

Reference: FOI.ICB-2627/152

Subject: Clinical Partners NHS Right to Choose Adult Autism Assessments

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

QUESTION	RESPONSE
For the avoidance of doubt, this request concerns Clinical Partners / Clinical Partners Ltd and NHS Right to Choose adult autism assessment referrals accepted at or around June 2025, including referrals from patients outside the BNSSG geographical area where Clinical Partners relied on a qualifying NHS Standard Contract held by BNSSG ICB. Please provide the following recorded information.	
1. Contract held with Clinical Partners Please confirm whether BNSSG ICB held, at or around June 2025, an NHS Standard Contract or other qualifying NHS contract with Clinical Partners for NHS Right to Choose adult autism assessments. Please provide: - the contract reference or identifying title; - the contract start date; - the contract end date; - any renewal, extension or variation dates; - the name of the contracting legal entity; - the NHS service covered by the contract; - whether the contract was relied upon by Clinical Partners for accepting NHS Right to Choose adult autism assessment referrals from patients	1. BNSSG ICB held an NHS Standard Contract with Clinical Partners in June 2025. - BNSSG_ICB_2024-2026_Clinical_Partners_ADHD & Autism Assessment and Treatment Services – CYP & Adults MH 1st December 2024 31st March 2026 - Variation agreement (VA1) was effective from 1st April 2025. This covered the movement of the contract from the 24-25 NHS Standard Contract long form template to the 25-26 NHS Standard Contract long form template, along with minor updates to the local contracting schedules. This was the only VA which was effective during the period specified. - Clinical Partners - Children, Young People and adults ADHD assessment and treatment, Children, Young People and adults Autism assessment.

registered with GP practices outside the BNSSG area. Clarification received: In relation to Q1.e, by “the name of the contracting legal entity” I mean the exact legal name of the provider or other party named in the relevant NHS Standard Contract or qualifying contract with BNSSG ICB. For example, please confirm whether the contracting party is Clinical Partners Ltd, another Clinical Partners group company, a parent company, a trading name, a subcontractor, a partnership, or any other legal person/entity named in the contract. If the contract uses both a trading name and a formal legal name, please provide both. If the contract includes a company number or other formal identifier, please also provide that if held. For the avoidance of doubt, this clarification relates only to Q1.e and should not narrow the remainder of my request.	g. BNSSG ICB held an NHS Standard Contract with Clinical Partners during the period specified and this included adult Autism assessment. Under Right to Choose rules, this would make them eligible to deliver services outside of the contracted area, within England.
2. Contract / service documents Please provide copies of the following documents, as held at or around June 2025: - the relevant NHS Standard Contract, including schedules where applicable; - the service specification for adult autism assessments; - any pathway document for Clinical Partners’ NHS Right to Choose adult autism assessments;	a. Please see enclosed versions on 2024-25 and 2025-26 templates, including a copy of the VA1.    Q2a Clinical Partners contract 24-26_(R).pd Q2a Clinical Partners contract 25-26_(R).pd Q2a FINAL_BNSSG_ICB_25 The ICB has applied Section 43(2) (Prejudice of commercial interests) to the ASD pricing information.

- d. any mobilisation, operating model, referral-management or pathway-governance document relating to the service;
- e. any document setting out Clinical Partners' obligations regarding patient-facing information, referral information, website information, or information supplied to GPs/referrers.

If any material is considered commercially sensitive or otherwise exempt, please provide the non-exempt material with appropriate redactions rather than withholding entire documents.

Section 43(2) exempts from disclosure information which would, or would be likely to, prejudice the commercial interests of an organisation. The contract/s include information relating to the specific prices of the ASD contract value which the ICB considers commercially sensitive information. Section 43(2) is a qualified exemption and therefore the public interest test has been set out below.

The public interest arguments in favour of disclosing the information include the ICB's responsibility to be transparent and accountable in its decision making. The ICB has a responsibility to demonstrate that the agreements in place represent good value for public funding.

However, disclosing the information would potentially be detrimental to mental health budgets or future service considerations.

The ICB believes that the public interest lies in maintaining the exemption as it is in the public interest for the ICB to be able to commission services at a good value to ensure that mental health services are available.

- b. Please see Adult ASD service spec enclosed



Q2b Adult ASD
service spec v2.1.pdf

- c. The pathway from referral to assessment is outlined within section 2 of the enclosed service specification.
- d. Please refer to the contract. Additionally, BNSSG ICB publishes information about services on the website Remedy, which is

aimed at BNSSG clinicians but is publicly accessible. The current Remedy page can be found here: [Autism spectrum disorder \(ASD\) \(Remedy BNSSG ICB\)](#). Enclosed is an extract from the Remedy page as at December 2024.



Q2d Remedy Page
Extract - Dec 2024.pdf

There was no specific mobilisation document shared around June 2025, however, the service as a whole (including the ADHD and children and young people elements) was publicised to BNSSG GPs through an internal bulletin in December 2024 following contract award, please refer to question 6 response. This just provided an overview on referral route, services available and an outline of the history of the provider organisation. Additionally, in line with the Provider Selection Regime 2024 (PSR) regulations, BNSSG ICB were required to publish notification of contract award on the government Find a Tender service website. Please see [Clinical Partners ADHD & Autism Assessment and Treatment Services - CYP & Adults - Find a Tender](#). Again, this was upon contract award in December 2024, but it is included in this response for transparency.

- e. There is no specific stand-alone document setting out obligations regarding patient facing information and any requirements in respect of this would be covered within the contract. The Requestor may wish to view the nationally set NHS Standard Contract Service Conditions and General Conditions in place during June 2025, and these can be found at the following links:

	03-full-length-service-conditions-2526-cancer-amend-med-opt-mc.pdf 04-full-length-general-conditions-2526-med-opt-mc.pdf All providers holding an NHS Standard Contract are obliged to comply with the SC's and GC's, regardless of which ICB the contract was issued by. Please note: FOI requests and responses are publicly available and therefore personal information has been redacted. The ICB considers the names included in the enclosed document(s) to be personal information and therefore has applied a section 40 (Personal Information) exemption to this information.
3. Service model: online, video, face-to-face, hybrid or clinic-based Please provide recorded information showing whether, at or around June 2025, Clinical Partners' NHS Right to Choose adult autism assessment pathway was commissioned or approved as: a. remote-only; b. video-only; c. online-only; d. telephone-supported; e. hybrid; f. face-to-face; g. clinic-based; h. capable of face-to-face assessment by exception; or i. any other model.	3a-i. Please see section 4 of the enclosed service specification, which covers the location of services. This states: <i>"The provider will provide the service virtually.</i> <i>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".</i>

Please include any contract term, service specification wording, pathway document, provider submission, commissioner approval, contract-management note or correspondence that records the service model.	
4. Access, location and assessment-setting provisions Please provide recorded information showing any access or location provisions relating to how patients could receive an adult autism assessment from Clinical Partners under NHS Right to Choose. This includes, but is not limited to, any information about: a. local clinics; b. face-to-face appointments; c. online appointments; d. video appointments; e. secure video calls; f. whether assessment had to take place on a computer; g. whether mobile phones were permitted or excluded; h. whether patients could request a different assessment setting; i. whether patients outside BNSSG could access any physical location.	Please see response to question 3 for questions 4a-i. The NHS Standard Contract Service Conditions also reference location where the commissioner is not a party to the contract, see SC6.13, SC6.13.2, SC6.16, SC6.16.1, SC6.16.1.1 and SC6.16.1.2. 03-full-length-service-conditions-2526-cancer-amend-med-opt-mc.pdf
5. Reasonable adjustments, accessibility and clinical suitability Please provide recorded information showing any reasonable-adjustment, accessibility or clinical-suitability provisions for patients for whom video,	All expectations around access to appointments and reasonable adjustments are set out within the provider contract, in particular, the service specification and quality specification; and these will also note the national guidance and legislation that the provider is expected to deliver services in accordance with (eg NICE guidance). Please also see responses to questions 3 and 4 around location of services.

webcam, online or remote assessment may be unsuitable. This includes, but is not limited to: - Equality Act reasonable-adjustment provisions; - autism-specific accessibility provisions; - mental-health, PTSD, anxiety or communication-related adjustment provisions; - provisions for patients with suspected autism who may struggle with remote communication; - provisions for changing the setting, pacing, duration or format of assessment; - escalation routes where a patient says video assessment is not clinically suitable or accessible; - guidance to Clinical Partners staff on handling requests for face-to-face or alternative assessment arrangements.	The requestor may also find it useful to view the NHS Standard Contract Service Conditions, specifically SC6.13, SC6.16, SC7 and SC13. 03-full-length-service-conditions-2526-cancer-amend-med-opt-mc.pdf necessary for that individual to receive emergency treatment. There is also national guidance which covers Reasonable Adjustments, please see: NHS Choice Framework - what choices are available to you in your NHS care - GOV.UK Additionally, guidance at https://www.england.nhs.uk/long-read/patient-choice-guidance/#for-primary-care-referrers confirms that it is the responsibility of the referrer to determine whether a service is clinically appropriate for a patient before the referral is made. See the section titled “Legal Rights to choice – elective referrals”.
6. Patient-facing and referrer-facing information Please provide recorded information showing what patients, GPs, referrers or ICBs were to be told, before referral or while waiting, about whether Clinical Partners’ NHS Right to Choose adult autism assessments were online-only, video-only, remote-only, hybrid, face-to-face or clinic-based. This includes: - website wording approved, reviewed or held by BNSSG ICB; - patient leaflets; - GP/referrer guidance; - referral forms;	The following item was included in the 5 December 2024 issue of the GP Bulletin sent out by OneCare. New ADHD and autism assessment and treatment service The ICB has approved Clinical Partners to deliver ADHD and autism assessment services for children, young people and adults in BNSSG from 1 December 2024. The new contract will expand Clinical Partners’ services to include ADHD titration and medication. Refer here or via a GP referral form to rtc@clinical-partners.co.uk. For more information please note the corrected email address bnssg.mh.contract@nhs.net BNSSG ICB publishes information about services on the website Remedy, which is aimed at BNSSG clinicians but is publicly accessible. The current Remedy page can be found here: Autism

e. standard emails; f. FAQs; g. provider information submitted to BNSSG ICB; h. any record of BNSSG ICB reviewing or approving Clinical Partners' public-facing information.	spectrum disorder (ASD) (Remedy BNSSG ICB). Enclosed is an extract from the Remedy page as at December 2024, please refer to question 2.d.
7. Changes, clarification or narrowing of the model Please provide recorded information showing whether the Clinical Partners NHS Right to Choose adult autism assessment service model changed, narrowed, was clarified, or was re-described between June 2025 and February 2026. This includes any information about: a. a move from hybrid or face-to-face availability to online-only delivery; b. clarification that NHS Right to Choose adult autism assessments were online-only; c. differences between private-service provision and NHS Right to Choose provision; d. whether existing waiting-list patients were told of any change or clarification; e. whether GPs or referring practices were told of any change or clarification; f. whether Clinical Partners was asked to amend website or patient-facing information.	The service was commissioned by BNSSG ICB as a remote service from the contract start date on 1st December 2024. The service delivery model has not been changed, narrowed, or redescribed during the period stated. For transparency, between 1st April 2025 and 1st April 2026, minor changes were made to the adult Autism service specification, however these were limited to the removal of a waiting time standard in section 2.4 and are listed in the enclosed variation agreement.
8. Contract management and governance records Please provide recorded information held between January 2025 and February 2026 relating to BNSSG ICB's contract management or governance oversight	Between January 2025 and February 2026, a total of 4 Contract Review meetings (CRM) were held by the BNSSG ICB Contract Manager and representatives from Clinical Partners. These have previously been released as part of a separate FOI, which can be found here: FOI.ICB-2526/323: ADHD Services Decision Makers and Governance

of Clinical Partners' NHS Right to Choose adult autism assessment pathway. This includes records concerning: a. waiting times; b. referral volumes; c. accepted referrals; d. patient complaints; e. access issues; f. reasonable-adjustment requests; g. online-only or video-only delivery; h. face-to-face requests; i. patient-choice concerns; j. provider website wording or patient-facing information. I am not requesting patient-identifiable information about other patients.	Although the FOI referenced relates to ADHD services, the CRM meetings covered the contract in its entirety and included the adult Autism service. The specific files are: 03.b.41 – Draft Clinical Partners Q3 CRM minutes 27.2.25 03.b.42 – Clinical Partners Q4 CRM minutes 22.5.25 03.b.39 – Draft Clinical Partners Q1 CRM minutes 11.9.25 03.b.40 – Draft Clinical Partners Q2 CRM minutes 4.12.25     Q8 03.b.41 - Draft Q8 03.b.42 - Clinical Q8 03.b.39 - Draft Q8 03.b.40 - Draft Clinical Partners Q3 CPartners Q4 CRM minClinical Partners Q1 CClinical Partners Q2 C It must be understood that this information will only reflect contract oversight which took place by BNSSG ICB in our role as host commissioner for the contract and extends to activity for patients referred from GP practices within BNSSG. However, where activity takes place under Right to Choose and the ICB is not a party to the qualifying contract, the terms of that contract will still apply – please see section 25.14 of the NHS Standard Contract technical guidance 25-26 version. Although this was updated in September 2025, from the previous version issued in April 2025, this section is not highlighted as having changed from the original 08-nhssc-technical-guidance-september-update.pdf d. The ICB received less than 10 complaints and less than 10 MP complaints relating to Clinical Partners from Jan 2025 – Feb 26.
9. Please also confirm whether BNSSG ICB accepts that it was the qualifying contract-holder for Clinical Partners' NHS Right to Choose adult autism	BNSSG ICB held an NHS Standard Contract with Clinical Partners during the period specified and this included adult Autism assessment.

assessments at or around June 2025. If BNSSG ICB does not accept this, please provide any recorded information explaining why BSW ICB identified BNSSG ICB as the qualifying contract-holder.	Under Right to Choose rules, this would make them eligible to deliver services outside of the contracted area, within England.
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The information provided in this response is accurate as of 18 September 2026 and has been approved for release by Helena Fuller, Director of Contracts and Procurement for NHS Bristol, North Somerset and South Gloucestershire ICB.

NHS Standard Contract 2024/25

Particulars (Full Length)

Contract title:	Clinical Partners ADHD & Autism Assessment and Treatment Services – CYP & Adults
Contract ref:	BNSSG_ICB_2024-2026_Clinical_Partners_ADHD & Autism Assessment and Treatment Services – CYP & Adults MH

Version 2, April 2024

Prepared by: NHS Standard Contract team, NHS England
england.contractshelp@nhs.net

DATE OF CONTRACT	13th December 2024
SERVICE COMMENCEMENT DATE	1st December 2024
CONTRACT TERM	Until 31st March 2026
COMMISSIONERS	Bristol, North Somerset and South Gloucestershire (BNSSG) ICB ODS code QUY Floor 2, North Wing, 100 Temple Street, Redcliffe, Bristol, BS1 6AG
CO-ORDINATING COMMISSIONER <i>See GC10 and Schedule 5C</i>	Bristol, North Somerset and South Gloucestershire (BNSSG) ICB Floor 2, North Wing, 100 Temple Street, Redcliffe, Bristol, BS1 6AG
PROVIDER	Clinical Partners Unit 6, Chaldicott Barns Semley Shaftesbury SP7 9AW ODS [DL501] Company number: 07590254
CONTRACT AWARD PROCESS <i>See s15 of the Contract Technical Guidance</i>	PSR direct award process B in accordance with the rules of that framework and regulation 18 of the PSR Regulations

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Definitions and Interpretation

CONTRACT

Contract title: Clinical Partners ADHD & Autism Assessment and Treatment Services – CYP & Adults

Contract ref: BNSSG_ICB_2024-2026_Clinical_Partners_ADHD & Autism Assessment and Treatment Services – CYP & Adults MH

This Contract records the agreement between the Commissioners and the Provider and comprises

1. these **Particulars**, as completed and agreed by the Parties and as may be varied from time to time in accordance with GC13 (*Variations*);
2. the **Service Conditions (Full Length)**, as published by NHS England from time to time at: <https://www.england.nhs.uk/nhs-standard-contract/>;
3. the **General Conditions (Full Length)**, as published by NHS England from time to time at: <https://www.england.nhs.uk/nhs-standard-contract/>.

Each Party acknowledges and agrees

- (i) that it accepts and will be bound by the Service Conditions and General Conditions as published by NHS England at the date of this Contract, and
- (ii) that it will accept and will be bound by the Service Conditions and General Conditions as from time to time updated, amended or replaced and published by, NHS England pursuant to its powers under Regulation 17 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, with effect from the date of such publication.

IN WITNESS OF WHICH the Parties have signed this Contract on the date(s) shown below

SIGNED by


For and on behalf of
Bristol, North Somerset & South
Gloucestershire ICB


.....
Signature

Deputy CEO & Chief Finance Officer

.....
Title
13/12/2024

.....
Date

CONTRACT

Contract title: Clinical Partners ADHD & Autism Assessment and Treatment Services – CYP & Adults

Contract ref: BNSSG_ICB_2024-2026_Clinical_Partners_ADHD & Autism Assessment and Treatment Services – CYP & Adults MH

This Contract records the agreement between the Commissioners and the Provider and comprises

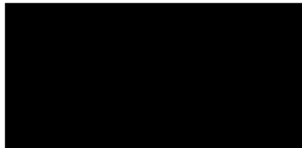
1. these **Particulars**, as completed and agreed by the Parties and as may be varied from time to time in accordance with GC13 (*Variations*);
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IN WITNESS OF WHICH the Parties have signed this Contract on the date(s) shown below

SIGNED by



.....
Signature


**For and on behalf of
Clinical Partners**

Director of NHS Partnerships and Innovation

Date: 28th November 2024

SERVICE COMMENCEMENT AND CONTRACT TERM	
Effective Date <i>See GC2.1</i>	1st December 2024
Expected Service Commencement Date <i>See GC3.1</i>	1st December 2024
Longstop Date <i>See GC4.1 and 17.10.1</i>	3 months after service commencement date
Contract Term	Until 31st March 2026
Commissioner option to extend Contract Term <i>See Schedule 1C, which applies only if YES is indicated here</i>	No
Commissioner Notice Period (for termination under GC17.2)	3 months
Commissioner Earliest Termination Date (for termination under GC17.2)	3 months following service commencement date
Provider Notice Period (for termination under GC17.3)	3 months
Provider Earliest Termination Date (for termination under GC17.3)	3 months following service commencement date
SERVICES	
Service Categories	Indicate <u>all</u> categories of service which the Provider is commissioned to provide under this Contract. <i>Note that certain provisions of the Service Conditions and Annex A to the Service Conditions apply in respect of some service categories but not others.</i>
Accident and Emergency Services (Type 1 and Type 2 only) (A+E)	No
Acute Services (A)	No
Ambulance Services (AM)	No
Cancer Services and/or Radiotherapy Services (CR)	No
Continuing Healthcare Services (including continuing care for children) (CHC)	No
Community Services (CS)	No
Diagnostic, Screening and/or Pathology Services (D)	No
End of Life Care Services (ELC)	No
Mental Health and Learning Disability Services (MH)	Yes

Mental Health and Learning Disability Secure Services (MHSS)	No
NHS 111 Services (111)	No
Patient Transport Services (non-emergency) (PT)	No
Urgent Treatment Centre Services (including Walk-in Centre Services/Minor Injuries Units) (U)	No
Service Requirements	
Prior Approval Response Time Standard	Not Applicable
See SC29.21	
GOVERNANCE AND REGULATORY	
Nominated Mediation Body (where required – see GC14.4)	CEDR
Provider's Nominated Individual	[REDACTED]
Provider's Information Governance Lead	[REDACTED]
Provider's Data Protection Officer (if required by Data Protection Legislation)	[REDACTED]
Provider's Caldicott Guardian	[REDACTED]
Provider's Senior Information Risk Owner	[REDACTED]
Provider's Accountable Emergency Officer	[REDACTED]
Provider's Safeguarding Lead (children) / named professional for safeguarding children	[REDACTED]
Provider's Safeguarding Lead (adults) / named professional for safeguarding adults	[REDACTED]
Provider's Child Sexual Abuse and Exploitation Lead	[REDACTED]
Provider's Mental Capacity and Liberty Protection Safeguards Lead	[REDACTED]
Provider's Prevent Lead	[REDACTED]
Provider's Freedom To Speak Up Guardian(s)	[REDACTED]
Provider's UEC DoS Contact	Not Applicable
Commissioners' UEC DoS Leads	Not Applicable

Provider's Infection Prevention Lead	[REDACTED]
Provider's Health Inequalities Lead (NHS Trusts and NHS Foundation Trusts only)	Not Applicable
Provider's Net Zero Lead (NHS Trusts and NHS Foundation Trusts only)	Not Applicable
Provider's Responsible Person for the Mental Health Units (Use of Force) Act 2018	Not Applicable
Provider's Wellbeing Guardian (NHS Trusts and NHS Foundation Trusts only)	Not Applicable
CONTRACT MANAGEMENT	
Addresses for service of Notices See GC36	Co-ordinating Commissioner: [REDACTED] Head of Contracts – Acute and Mental Health Address: Bristol, North Somerset and South Gloucestershire (BNSSG) ICB Floor 2, North Wing, 100 Temple Street, Redcliffe, Bristol, BS1 6AG Email: bnssg.mh.contract@nhs.net [REDACTED] - Director for NHS Partnerships & Innovation Clinical Partners Limited, Unit 6, Chaldicott Barns, Tokes Lane, Semley, Wiltshire, SP7 9AW - Company no. 07590254 nhspartnerships@clinical-partners.co.uk
Frequency of Review Meetings See GC8.1	Quarterly
Commissioner Representative(s) See GC10.3	[REDACTED] Contract Manager Address: Bristol, North Somerset and South Gloucestershire (BNSSG) ICB Floor 2, North Wing, 100 Temple Street, Redcliffe, Bristol, BS1 6AG Email: bnssg.mh.contract@nhs.net
Provider Representative See GC10.3	[REDACTED] Clinical Partners Limited, Unit 6, Chaldicott Barns, Tokes Lane, Semley, Wiltshire, SP7 9AW - Company no. 07590254 [REDACTED]

SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM

A. Conditions Precedent

The Provider must provide the Co-ordinating Commissioner with the following documents:

1. Evidence of appropriate Indemnity Arrangements (appendix 1.1a & b)
2. Evidence of CQC registration in respect of Provider and Material Sub-Contractors <https://www.cqc.org.uk/location/1-9152789217>
3. Evidence of the Provider Licence in respect of Provider and Material Sub-Contractors (where required) (appendix 1.2)
4. Local requirements
 - 4.1 Counter Fraud / bribery policy (appendix 1.3)

The Provider must complete the following actions:

Not Applicable

SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM

B. Commissioner Documents

Date	Document	Description
Not Applicable		

SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM

C. Extension of Contract Term

Not Applicable

1	[REDACTED]	
	[REDACTED]	
	[REDACTED]	
	[REDACTED]	
2	[REDACTED]	
	[REDACTED]	
3	[REDACTED]	
	[REDACTED]	
4	[REDACTED]	
	[REDACTED]	
5	[REDACTED]	
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6	[REDACTED]	
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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	Clinical Partners
Period	1 st December 2024 – 31 st 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.

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

2.5 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 individual's 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.

53 | Particulars (Full Length)

[illegible]

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SCHEDULE 2 – THE SERVICES

Ai. Service Specifications – Enhanced Health in Care Homes

Not Applicable

SCHEDULE 2 – THE SERVICES

Aii. Service Specifications – Primary and Community Mental Health Services

Not Applicable

SCHEDULE 2 – THE SERVICES

B. Indicative Activity Plan



SCHEDULE 2 – THE SERVICES

C. Activity Planning Assumptions

Not Applicable

SCHEDULE 2 – THE SERVICES

D. Not used

SCHEDULE 2 – THE SERVICES

E. Not used

SCHEDULE 2 – THE SERVICES

F. Clinical Networks

Not Applicable

SCHEDULE 2 – THE SERVICES

G. Other Local Agreements, Policies and Procedures

Appendix 2G1 - Business Continuity Plan (provider)

Appendix 2G2 - Complaint policy (provider)

Schedule 2G3 – Local System / Locality Partnerships (LPs) Operating Plan Obligations

The BNSSG ICS recognise that the collective decision-making between different bodies is the best way to arrange services and will be mindful that where the system wants or needs to consider making changes to service provision, there needs to be a flexible, sensible, transparent and proportionate process for decision-making that allows shared responsibility and adheres to statutory responsibilities. The ICB/ICS through its governance will ensure structures are in place to manage future commissioning arrangements decisions and management of potential challenges that may arise now the Provider Selection Regime (PSR) is now in effect from 1st January 2024.

The Parties to this contract must at all times use all reasonable endeavors to contribute towards the implementation of any Locality Partnership priorities to which both the Provider and Commissioners are party and must perform any specific obligations on their respective parts agreed as part of or pursuant/in accordance with to that Locality Partnership priorities from time to time, as set out in the agreed local system ambitions and indicative milestones. At a future point the commissioner role within this would be expected to reduce with greater cross partner system assurance expected to take its place.

These ambitions could be for example:

- Being accountable to other service providers for the delivery of services and use of resources within the respective LPs
- Work to a shared vision and a single plan supported by consistent ways of working
- Establish a governance infrastructure which enables and embeds shared decision making with delegated accountability from each organisation
- Develop and abide by a set of behaviours to establish trust, mutual respect and interdependence

Organisations within the LPs will be expected to take collective responsibility for the delivery of the system/local plan, working together to ensure best use of their collective resources. The Provider must equally ensure that the Services are organised and delivered in such a way as to integrate effectively with the local configuration of any Primary Care Networks established in the geographical area within which the Services are to be delivered.

Supporting Change

Planning, implementing, and delivering service developments across the BNSSG ICS system is fundamental in improving the quality and affordability of services provided to our population. There will be a number of initiatives that will be identified as part of the future planning processes and although it is recognised that in many instances, significant additional work is required from both the commissioner and providers to agree the roll-out and subsequent impacts of these all parties agree to work together collaboratively to agree joint approaches for developing initiatives with particular importance given to mutually agreeing the planned impact of changes on activity and financial flows within the system.

Schedule 2G4 – Provider discharge/transfer policy

Discharge/Transfer from Clinical Partners:

- Patients will be discharged if not diagnosed with ADHD or ASD.
- Patients will be discharged if not receiving medication from the service, or under shared care.

- Assessment report following a diagnosis, including person centred care and any treatment recommendations is sent to the patient or carer/guardian and their GP.
- Patients will be discharged after 2 DNAs/Not Brought: (Children and those who are vulnerable may not attend appointments simply because they have to rely on parents or carers. In this case, 'They are Not Brought' rather than did not attend would be a more appropriate definition. Clinical Partners will also consider that a DNA could be due to circumstances or an event not related to any mental health consideration. In this event every effort is made to contact the service user and rearrange the appointment. Special consideration will be given to children and young people especially if, from previous knowledge of the child or young person or from the response of the family, it is felt that significant risks are present, and the member of staff will liaise with other professionals.) If a service user fails to attend the following steps are followed:
 - An attempt is made to contact them via telephone on the same day.
 - If unable to make contact a letter is sent requesting the service user make contact.
 - If no contact is made within 2 weeks of this letter, the patient is discharged
 - If the service user fails to attend for a second planned appointment a discharge letter is sent by Clinical Partners to the service user and their GP.
 - Discharge can be discretionary and is assessed on a case by case basis depending on individuals circumstances in consultation with the referring ICB.
- Referrals will be declined/patients will be discharged if they have already had a diagnosis (exceptions to this rule must be discussed with the commissioner).
- Patients will be discharged if they are already on another waiting list

DNA fees are included within the local pricing schedule. This would also apply to non contract activity, performed under NHS Choice Framework.

SCHEDULE 2 – THE SERVICES

H. Transition Arrangements

Not Applicable

SCHEDULE 2 – THE SERVICES

I. Exit Arrangements

[REDACTED]	
[REDACTED]	
I.	[REDACTED]
I.	[REDACTED]

SCHEDULE 2 – THE SERVICES

J. Transfer of and Discharge from Care Protocols

The Provider shall adhere to the transfer of and discharge from care obligations as detailed in NHS Standard Contract 2024/2025 Service Conditions and General Conditions. Transfer of and discharge from care will be carried out in line with mental health legislation and guidance and any agreed local protocols with and between providers that should be reviewed annually between providers.

The Provider will have policies and procedures in place (see section 2G) which includes ensuring that any service user who is identified as being at risk as a result of their mental health needs, or who requires additional services in order to meet their needs is signposted and supported in accessing those services.

In addition, the Provider (if applicable) will work with its NHS partner organisations to ensure that service users' discharges are well organised, safe and as far as possible in accordance with the service user's wishes.

Principles of Transfer / discharge

Transfer and Discharge of service users can bring specific risks and issues that require careful consideration and planning in order to minimise and manage risks effectively and ensure continuity of care. General principles relating to communication, planning and implementation of care apply to both transfer and discharge of care happening across a wide variety of care settings. Specific considerations may be required depending upon the setting from which a service user's care is transferred or discharged to and from and may vary depending upon the service user group e.g., Learning Disability, Frail and Elderly and end of life care.

It is important that service users' are involved in the planning and decision-making about the transfer or discharge of their care.

Service users and carers (if applicable) must have clear information provided about the referral pathways and processes for any services the service user patient is being discharged from or transferred to (this should include information about possible waiting times, assessment process, intervention type, timescale of intervention).

It should be acknowledged with service users, that discharges and transfers are often an anxiety provoking time. Service users should be provided with support through this process, having the opportunities to discuss concerns as well as other issues. Withdrawal or ending of support/treatment and if required transition from one service to another may evoke strong emotions and reactions and the Provider should ensure that such changes are discussed carefully with the service user and / or their representative beforehand and are structured and phased.

Family and carers should have the opportunity (with the agreement of the service user) to be involved in the planning of transfers or discharge, where possible. Involved family and carers must be notified before the patient is transferred or discharged.

Planning with regards to transfer and discharge must be fully and accurately documented in order that all parties relevant to the transfer or discharge can clearly understand the arrangements and refer to these when needed.

Please refer to Service specifications in section 2A regarding ADHD and Autism specific transfer and/or discharge requirements into Primary Care setting.

SCHEDULE 2 – THE SERVICES

K. Safeguarding Policies and Mental Capacity Act Policies

Appendix 2K.1.1 & Appendix 2K1.2 Provider safeguarding adults and children policies Appendix 2K.2 Provider Mental Health/MCA policy
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SCHEDULE 2 – THE SERVICES

L. Provisions Applicable to Primary Medical Services

Not Applicable

SCHEDULE 2 – THE SERVICES

M. Development Plan for Personalised Care

Embedding Personalised Care as the default delivery model is a priority area of focus for the health and care community and is one of the five key priorities for the NHS within the NHS Long Term Plan. The publication of the document [Universal Personalised Care: Implementing the Comprehensive Model](#) document sets out how the NHS Long Term plan commitments for Personalised Care are to be delivered and become business as usual.

Personalised Care means that people have choice and control over the way their care is planned and delivered based on 'what matters' to them and their individual strengths and needs.

Throughout 2024/2025 the Head of Personalised Care and Programme Manager will support Integrated Care System partners with the embedding and delivery of Personalised Care as business as usual. A coordinated approach through the Personalised Care Steering Group will focus on a cross system collaborative model and each organisation is expected to engage and participate.

The operating model [Newest Operating Model-270421 \(england.nhs.uk\)](#) outlines the key areas and important enablers as:

- Shared Decision Making
- Personalised Care and Support Planning
- Patient Choice / Optimal Medical Pathway
- Social prescribing and Community Based Approaches
- Supported Self-Management
- Personal Health Budgets / Integrated Budgets
- NHS @ Home

With leadership, co-production, workforce, finance, commissioning and payment key enablers.

Successful deployment of these six components is expected to deliver the following:

- Whole-population approaches to supporting people of all ages and their carers to manage their physical and mental health and wellbeing and make informed decisions and choices when their health changes.
- A proactive and universal offer of support to people with long-term physical and mental health conditions to build knowledge, skills and confidence and to live well with their health conditions.
- Intensive and integrated approaches to empowering people with more complex needs to have greater choice and control over the care they receive.
- Co-produced and co-designed programs with people and communities in line with the principles of [NHS England » Working in partnership with people and communities: Statutory guidance](#)

1. Delivery of BNSSG personalisation action plan as set out in the Joint Forward Plan 2024-2029

BNSSG Head of Personalised Care and Programme Manager alongside the ICB and ICS partners will coordinate an action plan to embed Personalised Care across the BNSSG system and there is an expectation that all ICS partners and providers will engage and participate, with the host platform being the Personalised Care Steering Group and nominate senior decision maker/s to attend the Personalised Care Steering Group.

2. Shared Decision Making

Shared Decision Making relates to 100% of people that utilize the health and care system. Shared Decision Making enables people who use services to make choices about the provider, team and services that will best meet their needs and what matters to them. In brief, Shared Decision Making is a process in which Service Users and clinicians work together to discuss the risks, benefits and consequences of different care, treatment, tests and support options, and make a decision based on evidence-based, good quality information and their personal preferences. Facilitating Shared Decision Making in everyday clinical practice are legal and NHS Constitution requirements, as well as specific contractual obligations under SC6.1 and SC10.2.

Providers are required to ensure that NG197 baseline assessment [NG197](#) has been completed and engage and participate in a collective understanding of the wider needs and implementation of a consistent approach across BNSSG.

Providers are required to:

- Ensuring workforce have access to training and support to embedding Shared Decision Making, such as via the [Personalised Care Institute](#); and that this is advertised through system training platforms
- Engage in discussion around sustainable models for training in health coaching and/or motivational interviewing
- Ensure that treatment pathways promote and allow sufficient time for service users to understand their health and care needs and feel prepared and informed to make a decision prior to consent to treatment. This includes for example, reviewing decisions with patients who have been on waiting lists for prolonged periods or where additional risks are identified during pre-operative assessments

3. Personalised care and support plans (PCSPs)

PCSPs are recommended for all long-term condition pathways plus other priority areas as set out in the NHS Long Term Plan. These include maternity services, palliative and end of life care, residential care settings, cancer, dementia, and cardio-vascular diseases, and more broadly, people with more complex needs.

PCSPs must also be in place to underpin any use of personal health budgets.

Where PCSPs are developed ensure that the PRSB standards are met [Personalised Care and Support Plan Standard - PRSB \(theprsb.org\)](#) and promote the provision for a service user and or carer to only need to tell their story once and consider how the plan can where consent given be shared across systems.

In digital programmes support the provision of a digital record that allows the sharing of the About Me standard.

4. Supported self-management

As part of Shared Decision Making and PCSPs, the support Service Users need to help them manage their long-term condition/s should be discussed with them. Interventions that can help people to develop the capacity to live well with their condition(s) include health coaching, self-management education, and peer support. [NHS @home](#) also supports more connected, personalised care using technology such as remote monitoring devices to support people to better self-manage their health and care at home with education and support from clinical teams.

Promote both staff knowledge and understanding of supported self-management offers and that of the people of BNSSG; such as:

- Live Longer Better Programme [LIVE LONGER BETTER - Home](#) for both citizens and staff
- Hope Programme for the South west [Hope Programme for the South West — Hope For The Community CIC \(h4c.org.uk\)](#)

5. Personal health budgets (PHBs)

Personal health budgets (PHB) are one of the components to embedding personalised care. A PHB can be defined as an amount of money identified to support a person's identified health and wellbeing needs, planned and agreed between the person and their local NHS team. PHB's can be arranged for adults over 18 or for a child or young person in receipt of health funding.

ICBs and NHS providers have a duty to:

- Arrange for the provision of PHBs
- Publicise and promote PHBs
- Provide information and support for potential budget holders
- Consider requests for PHBs

Legal rights to have PHBs now cover:

- adults eligible for NHS Continuing Healthcare and children / young people eligible for continuing care;
- individuals eligible for NHS wheelchair services; and
- individuals who require aftercare services under section 117 of the Mental Health Act.

Providers are required to consider and include within business plans, business model's and financial modelling consideration of PHB's as a way to alternatively meet people's needs as part of business as usual.

Requirement to establish and update information accessible to the public on the rights to PHB's and the processes to request such an offer.

SCHEDULE 2 – THE SERVICES

N. Health Inequalities Action Plan

Background

Integrated Care Systems have four core purposes:

1. Improving outcomes in population health and healthcare
2. Tackling inequalities in outcomes, experience and access
3. Enhancing productivity and value for money; and
4. Helping the NHS to support broader social and economic development

The renewed emphasis that health and care now has on population health outcomes and tackling health inequalities means that the ICB and Providers need to understand more clearly where there are inequalities in access to, experience of and outcomes from care and treatment and work together to reduce these. Successfully tackling health inequalities will always necessitate close working with other local organisations from the statutory sector and beyond. The specific actions in this schedule are to support commissioners, providers and others, as part of the wider system, to work together to address this issue.

Actions for the Provider:

Reporting

Performance reports relating to waiting times and access to different types of appointments (face to face, telephone, video) broken down by at a minimum ethnicity and Index of Multiple Deprivation will be discussed at the provider's appropriate group and / or committee and assurance given to provider Board's in line with the provider's governance arrangements.

Monitoring the impact of improvement work

Providers will work with system partners to ensure that the monitoring of the impact of improvement work will be broken down by ethnicity and Index of Multiple Deprivation as a minimum. The monitoring information will be used to assess the impact of changes on people likely to experience inequalities in access, experience and outcomes.

Adoption and spread of 'Did Not Attend' (DNA) work

Providers will use what will be learnt from the Outpatient Health Inequalities Did Not Attend project taking place across North Bristol NHS Trust and University Hospitals Bristol and Weston NHS Foundation Trust and adapt and spread it to other specialties where there is the potential for improvements in DNA rates for people with certain characteristics.

SCHEDULE 3 – PAYMENT

A. Aligned Payment and Incentive Rules

Not Applicable

SCHEDULE 3 – PAYMENT

B. Locally Agreed Adjustments to NHS Payment Scheme Unit Prices

Not Applicable

SCHEDULE 3 – PAYMENT

D. Expected Annual Contract Values

[illegible]

SCHEDULE 3 – PAYMENT

E. Timing and Amounts of Payments in First and/or Final Contract Year

Not applicable – payment approach is detailed in Schedule 3D.
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SCHEDULE 3 – PAYMENT

F. CQUIN

Not Applicable

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			
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 an 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) 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.	The NQB process will be triggered to consider the escalated related concerns/risks and decisions made on required actions going forward.	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 the ICS to mitigation/closure and de-escalation as necessary. Reporting to: System Quality Group (on an exception basis only)	Ongoing

- 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. - 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 Patient Safety Specialists in accordance with NHSE's NHS England » Identifying Patient Safety Specialists - Just Culture evident	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 PSII (where required).	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 BNSSG Integrated Care Board to include themes, trends, and safety actions for improvement. Inclusion of 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. Adhoc learning at Quarterly BNSSG Learning Meeting. PSII may be shared with the ICB when provider Executive 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 from deaths. SJRs follow guidance from the AHSN and are completed in accordance with the Learning from deaths policy for the provider.	Adhoc: Reported as Patient Safety Incident/death occurs Adhoc: Improvement Plan/review Ongoing: learning at Quarterly BNSSG Learning Meeting Escalation: by exception
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- 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 and learning from mortality reviews/LeDeR. Reg 28 learning – comply with Prevention of Future Death Coroner reports. 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 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 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 – Compliance and engagement in Learning Disability Mortality Review (LeDeR) programme. – Engagement with Medical Examiner Role. Childrens 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	
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		Collaborate with ICB and NHS England as part of a learning system that shares insights between organisations and services to improve safety (source: <i>Overview of NHSEI's Quality Functions & Responsibilities of ICS's</i>)	
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: • 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 • 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		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. Duty of Candour section confirming any Duty of Candour declarations within the Quality report (on an exception basis only).	Annual

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			
Complaint Management Complaints monitoring report, setting out numbers of complaints received and including analysis of key themes in content of complaints 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.	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 services where required are shared. Complainant feedback following completion of the complaint. Reported via Quality report.	Monthly compliance of all measures reported in line with Quality report frequency.

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 * Healthwatch * National and local review/surveys * Patient 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 play 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 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 provider's experience or complaints policies. This should include an annual update on PLACE (Patient Led Assessment of Care Environment).	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 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.	Annual
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	Evidence of adopting of the NHSE Freedom to Speak Up: Whistleblowing Policy for the NHS Example of any concerns raised and how addressed reported	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/

- Investigations will be evidence-based and led by someone suitably independent in the 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.	in Board Report		
Accessible Information Standard As per Service Condition 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 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 CAS system. 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	Report via Quality Report including new/emerging risks. Provider to attend to discuss new/emergent	Annual Ad hoc

	supported by a report with actions planned to mitigate the risks and progress against the actions.	risks for ICS mitigation at System Quality Group (if required).	
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 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 commissioner of CQC/other visits within 2 days and make available feedback and remedial action (this will be provided via the CQC report).	By Exception
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
Staff 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.

Providers must ensure that all staff receive training in how to interact appropriately with people with a learning disability and autistic people, at a level appropriate to their role. General Condition 5.5 (FL) and 5.4 (SF) and Definitions	The Health and Care Act 2022 makes provision for mandatory training on 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.	Training compliance of all staff. Reported via local Quality report.	Quarterly data collected.
Staff Wellbeing Measures Understanding of factors affecting staff satisfaction and plans in place to measure improvements in staff experience, improving retention and turnover.		To be included within Annual Quality Report.	Annual
Reasonable adjustments	Service Users with a known learning disability and/or autism spectrum condition and also meet the criteria for the service will be able to access mainstream services in line with guidance. Evidence that providers have the ability to identify and record reasonable adjustments where required.	To be included within Local Quality Report.	As per frequency of Contract Review Meeting.
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 in and plans developed to address any areas of risk or safety concerns.		To be included within Annual Report	Annual

LeDeR Programme	Provider should notify the LeDeR portal (Report the death of someone with a learning disability (leder.nhs.uk)) 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.
STOMP/STAMP	Provider should be aware of STOMP/STAMP practices with the aim to reduce over prescribing (as per your local practice)	Clinical audit of medication charts and annual reviews to ensure medications are reviewed and challenged.	Annual

SCHEDULE 5 – GOVERNANCE

A. Documents Relied On

Documents supplied by Provider

Date	Document
May 2024	Appendix 5A1 Whistleblowing Policy
September 2024	Appendix 5A2 Medicine Management Policy

Documents supplied by Commissioners

Date	Document
March 2024	5A3 – Who Pays Guidance (link below) NHS England » Who Pays?
July 2024	Appendix 5A4 – Accreditation confirmation letter

SCHEDULE 5 - GOVERNANCE**B. Provider's Material Sub-Contracts**

Sub-Contractor [Name] [Registered Office] [Company number]	Service Description	Start date/expiry date	Processing Personal Data – Yes/No	If the Sub-Contractor is processing Personal Data, state whether the Sub- Contractor is a Data Processor OR a Data Controller OR a joint Data Controller
N/A				

SCHEDULE 5 - GOVERNANCE

C. Commissioner Roles and Responsibilities

Co-ordinating Commissioner/Commissioner	Role/Responsibility
BNSSG ICB	Commissioner

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

Approach Summary

For 2024/25, as per last year, the standard national contract **SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS** is being used consistently for all Voluntary, Community and Social Enterprise (VCSE) contracts.

Mental Health Services Data Set (MHSDS) has always been a mandatory contract requirement. There continues to be national and local need to include non-statutory providers, particularly to evidence the transformation of community mental health services.

Planning implementation of a community wide mental health electronic patient record (EPR) system across BNSSG and BSW is well underway, as supported by the BNSSG CMH Programme Board and Digital Delivery Board.

You will have attended briefings and a workshop to guide you about this work. Resource is now in place to support organisations deliver MHSDS and ensure the EPR meets the sectors needs. **The primary ask of this years contract is to engage fully in this work. It is critical to demonstrating progress with service transformation, value of services and progress with digital maturity ahead of recommissioning.**

The standard reporting template for case holding and non-case holding services introduced in 2022/23 was only supplied by a very small number of providers in 2023/24. This was devised to help close the data gap caused by non-provision of MHSDS. Flowing MHSDS is now the priority. Local reporting is a last resort and must be met if MHSDS fails. The template has been left in the contract for that reason.

A reminder of the additional national and local drivers behind the content of the schedule:

- National:
 - Introduction of new community mental health wait times standards are dependent on the flow of all data, to track two contacts irrespective of the provider.
 - Three Patient Reported Outcome Measure (PROMs) tools have been mandated for introduction before March 2024. The three tools are: DIALOG, Goal Based Outcomes (GBO) and REQOL (Recovering Quality of Life). Paired outcome scores will be used to trigger and stop the clock for waiting time monitoring. See local section*. A Frequently Asked Questions (FAQ) document has been issued and implementation guidance is in production.
- Local:
 - VCSE gap in population health management linked dataset and consequent gap activity; ability to assess outcomes; missing sectors of the mental health need and information about those population groups etc.
 - Community Mental Health Framework Outcomes Framework: The CMHP Target Operating Model (TOM) instigated an outcomes driven approach to transforming community mental health services. A draft Outcomes Framework (OF) was part of that document. As the programme has evolved, as has the OF. Measures have been redefined to mental health service provision in primary care and the introduction of locality based Integrated Mental Health Teams. Appropriate measures should apply consistently to VCSE service provision, to enable real-time monitoring of services and longer-term evaluation within the programme.
 - *Decision to implement DIALOG as a priority PROM across the Avon and Wiltshire Partnership Trust (AWP) footprint, covering Bristol, North Somerset, South Gloucestershire (BNSSG) Bath and North East Somerset, Swindon and Wiltshire (BSW) as part of Personal Wellbeing Plans.

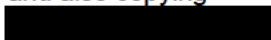
Providers can access further support to understand and consider this by contacting their contract lead contact, who will facilitate a conversation with Business Intelligence.

Reference Materials

See links within the schedule. Additional useful links are:

Mental Health Waiting Times Guidance	NHS England » Mental health access and waiting time standards mental-health-clinically-led-review-of-standards.pdf (england.nhs.uk)
DIALOG	Dialog Scale.pdf (elft.nhs.uk)
Goal Based Outcomes	Goal Based Outcomes (GBO) (corc.uk.net)
REQOL	ReQoL: OVERVIEW

A. Reporting Requirements

		Reporting Period	Format of Report	Timing and Method for delivery of Report
	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. This guidance mandates the collect and flowing of MHSDS and also includes the requirement for Patient Reported Outcome Measures. More detail included in Appendix 6A.	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
	National Requirements Reported Locally			
1	Activity and Finance Report (<i>note that, if appropriately designed, this report may also serve as the reconciliation account to be sent by the Provider under SC36.12</i>) Activity Report (See appendix 6A1)	Quarterly, broken down by month	MS Word or PDF	Quarterly reports sent no later than the following dates: Sent to: bnssg.mh.contract@nhs.net and also copying 

		Reporting Period	Format of Report	Timing and Method for delivery of Report
2	Service Quality Performance Report, detailing performance against National Quality Requirements, Local Quality Requirements and the duty of candour	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 Sent to: bnssg.mh.contract@nhs.net and also copying [REDACTED]
3	Complaints monitoring report, setting out numbers of complaints received and including analysis of key themes in content of complaints	Summary of complaints within quarter. Member survey report (including resolution process). For further information please see schedule 4 (Local Quality Schedule).	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 Sent to: bnssg.mh.contract@nhs.net and also copying [REDACTED]
4	Summary report setting out relevant information on Patient Safety Incidents and the progress of and outcomes from investigations into such Incidents, as agreed with the Co-ordinating Commissioner	As above (no.3)	As above (no.3)	As above (no.3)

	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	Quarterly	MS word or PDF	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 Sent to: bnssg.mh.contract@nhs.net and also copying 

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 wait time band: <7 days 7-14 days 15-30 days then monthly bands	Adult ADHD CYP ADHD Adult Autism CYP Autism	No
			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 wait time band: <7 days 7-14 days 15-30 days then monthly 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 <7 days 7-14 days 15-30 days then monthly 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
			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: <7 days 7-14 days 15-30 days then monthly bands	Adult Autism CYP Autism	No
	A measure of successful follow up		Adult ADHD CYP ADHD	No
				No
Activity	A measure of how many individual people the service is supporting & indication of their need			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 (1 st to last contact/ discharge) - [REDACTED]	Adult ADHD CYP ADHD Adult Autism CYP Autism [REDACTED]	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
		[REDACTED]	[REDACTED]	[REDACTED]
		[REDACTED]	[REDACTED]	[REDACTED]
		[REDACTED]	[REDACTED]	[REDACTED]
		[REDACTED]	[REDACTED]	[REDACTED]
		[REDACTED]	[REDACTED]	[REDACTED]
	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: [REDACTED]		N/A
		3 x case studies demonstrating impact 6 monthly 1 demonstrating complexity, 1 demonstrating learning, 1 demonstrating a positive outcome		N/A

Reportable demographics of service users against the 9 protected characteristics (to follow the NHS Data Dictionary categories NHS Data Model and Dictionary <https://www.datadictionary.nhs.uk/>

Person Characteristic	Data Dictionary reference
1. Age	Based on date of birth and date of contact
2. Disability	DISABILITYINDICATOR (datadictionary.nhs.uk)
	Flagging learning difficulties DISABILITYCODE (datadictionary.nhs.uk)
3. Gender reassignment	GENDERIDENTITYCODE (datadictionary.nhs.uk) [Person stated within the service]
	GENDERIDENTITYSAME.ATBIRTHINDICATOR (datadictionary.nhs.uk) [Person stated within the service]
4. Marriage and civil partnership	PERSONMARTIALSTATUS (datadictionary.nhs.uk)
5. Pregnancy and maternity	PREGNANCYSTATUS INDICATOR (datadictionary.nhs.uk)
6. Race	ETHNIC CATEGORY (datadictionary.nhs.uk)
7. Religion or belief	RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION CODE (datadictionary.nhs.uk)
8. Sex	PERSON STATED GENDER CODE (datadictionary.nhs.uk) [Matched to the spine]
	GENDERIDENTITYCODE (datadictionary.nhs.uk) [Person stated within the service]
9. Sexual orientation	PERSON STATED SEXUAL ORIENTATION CODE (datadictionary.nhs.uk)

https://www.datadictionary.nhs.uk/attributes/source_of_referral_for_mental_health_services_data_set.html?hl=source%2Creferral%2Cmental%2Chealth%2Cservices%2Cdata%2Cset

https://www.datadictionary.nhs.uk/data_elements/clinical_response_priority_type.html

Registered GP Practice (using Organisation Code Service list, L81XXX numbers and names)

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

B. Data Quality Improvement Plans

Data Quality Indicator	Data Quality Threshold	Method of Measurement	Milestone Date
N/A			

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

C. Service Development and Improvement Plans

[illegible]

Adult Autism:

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

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

D. Surveys

Type of Survey	Frequency	Method of Reporting	Method of Publication
Friends and Family Test (where required in accordance with FFT Guidance)	As required by FFT Guidance	As required by FFT Guidance	As required by FFT Guidance
Staff Survey (appropriate NHS staff surveys where required by Staff Survey Guidance)	As required by Staff Survey Guidance	As required by Staff Survey Guidance	As required by Staff Survey Guidance
[Other insert locally (for example, Service User Survey, Carer Survey)]	Please refer to schedule 4 – Local Quality Schedule for requirements.		

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

E. Data Processing Services

Not Applicable

SCHEDULE 7 – PENSIONS

Not Applicable

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

Contact: england.contractshelp@nhs.net

This publication can be made available in a number of alternative formats on request

NHS Standard Contract 2025/26

Particulars (Full Length)

Contract title:	<i>Clinical Partners ADHD & Autism Assessment and Treatment Services – CYP & Adults</i>
Contract ref:	BNSSG_ICB_2024-2026_Clinical_Partners_ADHD & Autism Assessment and Treatment Services – CYP & Adults MH (25-26)

Version 1, April 2025

DATE OF CONTRACT	13th December 2024
SERVICE COMMENCEMENT DATE	1st December 2024
CONTRACT TERM	Until 31st March 2026
COMMISSIONERS	Bristol, North Somerset and South Gloucestershire (BNSSG) ICB ODS code QUY Floor 2, North Wing, 100 Temple Street, Redcliffe, Bristol, BS1 6AG
CO-ORDINATING COMMISSIONER <i>See GC10 and Schedule 5C</i>	Bristol, North Somerset and South Gloucestershire (BNSSG) ICB Floor 2, North Wing, 100 Temple Street, Redcliffe, Bristol, BS1 6AG
PROVIDER	Clinical Partners Unit 6, Chaldicott Barns Semley Shaftesbury SP7 9AW ODS [DL501] Company number: 07590254
CONTRACT AWARD PROCESS <i>See s15 of the Contract Technical Guidance</i>	PSR direct award process B in accordance with the rules of that framework and regulation 18 of the PSR Regulations

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- GC5 Staff
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Definitions and Interpretation

CONTRACT

Contract title: Clinical Partners ADHD & Autism Assessment and Treatment Services – CYP & Adults

Contract ref: BNSSG_ICB_2024-2026_Clinical_Partners_ADHD & Autism Assessment and Treatment Services – CYP & Adults MH

This Contract records the agreement between the Commissioners and the Provider and comprises

1. these **Particulars**, as completed and agreed by the Parties and as may be varied from time to time in accordance with GC13 (*Variations*);
2. the **Service Conditions (Full Length)**, as published by NHS England from time to time at: <https://www.england.nhs.uk/nhs-standard-contract/>;
3. the **General Conditions (Full Length)**, as published by NHS England from time to time at: <https://www.england.nhs.uk/nhs-standard-contract/>.

Each Party acknowledges and agrees

- (i) that it accepts and will be bound by the Service Conditions and General Conditions as published by NHS England at the date of this Contract, and
- (ii) that it will accept and will be bound by the Service Conditions and General Conditions as from time to time updated, amended or replaced and published by, NHS England pursuant to its powers under Regulation 17 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, with effect from the date of such publication.

IN WITNESS OF WHICH the Parties have signed this Contract on the date(s) shown below

SIGNED by	
	Signature
	Deputy CEO & Chief Finance Officer
	
For and on behalf of	Title
Bristol, North Somerset and South	13/12/2024
Gloucestershire ICB	
	Date

CONTRACT

Contract title: Clinical Partners ADHD & Autism Assessment and Treatment Services – CYP & Adults

Contract ref: BNSSG_ICB_2024-2026_Clinical_Partners_ADHD & Autism Assessment and Treatment Services – CYP & Adults MH

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IN WITNESS OF WHICH the Parties have signed this Contract on the date(s) shown below

SIGNED by

.....
Signature


**For and on behalf of
Clinical Partners**

Director of NHS Partnerships and Innovation

Date: 28th November 2024

SERVICE COMMENCEMENT AND CONTRACT TERM	
Effective Date <i>See GC2.1</i>	1 st December 2024
Expected Service Commencement Date <i>See GC3.1</i>	1 st December 2024
Longstop Date <i>See GC4.1 and 17.10.1</i>	3 months after service commencement date
Contract Term	Until 31 st March 2026
Commissioner option to extend Contract Term <i>See Schedule 1C, which applies only if YES is indicated here</i>	No
Commissioner Notice Period (for termination under GC17.2)	3 months
Commissioner Earliest Termination Date (for termination under GC17.2)	3 months following service commencement date
Provider Notice Period (for termination under GC17.3)	3 months
Provider Earliest Termination Date (for termination under GC17.3)	3 months following service commencement date
SERVICES	
Service Categories	Indicate all categories of service which the Provider is commissioned to provide under this Contract. <i>Note that certain provisions of the Service Conditions and Annex A to the Service Conditions apply in respect of some service categories but not others.</i>
Accident and Emergency Services (Type 1 and Type 2 only) (A+E)	No
Acute Services (A)	No
Ambulance Services (AM)	No
Cancer Services and/or Radiotherapy Services (CR)	No
Continuing Healthcare Services (including continuing care for children) (CHC)	No
Community Services (CS)	No
Diagnostic, Screening and/or Pathology Services (D)	No
End of Life Care Services (ELC)	No
Mental Health and Learning Disability Services (MH)	Yes

Mental Health and Learning Disability Secure Services (MHSS)	No
NHS 111 Services (111)	No
Patient Transport Services (non-emergency) (PT)	No
Urgent Treatment Centre Services (including Walk-in Centre Services/Minor Injuries Units) (U)	No
Service Requirements	
Prior Approval Response Time Standard <i>See SC29.21</i>	Not applicable
GOVERNANCE AND REGULATORY	
Provider's Nominated Individual <i>See SC1.4</i>	Email: [REDACTED] Tel: [REDACTED]
Provider's 2018 Act Responsible Person <i>See SC3.17</i>	Email: [REDACTED] Tel: [REDACTED]
Commissioners' UEC DoS Leads <i>See SC6.18</i>	Not applicable
Provider's UEC DoS Contact <i>See SC6.18</i>	Not applicable
Provider's Health Inequalities Lead (NHS Trusts and NHS Foundation Trusts only) <i>See SC13.8</i>	Not applicable
Provider's Net Zero Lead (NHS Trusts and NHS Foundation Trusts only) <i>See SC18.2</i>	Not applicable
Provider's Infection Prevention Lead <i>See SC21.1</i>	Email: [REDACTED] Tel: [REDACTED]
Provider's Accountable Emergency Officer <i>See SC30.1</i>	Email: [REDACTED] Tel: [REDACTED]
Provider's Child Sexual Abuse and Exploitation Lead <i>See SC32.2</i>	Email: [REDACTED] Tel: [REDACTED]
Provider's Mental Capacity and Liberty Protection Safeguards Lead <i>See SC32.2</i>	[REDACTED] – Medical Director Email: [REDACTED] Tel: [REDACTED]
Provider's Prevent Lead <i>See SC32.2</i>	Email: [REDACTED] Tel: [REDACTED]
Provider's Safeguarding Lead (adults) / named professional for safeguarding adults <i>See SC32.2</i>	Email: [REDACTED] Tel: [REDACTED]
Provider's Safeguarding Lead (children) / named professional for safeguarding children <i>See SC32.2</i>	Email: [REDACTED] Tel: [REDACTED]

Provider's Controlled Drugs Accountable Officer (NHS Trusts, NHS Foundation Trusts and English Independent Hospitals only) <i>See SC33.12</i>	Not Applicable
Provider's Wellbeing Guardian (NHS Trusts and NHS Foundation Trusts only) <i>See GC5.9</i>	Not Applicable
Provider's Freedom To Speak Up Guardian(s) <i>See GC5.10</i>	██████████ – Medical Director Email: ██████████ Tel: ██████████
Provider's Caldicott Guardian <i>See GC21.3</i>	██████████ – Medical Director Email: ██████████ Tel: ██████████
Provider's Data Protection Officer (if required by Data Protection Legislation) <i>See GC21.3</i>	██████████ Email: ██████████ Tel: ██████████
Provider's Information Governance Lead <i>See GC21.3</i>	██████████ Email: ██████████ Tel: ██████████
Provider's Senior Information Risk Owner <i>See GC21.3</i>	██████████ Email: ██████████ Tel: ██████████
CONTRACT MANAGEMENT	
Addresses for service of Notices <i>See GC36</i>	Co-ordinating Commissioner: ██████████ Head of Contracts – Acute and Mental Health Address: Bristol, North Somerset and South Gloucestershire (BNSSG) ICB Floor 2, North Wing, 100 Temple Street, Redcliffe, Bristol, BS1 6AG Email: bnssg.mh.contract@nhs.net ██████████ - Director for NHS Partnerships & Innovation Clinical Partners Limited, Unit 6, Chaldicott Barns, Tokes Lane, Semley, Wiltshire, SP7 9AW - Company no. 07590254 nhspartnerships@clinical-partners.co.uk
Frequency of Review Meetings <i>See GC8.1</i>	Quarterly
Commissioner Representative(s) <i>See GC10.3</i>	██████████ Contract Manager Address: Bristol, North Somerset and South Gloucestershire (BNSSG) ICB

	Floor 2, North Wing, 100 Temple Street, Redcliffe, Bristol, BS1 6AG Email: bnssg.mh.contract@nhs.net
Provider Representative <i>See GC10.3</i>	Clinical Partners Limited, Unit 6, Chaldicott Barns, Tokes Lane, Semley, Wiltshire, SP7 9AW - Company no. 07590254
Nominated Mediation Body (where required – see GC14.4)	CEDR

SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM

A. Conditions Precedent

The Provider must provide the Co-ordinating Commissioner with the following documents in accordance with GC4.1:

1. Evidence of appropriate Indemnity Arrangements (appendix 1A1, 1A2 & 1A3)
2. Evidence of CQC registration in respect of Provider and Material Sub-Contractors <https://www.cqc.org.uk/location/1-9152789217>
3. Evidence of the Provider Licence in respect of Provider and Material Sub-Contractors (where required) (appendix 1A4)
4. Local Requirements
4.1 Counterfraud/Bribery Policy (appendix 1A5)

The Provider must complete the following actions in accordance with GC4.1:

Not Applicable

SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM

B. Commissioner Documents

Date	Document	Description
Not Applicable		

SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM

C. Extension of Contract Term

Not Applicable

SCHEDULE 2 – THE SERVICES

A. Service Specifications

[illegible][illegible]

[illegible]

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[illegible]

[illegible]



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Service Specification No.	2A3
Service	BNSSG Adult Autism Spectrum Disorder Service
Commissioner Lead	BNSSG Integrated Care Board (ICB)
Provider Lead	Clinical Partners
Period	1 st December 2024 – 31 st 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 individual's 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.

SCHEDULE 2 – THE SERVICES

Ai. Service Specifications – Enhanced Health in Care Homes

Not Applicable

SCHEDULE 2 – THE SERVICES

Aii. Service Specifications – Primary and Community Mental Health Services

Not Applicable

SCHEDULE 2 – THE SERVICES

B. Indicative Activity Plan

SCHEDULE 2 – THE SERVICES

C. Activity Planning Assumptions

Not applicable

SCHEDULE 2 – THE SERVICES

D. Not used

SCHEDULE 2 – THE SERVICES

E. Not used

SCHEDULE 2 – THE SERVICES

F. Clinical Networks

Not Applicable

SCHEDULE 2 – THE SERVICES

G. Other Local Agreements, Policies and Procedures

Appendix 2G1 - Business Continuity Plan (provider)

Appendix 2G2 - Complaint policy (provider)

Schedule 2G3 – Local System / Locality Partnerships (LPs) Operating Plan Obligations

The BNSSG ICS recognise that the collective decision-making between different bodies is the best way to arrange services and will be mindful that where the system wants or needs to consider making changes to service provision, there needs to be a flexible, sensible, transparent and proportionate process for decision-making that allows shared responsibility and adheres to statutory responsibilities. The ICB/ICS through its governance will ensure structures are in place to manage future commissioning arrangements decisions and management of potential challenges that may arise now the Provider Selection Regime (PSR) is now in effect from 1st January 2024.

The Parties to this contract must at all times use all reasonable endeavours to contribute towards the implementation of any Locality Partnership priorities to which both the Provider and Commissioners are party and must perform any specific obligations on their respective parts agreed as part of or pursuant/in accordance with to that Locality Partnership priorities from time to time, as set out in the agreed local system ambitions and indicative milestones. At a future point the commissioner role within this would be expected to reduce with greater cross partner system assurance expected to take its place.

These ambitions could be for example:

- Being accountable to other service providers for the delivery of services and use of resources within the respective LPs
- Work to a shared vision and a single plan supported by consistent ways of working
- Establish a governance infrastructure which enables and embeds shared decision making with delegated accountability from each organisation
- Develop and abide by a set of behaviours to establish trust, mutual respect and interdependence

Organisations within the LPs will be expected to take collective responsibility for the delivery of the system/local plan, working together to ensure best use of their collective resources. The Provider must equally ensure that the Services are organised and delivered in such a way as to integrate effectively with the local configuration of any Primary Care Networks established in the geographical area within which the Services are to be delivered.

Supporting Change

Planning, implementing, and delivering service developments across the BNSSG ICS system is fundamental in improving the quality and affordability of services provided to our population. There will be a number of initiatives that will be identified as part of the future planning processes and although it is recognised that in many instances, significant additional work is required from both the commissioner and providers to agree the roll-out and subsequent impacts of these all parties agree to work together collaboratively to agree joint approaches for developing initiatives with particular importance given to mutually agreeing the planned impact of changes on activity and financial flows within the system.

Schedule 2G4 – Provider discharge/transfer policy

Discharge/Transfer from Clinical Partners:

- Patients will be discharged if not diagnosed with ADHD or ASD.
- Patients will be discharged if not receiving medication from the service, or under shared care.
- Assessment report following a diagnosis, including person centred care and any treatment recommendations is sent to the patient or carer/guardian and their GP.
- Patients will be discharged after 2 DNAs/Not Brought: (Children and those who are vulnerable may not attend appointments simply because they have to rely on parents or carers. In this case, 'They are Not Brought' rather than did not attend would be a more appropriate definition. Clinical Partners will also consider that a DNA could be due to circumstances or an event not related to any mental health consideration. In this event every effort is made to contact the service user and rearrange the appointment. Special consideration will be given to children and young people especially if, from previous knowledge of the child or young person or from the response of the family, it is felt that significant risks are present, and the member of staff will liaise with other professionals.) If a service user fails to attend the following steps are followed:
 - An attempt is made to contact them via telephone on the same day.
 - If unable to make contact a letter is sent requesting the service user make contact.
 - If no contact is made within 2 weeks of this letter, the patient is discharged
 - If the service user fails to attend for a second planned appointment a discharge letter is sent by Clinical Partners to the service user and their GP.
 - Discharge can be discretionary and is assessed on a case by case basis depending on individuals circumstances in consultation with the referring ICB.
- Referrals will be declined/patients will be discharged if they have already had a diagnosis (exceptions to this rule must be discussed with the commissioner).
- Patients will be discharged if they are already on another waiting list

DNA fees are included within the local pricing schedule. This would also apply to non contract activity, performed under NHS Choice Framework.

Appendix 2G5 – Provider PSIRF Policy

SCHEDULE 2 – THE SERVICES

H. Transition Arrangements

Not Applicable

SCHEDULE 2 – THE SERVICES

I. Exit Arrangements

[REDACTED]	
[REDACTED]	
I.	[REDACTED]
I.	[REDACTED]

SCHEDULE 2 – THE SERVICES

J. Transfer of and Discharge from Care Protocols

The Provider shall adhere to the transfer of and discharge from care obligations as detailed in NHS Standard Contract 2025/2026 Service Conditions and General Conditions. Transfer of and discharge from care will be carried out in line with mental health legislation and guidance and any agreed local protocols with and between providers that should be reviewed annually between providers.

The Provider will have policies and procedures in place (see section 2G) which includes ensuring that any service user who is identified as being at risk as a result of their mental health needs, or who requires additional services in order to meet their needs is signposted and supported in accessing those services.

In addition, the Provider (if applicable) will work with its NHS partner organisations to ensure that service users' discharges are well organised, safe and as far as possible in accordance with the service user's wishes.

Principles of Transfer / discharge

Transfer and Discharge of service users can bring specific risks and issues that require careful consideration and planning in order to minimise and manage risks effectively and ensure continuity of care. General principles relating to communication, planning and implementation of care apply to both transfer and discharge of care happening across a wide variety of care settings. Specific considerations may be required depending upon the setting from which a service user's care is transferred or discharged to and from and may vary depending upon the service user group e.g., Learning Disability, Frail and Elderly and end of life care.

It is important that service users' are involved in the planning and decision-making about the transfer or discharge of their care.

Service users and carers (if applicable) must have clear information provided about the referral pathways and processes for any services the service user patient is being discharged from or transferred to (this should include information about possible waiting times, assessment process, intervention type, timescale of intervention).

It should be acknowledged with service users, that discharges and transfers are often an anxiety provoking time. Service users should be provided with support through this process, having the opportunities to discuss concerns as well as other issues. Withdrawal or ending of support/treatment and if required transition from one service to another may evoke strong emotions and reactions and the Provider should ensure that such changes are discussed carefully with the service user and / or their representative beforehand and are structured and phased.

Family and carers should have the opportunity (with the agreement of the service user) to be involved in the planning of transfers or discharge, where possible. Involved family and carers must be notified before the patient is transferred or discharged.

Planning with regards to transfer and discharge must be fully and accurately documented in order that all parties relevant to the transfer or discharge can clearly understand the arrangements and refer to these when needed.

Please refer to Service specifications in section 2A regarding ADHD and Autism specific transfer and/or discharge requirements into Primary Care setting.

SCHEDULE 2 – THE SERVICES

K. Safeguarding Policies and Mental Capacity Act Policies

Appendix 2K1 Provider Safeguarding Adults policy Appendix 2K2 Provider Safeguarding Children policy Appendix 2K3 Provider Consent to Treatment policy
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SCHEDULE 2 – THE SERVICES

L. Provisions Applicable to Primary Medical Services

Not Applicable

SCHEDULE 2 – THE SERVICES

M. Development Plan for Personalised Care

Embedding Personalised Care as the default delivery model is a priority area of focus for the health and care community and is one of the five key priorities for the NHS within the NHS Long Term Plan. The publication of the document [Universal Personalised Care: Implementing the Comprehensive Model](#) document sets out how the NHS Long Term plan commitments for Personalised Care are to be delivered and become business as usual.

Personalised Care means that people have choice and control over the way their care is planned and delivered based on ‘what matters’ to them and their individual strengths and needs.

Throughout 2025/2026 the Head of Personalised Care and Programme Manager will support Integrated Care System partners with the embedding and delivery of Personalised Care as business as usual. A coordinated approach through the Personalised Care Steering Group will focus on a cross system collaborative model and each organistaion is expected to engage and participate.

The operating model [Newest Operating Model-270421 \(england.nhs.uk\)](#) outlines the key areas and important enablers as:

- Shared Decision Making
- Personalised Care and Support Planning
- Patient Choice / Optimal Medical Pathway
- Social prescribing and Community Based Approaches
- Supported Self-Management
- Personal Health Budgets / Integrated Budgets
- NHS @ Home

With leadership, co-production, workforce, finance, commissioning and payment key enablers.

Successful deployment of these six components is expected to deliver the following:

- Whole-population approaches to supporting people of all ages and their carers to manage their physical and mental health and wellbeing and make informed decisions and choices when their health changes.
- A proactive and universal offer of support to people with long-term physical and mental health conditions to build knowledge, skills and confidence and to live well with their health conditions.
- Intensive and integrated approaches to empowering people with more complex needs to have greater choice and control over the care they receive.
- Co-produced and co-designed programs with people and communities in line with the principles of [NHS England » Working in partnership with people and communities: Statutory guidance](#)

1. Delivery of BNSSG personalisation action plan as set out in the Joint Forward Plan 2024-2029

BNSSG Head of Personalised Care and Programme Manger alongside the ICB and ICS partners will coordinate an action plan to embed Personalised Care across the BNSSG system and there is an expectation that all partners and providers will engage and participate, with the host platform being the Personalised Care Steering Group and nominate senior decision maker/s to attend the Personalised Care Steering Group.

2. Shared Decision Making

Shared Decision Making relates to 100% of people that utilize the health and care system. Shared Decision Making enables people who use services to make choices about the provider, team and services that will best meet their needs and what matters to them. In brief, Shared Decision Making is a process in which Service Users and clinicians work together to discuss the risks, benefits and consequences of different care, treatment, tests and support options, and make a decision based on evidence-based, good quality information and their personal preferences. Facilitating Shared Decision Making in everyday clinical practice are legal and NHS Constitution requirements, as well as specific contractual obligations under SC6.1 and SC10.2.

Providers are required to ensure that NG197 baseline assessment [NG197](#) has been completed and engage and participate in a collective understanding of the wider needs and implementation of a consistent approach across BNSSG.

Providers are required to:

- Ensuring workforce have access to training and support to embedding Shared Decision Making, such as via the [Personalised Care Institute](#); and that this is advertised through system training platforms
- Engage in discussion around sustainable models for training in health coaching and/or motivational interviewing
- Ensure that treatment pathways promote and allow sufficient time for service users to understand their health and care needs and feel prepared and informed to make a decision prior to consent to treatment. This includes for example, reviewing decisions with patients who have been on waiting lists for prolonged periods or where additional risks are identified during pre-operative assessments

3. Personalised care and support plans (PCSPs)

PCSPs are recommended for all long-term condition pathways plus other priority areas as set out in the NHS Long Term Plan. These include maternity services, palliative and end of life care, residential care settings, cancer, dementia, and cardio-vascular diseases, and more broadly, people with more complex needs.

PCSPs must also be in place to underpin any use of personal health budgets.

Where PCSPs are developed ensure that the PRSB standards are met [Personalised Care and Support Plan Standard - PRSB \(theprsb.org\)](#) and promote the provision for a service user and or carer to only need to tell their story once and consider how the plan can where consent given be shared across systems.

Plans should also set out approaches for the digitisation of PCSPs in compliance with the DAPB Information Standards Notice for Personalised Care and Support Plans [DAPB4022: Personalised Care and Support Plan - NHS England Digital](#). In digital programmes support the provision of a digital record that allows the sharing of the About Me standard.

4. Supported self-management

As part of Shared Decision Making and PCSPs, the support Service Users need to help them manage their long-term condition/s should be discussed with them. Interventions that can help people to develop the capacity to live well with their condition(s) include health coaching, self-management education, and peer support. [NHS @home](#) also supports more connected, personalised care using technology such as remote monitoring devices to support people to better self-manage their health and care at home with education and support from clinical teams.

Promote both staff knowledge and understanding of supported self-management offers and that of the people of BNSSG; such as

- Live Longer Better Programme [LIVE LONGER BETTER - Home](#) for both citizens and staff
- Hope Programme for the South west [Hope Programme for the South West — Hope For The Community CIC \(h4c.org.uk\)](#)

5. Personal health budgets (PHBs)

Personal health budgets (PHB) are one of the components to embedding personalised care. A PHB can be defined as an amount of money identified to support a person's identified health and wellbeing needs, planned and agreed between the person and their local NHS team. PHB's can be arranged for adults over 18 or for a child or young person in receipt of health funding.

ICBs and NHS providers have a duty to:

- Arrange for the provision of PHBs
- Publicise and promote PHBs
- Provide information and support for potential budget holders
- Consider requests for PHBs

Legal rights to have PHBs now cover:

- adults eligible for NHS Continuing Healthcare and children / young people eligible for continuing care;
- individuals eligible for NHS wheelchair services; and
- individuals who require aftercare services under section 117 of the Mental Health Act.

Providers are required to consider and include within business plans, business model's and financial modelling consideration of PHB's as a way to alternatively meet people's needs as part of business as usual.

Requirement to establish and update information accessible to the public on the rights to PHB's and the processes to request such an offer.

SCHEDULE 2 – THE SERVICES

N. Health Inequalities Action Plan

Background

Integrated Care Systems have four core purposes:

1. Improving outcomes in population health and healthcare
2. Tackling inequalities in outcomes, experience and access
3. Enhancing productivity and value for money; and
4. Helping the NHS to support broader social and economic development

The renewed emphasis that health and care now has on population health outcomes and tackling health inequalities means that the ICB and Providers need to understand more clearly where there are inequalities in access to, experience of and outcomes from care and treatment and work together to reduce these. Successfully tackling health inequalities will always necessitate close working with other local organisations from the statutory sector and beyond. The specific actions in this schedule are to support commissioners, providers and others, as part of the wider system, to work together to address this issue.

Actions for the Provider

Reporting

Performance reports relating to waiting times and access to different types of appointments (face to face, telephone, video) broken down by at a minimum ethnicity and Index of Multiple Deprivation will be discussed at the provider's appropriate group and / or committee and assurance given to provider Board's in line with the provider's governance arrangements.

Monitoring the impact of improvement work

Providers will work with system partners to ensure that the monitoring of the impact of improvement work will be broken down by ethnicity and Index of Multiple Deprivation as a minimum. The monitoring information will be used to assess the impact of changes on people likely to experience inequalities in access, experience and outcomes.

Adoption and spread of 'Did Not Attend' (DNA) work

Providers will use what will be learnt from the Outpatient Health Inequalities Did Not Attend project taking place across North Bristol NHS Trust and University Hospitals Bristol and Weston NHS Foundation Trust and adapt and spread it to other specialties where there is the potential for improvements in DNA rates for people with certain characteristics.

SCHEDULE 3 – PAYMENT

A. Aligned Payment and Incentive Rules

Not Applicable

SCHEDULE 3 – PAYMENT

B. Locally Agreed Adjustments to NHS Payment Scheme Unit Prices

Not Applicable

[illegible]



SCHEDULE 3 – PAYMENT

D. Expected Annual Contract Values

[illegible]

SCHEDULE 3 – PAYMENT

E. Timing and Amounts of Payments in First and/or Final Contract Year

Not Applicable – payment approach is detailed in Schedule 3D

SCHEDULE 3 – PAYMENT

F. CQUIN

Not Applicable

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) 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.	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

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. - 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	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. PSII (where required).	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. 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	Ad hoc: Reported as Patient Safety Incident/death occurs. Ad hoc: Improvement Plan/review. Ongoing: learning at Quarterly BNSSG Learning Meeting Escalation: by exception.

- 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. 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.		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 - 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.	
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		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: <i>Overview of NHSEI's Quality Functions & Responsibilities of ICSSs</i>).	
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: • 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		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. Duty of Candour section. confirming any Duty of Candour declarations within the Quality report (on an exception basis only). Reported via Quality report.	Annual

- 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			
Complaint Management Complaints monitoring report, setting out numbers of complaints received and including analysis of key themes in content of complaints. 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	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 services where required are shared. Complainant feedback following completion of the complaint. Reported via Quality report.	Monthly compliance of all measures reported in line with Quality report frequency.

• 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.			
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 * 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.	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 provider's experience or complaints policies. This should include an annual update on PLACE (Patient Led Assessment of Care Environment).	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 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.	Annual

- Accessible signposting in place for patients - Plan for optimising patient experience embedded with progress against deliverables.			
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 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.	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/
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/	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

https://www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/accessibleinfo/			
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	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.	By Exception

updates on action plans implemented as a result of inspections		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).	
National reports Ensure that all relevant recommendations from national reports published previously and within the contract year are acknowledged and acted upon. For example, Francis reports, Berwick, Winterbourne View Kirkup, HSSIB, etc.	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
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, improving retention and turnover.		To be included within Annual Quality Report.	Annual
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	Notifications to be uploaded onto the LeDeR portal.	ICB to monitor monthly notification, this data feeds into LeDeR Governance meeting with oversight of Executives.

	specific to that organisation or actions derived from a LeDeR theme as directed by the LeDeR Governance Group.		
Providers must ensure that all staff receive training in how to interact appropriately with people with a learning disability and autistic people, at a level appropriate to their role. General Condition 5.5 (FL) and 5.4 (SF) and Definitions	The Health and Care Act 2022 makes provision for mandatory training on 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.	Oliver McGowan Task and Finish Group continues IS Providers to include Oliver McGowan Tier 1 and Tier 2 training compliance with mandatory training. Update 6 monthly.	Data from Providers is fed into this meeting again an oversight report is 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/	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.

	v1.17 Improvement Standards added note.pdf		
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 effective in supporting autistic people and people with learning disabilities – to meet their mental Health needs. <u>Green Light Toolkit - NDTi</u>	1. Annual Audit 2. Results to inform Action Plan and Improvement schedule and correlated to NHSE Annual Benchmarking	Annual
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	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.

	people with a learning disability and/or autism.		
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) support autistic people.	Reasonable adjustment audit Annual review of all recommendations to be provided within quality report.	Annual to be reviewed at LeDeR Governance Group.

	- 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.		
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	- 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 Processes need to be in place to support safe use and management of controlled drugs, including the reporting	Monitoring report to include areas of concern identified and actions taken with planned timescales. Undertake quarterly Controlled Drugs audit of ward storage.	Quarterly

	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 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 related incidences across BNSSG. Work will be undertaken across BNSSG to standardise the approach	<u>Incidents</u> Quarterly qualitative report on shared learning related to medication incidents. Contribute to system wide safety newsletter Reporting compliance to:	Quarterly

	to system wide sharing and learning – e.g. incident reporting from Datix.	- 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 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	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

	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.		
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SCHEDULE 5 – GOVERNANCE**A. Documents Relied On****Documents supplied by Provider**

Date	Document
May 2024	Whistleblowing Policy
September 2024	Medicines Management Policy

Documents supplied by Commissioners

Date	Document
March 2024	Who Pays Guidance (link below) NHS England » Who Pays?
July 2024	Accreditation Confirmation letter

SCHEDULE 5 - GOVERNANCE**B. Provider's Material Sub-Contracts**

Sub-Contractor [Name] [Registered Office] [Company number]	Service Description	Start date/expiry date	Processing Personal Data – Yes/No	If the Sub-Contractor is processing Personal Data, state whether the Sub- Contractor is a Data Processor OR a Data Controller OR a joint Data Controller
Not Applicable				

SCHEDULE 5 - GOVERNANCE

C. Commissioner Roles and Responsibilities

Co-ordinating Commissioner/Commissioner	Role/Responsibility
BNSSG ICB	Commissioner

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

Approach Summary

For 2025/26, as per last year, the standard national contract **SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS** is being used consistently for all Voluntary, Community and Social Enterprise (VCSE) contracts.

Mental Health Services Data Set (MHSDS) has always been a mandatory contract requirement. There continues to be national and local need to include non-statutory providers, particularly to evidence the transformation of community mental health services.

A reminder of the additional national and local drivers behind the content of the schedule:

- **National:**
 - Introduction of new community mental health wait times standards are dependent on the flow of all data, to track two contacts irrespective of the provider.
 - Three Patient Reported Outcome Measure (PROMs) tools were mandated for introduction before March 2024. The three tools are: DIALOG, Goal Based Outcomes (GBO) and REQOL (Recovering Quality of Life). Paired outcome scores will be used to trigger and stop the clock for waiting time monitoring. See local section*. A Frequently Asked Questions (FAQ) document has been issued and implementation guidance is in production.
- **Local:**
 - VCSE gap in population health management linked dataset and consequent gap activity; ability to assess outcomes; missing sectors of the mental health need and information about those population groups etc.
 - Decision to implement DIALOG as a priority PROM across the Avon and Wiltshire Partnership Trust (AWP) footprint, covering Bristol, North Somerset, South Gloucestershire (BNSSG) Bath and North East Somerset, Swindon and Wiltshire (BSW) as part of Personal Wellbeing Plans.

Reference Materials

Additional useful link:

DIALOG [Dialog Scale.pdf \(elft.nhs.uk\)](https://elft.nhs.uk/DialogScale.pdf)

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

		Reporting Period	Format of Report	Timing and Method for delivery of Report	Service category
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 Sent to: bnssq.mh.contract@nhs.net and also copying [REDACTED]	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 November • Q3 October – December by 1st February • Q4 January – March by 1st May Sent to: bnssq.mh.contract@nhs.net and also copying [REDACTED]	A, MH
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

		Reporting Period	Format of Report	Timing and Method for delivery of Report	Service category
				Sent to: bnssg.mh.contract@nhs.net and also copying [REDACTED]	
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). For further information please see schedule 4 (Local Quality Schedule).	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 Sent to: bnssg.mh.contract@nhs.net and also copying [REDACTED]	All
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 Sent to: bnssg.mh.contract@nhs.net and also copying [REDACTED]	All

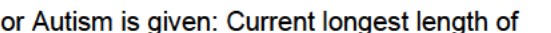
NHS Standard Contract 2025/26

		Reporting Period	Format of Report	Timing and Method for delivery of Report	Service category
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 at https://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 Sent to: bnssg.mh.contract@nhs.net and also copying [REDACTED]	All
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 Sent to: bnssg.mh.contract@nhs.net and also copying [REDACTED]	

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
			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

			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			
				
				
Activity	A measure of how many individual people the service is supporting & indication of their need	Where a diagnosis of ADHD or Autism is given: Current average (mean) length of stay on the active caseload - 	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 - 		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 (1 st to last contact/ discharge) - [REDACTED]	Adult ADHD CYP ADHD Adult Autism CYP Autism [REDACTED]	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
		[REDACTED]	[REDACTED]	[REDACTED]
		[REDACTED]	[REDACTED]	[REDACTED]
		[REDACTED]	[REDACTED]	[REDACTED]

	People report a positive experience of the service	Patient Reported Experience Measure – Friends & Family or adopt local CMHP PREM		N/A
	Demonstrable improvement in health & wellbeing of service users	Patient Reported Outcome Measurement – DIALOG, Goal Based Outcomes (GBO) or REQOL: 3 x case studies demonstrating impact 6 monthly 1 demonstrating complexity, 1 demonstrating learning, 1 demonstrating a positive outcome	To be included in Annual Service Quality Report	N/A
			To be included in Q2 & Q4 reports	N/A

Reportable demographics of service users against the 9 protected characteristics (to follow the NHS Data Dictionary categories NHS Data Model and Dictionary <https://www.datadictionary.nhs.uk/>

Person Characteristic	Data Dictionary reference
1. Age	Based on date of birth and date of contact
2. Disability	DISABILITYINDICATOR (datadictionary.nhs.uk)
	Flagging learning difficulties DISABILITYCODE (datadictionary.nhs.uk)
3. Gender reassignment	GENDERIDENTITYCODE (datadictionary.nhs.uk) [Person stated within the service]
	GENDERIDENTITYSAME.ATBIRTH.INDICATOR (datadictionary.nhs.uk) [Person stated within the service]
4. Marriage and civil partnership	PERSONMARTIALSTATUS (datadictionary.nhs.uk)
5. Pregnancy and maternity	PREGNANCYSTATUS.INDICATOR (datadictionary.nhs.uk)
6. Race	ETHNIC.CATEGORY (datadictionary.nhs.uk)
7. Religion or belief	RELIGIOUS.OR.OTHER.BELIEF.SYSTEM.AFFILIATION.CODE (datadictionary.nhs.uk)
8. Sex	PERSON.STATED.GENDER.CODE (datadictionary.nhs.uk) [Matched to the spine]
	GENDERIDENTITYCODE (datadictionary.nhs.uk) [Person stated within the service]
9. Sexual orientation	PERSON.STATED.SEXUAL.ORIENTATION.CODE (datadictionary.nhs.uk)

https://www.datadictionary.nhs.uk/attributes/source_of_referral_for_mental_health_services_data_set.html?hl=source%2Creferral%2Cmental%2Chealth%2Cservices%2Cdata%2Cset

https://www.datadictionary.nhs.uk/data_elements/clinical_response_priority_type.html

Registered GP Practice (using Organisation Code Service list, L81XXX numbers and names)

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

B. Data Quality Improvement Plans

This is a non-mandatory model template for population locally. Commissioners may retain the structure below, or may determine their own. Refer to s43 of the Contract Technical Guidance.

	Data Quality Indicator	Data Quality Threshold	Method of Measurement	Milestone Date
1	Not Applicable			

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

C. Service Development and Improvement Plans

[illegible]

Adult Autism:

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

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

D. Surveys

Type of Survey	Frequency	Method of Reporting	Method of Publication
Friends and Family Test (where required in accordance with FFT Guidance)	As required by FFT Guidance	As required by FFT Guidance	As required by FFT Guidance
Staff Survey (appropriate NHS staff surveys where required by Staff Survey Guidance)	As required by Staff Survey Guidance	As required by Staff Survey Guidance	As required by Staff Survey Guidance
[Other insert locally (for example, Service User Survey, Carer Survey)]	Please refer to schedule 4 – Local Quality Schedule for requirements.		

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

E. Data Processing Services

Not Applicable

SCHEDULE 7 – PENSIONS

Not Applicable

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

Contact: england.contractshelp@nhs.net

This publication can be made available in a number of alternative formats on request

NHS Standard Contract

Variation Agreement template (full length or shorter-form Contract)

March 2025

Prepared by: NHS Standard Contract Team, NHS England
england.contractshelp@nhs.net
(please do not send variation agreements to this email address)

Contract/Variation Reference: BNSSG_ICB_2024-2026_Clinical_Partners_ADHD & Autism Assessment and Treatment Services – CYP & Adults MH (25-26)

Proposed by: Commissioner on behalf of BNSSG ICB

Date of Variation Agreement: Date signed by last party

Capitalised words and phrases in this Variation Agreement have the meanings given to them in the Contract referred to above.

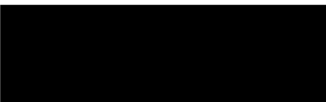
1. In consideration of their respective obligations under the Contract (as varied by this Variation Agreement) the Parties have agreed the Variation [summarised] [full details of which are set out] below (*delete as applicable*):

- Contract moved onto 25-26 template
- Governance and Regulatory - new contact for Providers 2018 Act Responsible Person added by provider in line with additional information required for 25-26 template.
- Updated service specifications added for:
 - Schedule 2A1: Adult ADHD service specification:
 - Schedule 2A2: Children & Young People ADHD service specification:
 - Schedule 2A3: Adult Autism Service Specification
 - Schedule 2A4: Children & Young People's Autism Service Specification
- Schedule 2B – addition of reference to Indicative Activity Plan.
- Schedules 2G3, 2J, 2M and 2N reviewed for 25-26 and updated where required.
- Schedule 3C – Local Prices updated and revised pricing schedules added as follows:
 - ADHD: to include new pathway price for CYP where GP takes on prescribing in primary care but responsibility for physical health checks and reviews remains with provider.
 - ASD: schedule updated to remove reference to specific screening tools.
- Schedule 4 – Local Quality Requirements – updated schedule for 25-26.
- Schedule 6A reviewed for 25-26, updates made to include 6A national requirements reported centrally and national requirements reported locally as per the full length contract template.
- Schedule 6A local reporting template updated.

2. The Variation is reflected in the revised Particulars bearing the contract reference and variation number set out above. The Parties agree that the Contract is varied accordingly.

3. The Variation takes effect on 1st April 2025.

IN WITNESS OF WHICH the Parties named below have signed this Variation Agreement on the date(s) shown below

Signed by	
for and on behalf of THE CO-ORDINATING COMMISSIONER*	
Signature	
Title	Interim Chief Finance Officer
Date	03/03/2026

Signed by	
for and on behalf of	Clinical Partners Limited
Signature	
Title	Business Development Director
Date	05/01/2026

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

Contact: england.contractshelp@nhs.net

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Service Specification No.	2A3
Service	BNSSG Adult Autism Spectrum Disorder Service
Commissioner Lead	BNSSG Integrated Care Board (ICB)
Provider Lead	Clinical Partners
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 individual's 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.

FOI.ICB-2627/152 - Clinical Partners NHS Right to Choose Adult Autism Assessments

On the adult autism page in Dec 24 the text relating to Clinical Partners was:

Clinical Partners are commissioned to provide Autism services for CYP/adults in BNSSG, from 1 December 2024. Age range for the service is 18 years and over. They have delivered services under Right to Choose in BNSSG for some time. Referrals can be made via <https://www.clinical-partners.co.uk/nhs-services/right-to-choose> or GP referral form to rtc@clinical-partners.co.uk

Other providers - Right to Choose For patients wishing to choose a “Right to Choose” provider it is important the patient understands that the provider may not integrate with local BNSSG pathways and/or other services as the provider does not hold a contract directly with BNSSG ICB. It is advisable for the GP and patient to agree the most suitable provider as the referral must be “clinically appropriate” for the patient under choice framework Patients will only be eligible for NHS treatment if referred by their GP. Please note some RTC providers offer an assessment only service. Post diagnostic support is not always available Please see the " attached spreadsheet which summarises the current services offered by RTC providers, including referral information and exclusions. See the relevant tab at the bottom of the page for ADHD/ASD Adults/Children

Post diagnostic support - where a provider has indicated availability of post diagnostic support, referrers/patients should contact them directly to check what this includes before making a decision on this basis. Some post diagnostic support offers for ADHD and Autism may be limited to signposting to other organisations; so patient expectation around this should be managed at the outset

If looking after June 25, the first part re Clinical Partners is same as above³ but directed to the new Right to Choose page (which was set up on 24 March 26) where the spreadsheets were kept & all the ADHD/Autism pages linked to this for information on referrals. The information on there is as follows:

Providers with a BNSSG ICB contract						
Clinical Partners	18+	Yes	Limited	https://www.clinical-partners.co.uk/nhs-services/right-to-choose	Referrals can be made via Clinical Partners website or by sending a referral form to rtc@clinical-partners.co.uk	No

Clinical Partners Q1 Contract Review meeting

**Minutes of the meeting held on Thursday 11th September 2025
at 1pm via MS Teams**

Minutes

Present		
	Contract Manager MH, LD & Autism, BNSSG ICB	
	Senior Contract Manager, Communities & Childrens, BNSSG ICB	
	Strategic Partnership Manager, Clinical Partners	
	Contract Performance Supervisor, Clinical Partners	
	Contracting Lead, Clinical Partners	
	Director of Clinical Operations, Clinical Partners	
Apologies		
	Senior Performance Manager LD & Autism, BNSSG ICB	

	Item	Action
1	Apologies Apologies were noted from [REDACTED]	
2	Declarations of interest [REDACTED] declared that she was currently on the waiting list for ADHD assessment with Clinical Partners. No other declarations were noted.	
3	Notes of the last meeting, review of actions and risks The notes of the previous meeting were agreed. The action log was reviewed and updates noted.	
4	Quality Report requirement discussion Annual Quality Report feedback: CP colleagues re-iterated that there were no patient safety incidents recorded for the period of the report; although this was only 4 months because the contract didn't go live until December 2024. It is expected that more information will be seen around trends and themes from patient concerns and complaints when a full year report for 25-26 is produced. [REDACTED]	

2

	Item	Action
6	Update on current service risks and emerging risks Current risks were discussed. [REDACTED]	
7	Additional updates on Q1 service delivery Nothing by exception.	
8	Update on any future service delivery [REDACTED]	
9	Any Other Business Nothing raised.	
10	Date of next meeting Thursday 4th December 2025, 1pm.	

Clinical Partners Q2 Contract Review meeting

**Minutes of the meeting held on Thursday 4th December 2025 at
1pm via MS Teams**

Minutes

Present		
	Contract Manager MH, LD & Autism, BNSSG ICB	
	Senior Contract Manager, Communities & Childrens, BNSSG ICB	
	Strategic Partnership Manager, Clinical Partners	
	Contract Performance Supervisor, Clinical Partners	
	Contracting Lead, Clinical Partners	
Apologies		
	Senior Performance Manager LD & Autism, BNSSG ICB	
	Director of Clinical Operations, Clinical Partners	

	Item	Action
1	Apologies Apologies noted from [REDACTED]	
2	Declarations of interest [REDACTED] declared that she was currently on the waiting list for ADHD assessment with Clinical Partners. No other declarations were noted.	
3	Notes of the last meeting, review of actions and risks The notes of the previous meeting were agreed. The action log was reviewed and updates noted.	
4	Quality Report requirement discussion Serious incidents: No serious incidents were reported for BNSSG patients during the quarter. Patient Satisfaction & Complaints: Three complaints were received; two were not upheld, one was partially upheld due to a missed referral. Disputes over diagnosis were noted as a common theme and this is the case nationally as well. [REDACTED] discussed efforts to manage patient expectations and improve response rates to the patient experience questionnaires. Autism clinician report: [REDACTED] Devon ADHD assessment case: [REDACTED]	

	Item	Action
	[REDACTED] Action – [REDACTED] to share details and CP colleagues to review and respond.	T
5	Reporting Requirements Update [REDACTED] presented the Q2 activity report and the following points were noted: 1,327 referrals received, with a noted seasonal decrease in CYP referrals attributed to school holidays. 32% increase compared to Q1. LG acknowledged a reporting error regarding CYP referrals, which was corrected during the meeting. 3,650 awaiting diagnostic assessment, 259 adults and 90 children awaiting titration at the end of November. - Detailed breakdowns about cancelled appointments were provided, with 57% of cancellations by the provider being feedback appointments which are subject to change. [REDACTED] noted that the number of DNA's had doubled compared to Q1, (although the percentage increase may not represent this as appointment numbers are different) and asked what actions were being taken by the provider to keep this to a minimum. [REDACTED] advised that mitigations such as flexible booking and reminders were in place and welcomed further suggestions for the reduction of DNA's going forward.	
6	Update on current service risks and emerging risks [REDACTED] raised a concern about current titration waiting times and asked for an update on actions being taken to reduce this. [REDACTED] provided an overview of the scaling up of the prescribing service, including the successful EPS pilot for BNSSG and West Yorkshire, with plans for full rollout by March 2026. Increased clinician capacity and strong treatment trajectory were planned, with ongoing monitoring for safety and compliance. It was also noted that Clinical Partners continue to publish current waiting times on their website, which is available to members of the public prior to referral being made. Action – [REDACTED] to share delivery plans for the prescribing scale up with [REDACTED] including the trajectory for reduction in waiting times. It was noted that future reports would reflect increased activity within ADHD prescribing. Data reporting for medication was discussed, with [REDACTED] confirming triangulation of NHSBSA, EMS, and EPR data to ensure accurate billing and activity tracking. The process was complex but being shared with other ICBs. [REDACTED]	[REDACTED]
7	[REDACTED] [REDACTED]	

	Item	Action
	[REDACTED]	
8	Update on any future service delivery ■ noted that some quarterly reports had been submitted after the deadline and asked whether there was any support required from the ICB, eg alignment of deadlines to the provider reporting processes. ■ advised that delays had been a result of resource constraints and confirmed that future deadlines were feasible. It was agreed that although the next CRM isn't until May 2026 Q3 and Q4, it would be helpful to have a quick check in around February 2026 rather than a full CRM. Action – ■ to arrange. Some outstanding items for the contract were noted, which included the liability certificate and subcontracting details. ■ that confirmed subcontracting had not yet launched and agreed to send the liability certificate for contract variation sign-off before Christmas. Action – ■.	■ ■
9	Any Other Business ■ advised that he would be moving to a new role as Head of Strategic Partnerships and that there would be a future handover of responsibilities.	
10	Date of next meeting Thursday 14th May 2026, 9.30-11am.	

Clinical Partners Q3 Contract Review meeting

**Minutes of the meeting held on Thursday 27th February 2025 at
2pm via MS Teams**

Minutes

Present		
	Contract Manager MH, LD & Autism, BNSSG ICB	
	Senior Performance Manager LD & Autism, BNSSG ICB	
	Senior Contract Manager, Communities & Childrens, BNSSG ICB	
	Strategic Partnership Manager, Clinical Partners	
	Delivery Performance Manager, Clinical Partners	
	Director of Clinical Operations, Clinical Partners	
	Contracting Lead, Clinical Partners	
Apologies		
	Director for NHS Partnerships & Innovation, Clinical Partners	

	Item	Action
1	Apologies Noted from [REDACTED] from future meeting invitations. Action – [REDACTED]	[REDACTED]
2	Declarations of interest Nothing raised.	
3	Notes of the last meeting, review of actions and risks First quarterly meeting for this contract so no previous minutes. The action tracker was reviewed – some of these have carried across from the contract negotiation and implementation meetings as they are still relevant.	
4	Quality Report requirement discussion CP colleagues requested feedback on the first quarterly report and the following was noted: - Report needs to include headings listed in the contract reporting schedule 6A: a) Update on service including service development b) KPI report c) Risks d) Plans for service delivery for the following quarter	

	Item	Action
	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. • Inclusion of visual reporting tools such as graphs which help to illustrate themes and trends. • Avoid using the term "CAMHS" and instead refer to "CYP" • Splitting of data into age cohorts between ADHD & Autism. ■ asked whether referrals had increased now that CP had gone from RTC to commissioned provider and it was noted that it was difficult to compare activity in December with previous months as this is when there are a greater number of bank holidays, plus a seasonal drop off. ■ agreed to provide data from December 2023 to aid comparison. Action – ■ There were no serious incidents in December. Patient satisfaction is measured externally and a report will be shared in the next few months. Reporting around complaints is being developed as these aren't currently split by ICB, so CP colleagues will go through these manually to identify any for BNSSG. The annual quality report template was discussed – this is due for submission at the beginning of May. ■ acknowledged that it would only include the period since the BNSSG service went live. CP colleagues will review and raise any queries as needed, but initial thoughts were that this was fairly similar to expectations of other ICB's.	■
5	Reporting Requirements Update Discussed under previous item – nothing to add.	
6	Update on current service risks and emerging risks Current risk links to the GP collective action in that referrers may decline to use organisation specific referral forms, in favour of a generic area one. CP colleagues advised that this is wider than BNSSG and although they can be accepted, they take longer to process, so aren't as efficient. ■ mentioned that CP are looking at being set up on ERS. ■ advised that this is something she has been looking at in BNSSG and they agreed to discuss separately. Action – ■. NHS Payment Scheme Consultation – CP colleagues advised that a letter had been received from BNSSG ICB setting out some	■

	Item	Action
	information around this. The proposals are under consultation until the end of February, however, feedback from CP is that BNSSG initial approach sounded sensible.	
7	Additional updates on Q3 service delivery Waiting times to titration are currently around 12-18 months and this has been the case since the contract went live. CP reported that they are making progress with these and are recruiting titration clinicians so that this can be scaled up and waiting times reduced. Waiting time for ADHD assessment is currently 9-11 weeks for the cohort of referrals received in December.	
8	Update on any future service delivery Nothing by exception.	
9	Any Other Business It was noted that the updates to the CYP ADHD service spec around shared care will be made when the current contract is moved to the 25-26 template. This is a more efficient approach as the new template will require a contract variation anyway. Further examples of reporting will be shared over the next quarter in order for feedback from ICB colleagues so that new templates can be tested.	
10	Date of next meeting Q4 Thursday 22 nd May 2025 2-3pm, MS Teams	

Clinical Partners Q4 Contract Review meeting

**Minutes of the meeting held on Thursday 22nd May 2025 at 2pm
via MS Teams**

Minutes

Present		
	Contract Manager MH, LD & Autism, BNSSG ICB	
	Senior Contract Manager, Communities & Childrens, BNSSG ICB	
	Strategic Partnership Manager, Clinical Partners	
	Delivery Performance Manager, Clinical Partners	
	Contracting Lead, Clinical Partners	
Apologies		
	Senior Performance Manager LD & Autism, BNSSG ICB	

	Item	Action
1	Apologies Apologies were noted from [REDACTED].	
2	Declarations of interest Nothing raised.	
3	Notes of the last meeting, review of actions and risks The draft notes of the previous meeting were accepted and actions discussed and updated.	
4	Quality Report requirement discussion Annual quality report: This has been shared with ICB Quality colleagues and feedback will be provided following this. Patient Satisfaction & Complaints: It was noted that numbers of patient experience surveys sent out were based on the previous months activity. [REDACTED] asked if it would be possible for future reports to be split by CYP and adults. Action – [REDACTED] to check. Two complaints were received in March, one of these was upheld. There were no serious incidents.	[REDACTED]
5	Reporting Requirements Update [REDACTED] thanked CP colleagues for the re-formatted KPI report. The following points were noted:	

	Item	Action
	- Referral numbers include patients who have been screened and accepted and also those who are awaiting screening. - There has been an increase in referrals of around 250% since the contract went live, particularly in CYP ADHD as this wasn't previously available under RTC. - There were a total of 1119 waiting across adult and CYP ADHD and Autism in Q4 and this includes referrals received in the quarter as well as the backlog. There are some longer waits and CP are reviewing the reasons for these. 132 adults and 58 CYP are currently awaiting titration. No patients started titration in Q4 and there are some issues around prescribing. Action – [REDACTED] to obtain an update on timelines for this to be resolved. 538 appointments took place in Q4 and 103 appointments were cancelled. - Diagnosis rates in Q4 were 91% for CYP ADHD, 89% for CYP Autism, 90% for adult ADHD and 95% for adult Autism. This figure is based on when the outcome report was sent out. - There were 18 DNA's in Q4 and it was clarified that none of these had resulted in discharge, which was why DNA had shown as zero in the reasons for discharge table. CP colleagues added that non engagement was different to DNA and related to cases where attempts to contact a patient to book an assessment had been unsuccessful. [REDACTED] had asked whether some activity figures could be shared with the AWP Autism service and CP colleagues confirmed that it would be acceptable to share referral numbers as they were MHSDS reportable. [REDACTED] is keen to begin discussions related to the SDIP and [REDACTED] will check with MH for a contact at AWP to progress this. Action – [REDACTED]	
6	Update on current service risks and emerging risks Current risks are around the impact of IAPs on contracting arrangements and the increases in demand.	
7	Additional updates on Q4 service delivery DNA prices: BNSSG ICB is an outlier on DNA costs and many ICB's don't pay these, so the BNSSG position on this will need to be reviewed in the future. CP colleagues were asked whether there	

	Item	Action
	would be any appetite to review the DNA fees within this contract year and [redacted] responded that it would require some modelling work internally to understand potential impacts before a position can be confirmed. Action – [redacted] There was a discussion around use of generic referral forms by primary care and [redacted] referred to the contract negotiation period where it was agreed that generic forms would be accepted. This was part of the collective action, however, there have now been further developments on this and it is acknowledged that this position may have changed. [redacted] will look to get an update on this; it was noted that using the CP referral form could actually save time as it captures all information needed from the outset, so would avoid further queries being sent back to GPs at referral stage. Action – [redacted]	[redacted] [redacted]
8	Update on any future service delivery [redacted]	
9	Any Other Business 25-26 contract variation: this is in progress, a few queries remain around the service spec and it would be helpful to also resolve the DNA price discussion before it's issued. [redacted] mentioned that there may be a change to the ADHD & Autism pathway in terms of timing for issuing the questionnaire as an approach has been tested in another area to send it to patients before the booking call takes place. Indications show that this is resulting in a more streamlined pathway and enabling patients to progress through this more quickly.	
10	Date of next meeting [redacted] to suggest dates for Q1 and Q2 meetings, after which CRM's will move to 6 monthly; unless more frequent meetings are required. Action – [redacted]	[redacted]