Reference: FOI.ICB-2526/392

Subject: Commissioned Children's and Adults ADHD Assessment Services and Right to Choose

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

QUESTION	RESPONSE
1. Do you currently have a commissioned adult ADHD assessment service?	Bristol, North Somerset and South Gloucestershire (BNSSG) ICB holds contracts for adult ADHD assessment and Treatment with Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) and Clinical Partners.
2. How many adults do you have waiting for an adult ADHD assessment?	For Adult ADHD as of Feb 2026 there are 3,993 service users on the waiting list. The requester is advised to contact AWP directly for up to date and accurate data: https://www.awp.nhs.uk/contact-us/freedom-information At the end of December 2025, Clinical Partners reported a waiting list of **1154** for adult ADHD diagnostic assessment. Clinical Partners may be able to provide a more up to date figure when contacted directly. This figure also does not include adults referred to other providers operating under right to choose in BNSSG and the ICB does not hold this data.
3. What is your current expected waiting time (in weeks) for an adult ADHD Assessment?	The ICB does not hold waiting time data for AWP and the requester is advised to contact the provider directly, https://www.awp.nhs.uk/contact-us/freedom-information However, we are aware from our transformation redesign work that average waiting times can be difficult to predict given referral volume. We also know that waits can be as long as around 6-7 years for routine

	adults ADHD in BNSSG, and we are working to redesign services to reduce this. The ICB does not hold an expected waiting time for Clinical Partners as data is not collected from them in this way. They do publish information about waiting times on their website and the requester is advised to access this; NHS Right to Choose wait times and updates | Clinical Partners A variety of contact methods for Clinical Partners are available at the following link: Contact us | Clinical Partners
4. What is your current longest waiting time (in weeks) for an adult ADHD Assessment?	The ICB does not hold waiting time data for AWP and the requester is advised to contact the provider directly; https://www.awp.nhs.uk/contact-us/freedom-information At the end of December 25-26, Clinical Partners longest waiting time for adult ADHD assessment was in excess of 52 weeks. The ICB does not have data on the exact number of weeks. They do publish information about waiting times on their website and the requester is advised to access this. NHS Right to Choose wait times and updates | Clinical Partners
5. What is your process for reviewing and deciding whether to accept or reject adults who have been referred for an ADHD assessment?	The ICB does not review referrals for ADHD assessment, criteria for acceptance is set by the provider and the requester is advised to contact them directly for this information. AWP: https://www.awp.nhs.uk/contact-us/freedom-information Clinical Partners: https://www.clinical-partners.co.uk/contact-us/
6. Is your organisation confident that it is satisfying the NICE guidelines for adults with ADHD?	Providers who hold a contract with BNSSG ICB for ADHD assessment are expected to comply with the relevant NICE guidance and this is set out in the service specification. The spec refers to the NICE guidance as follows:

	The adult ADHD service provided will be informed by the following guidance and good practice guidelines: 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 Evidence of compliance with this guidance is not specifically collected from providers, however, there are other reporting requirements that they are obliged to follow which cover Quality (Serious incidents, Duty of Candour, Complaints etc) and Activity (waiting times, outcomes etc). An example of the information collected from Clinical Partners is enclosed. Q6 and 12 - Quality schedule 25-26.pdf Q6 and 12 - Reporting schedule 25
7. Do you currently have a commissioned child ADHD assessment service?	The ICB holds contracts for Children and Young People (CYP) ADHD assessment and Treatment with Sirona Care and Health and Clinical Partners.
8. How many children do you have waiting for a child ADHD assessment?	At the end of December 2025, Clinical Partners reported a waiting list of **1398** for CYP ADHD diagnostic assessment. Clinical Partners may be able to provide a more up to date figure when contacted directly. This figure also does not include children referred to other providers operating under right to choose in BNSSG and the ICB does not hold this data.

<table>
<tr><td></td><td>As of December 2025, Sirona care & health reported the following waiting time data:
<table>
<tr><th></th><th>18 weeks and under</th><th>19-25 weeks</th><th>26-51 weeks</th><th>52-77 weeks</th><th>78-103 weeks</th><th>Over 104 weeks</th></tr>
<tr><td>Sirona</td><td>311</td><td>208</td><td>700</td><td>466</td><td>418</td><td>600</td></tr>
</table></td></tr>
<tr><td>9. What is your current expected waiting time (in weeks) for a child ADHD Assessment?</td><td>The ICB does not hold an expected waiting time for assessments by Clinical Partners. (This excludes wait times to commence treatment i.e. medication post-assessment if agreed). They do publish information about waiting times on their website and the requester is advised to access this; NHS Right to Choose wait times and updates | Clinical Partners.

Average waiting times are published by Sirona care and health on their website Waiting times - Sirona care & health</td></tr>
<tr><td>10. What is your current longest waiting time (in weeks) for a child ADHD Assessment?</td><td>At the end of December 25-26, Clinical Partners longest waiting time for CYP ADHD assessment was between 40-52 weeks. The ICB does not have data on the exact number of weeks.

They do publish information about waiting times on their website and the requester is advised to access this; NHS Right to Choose wait times and updates | Clinical Partners.

Waiting times are reported in categories of wait length. Please see Q8.</td></tr>
<tr><td>11. What is your process for reviewing and deciding whether to accept or reject children who have been referred for an ADHD assessment?</td><td>The ICB does not review referrals for ADHD assessment, criteria for acceptance is set by the provider and the requester is advised to contact them directly for this information.</td></tr>
</table>

	Providers have a triaging process to assess whether a child or young person meets the acceptance criteria for an ADHD assessment. Please contact the providers directly: Sirona care and health: sirona.hello@nhs.net Clinical Partners: Contact us | Clinical Partners
12. Is your organisation confident that it is satisfying the NICE guidelines for children with ADHD?	Providers who hold a contract with BNSSG ICB for ADHD assessment are expected to comply with the relevant NICE guidance and this is set out in the service specification. Evidence of compliance with this guidance is not specifically collected from providers, however, there are other reporting requirements that they are obliged to follow which cover Quality (Serious incidents, Duty of Candour, Complaints etc) and Activity (waiting times, outcomes etc). An example of the information collected from Clinical Partners is enclosed. Q6 and 12 - Quality schedule 25-26.pdf Q6 and 12 - Reporting schedule 25
13. Has your organisation put any restrictions on Right to Choose services for diagnoses. a. If so, what restrictions have been put in place. b. If so, which companies, does it apply to.	There are currently no restrictions on right to choose referrals and under the NHS Standard Contract, providers are obliged to accept clinically appropriate referrals. Indicative Activity Plans have been set with some providers, which confirm the level of activity the ICB wishes to commission from them for the financial year. Where a provider reaches their activity limit for the year, they will place new referrals on a waiting list until the next financial year. Indicative Activity Plans were put in place with providers where 24-25 spend was over £50k.

	ADHD and Autism providers in scope of IAPs in 25-26 are: • ADHD 360 • Axia ASD • The Centre for ADHD Research and Excellence (CARE) ADHD • Clinical Partners • Dr J & Colleagues (Jajawi & Asker Ltd) • Evolve Psychology • Paloma Health (Your Patient Choice Ltd) • Problem Shared (Teledoctor Ltd) • Psicon • Psychiatry UK • RTN Medical • RTN Mental Health Solutions T/A RTN Diagnostics The ICB has also published some information about access to ADHD and Autism services on our website: Accessing autism and ADHD assessments via Right to Choose - BNSSG Healthier Together
14. Has your organisation paused taking on new ADHD diagnoses at all. a. If so, why.	Please see above.

The information provided in this response is accurate as of 12 March 2026 and has been approved for release by Caroline Dawe, Deputy Director of Performance and Delivery, Acute and Integrated Care, MHLDA and EPRR and Jenny Bowker, Deputy Director of Performance Delivery, Primary Care and Children's Services for NHS Bristol, North Somerset and South Gloucestershire ICB.

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