

Reference: FOI.ICB-2324/375

Subject: Children and Young Peoples (CYP) Autism Spectrum Disorder Service

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

QUESTION	RESPONSE
<ol style="list-style-type: none">1. Please provide a list of all providers the ICB holds contracts with for this service.2. For each contracted provider, please provide the Service Specification that describes the service (whether standalone or integrated in a broader Service Specification)	<ol style="list-style-type: none">1. Sirona care and health CIC hold the Children’s Community Health Partnership (CCHP) contract for NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB). The CCHP service offer includes the Autism Spectrum Disorder service for Children and Young People. The ICB does not hold any other contract for Children and Young Peoples Autism Spectrum Disorder service.2. The service specification for Autism Spectrum Disorder, as part of BNSSG ICB’s CCHP contract, is enclosed.

The information provided in this response is accurate as of 26 January 2024 and has been approved for release by Sarah Truelove, Deputy Chief Executive and Chief Finance Officer for NHS Bristol, North Somerset and South Gloucestershire ICB.

Service Specification: v0.8

**Autistic Spectrum Disorder Assessment & Diagnosis
Pathway 0 – 18 years**

This specification must be read along with the overarching specification which applies to all services
<p>The purpose of this document is to specify diagnostic pathways for children and young people with Autistic Spectrum Disorder. It describes the role, function and responsibilities of services. The expectation is to move away from traditional delivery that has resulted in significant waiting lists and times to a more flexible and responsive model.</p>
1. Needs
<p>1.1 Background</p> <p>Autism was once thought to be an uncommon developmental disorder, but recent studies have reported increased prevalence and now the condition is thought to occur in at least 1% and probably nearer 2.5% of children. NICE recognises that individuals and groups prefer a variety of terms, including autism spectrum disorder, autistic spectrum condition, autistic spectrum difference and neuro-diversity. The ASD NICE quality standard recognises the important role that families and carers play in supporting their child and aims to improve the experience of not only the children and young people but also those who care for them.</p> <ul style="list-style-type: none">• Without understanding, autistic people and families are at risk of being isolated and developing mental health problems• Autism is much more common than many people think. There are around 700,000 people on the autism spectrum in the UK – that's more than 1 in 100. If you include their families, autism is a part of daily life for 2.8 million people• Autism doesn't just affect children. Autistic children grow up to be autistic adults• Autism is a hidden disability – you can't always tell if someone is autistic.• The right support at the right time can make an enormous difference to people's lives.• 34% of children on the autism spectrum say that the worst thing about being at school is being picked on• 63% of children on the autism spectrum are not in the kind of school their parents believe would best support them• 17% of autistic children have been suspended from school; 48% of these had been suspended three or more times; 4% had been excluded from one or more schools• Seventy per cent of autistic adults say that they are not getting the help they need from social services.• At least one in three autistic adults is experiencing severe mental health difficulties• Only 16% of autistic adults in the UK are in full-time paid employment, and only 32% are in some kind of paid work• Only 10% of autistic adults receive employment support but 53% say they want it
<p>1.2 National and international context</p>

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

However recent studies from other countries point to a greater incidence than 1% of population. The Autism and Developmental Disabilities Monitoring Network in the USA looked at 8 year old children in 14 states in 2008, and found a prevalence rate of autism within those states overall of 1 in 88, with around five times as many boys as girls diagnosed (Autism and Developmental Disabilities Monitoring Network Surveillance Year 2008 Principal Investigators, 2012)

The National Center for Health Statistics in the USA published findings from telephone surveys of parents of children aged 6-17 undertaken in 2011-12. The report showed a prevalence rate for autism of 1 in 50 (Blumberg, S .J. et al, 2013)

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

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

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

1.2 Local ASD data

Pupils with SEN and Primary need of ASD. (Jan 2018)

<https://www.gov.uk/government/collections/statistics-special-educational-needs-sen>

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

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Children with Autism known to schools

<https://fingertips.phe.org.uk/profile/learning-disabilities/data#page/0/gid/1938132702/pat/6/par/E12000009/ati/102/are/E06000023>

	2015	2016	2017	2018
Children with Autism known to schools	1245	132785	1383	134998
Bristol	665	62965	728	64677
North Somerset	197	30266	210	30723
South Gloucestershire	383	39554	445	39598
Grand Total	1245	132785	1383	134998

1.4 Local context

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

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

These services are not provided exclusively by the NHS.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Other stakeholders have told us they want:

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

2. Outcomes

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

2.1 NHS Outcomes Framework Domains and Indicators

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

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

2.2 Local Area Strategic Outcomes

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

2.2 Service Outcomes

- Addressing inequalities in access
- Better managed transitions to adult services.
- Increased awareness, clear pathways and joint working with other services including voluntary / third sector organisations who work with children and young people with ASD needs.
- The service will work with children, young people, families and partner agencies to support individual users to engage with services. This may include, where appropriate, contact in collaboration with other professionals, seeing children in an alternative setting, and flexibility about timing of appointments. The service will support partner agencies to hold and manage risk around the individual, through collaborative approaches.
- Increased flexibility and perseverance in engaging creatively with children and families who find services difficult to access.
- Choice and responsive service
- The service contributes to reducing the stigma of autism
- Increasing integrated delivery to ensure everybody has a shared vision of improving ASD support
- Engage as appropriate in Education, Health and Care Assessment and Plan development
- Ensure good joint working and flexible transition through 16 - 18 years transition to adulthood pathway and developed protocols.

3. Scope

3.1 Aim

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

3.2 Objectives

The Provider must:

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

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

and providing clear protocols on information sharing.

- Consent will be asked for¹ from children, young people and parent / carers regarding information sharing with other agencies (rather than a blanket decision not to share health information with such agencies).
 - Including information about non-attendance, to mitigate against the risks inherent in the fact that children and young people are often dependent on others to access care.
- Address health inequalities, by providing an ASD service acceptable to vulnerable groups. Vulnerable groups will be targeted with the aim of equity of outcome through flexible, intense, strength based joint working.

3.2 Legal and Regulatory Framework

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

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

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

Children and Families Act 2014

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

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

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

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

3.3 Service description

3.3.1 The Provider is required to:

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

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

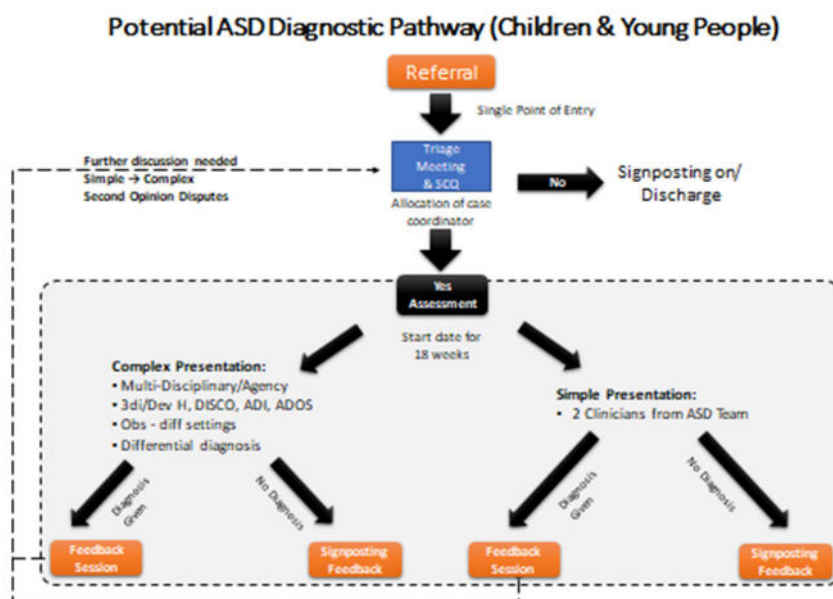
3.3.2 Service Description

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

The key areas of the service delivery are:

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

3.3.2.1 Bristol & South Gloucestershire pathway



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

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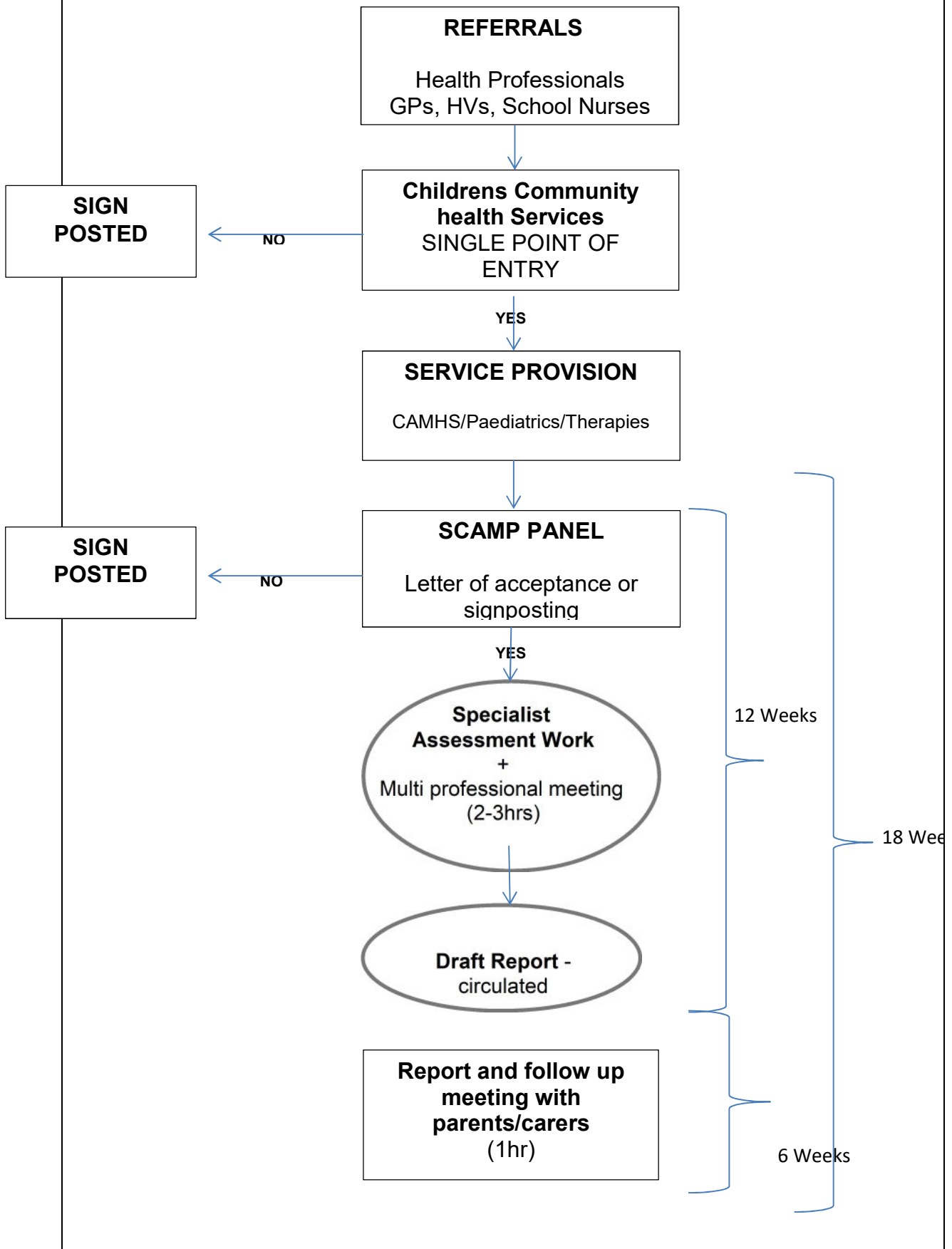
2. Referral information passed to ASD diagnostic assessment team manager / coordinator. Triage form to be populated with this information for review by multi professional representatives focussing on school aged / preschool aged in a weekly triage meeting. At this meeting the outcome will be
 - Referral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

Referrer and parents and GP will be informed of outcome

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

3.3.2 North Somerset pathway

Autistic Spectrum Disorder Pathway



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

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

a) Early Years SCAMP Assessment (preschool children)

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

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

b) Standard SCAMP Assessment (school aged children)

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

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

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

c) Enhanced SCAMP Assessment (comorbidities)

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

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

3.4 Acceptance criteria

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

The Provider will:

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

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

3.5 Exclusion criteria

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

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

3.6 Outputs

The Provider will:

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

3.6 Key Performance Indicators

3.6.1 Workforce

Target:

100% of staff (non – probationary) have had basic Autism training

3.6.2 Referral

Target:

95% ASD referrals are triaged within 10 working days

3.6.3 Assessment

Target:

95% Assessments started within 12 weeks following acceptance of referral and completed within 18 weeks.

3.6.4 Post Diagnosis

Target:

95% Assessment follow up offered within 8 weeks of diagnosis

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

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

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

3.9 Care transition protocols

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

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

The Provider will:

- Ensure the workforce including frontline staff has the necessary compassion, values and behaviours to provide person-centred, integrated care and enhance the quality of experience through education, training and regular

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continuing personal and professional development (CPPD) to enable positive relationships and instils respect for children / young people and parents / carers.

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

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

3.11 Activity

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

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

3.12 Information Governance and Accountability

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

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

3.13 Interdependence with other services / providers

3.13.1

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

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

4. Applicable Service Standards

4.1 Applicable national standards

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

Strategy (2010)

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

4.4 Applicable local standards

Provision of transition focussed services.

5. Monitoring & Evaluation

5.1 Data recording

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

Workforce

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

Referral

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

Assessment

- Number of assessments started within 12 weeks following acceptance of referral
- % of assessments started within 12 weeks following acceptance of referral
- Number of c&yp waiting between 12 – 24 weeks to start assessment and diagnosis process
- Number of c&yp waiting between 25 – 51 weeks to start assessment and diagnosis process
- Number of c&yp waiting more than 52 weeks to start assessment and diagnosis process
- % of assessments leading to diagnosis

Post Diagnosis

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

6. Location of Provider Premises

6.1 The Provider's premises are located at:

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

7. Service Delivery

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

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

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

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

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

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

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

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

Appendices

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