. Any extension options (duration) h. Annual contract value and total maximum contract value (if different) i. Procurement route used (e.g. open competition, provider selection regime, direct award, framework call-off)	Please see table below*

j. Whether the contract is place-based, ICB-wide, or joint with the local authority	

*

A - title	B - description	C – age	D - provider	E – start	F - end	G - extension	H - value	I - route	J - info
Clinical Partners ADHD & Autism Assessment and Treatment Services – CYP & Adults	ADHD & Autism Assessment and Treatment Services – CYP & Adults	5 years +	Clinical Partners	1.12.24	31.3.26	Not used	£0 rated contract	PSR B	BNSSG ICB is the Co-ordinating Commissioner and there are no other parties to this contract.
Children's Community Health Partnership (CCHP)	Public Health Nursing – School Nursing and Health Visitors Community Paediatrics (including ADHD assessment) Autism Spectrum Disorder Assessment, Therapies - Occupational Therapy, Speech and Language Therapy and Physiotherapy Child and Adolescent Mental Health	The CCHP contract covers CYP aged 0-18 Specific age ranges for neurodevelopmental services are: ADHD Assessments: 5y – 17y 6m Autism: 2y 4m-17y 6m Neurodisability: 0-18	Sirona care and health CIC	01.04.17	31.03.22	5 years End date 31.3.27	Original Contract Value (10 years) £389,489,726	PCR 2015 Competitive	BNSSG ICB is the co-ordinating commissioner for this contract. Co-commissioners are Bristol City Council, South Gloucestershire Council, NHSE South West. Bath, Swindon and Wiltshire (BSW) ICB are also a co-commissioner specifically for the Lifetime Service only). BSW ICB will cease being a co-commissioner on 31st March 2026 when they no longer require the service.

	Services (CAMHS) Children with life limiting conditions Services for vulnerable children and young people; including services for Children In Care, youth offenders, and drug and alcohol services for young people.								

2. Contract documentation

For each contract listed above, please provide:

a. The service specification / schedule, including any KPIs or performance measures (for example, waiting-time targets, activity volumes, quality indicators)

b. Any published contract award notice or summary (if available)

If you consider some commercial details exempt from disclosure, please provide the remainder of the document with only the specific exempt passages redacted and cite the exemption relied upon.

a. Please see enclosed service specifications, Quality Schedule and Reporting Requirements (national and local) for our Right to Choose ADHD & Autism contract and Children's Community Healthcare Partnership.

b. Clinical Partners ADHD & Autism Assessment and Treatment Services - CYP & Adults - Find a Tender

Provision of Children's Community Health Services within the Bristol, North Somerset & South Gloucestershire areas - Contracts Finder

3. Commissioning responsibility Please provide: a. The job title of the senior commissioner with overall responsibility for neurodevelopmental (autism/ADHD) services for for adults b. The name of the current postholder(s) c. The generic team email address(es) to be used for correspondence relating to these services If you are able to disclose a direct contact email for these postholders, please do so; if not, please confirm that the generic team mailbox is the appropriate contact route.	Names and roles of ICB board members with responsibility for neurodevelopmental services is available on the BNSSG ICB website: Our Integrated Care Board - BNSSG Healthier Together If you would like to contact these departments, please use the following contact details, stating which department you require: bnssg.customerservice@nhs.net, Tel: 0117 900 2655 or 0800 073 0907 (freephone).

The information provided in this response is accurate as of 5 February 2026 and has been approved for release by Helena Fuller, Deputy Director of Business, Strategy and Planning for NHS Bristol, North Somerset and South Gloucestershire ICB.

Service Specification No.	**2A1**
Service	**Attention Deficit Hyperactivity Disorder (ADHD) – Adults (18+ years)**
Commissioner Lead	**BNSSG Integrated Care Board (ICB)**
Provider Lead	
Period	**1st December 2024 – 31st March 2026**
Date of Last Review	**January 2024**
Date of Next Review	**Quarter 4 2026**

1. Purpose

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

Aims and objectives

1. To improve ADHD related outcomes for each service user. A range of screening tools, tests and scales are available including (list not exhaustive):

    - Adult ADHD Self-Report Scale (ASRS-18)
    - WEISS FI scale
    - Adult ADHD Quality of Life Questionnaire (AAQoL)
    - Mental Health Quality of Life questionnaire MHQoL
    - Warwick and Edinburgh Mental Wellbeing scale
    - Barkley ADHD rating scale
    - Hospital Anxiety and Depression Scale (HADS)
    - Diagnostic Interview for ADHD in adults (DIVA)
    - Conners' Adult ADHD Rating Scales (CAARS)
    - Wender Utah Rating Scale
    - Autism Spectrum Quotient (AQ-10)

    The provider should be adopting a range of screening tools to provide a comprehensive assessment.

    - PROMS are measured at assessment, end of titration and at annual review.

2. To provide a quality service that ensures there is optimal patient safety, clinical effectiveness and a person-centred approach to care taken.
3. Provide accessible assessments and diagnosis either face to face or virtually with clear reasoning behind decision reached (see section 4 of this specification, location of the provider's premises).
4. To offer advice specific to the individual to other services and agencies, to include primary mental health care, third sector provision, secondary and tertiary services; regarding the management of ADHD with an interagency and multidisciplinary approach.
5. Treatment plans will be devised collaboratively with reference to the service user's goals to meet psychological, behavioural and occupational needs. Environmental modifications will be considered and progress to pharmacological interventions considered only if ongoing impairment in one domain subsequent to this is present (NICE, 2018).

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

1. ADHD: diagnosis and management NICE guideline NG87, published 14 March 2018, last updated 13 Sep 2019.

https://www.nice.org.uk/guidance/ng87#:~:text=In%20September%202019%2C%20we%20amended,that%20poses%20an%20increased%20cardiovascular
2. Royal College of Psychiatrists – ADHD in adults: good practice guidelines. https://www.rcpsych.ac.uk/docs/default-source/members/divisions/scotland/adhd_in_adultsfinal_guidelines_june2017.pdf
3. British Journal of General Practice guidance – Assessments for adult ADHD: what makes them good enough? https://bjgp.org/content/73/735/473
4. British Association of Psychopharmacology's guidelines (Bolea-Alamañac et al, 2014) https://www.bap.org.uk/pdfs/BAP_Guidelines-AdultADHD.pdf and the European Consensus Statement (Kooij et al, 2010) https://pubmed.ncbi.nlm.nih.gov/30453134/
5. General Medical Council guidance 2021 on shared care and prescribing. https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-practice-in-prescribing-and-managing-medicines-and-devices/shared-care

The Provider will work under the following values:

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

1.1 National evidence base

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

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

The rights of people with ADHD in the UK are protected under the Human Rights Act 1998 (article 14: right to non-discrimination), and further under the UK Equality Act 2010, which protects people with a disability (including ADHD). People with ADHD also have rights under the Public Sector Equality Duty in England, Scotland and Wales, which places an obligation on public authorities to positively promote equality, not merely to avoid discrimination.

1.2 Right to Choose

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

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

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

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

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

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

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

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

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

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

It aims to:

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

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

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

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

The core reference for Adult ADHD provision:

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

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

1.3.1 Strategic context

1. Under the NHS Long Term plan, https://www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24 the formation of Primary Care Networks (PCNs) in combination with the establishment of NHS Integrated Care Systems (ICSs), represents an opportunity to establish new and effective working practices to enable consistent and accessible healthcare for all people with ADHD. The NHS Community Mental Health Framework, https://www.england.nhs.uk/mental-health/adults/cmhs also sets out a vision for how community services should modernise to offer joined-up-care for those with mental health needs, within ICSs.
2. Recent guidance, stemming from professionals across primary, secondary, and tertiary care in the UK, has recommended the development of an ADHD specialism within primary care as part of a roadmap for improving access to treatment: https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-022-04290-7
   The evidence base outlined above, and current guidelines, highlight the key role primary care services have to play in the provision of healthcare for people with ADHD, and the potential for supporting an expansion of this role. Not only are primary care practitioners, such as GPs, often the gatekeepers through the referral system to secondary care services, such as adult mental health and specialist ADHD services, but NICE guidelines recommend that they also provide healthcare support such as routine monitoring and prescribing of medication under shared care agreements with secondary care services. Furthermore, primary care services have an increasing role to play in terms of providing mental health and well-being support to people with ADHD, with additional roles such as mental health workers and social prescribing link workers funded through PCNs.

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

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

2. Service Scope

2.1 Attention Deficit Hyperactivity Disorder summary

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

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

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

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

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

2.1.1 Service description

Function of the Adult ADHD Service

The Provider shall only be accredited via BNSSG ICB's accreditation process to provide those services for which they have been qualified.

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

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

2.1.2 Care pathway

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

The pathway for shared prescribing is outlined in this document in Section 2.7.5. GP Practices may choose not to enter into shared care with a provider.

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

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

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 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 and sources

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

2.4 Referral processes and Waiting List

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. 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.

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 2A1_2A3.

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.

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

2.6 Did Not Attends (DNAs)

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.

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 the Payment schedule (schedule 3C – Local Prices) of this contract.

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 standards

As detailed in and derived from the documentation referenced under section 1 Aims and objectives, the locally agreed assessment standards are referenced on REMEDY https://remedy.bnssg.icb.nhs.uk/adults/mental-health/adhd-adult/ and the Provider will comply as follows:

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

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

- Information about the professional(s) who undertook the assessment, their role title, professional registration, and that the person/people undertaking the assessment are consistent with adopting NICE guidance on the composition of assessment teams. A diagnosis of ADHD can be made by a single clinician with appropriate training and experience in ADHD assessment (e.g., Psychiatrist, Psychologist or another appropriate qualified professional).

- In those circumstances where (ADHD) medication has been initiated following an assessment, it is important that the rationale for the treatment be stated by the professional who initiated the treatment. Reference to the guidelines and clinical practice to be included.

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

2.7.2 Diagnostic outcomes

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

- Diagnosis of ADHD.
- Confirmation of a previous or childhood diagnosis of ADHD.
- Non-diagnosis of ADHD.
- Identification of other needs/conditions and signposting.
- Liaison with other services, if required.
- Acceptance into the service for necessary treatment and interventions.
- Shared care agreement with GP with appropriate advice and support.

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

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

The Provider will provide:

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

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

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

2.7.5 Transfer to Shared care arrangement with Primary Care

Providers must be aware that some GPs in BNSSG are not undertaking shared care or Local Enhanced

Services, so communication with the service user's GP is essential. If a GP does not agree to undertake prescribing and monitoring under a formal "Shared Care" agreement, they are under no obligation to do so. In such an event, the total clinical responsibility for the patient for the diagnosed condition remains with the specialist Provider.

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

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

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

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

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

2.7.6 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

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

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

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

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

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

First line treatments
- Methylphenidate modified-release and immediate-release. 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.
- Lisdexamfetamine.

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

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

- All physical health monitoring should be undertaken as per the BNSSG shared care protocol to prepare for medication initiation.
- Treatment should be initiated and titrated until stable.
- Shared care with GP can be sought if all principles listed in 2.7.5 are met.

2.8.2 Treatments not suitable for shared care

- Dual treatment of stimulants or stimulants with atomoxetine is non-formulary in BNSSG and therefore is not suitable for shared care.

- NICE NG87 advises not to offer Guanfacine for adults without advice from a tertiary ADHD service. Therefore, GPs will be advised not to accept shared care of Guanfacine from providers.

2.8.3 Annual Reviews

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

2.9 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.

Service access will be monitored through reports from the provider and through regular contract review meetings with BNSSG ICB. Reporting frequency to be in line with the Contract Management, Reporting and Information (schedule 6A) requirements.

2.10 Days/hours of operation

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

2.11 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 support the local BNSSG Integrated Care System and at times will be requested by the co-ordinating commissioner 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 skill mix to meet the defined needs of the service users and to provide the interventions. The service should ensure that they have the expertise to provide cultural awareness services.

2.13.1 Staff Training and Development

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

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

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

2.13.2 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, as well as any virtual provision shall be fully compliant with the Disability Discrimination Act (2005), the Equality Act (2010) and any other statute or common law relevant to the provision of the service and relating to Equality and Discrimination.

The Provider will treat all service users in a safe and appropriate environment (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 for whom English is not a first language.
- Support effectiveness of service in reducing health inequalities.

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 NHS Standard Contract condition GC13. If changes are made without Commissioner agreement, the Commissioner may be entitled under the Contract to refuse to meet any increased costs which ensue.

3. Applicable Service Standard

3.1 Applicable national standards (eg NICE)

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

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

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

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

4. Location of Provider's premises

The Provider will provide the service virtually.

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.

Service Specification No.	**2A3**
Service	**BNSSG Adult Autism Spectrum Disorder Service**
Commissioner Lead	**BNSSG Integrated Care Board (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 Adult Autism Service.

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

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

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

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

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

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

Common differential and co-occurring conditions include:

- Neurodevelopment disorders e.g., Attention Deficit Hyperactivity Disorder (ADHD), global developmental delay.
- Mood disorder.
- Anxiety disorder.
- Obsessive Compulsive Disorder (OCD).
- Attachment disorders.
- Effect of early childhood trauma.
- Psychosis.

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

1.1 National evidence base

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

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

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

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

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

The key principles of care include:

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

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

1.2 Right to Choose

Since 2014, in England under the Right to Choose Guidance NHS patients have a legal right to choose their mental healthcare provider and their choice of mental healthcare team. If a patient decides the waiting time for their autism assessment is too long, then they can choose alternative providers. The provider must be commissioned for the service by an ICB in England in order to offer Right to Choose. NHS Choice Framework - what choices are available to you in your NHS care - GOV.UK (www.gov.uk)

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

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

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

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

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

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

1.3 Local Context

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

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

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

It aims to:

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

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

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

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

2. Service Scope

2.1 Aims

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

2.1.1 Objectives

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

2.1.2 Service summary

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

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

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

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

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

2.2 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 and sources

Referral criteria for Diagnostic Assessment:

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

Referral criteria for Post Diagnostic support (where commissioned):

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

2.4 Referral process, triage, screening and waiting list

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

Referral routes for diagnostic assessment:
- GP

Referral Route for Post Diagnostic Support:
- GP

The Provider will undertake screening and triage of all referrals to ensure that an individual is on the correct pathway and that all eligibility criteria have been met. The Provider must aim to triage BNSSG referrals within 5 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. This step may include administrative staff as well as clinical input. Information on the referral may also direct next steps, for example that a referral should be expedited due to significant risk or need, or that the level of complexity may dictate a more nuanced approach to the assessment.

Prioritisation for assessment is not normally given, but certain patients may be prioritised depending on their circumstances at the discretion of the clinician. 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.

2.5 Any exclusion criteria

Anyone under 18 years of age.

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

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

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

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

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 2A1_2A3.

2.6 Did Not Attends (DNAs)

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.

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.

2.7 Assessment

2.7.1 Clinical profession conduction assessments

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

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

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

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

2.7.2 Adult autism assessment quality standards

1. Assessments should be performed by clinicians who have the relevant experience both in the assessment of autism and in its common comorbidities and differential diagnoses. Ideally, clinicians involved in assessments should have access to the expertise of a multidisciplinary team.
2. Prior to starting the assessment, ensure that the individual understands the purpose, potential benefits, and risks of the diagnosis.
3. The assessment must comprehensively cover the following areas: core features of autism, early developmental history, behavioural issues, functional abilities in different settings such as home, school, and work, and any current or past physical or mental health conditions.
4. Utilise structured clinical interviews to systematically gather information relevant to the diagnosis. These interviews should be based on established criteria (DSM-5 and ICD-11) and protocols to ensure consistency and reliability. This is distinct from an assessment with family/carers or conversations with siblings (for example, developmental history taking or asking for descriptions of current concerns). This is also distinct from semi-structured behavioural observation assessments that specifically focus on traits associated with autism (for example, the Autism Diagnostic Observation Schedule – 2; ADOS-2 (35)). The clinical interview is pivotal for putting into context scores obtained on standardised questionnaires that may be used for screening or triage, or scores on semi-structured assessment tools. This also helps to address the question as to whether the service user may have differential or co-occurring diagnoses; crucial for formulation and reaching clinical conclusions. Therefore, the clinical interview must include screening or assessment of common differential or co-occurring diagnoses, as part of the clinical interview conducted by a clinician with a medical background or a qualified mental health professional.
5. The assessment should also include information gathered from an informant. Early developmental information is an important part of an autism assessment and should be gathered from a person who knew the service user as a child where possible. This is not always possible when assessing adults. Wherever possible corroborative information should also be sought from family members, spouses, friends, carers, this is especially true if no early childhood informant is available. There will be circumstances where no corroborative information is available. Though this does not necessarily negate the possibility of an assessment, it should be factored into the formulation of the person. If no childhood informant is available information should be gathered from a person who knows the individual well currently.
6. Consider using validated assessment tools like the Autism Diagnostic Interview – Revised (ADI-R) and Autism Diagnostic Observation Schedule (ADOS-2). These tools should be tailored to individual needs and should complement, not replace, clinical judgement. The use of these tools is not mandatory but should be considered in complex cases.
7. Collect information on how the individual currently functions in various social and adaptive contexts. Observe and document behavioural patterns, communication abilities, and daily living skills. This may or may not include the use of standardised assessments for this purpose (for example the ADOS-2). If standardised assessments are used it is important that clinicians are appropriately trained in their use and that the scores are interpreted in the context of the information gathered during the clinical interview. Scores by themselves are not sufficient to indicate a positive or negative diagnosis.
8. A thorough assessment should evaluate the possibility of other neurodevelopmental conditions, mental disorders, physical disorders, and communication difficulties. It is essential to distinguish autism from other conditions that may have overlapping symptoms.
9. Assess potential risks such as tendencies for self-harm, breakdown of existing support systems, or rapid escalation of behavioural issues. Develop a risk management plan as a preventive measure, should these risks be significant. Document the risks and management plan in the report.
10. The assessment setting should be conducive for the individual being evaluated. It should be quiet, free from distractions, and physically comfortable to ensure accurate and reliable data collection.
11. Once the assessment is complete, provide clear and easily understandable feedback, both verbally and in writing. Discuss the diagnostic outcome and its implications and ensure that all of the

individual's questions and concerns are addressed. The process and outcome of this discussion should be documented.

12. After the assessment, a recommendation should be developed and documented. This plan should be individualised, focusing on the person's unique strengths, weaknesses, and needs. It should also link the individual to post-diagnostic support services.
13. If a diagnosis of autism has been made, follow-up should be arranged in order to provide information about the diagnosis and allow an opportunity for questions by the service users or their carers/family members. This follow-up could be an individual appointment or happen as part of a group.

2.7.3 Enhanced autism assessment

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

2.7.4 Formulating a view about diagnosis

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

2.7.5 Outcome post assessment

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

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

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

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

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

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

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

In complex cases, it is expected where a service user is known and accessing other services e.g. housing, social care that the provider will engage with other health professional as and when required, in line with rules around patient consent to information sharing.

2.7.6 Post diagnostic support

Upon diagnosis, the service user should be provided with some psycho educational support in the form of signposting to community, voluntary and other services local to BNSSG.

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

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

2.9 Performance Reporting

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

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 (CSU).

- Local mental health trust (AWP).
- Local primary and community teams and other interface services.
- Social services.
- Independent and third sector providers (voluntary sector).

2.12 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:

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

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

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

2.13.2 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:

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

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

2.15 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 (DSPT) to evidence this.

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

The Provider will identify an Information Governance lead.

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

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

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

2.16 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

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

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

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

4. Location of Provider Premises

The provider will provide the service virtually.

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.

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

Referral to be made through patient's GP.

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.

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 Guidance NG87 Attention deficit hyperactivity disorder: diagnosis and management and, for BNSSG patients, compliant with BNSSG Paediatric 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 Paediatric 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).

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

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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:

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- 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.

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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.

Service Specification No.	**2A4**
Service	**BNSSG Autism Spectrum Disorder (ASD) 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 Autism Spectrum Disorder (ASD) 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.

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

The core features of autism include:

- Persistent difficulties in social interaction and communication
- Presence of stereotypic (repetitive and rigid) behaviours
- Resistance to change or restricted interests
- Emotional regulation difficulties

There are many conditions that may present with similar features to autism spectrum disorder in service users including, but not limited to:

- Neurodevelopment disorders e.g., global developmental delay
- Attention deficient hyperactivity disorder
- Mood disorder
- Anxiety disorder
- Obsessive-Compulsive Disorder (OCD)

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

1.1 National evidence base

National strategy for autistic children, young people and adults: 2021 to 2026
The government's national strategy for improving the lives of autistic people and their families and carers in England. The strategy has six main areas for improvements:

1. Helping people to understand autism.
2. Helping autistic children and young people at school.
3. Helping autistic people to find jobs.

4. Making health and care services equal for autistic people.
5. Making sure autistic people get help in their communities.
6. Help for autistic people in the justice system.

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

There are an estimated 700,000 autistic adults and children in the UK, approximately 1% of the population although recent studies have reported increased prevalence and now that number is thought to be closer to 2.5% of children. In addition, there are an estimated 3 million family members and carers of autistic people in the UK. At least one associated mental health disorder occurs in approximately 70% of people with ASD (NICE).

1.2 Right to Choose

Since 2014, in England under the NHS Right to Choose Guidance patients have a legal right to choose their mental healthcare provider and mental healthcare team. If a patient decides the waiting time for their autism assessment is too long, then they can choose alternative providers. The provider must be commissioned for the service by an ICB in England in order to offer Right to Choose.
NHS Choice Framework - what choices are available to you in your NHS care - GOV.UK (www.gov.uk)

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

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

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

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

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

- Have a commissioning contract with any ICB in England or NHS England for the required service.
- Have a multi-disciplinary team including a paediatrician and/or child and adolescent psychiatrist as well as a psychologist with training and experience in working with autistic children and young people.

1.3 Local Context

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

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

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

It aims to:

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

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

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

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

2. Service Scope

2.1 Aims

To provide an accessible, high quality and timely ASD diagnostic service for Children and Young People, 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 local to BNSSG, Providers should support autistic Children and Young People to access a sufficient level of support to enable their continued independence and well-being.

2.1.1 Objectives

- To provide accurate autism diagnostic assessment.
- To provide a report following assessment which identifies the service user's needs so that individually tailored post diagnostic support where required can be discussed between the patient and their GP.
- To 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 receive an assessment within 12 weeks as per NICE guideline.
- 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.

2.1.2 Service summary

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

- 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.
- Right to choose information to be published in appropriate and accessible format.

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

Referrals should be accepted for children and young people aged between 2 years 4 months up to the age of 17 years 9 months, registered with a GP within BNSSG and identified as having needs that may be associated with autism that are significantly impacting their daily life despite support and intervention. Any deviation to this age range will need to be agreed with the Commissioner; however, it is recognised that where assessments are conducted entirely online, the provider may have an increased lower age limit.

If a young person is 17 years 6 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 Autism Assessment they may offer to transfer the patient to their Adult Autism Assessment service (the date of the original referral to children and young people autism services will be honoured). Transfer to an adult service should only be done with consent from the patient.

Referrals must contain the following information:

- Evidence of difficulties in the areas of development, including social communication and interaction, and restricted and repetitive behaviours.
- Evidence that these difficulties significantly impact the child/young person's daily life.
- Evidence of the difficulties the child or young person experiences at home and within an educational setting.
- Information on interventions and support implemented and how well these have worked.

2.4 Referral process and Waiting List

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

The Provider will undertake screening and triage of all referrals to ensure that an individual is on the correct pathway and that all eligibility criteria have been met. The Provider must aim to triage BNSSG referrals within 5 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. This step may include administrative staff as well as clinical input. Information on the referral may also direct next steps, for example that a referral should be expedited due to significant risk or need, or that the level of complexity may dictate a more nuanced approach to the assessment.

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

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.

2.5 Any exclusion criteria

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

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

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

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

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.

2.6 Was Not Brought (Did Not Attends)

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 DNA after a second appointment it is expected that the patient will be discharged back to 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

The key areas of the service delivery are:
- Assessment
- Post diagnosis advice and information

2.7.1 Assessment

The Assessment will be conducted over a number of appointments, tailored to the need of the service user. In accordance with NICE guidance, providers should set up a multi-disciplinary team with a core membership of:

- A paediatrician and/or a child and adolescent psychiatrist.
- Speech and language therapist.
- Psychologist with training and experience of working with autistic children and young people.

The team should also have access to the following professionals if they are not already in the team:

- Paediatrician or paediatric neurologist.
- Child and adolescent psychiatrist.
- Psychologist with training and experience complementary to the psychologist in the core team.
- Occupational therapist.

It is good practice to also include other relevant professionals who may be able to contribute to the autism diagnostic assessment. For example, a specialist health visitor or nurse, specialist teacher or social worker.

The Children's ASD Diagnostic Service will offer:

- Initial triage based on a balance of waiting time and clinical assessment of need.
- Diagnostic assessment including gathering of developmental history. Virtual observations using agreed tools and process, although face to face is preferred.
- Active signposting to appropriate services local to BNSSG.
- 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 autism 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 may be referred on to other services, depending upon needs and presentation.
3. A diagnosis of autism is uncertain or inconclusive. A recommendation may be made to access a review 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 about signposting to other community, voluntary and other services 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 and support to patients, staff need to be mindful that a family member may be a carer and signpost them to support services that can provide information.

2.7.3 Advice and Information

Following diagnosis, the individual (and their carer, if appropriate) should be provided with one follow up support session in the form of psychoeducation to develop a care plan.

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. This will result in an individualised care plan being formulated which identifies and addresses individualised needs.
- 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.
- 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.

2.7.4 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 discuss other factors that may help explain their presentation, but also to understand the strengths and needs they present with. Service users will also be signposted and/or referred to appropriate services, as required.

2.7.5 Needs Assessment

If a service user has been given a positive diagnosis, they will be offered a follow-up appointment with a member of the team to discuss their needs and be signposted towards a range of mainstream and/or voluntary sector provision local to BNSSG. At the end of the completed diagnostic assessment, the child or young person will be discharged from the Autism diagnostic assessment service pathway.

2.7.6 Discharge processes

Service is primarily diagnostic. 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

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

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 Customer Care should be provided if necessary. Translation and Interpreting services must meet the relevant standards.

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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.

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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/

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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

- Autism spectrum disorder in children: diagnosis (2023) Diagnosis | Autism in children | CKS | NICE
- Autism spectrum disorder in children: management (2023) Management | Autism in children | CKS | NICE
- Autism Quality standard [QS51] Overview | Autism | Quality standards | NICE
- Autism in children (May 2023)Autism in children | 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 2.4 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 2.11 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.

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])

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

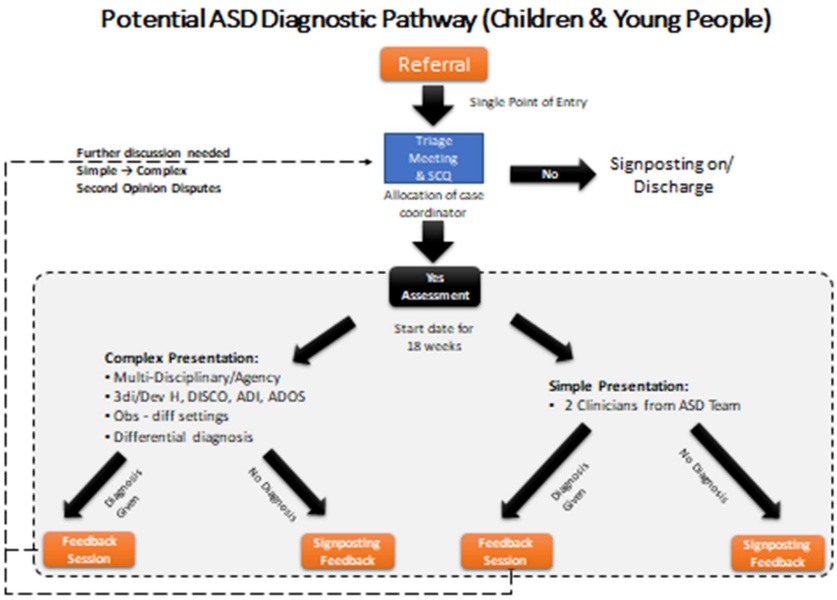
3.3.2 Service Description

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



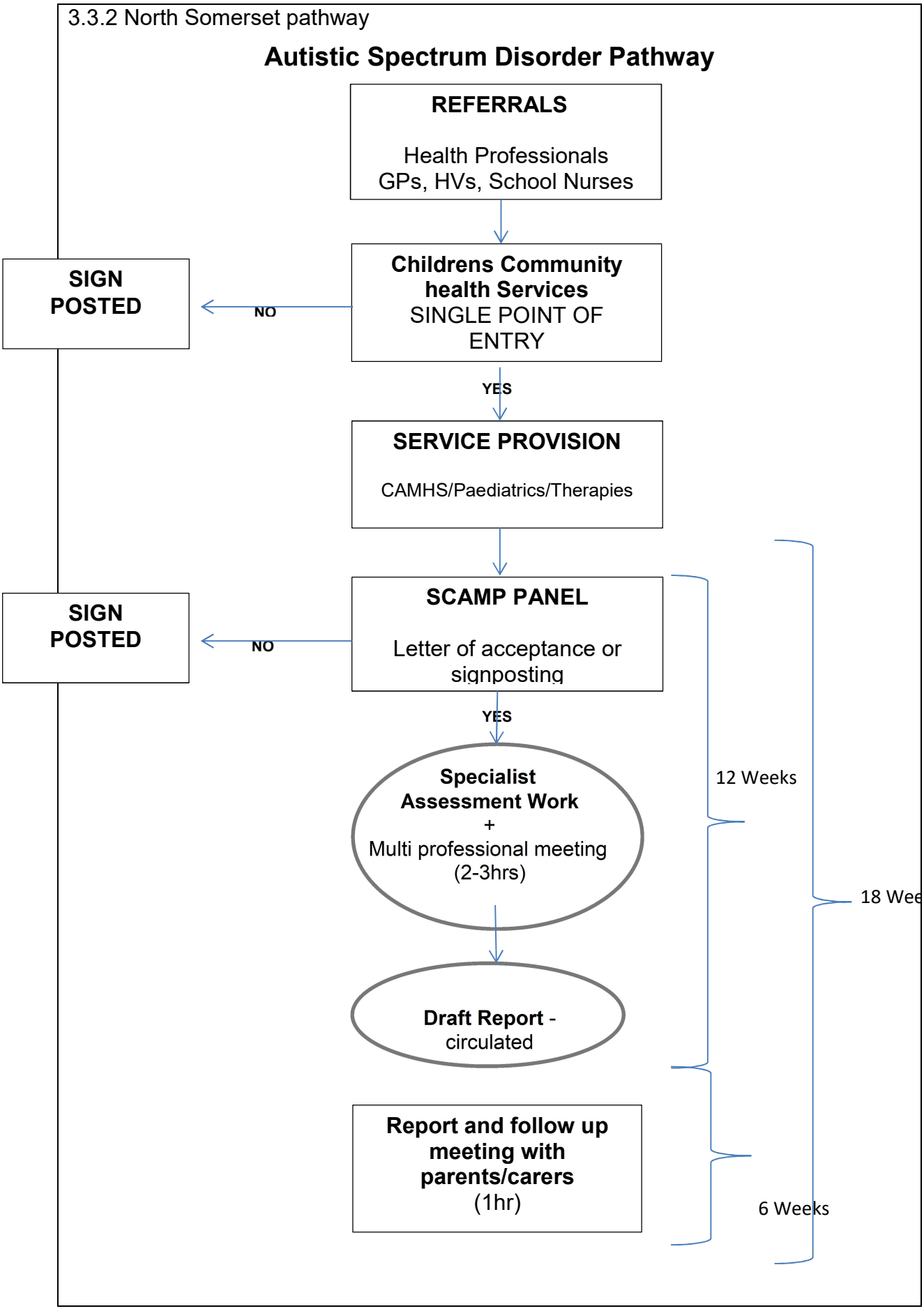
1. Referral from professionals or parents or young person via web-based Single Point of Entry (SPE) form together with completed supporting information forms from parents, educational setting and young person (as applicable) with clear indication that an ASD diagnostic assessment is requested. If incomplete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



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)

SCHEDULE 4 – LOCAL QUALITY REQUIREMENTS

Quality Requirement	Threshold	Method of Measurement	Period over which the Requirement is to be achieved
ADHD and Autism independent sector providers			
Emerging Risks In the event of any significant individual concern, emerging risk or impact to service provision the Provider is to share this with the ICB. **Implementation of an escalation procedure** Under the National Quality Board (NQB) Guidance, where there are concerns/risks escalated by the provider not able to be addressed by the Provider and requires BNSSG ICS support, the following process will be implemented: - **Intelligence sharing meeting** An initial meeting of key stakeholders to establish the facts of the concern/risk being escalated and to agree if further formal steps are required. - **Rapid Quality Review (RQR)** Multi-stakeholder meetings set up to facilitate rapid diagnosis of quality concerns/issues and to agree next steps, including action/improvement plans. Joint approach and co-production of reports/improvement action planning. - **Quality Improvement Group (QIG)**	Case by case basis The NQB process will be triggered to consider the escalated related concerns/risks and decisions made on required actions going forward.	Risks to be raised at the earliest opportunity to either the Mental Health Contracting Team, the Patient Safety Team, the Quality Oversight sub-group or the System Quality Group Provider oversight of initial concerns/risks escalated by the: • ICB Health & Care Improvement Groups (HCIGs) • Provider Collaboratives • Primary Care • System Partners • Local Authority Oversight of risk management within BNSSG ICS to mitigation/closure and de-escalation as necessary. Reporting to: System Quality Group (on an exception basis only).	Ongoing

To support planning, coordination and facilitate the sustained delivery of actions to mitigate and address the quality risks/ concerns within an individual provider or across the providers in the local system more generally. Where there are Healthcare Associated Infections (HCAI) related concerns/risks escalated by the provider the process will also be applied.			
Providers who have transitioned onto PSIRF - Implementation of an Incident Management Program The Provider must comply with guidance from the NHSE Patient Safety Incident Response Framework for NHS funded patients: - To standardise patient safety incident responses, proportionate review has been aligned to the Patient Safety Incident Response Framework (PSIRF). Once an organisation transitions to the PSIRF, a summary report setting out relevant information on Patient Safety Incidents and the progress of and outcomes from investigation/s into such Incidents, in line with the organisations Patient Safety Incident Response Plan (PSIRP) and policy will be required. The proportionate reviews/investigation/thematic analysis should include whether a lapse in care/service provision has been identified and whether lapses of care are contributory or non-contributory to the case/s under review.	Adhere to national and where necessary, local deadline in alignment to organisations PSIRP and policy and 100% as per national requirements thereafter. Summary report setting out relevant information on Patient Safety Incidents and the progress of and outcomes from investigations into such Incidents, in line with the organisations Patient Safety Incident Response Plan (PSIRP) and policy will be required. Report detailing sharing of learning with the BNSSG Integrated Care Board to include themes, trends, and safety actions for improvement.	Annual summary report: identify learning through summary report setting out relevant information on Patient Safety Incidents and the progress of and outcomes from investigations into such Incidents and associated learning, in alignment with providers PSIRP. Sharing of learning with the ICB to include themes, trends, and safety actions for improvement. Inclusion Patient Safety Partners and Patient Safety Specialists in co-production of report. Patient Safety Incident Response Policy + Patient Safety Incident Response Plan (PSIRP) to be shared with ICB and published on website. Reported in Quality and Performance Report and by exception to the System Quality Group. Ad hoc learning at Quarterly BNSSG Learning Meeting.	Ad hoc: Reported as Patient Safety Incident/death occurs. Ad hoc: Improvement Plan/review. Ongoing: learning at Quarterly BNSSG Learning Meeting Escalation: by exception.

- Some patient safety incidents, such as Never Events and deaths thought more likely than not to have been due to problems in care require a locally led Patient Safety Incident Investigation (PSII). In alignment with the organisations PSIRP and policy where a PSII is required this will be recorded on LfPSE (Learning from Patient Safety Events). - Inclusion and collaboration with Patient Safety Partners - Provider should designate a Patient Safety Specialist(s) in accordance with NHSE's https://www.england.nhs.uk/patient-safety/patient-safety-involvement/patient-safety-specialists/ - Just Culture evident - Provider Mortality Where the patient has been in an in-patient facility and a lapse in care or service delivery is noted on a Structured Judgement Review, a PSII process may be undertaken in line with the PSIRF national guidance/in alignment with provider PSIRP. To provide assurance that systems are in place to review death figures and trends, and significant causes. Provider to share findings, learning and actions from mortality reviews/LeDeR. Reg 28 learning – comply with Prevention of future death coroner reports.	PSII (where required).	PSII may be shared with the ICB when provider Executive has sign off has been completed. Where unexpected deaths are investigated by PSII approach, Learning from Death Review and Learning Disabilities Mortality Review programme and annual report should state the number of patient deaths having lapses in care/service provision, through the PSII/Structured Judgement Review (SJR) process, to have been a significant factor in the death and learning and actions from deaths. SJRs follow guidance from the AHSN and are completed in accordance with the Learning from deaths policy for the provider. Compliance with national requirements such as: • National Quality Board Guidance July 2018 requiring working in conjunction with acute providers where patients have received community provision at the time of death or shortly before this • Learning from Death Review and Learning Disabilities Mortality Review programme • Compliance and learning with the Learning Disabilities Mortality Review **(LeDeR)** programme. Mental Health Provider specific: Report to detail and evidence process regarding: - Thematic reviews of deaths - Compliance with national requirements regarding Learning from Deaths reviews	

The provider will work openly, transparently and collaboratively to complete reviews where patients have been receiving care from different providers related to the PSII. All providers to support the acute providers, where relevant in the review of 'in hospital' deaths including thematic review. The process and outcome should be notified to host Commissioner.		- Compliance and engagement in Learning Disability Mortality Review (LeDeR) programme. - Any actions required - Engagement with Medical Examiner Role. Children's deaths follow a CDOP pathway or otherwise directed by the providers children's services. LfPSE event sign off – partner organisation to close directly and have oversight of outstanding investigation closure/s. STEIS event sign off – backlog of historic investigation/s to be detailed by provider to Commissioner who will continue to support closure on STEIS. Collaborate with ICB and NHS England as part of a learning system that shares insights between organisations and services to improve safety. (*source: Overview of NHSEI's Quality Functions & Responsibilities of ICSs*)**.**	
Duty of Candour As per Service Condition 35 - Compliance with national guidance where the provider must inform patients where there has been a significant failure in their care or treatment; Involvement of patients and relatives in the investigation of serious incidents and informing them of the outcome where desired. As per CQC requirements:		Evidence of robust system in place to meet the duty of candour regulation. Evidence of how the leadership and culture reflects the vision and values and encourages openness and transparency. Discussion of breaches.	Annual

• Provider must promote a culture that encourages candour, openness and honesty at all levels. There should also be a commitment to being open and transparent at board level, or its equivalent such as a governing body • Robust system to be in place to meet the duty of Candour Regulation; to include: - training for all staff on communicating with people who use services about notifiable safety incidents - incident reporting forms which support the recording of a duty of candour notification - support for staff when they notify people who use services when something has gone wrong - oversight and assurance - up to date contract details for service users • Record in patient notes and the event reports: - Compliance with the Duty of Candour process including open communication with affected individual(s) and/or their next of kin - Exception to patient contact: where individuals cannot be contacted/traced, to record of attempts to make contact or individuals decline contact or do not wish to discuss at this point in their lives. Where sufficient effort has been made but contact has not been achieved, this will not constitute a breach (in line with guidance) • Relevant provider policies to include responsibility to fulfil Duty of Candour i.e. Being Open Policy ***Guidance:*** https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour		Duty of Candour section. confirming any Duty of Candour declarations within the Quality report (on an exception basis only). Reported via Quality report.	
Complaint Management Complaints monitoring report, setting out numbers of complaints received and including analysis of key themes in content of complaints.	90% of complaints raised acknowledged within 3 working days.	Evidence of monthly compliance in responding to agreed response times. Evidence of learning and changes made to	Monthly compliance of all measures reported in line with Quality report frequency.

Provider to respond to patient feedback in a timely way and ensure complaints are handled in line with national regulations: • Number of complaints with trends and actions arising, including information on those upheld • Number of complaints received each month • Number of concerns/PALS enquiries received each month • Number of complaints received acknowledged within 3 days • Number of compliments received each month/themed • Ombudsman complaints summary (including number of open Ombudsman cases each month) Ensure lessons learnt are embedded within the wider organisation. Assurance that complainant is satisfied with the process and outcomes of their complaint including where possible equality information is collected as part of the patient and carer satisfaction survey.		services where required are shared. Complainant feedback following completion of the complaint. Reported via Quality report.	
Patient experience Provider has robust processes for responding, understanding and learning from the experiences of patients, utilising (not exhaustive) * FFT Scores * Local patient participation and engagement work * Formal complaints, PALs concerns, MP enquiries * Social Media * CQC patient experience portal	Provider will report on patient experience to share trends captured, learning, and associated action plans along with examples of feedback that have resulted in service changes, how feedback of changes are shared with stakeholders, and compliance to the	Report to provide summary of compliance to provider policy, along with systems in place to monitor patient experience (quantitative and qualitative experiential methodologies) to capture monthly feedback from a range of sources. Evidence of triangulating all feedback against other quality measures i.e. patient experience (complaints, PALS, surveys, patient stories, compliments), clinical effectiveness (patient outcomes) and safety (incident reporting) to elicit	Annual

* Healthwatch * National and local review/surveys * Patient and carers surveys * Compliments * Learning from Patient Safety Events/Investigations * The use of PROM's (patient related outcome measures) * Carers workstreams * NHS Choices summary * Quality Walkabouts - Patient Participation Groups plays an active role in delivering feedback, with the provider delivering tangible changes/improvements resulting from input. - Accessible signposting in place for patients - Plan for optimising patient experience embedded with progress against deliverables.	provider's experience or complaints policies. This should include an annual update on PLACE (Patient Led Assessment of Care Environment).	learning, themes and trends. Examples of improvement to service provision as a result of learning from patient experience. Patient stories reviewed and acted upon. Evidence of Quality Improvement projects/workstreams.	
Freedom to Speak Up Provider to adopt the NHSE Freedom to Speak Up: Whistleblowing Policy for the NHS as a minimum standard to help to normalise the raising of concerns for the benefit of all patients**:** • Encourage staff to speak up in line with the Freedom to Speak Up Review and set out the steps they will take to get to the bottom of any concerns • Investigations will be evidence-based and led by someone suitably independent in the	Evidence of adopting of the NHSE Freedom to Speak Up: Whistleblowing Policy for the NHS. Example of any concerns raised and how addressed reported in Board Report.	To be included within Quality Report.	Annual 5.10 Guidance: https://www.england.nhs.uk/ourwork/freedom-to-speak-up/developing-freedom-to-speak-up-arrangements-in-the-nhs/

organisation/practice, producing a report which focuses on learning lessons and improving care • Whistleblowers will be kept informed of the investigation's progress High level findings are provided to the organisation's board, and the policy will be annually reviewed and improved.			
Accessible Information Standard As per Service Conditions 12.3 Provider to ensure people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand Evidence to be provided about compliance with the Accessible Information Standard https://www.england.nhs.uk/ourwork/accessibleinfo/ https://www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/accessibleinfo/	In year plan and delivery.	Evidence of assessing compliance and any actions required using the Accessible Information Standard's conformance criteria and reporting breaches. Evidence of implemented accessible complaints policy. Evidence of published accessible communications policy. Reported via Quality Report	Annual
Safety Alerts The provider will have processes for assessing, and implementing (where appropriate), alerts received via the Central Alert System (CAS). The CAS is a web-based cascading system for issuing patient safety alerts and important public health messages and other safety critical information.	The provider will report any exceptions to the implementation of CAS alerts.	Report via Quality report.	Annual

Risk Management The provider must have a corporate risk reporting system that includes clinical risk assessment and risk register reporting.	All Clinical and non-clinical high risks to be reported on the corporate risk register supported by a report with actions planned to mitigate the risks and progress against the actions.	Report via Quality Report including new/emerging risks. Provider to attend to discuss new/emergent risks for BNSSG ICS mitigation at System Quality Group (if required)	Annual Ad hoc
Legal Claims/Inquests To understand the level of harm and negligence attributed to the organisation.	Provider to evidence process that learning and improvement takes place as a result of a claim or inquest.	Report to cover themes/trends/learning. Reported via Quality Report.	Annual
External Visits Provider to advise ICB of the outcome of any CQC visits, Regulator Visits, External visits, National Enquiries or regulatory inspections, share plans and actions resulting from these at the same time or earlier than when submitted to the relevant external regulators and progress updates. Specifically, to advise both ICB's Lead Director for Quality within 2 days of any visit, including subsequent monthly updates on action plans implemented as a result of inspections	100% fully compliant with all CQC/other regulations enforcement.	Updates as and when inspections occur and on agreed frequency subsequently until issues are addressed. A copy of all external CQC/other reports including associated action plans to be provided to commissioner once submitted to CQC. Report within 2 working days any breach of registration or any conditions imposed by CQC/other. To advise the commissioners of CQC/other visits within 2 days and make available feedback and remedial action (this will be provided via the CQC report).	By Exception
National reports Ensure that all relevant recommendations from national reports published previously and within the contract year are	N/A	The Provider will review all National Guidance or Reports. Updates on any assessments and actions against these recommendations and reports will be reflected within the Provider's Quality Report.	By Exception

acknowledged and acted upon. For example, Francis reports, Berwick, Winterbourne View Kirkup, HSSIB, etc.			
Clinical Audit Provider has continuous improvement to improve care, experience and efficiency through participation in national and clinical audits and outcome programmes *as well as a platform for shared learning across the organisation/practice.*	The provider must participate in any mandatory national clinical audit. Provider to share learning identified and action plans from National reports, national audit and outcome programmes, local audit overviews, and any audits included in the Quality Account.	Annual clinical audit/quality improvement plan to be provided to the commissioner. The commissioner may request to review completed audits in line with commissioning priorities, emerging in year themes and to support quality visits. Progress against audits planned, details of themes arising and lessons learnt from completed audits. Clear platform to share audit results and learning.	Annual
NICE Compliance https://www.nice.org.uk/standards-and-indicators NICE Guidelines and Quality Standards applicable to and in use by the Provider will be monitored and plans developed to address any areas of risk or safety concerns.		To be included within Annual Report.	Annual
Staff Training (Stat man training) Evidence that a clear program is in place for all clinical and non-clinical staff statutory and mandatory training and evidence all staff have received this training	>95%	Compliance of training monitored monthly and included in provider's report.	Monthly data collected and reported via Quality report frequency.
Staff Wellbeing Measures Understanding of factors affecting staff satisfaction and plans in place to measure improvements in staff experience,		To be included within Annual Quality Report.	Annual

improving retention and turnover.			
All providers who hold waiting lists **Clinical Waiting List Review** Patients on waiting lists will be monitored appropriately to ensure robust clinical oversight and identification of patients whose condition requires escalation. The provider will evidence appropriate action as a result of clinical validation of waiting lists.	The provider will consider the clinical patient safety, harm, experience and duty of candour in wait list reviews. Escalate as appropriate through established forums and contract routes.	Ad hoc as discussions are undertaken to review patient waits by the provider, quality, performance, and commissioners. This will be escalated as appropriate through established forums and contract routes.	Ad Hoc
LeDeR Programme	Provider should notify the LeDeR portal when a person dies who has a learning disability and /or autism and is over the age of 18 years The Provider must support the LeDeR programme with information requests from all ICB's. The Provider will support actions following LeDeR reviews either individual actions specific to that organisation or actions derived from a LeDeR theme as directed by the LeDeR Governance Group.	Notifications to be uploaded onto the LeDeR portal.	ICB to monitor monthly notification, this data feeds into LeDeR Governance meeting with oversight of Executives.
Providers must ensure that all staff receive training in how to interact appropriately with people with a learning disability and	The Health and Care Act 2022 makes provision for mandatory training on	Oliver McGowan Task and Finish Group continues	Data from Providers is fed into this meeting again an oversight report is

autistic people, at a level appropriate to their role. General Condition 5.5 (FL) and 5.4 (SF) and Definitions	learning disability and autism for all staff. The recommendation of the Oliver McGowan Mandatory Training on Learning Disability and Autism as the "preferred and recommended" training package. In accordance with the requirements of the Oliver McGowan Code of Practice.	**IS Providers** to include Oliver McGowan Tier 1 and Tier 2 training compliance with mandatory training. Update 6 monthly.	provided to LeDeR Governance Group with oversight of the Exec's.
NHSE Learning Disability Improvement Standards project (NHSE Annual benchmarking data collection)	Providers are expected to be registered with the NHSE Learning Disability Improvement Standards project and submit annual assessments against the learning disability improvement standards, against for four standards. https://www.england.nhs.uk/wp-content/uploads/2020/08/v1.17_Improvement_Standards_added_note.pdf	This is done through 3 levels of data collection: 1. Organisational level data collection 2. Staff Survey 3. Service user Survey	Once a year and this is shared through Trust specific annual report on the performance against each of the areas.
Greenlight toolkit Mental health services: (Acute mental health provisions)	The Green Light Toolkit (GLTK – updated version 2022) supports the audit **and improvements within a mental health service, so that it is**	1. Annual Audit 2. Results to inform Action Plan and Improvement schedule and correlated to NHSE Annual Benchmarking	Annual

	effective in supporting autistic people and people with learning disabilities – to meet their mental Health needs. Green Light Toolkit - NDTi		
Healthcare passport	**Non Acute Providers:** Promote, and contribute to the use of Health Passports for people with a learning disability and autistic people to inform that specific risks are met and support increasing awareness of health passports both service users and carers. **Acute providers** Monitor, promote and contribute to the use of health passports for people with a learning disability and/or autism.	Non-acute Providers promote the use of health passports. Acute Providers: Monitor how many patients bring in a health passport six monthly.	Acute Providers: Review the number of people bringing in their health passport on admission 6 monthly and include in LDA activity report.

Learning Disability Screening access	Sirona to continue and improve access to the cancer screening.	This is included in the quarterly annual health check teaching to GPs	Quarterly report.
Reasonable adjustments	All providers to have an embedded reasonable adjustment flag on their IT system. All providers should share progress of reasonable adjustments, highlighting how these are benefitting individuals and how they are embedded to provide ongoing support. Working towards embedding the Autism Audit findings For consideration: Website information to include where practical - Clear information on how to contact the Learning Disability Autism Liaison Service (LDALS)	Reasonable adjustment audit Annual review of all recommendations to be provided within quality report.	Annual to be reviewed at LeDeR Governance Group.

	support autistic people. - the autism hospital passport. In clinical areas, where appropriate: - add LDALS team information in poster form in waiting areas including a QR code or text number that an autistic person could access. - If sensory products already established, raise awareness for all staff to made aware of sensory products and where they are stored. - Promote use of a wallet card to disclose autism. Environment Design; where applicable - When planning new buildings utilise Experts by Experience to inform design. - Create a predictable environment. - Swap noise alarms for silent/light alarms.		

	- Reduce noise and echoes. - Change fluorescent lighting. - Improve natural daylight and natural ventilation. Mental Health Emergency, where applicable: - Improve staff awareness of the Autism Healthcare Passports and promote the use of these. - Provide a mental health plan including useful information and additional sections completed by professionals for the autistic person to be discharged with. - Specific training packages to increase knowledge and understanding of how to support someone in mental health crisis.		
Medicines Management	**Safe management of Controlled Drugs**	Monitoring report to include areas of concern identified and actions taken with planned timescales.	Quarterly

	Processes need to be in place to support safe use and management of controlled drugs, including the reporting and investigating of concerns and sharing learning. Electronic controlled drug monitoring (such as ADIoS) reports and any areas of concern to be submitted for discussion. Monitor Controlled Drugs of schedule 2, 3, stock supply trends to all locations supplied by the Trust (including supply external to the Trust) to identify excessive ordering/use and investigate to confirm usage is clinically appropriate. Monitoring will include sub-contracted pharmacy services e.g. prescribing on FP10 and outpatient prescription services.	Undertake quarterly Controlled Drugs audit of ward storage. Undertake quarterly reporting of Controlled Drugs related incidents to NHS England. Engage with the Controlled Drugs Local Intelligence Network through attendance at Controlled Drugs Local Intelligence Network meetings. Sharing learning identified by the Controlled Drugs Local Intelligence Network within your organisation to improve patient safety. Reporting assurance data compliance including the electronic controlled drug monitoring to: - Provider Quality Review Meetings - BNSSG Medicines Quality and Safety Group	
Medicines Management	**Incidents** Share the themes and learning from medication	<u>Incidents</u>	Quarterly

	related incidences across BNSSG. Work will be undertaken across BNSSG to standardise the approach to system wide sharing and learning – e.g. incident reporting from Datix.	Quarterly qualitative report on shared learning related to medication incidents. Contribute to system wide safety newsletter Reporting compliance to: - Standard agenda item BNSSG Medicines Quality and Safety Group.	
STOMP/STAMP	Psychotropic prescribing – Learning Disabilities (LD) Aim to reduce inappropriate prescribing of psychotropic medications to service users with a known LD condition, autism or both in line with 'stopping over medication of people with a learning disability' (STOMP). Service user should receive an annual review conducted by the provider, as a minimum, where they have a diagnosis of a known LD	Annual report of any inappropriate prescribing, including learning from incidents and how these were shared with the prescriber and multidisciplinary team and within the wider organisation. Annual report showing number of patient's meeting criteria compared to those who received annual review when due. Audit of clinic letters to evidence that communication to GP's includes a plan about stopping the inappropriate psychotropic medication. Reporting assurance data compliance to: - BNSSG Medicines Quality and Safety Group	Annual

	condition and are prescribed psychotropics Aim to reduce inappropriate prescribing of psychotropic medications to children and young people with a known LD condition, autism or both, in line with 'stopping over medication of people with a learning disability' (STOMP). (STAMP encompasses STOMP in children). Children to be reviewed 6 monthly, audit report will be compiled annually). Service user should receive a review at least 6-monthly, conducted by the provider, where they have a diagnosis of a known LD condition, autism or both, and are prescribed psychotropics An annual report to be completed in relation to this indicator.		

	Definitions for reference: STOMP stands for stopping over medication of people with a learning disability, autism or both with psychotropic medicines. STAMP stands for supporting treatment and appropriate medication in paediatrics.		

A. Reporting Requirements

		Reporting Period	Format of Report	Timing and Method for delivery of Report	Service category
	National Requirements Reported Centrally				
1	As specified in the Schedule of Approved Collections published at https://digital.nhs.uk/isce/publication/nhs-standard-contract-approved-collections where mandated for and as applicable to the Provider and the Services	As set out in relevant Guidance Per calendar month	As set out in relevant Guidance Minimum data set: MHS000 MHS001 MHS002 MHS101	As set out in relevant Guidance Reported monthly via MHSDS portal	**All**
2	Patient Reported Outcome Measures (PROMS) https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/patient-reported-outcome-measures-proms	Annually	MS Word or PDF	To be included in Providers Annual Quality report. Report to be submitted by 1st May 2026	**All**
	National Requirements Reported Locally				
1a	Activity and Finance Report	Quarterly, broken down by month	MS Word or PDF	To be included in quarterly reports: • Q1 April – June by 1st August • Q2 July – September by 1st	**A, MH**

		Reporting Period	Format of Report	Timing and Method for delivery of Report	Service category
				November • Q3 October – December by 1st February • Q4 January – March by 1st May	
2	Service Quality Performance Report, detailing performance against National Quality Requirements, Local Quality Requirements and the duty of candour, including, without limitation:	Quarterly (Some to be reported annually)	MS Word or PDF	To be included in quarterly reports: • Q1 April – June by 1st August • Q2 July – September by 1st November • Q3 October – December by 1st February • Q4 January – March by 1st May	
2a	details of any thresholds that have been breached and breaches in respect of the duty of candour that have occurred;				**All**
2b	details of all requirements satisfied;				**All**
2c	details of, and reasons for, any failure to meet requirements				**All**
3	Where CQUIN applies, CQUIN Performance Report and details of progress towards satisfying any CQUIN Indicators, including details of all CQUIN Indicators satisfied or not satisfied	N/A	N/A	N/A	**All**
4	Complaints monitoring report, setting out numbers of complaints received and including analysis of key themes in content of complaints	Monthly compliance of all measures reported in line with Quality report frequency. Summary of complaints within quarter. Member survey report (including resolution process).	MS Word or PDF	To be included in quarterly reports: • Q1 April – June by 1st August • Q2 July – September by 1st November • Q3 October – December by 1st February • Q4 January – March by 1st May	**All**

		Reporting Period	Format of Report	Timing and Method for delivery of Report	Service category
		For further information please see schedule 4 (Local Quality Schedule).			
5	Report against performance of Service Development and Improvement Plan (SDIP)	Ongoing	MS Word or PDF	In accordance with relevant SDIP	**All**
6	Summary report setting out relevant information on Patient Safety Incidents and the progress of and outcomes from Patient Safety Investigations, as agreed with the Co-ordinating Commissioner	In line with requirement 4 Complaints Monitoring Report (above)	As above (requirement 4)	As above (requirement 4)	**All**
7	Data Quality Improvement Plan: report of progress against milestones	N/A	N/A	N/A	**All**
8	Report on outcome of reviews and evaluations in relation to Staff numbers and skill mix in accordance with GC5.2 (*Staff*)	Annually	MS Word or PDF	To be included in Q4 report: Report to be submitted by 1st May 2026	**All**
9	Where the Services include Specialised Services and/or other services directly commissioned by NHS England (or commissioned by an ICB, where NHS England has delegated the function of commissioning those services), specific reports as set out athttps://www.england.nhs.uk/nhs-standard-contract/dc-reporting/ (where not otherwise required to be submitted as a national requirement reported centrally or locally)	As set out at https://www.england.nhs.uk/nhs-standard-contract/dc-reporting/	As set out at https://www.england.nhs.uk/nhs-standard-contract/dc-reporting/	As set out at https://www.england.nhs.uk/nhs-standard-contract/dc-reporting/	**All**
10	Report on progress against Green Plan in accordance with SC18.2 (NHS Trust/FT only)	Annually	MS Word or PDF	To be included in Q4 report: Report to be submitted by 1st May 2026	**All**

		Reporting Period	Format of Report	Timing and Method for delivery of Report	Service category
	Local Requirements Reported Locally				
1	General Update/Performance report for each contract meeting Must include: A. Update on Service including service development B. KPI report C. Risks D. Plans for Service Delivery for the following quarter E. Service User Feedback F. Update on any serious incidents including learning G. Safeguarding Concerns H. Complaints I. Any additional requests captured in reporting schedules			The Provider must submit any patient-identifiable data required in relation to Local Requirements Reported Locally via the Data Landing Portal in accordance with the Data Landing Portal Acceptable Use Statement. • Q1 April – June by 1st August • Q2 July – September by 1st November • Q3 October – December by 1st February • Q4 January – March by 1st May	

Non-Statutory Mental Health Providers Outcomes and Key Performance Indicators

Local reporting for a case holding service – data required quarterly, broken down by month, except where specified.

Type of measure	Descriptor	Key Performance Indicator	Data split	KPI captured by providers MHSDS submission?
Demand	An understanding of the volume, source and urgency of demand	Total referrals received in the month	Adult ADHD CYP ADHD Adult Autism CYP Autism	Yes
		The number of referrals received in the month broken down by referral source		No
		The number of referrals received from a GP in the month broken down by GP practice		Yes

		The number of referrals received in the month which met the providers criteria for urgent prioritisation		No
	An understanding of the appropriateness of referrals	The number of referrals accepted and declined in the month		No
		Breakdown of the reasons why referrals were declined across the quarter, with an indication of the source to be included in performance narrative		No
Waiting time	A measure of how many people are waiting for support and for how long	Snapshot at end of month of how many people are waiting for diagnostic assessment by monthly wait time bands.	Adult ADHD CYP ADHD Adult Autism CYP Autism	No
		ADHD specific - Snapshot at end of month of how many people are waiting for titration by monthly wait time bands.	Adult ADHD CYP ADHD	No
		Autism specific - Snapshot at end of month of how many people are waiting for post diagnostic therapy (if applicable) by monthly wait time bands.	Adult Autism CYP Autism	No
	A measure of the actual time waiting for support	Where a first appointment (diagnostic assessment) took place in a month, how long did people wait from referral by monthly wait time bands.	Adult ADHD CYP ADHD Adult Autism CYP Autism	No
		% of referrals triaged within 5 days, 10 days, 15 days, 20 days, 20+ days.		No
		ADHD specific - Where a first titration appointment has taken place in a month, how long did people wait from date of diagnostic assessment by monthly wait time bands.	Adult ADHD CYP ADHD	No

		Autism specific - Where a first post diagnostic therapy appointment has taken place in a month, how long did people wait from date of diagnostic assessment by monthly wait time bands.	Adult Autism CYP Autism	No
	A measure of successful follow up	ADHD specific - Total waiting list size where 12 month annual follow up review appointment is due within the month where no or only partial shared care is available	Adult ADHD CYP ADHD	No
		ADHD specific - number of overdue 12 month annual follow up review appointments due in the month where no or only partial shared care is available, with reasons for this - eg numbers waiting, patient non engagement, DNA.		No
Activity	A measure of how many individual people the service is supporting & indication of their need	ADHD specific - Total number of people on the case load at the end of the month receiving treatment (medication only) where no shared care is available.		No
		Where a diagnosis of ADHD or Autism is given: Current average (mean) length of stay on the active caseload - for ADHD this will be until medication stabilisation at which point they would either be discharged back to their GP if shared care is available, or retained by the provider.	Adult ADHD CYP ADHD Adult Autism CYP Autism	No
		Where a diagnosis of ADHD or Autism is given: Current longest length of time on the active caseload - for ADHD this will be until medication stabilisation at which point they would either be discharged back to their GP if shared care is available, or retained by the provider.		No
	An understanding of the service capacity	The planned number of appointment slots / patient contacts available in the month based on workforce and average appointment/contact length	Adult ADHD CYP ADHD Adult Autism CYP Autism	No
		OR expected caseload size		No
		The number of appointments delivered in the month, by type of appointment (new/follow up) and appointment outcome (attended, cancelled by service, cancelled by client, DNA)		No

Flow	A measure of how many people were supported and unable to engage with the service	Number of people in the month who were discharged, broken down by whether treatment concluded or broke down due to not attending and the point in episode of care that they were discharged - eg, following assessment, titration, medication etc.	Adult ADHD CYP ADHD Adult Autism CYP Autism	No
	An understanding of length of support required, when treatment was completed	Average (mean) length of stay on the caseload for cases closing in the month (1st to last contact/ discharge) - for ADHD this will be until medication stabilisation at which point they would either be discharged back to their GP if shared care is available, or retained by the provider.	Adult ADHD CYP ADHD Adult Autism CYP Autism *Only include ADHD where shared care is available or assessment does not result in diagnosis.	No
Outcomes	People who have a protected characteristic meaning that they may have an additional challenge in accessing mental health support are supported	Total number of referrals in the month broken down by their demographics and protected characteristics (across the full code list, to show the level of completeness for each) (Demographic information to be assessed based on number of referrals by GP practice above)	See "supporting information" tab	Yes - but not all indicators are included in the mandatory table: Not included in mandatory table for reporting on MHSDS: Disability indicator Pregnancy status Religion or belief Sexual orientation
	Service specific outcomes	Number and percentage of service users diagnosed with ADHD / Autism	Broken down by ADHD or Autism and adult or CYP.	No
		Number and percentage of service users diagnosed with ADHD who are then started on medication	Broken down by adult or CYP.	No
		ADHD specific - Number of Shared Care Agreements:		

		Not accepted by GP		
		Accepted by GP for medication only (provider retains annual review)		
		Full shared care accepted by GP to include medication and annual review.	Adult ADHD	No
	People report a positive experience of the service	Patient Reported Experience Measure – Friends & Family or adopt local CMHP PREM	To be included in Annual Service Quality Report	N/A
	Demonstrable improvement in health & wellbeing of service users	Patient Reported Outcome Measurement – DIALOG, Goal Based Outcomes (GBO) or REQOL: For ADHD, this should be measured at assessment, end of titration and annual review		N/A
		3 x case studies demonstrating impact 6 monthly 1 demonstrating complexity, 1 demonstrating learning, 1 demonstrating a positive outcome	To be included in Q2 & Q4 reports	N/A