NHS Sheffield CCG

Adult Autism and Neurodevelopment Diagnostic and Post Diagnostic Service

Ref:- YHCS/SHEF/AD/16/12

PQQ Document 2

**Specification of Required Services**

The Specification of Service Requirements for an Adult Autism and Neurodevelopment Diagnostic and Post Diagnostic Service

The summary table below identifies the minimum standards (Essential aspects required of this service. The table is followed by a detailed description of the plans and outcomes required of each part of the Service. All the Essentials must be met in the delivery of the Service either by the main provider themselves or covered by the co-provided / collaborative parts of the delivery supply chain being proposed. E.g. collaborative use of the voluntary sector to deliver one element of the service.

The features given here are not in any order of importance.

| Minimum Standards Required of the Service | |
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|  | The full service must be mobilised and commence on 1 October 2016  The service must be and must remain viable and sustainable over the expected period of the Contract. |
|  | The service is required to cover people over 16 and provide the necessary links as appropriate and detailed later in this document to enable seamless transition from children’s services. |
|  | Services to cover normal working hours (9-5) Monday to Friday with flexibility where needed to accommodate challenges that individuals may have in making appointments within these times, or to offer flexible group activity. |
|  | The service must deliver principles outlines within the national strategy “Think Autism”, the Autism Act and relevant NICE Clinical Guidance and Quality Standards. |
|  | The service will be delivered in a way that is consistent with the ‘I statements’ in “Think Autism” (see Appendix A in the specification) which will be used to develop Key Performance Indicators |
|  | The service must work to a trajectory to ensure people referred for a diagnostic assessment for autism have their diagnostic assessment started within 3 months of their referral. |
|  | The service must be sufficiently staffed with both support staff and clinical practitioners with the appropriate professional qualifications, licences and skill set and dedicated to the service to meet the needs identified of the service. |
|  | The service practitioners must have as individuals or within the Service as a whole a comprehensive knowledge of all the relevant Mental Health Acts , laws, Regulations and best practice guidance in delivery of this Service. |
|  | Services must be able to recognise the needs of the presenting patient and be able to respond to service users who present with sight, hearing, learning or literacy difficulties, in adherence with all equality legislation. |
|  | The service practitioners must able to provide direct patient care both planned and on an ad-hoc basis. |
|  | Service practitioners must provide education and training for other organisation’s clinical and non-clinical staff as appropriate to support partner services to be autism aware, autism friendly and to make reasonable adjustments. |
|  | The service will ensure of a planned and targeted approach using staff with the appropriate skills (clinical and non-clinical) to raise knowledge and understanding and aimed at the relevant audiences. |
|  | The service will provide materials to raise knowledge and understanding aimed at the relevant audiences. |
|  | The service will provide all written materials in various and appropriate formats and languages (including protocols), suited to the needs of service users in line with Accessible Information Standards. |
|  | The service will establish and widely publish/communicate and market with other clinical staff and care providers, information relating to autism and the criteria for referral. |
|  | The service will raise awareness amongst, and develop screening tools for, universal healthcare and social care professionals. |
|  | The service will be provided by a multi-disciplinary team. |
|  | The service will utilise a wide skill mix and ensure that clinical resources are only used at the appropriate time and not throughout the whole pathway of care. |
|  | The service will signpost/refer people to other services as necessary, including the Housing Association, education providers, DWP, educational providers, voluntary organisations, etc. |
|  | The service will develop and deliver a variety of post-diagnostic support packages to meet the needs of service users. |
|  | Care plans must be person-centred with clear goals, developed and implemented in partnership between the service user and their family and/or carers (if appropriate) and the team. |
|  | Providers must have in place mechanisms that actively seek and develop responsively to the experiences and views of patients and service users in relation to the provision of the service. There should be a demonstrable commitment by the provider to take follow up action should the patient experience indicators show unsatisfactory results. |
|  | The service will be provided at a site/sites easily accessible by public transport. |
|  | The service must be co-produced, developed and delivered together with experts by experience/family/carers (for example, delivering user-led group sessions/peer support/family therapy/buddying/mentoring). |
|  | The service will offer a named key worker for people with autism to coordinate the care and support detailed in their personalised plan. |
|  | The post-diagnostic support phase will be targeted and time-limited, with clear objectives. Following the personalised post-diagnostic phase, the person’s progress should be reviewed and their plan developed accordingly to ensure effective transition to mainstream support services. |
|  | The service must support access to early intervention by providing access to advice or clinical support for people with existing diagnoses of autism of other developmental disorders. |
|  | The service must make available information regarding all aspects of the pathway, the types of people involved in delivering the service and provide signposting information to other related services. |
|  | Service practitioners will be required to work with other organisations developing training programmes with possible joint delivery by the Service Provider and other organisations. |
|  | Service provision will be as seamless as possible and practicable. |
|  | The service will enable and concentrate on early intervention. |
|  | The service will recognise the importance of and provides for the highest quality of care and the best possible outcomes. |
|  | The service must be inclusive of supporting families and carers. |
|  | The service will maximise the use of the other organisations that can be used to assist in provision of the service. |
|  | The service must work jointly with appropriate children’s services to ensure a smooth transition into the service. Previous waiting times to receive an ASC intervention in children’s services will be taken into account and deducted from waiting times in adult services. |
|  | The service will be delivered by a contractor that has achieved level 2 of the NHS IGSOC toolkit by award of any contract. |
|  | The electronic communication systems used by the Service must be N3 compatible. |
|  | The electronic communication systems used by the Service must be able to interact with those Clinical Information systems in use by the clinical service users and work across the related platforms (i.e. EMIS, SystemOne, Insight, Lorenzo, etc.). |
|  | All personal data held must meet the requirements of the varying regulations on maintaining and handling such data as applicable to NHS England (e.g. Data Protection and Caldicott). |
|  | The service will be managed using a robust Governance Process that recognises and engages all key stakeholders and users of the Service. |
|  | The Service must provide the management information and reports required by regulatory bodies plus any local agreed at the time of and in the formats required. |
|  | A service that provides face-to-face pre-diagnostic support to determine the rationale for the diagnosis and outcomes the person is looking to achieve. |
|  | A service that offers outreach clinic sessions in different locations including education providers. |
|  | The levels of professionally qualified clinicians should be able to expand and contract based on any predicted or proven levels of demand of the service. This would be the topic of contract management. |

**Outline of Service Specifications**

# Once finalised as a result of the competition this Requirement will eventually form SCHEDULE 2 – THE SERVICES of the NHS Standard Contract 2016/2017

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| **Service Specification No.** |  |
| **Service** | Adult Autism and Neurodevelopment Diagnostic and Post Diagnostic Service |
| **Commissioner Lead** | NHS Sheffield CCG (SCCG) |
| **Local Tariff** | £914 per patient per pathway with an LQIP of 5% |
| **Period** | 1st October 2016 for 2 years |
| **Date of Review** |  |
| **1. Population Needs** | | |
| * 1. **National/local context and evidence base**      1. **National context**   It is estimated that more than half a million people in England have autism. This is equivalent to more than 1% of the population. Following the 2009 Autism Act, the Government produced the Fulfilling and rewarding lives strategy for adults with Autism in 2010. A new strategy – Think Autism – was published in 2014. This specification sits within this developing national framework.   * + 1. **Local context**   Based on national prevalence data, there are understood to be 6,600 people in Sheffield on the autistic spectrum, including a high prevalence of people with learning disability, for whom a service is already commissioned. However it is not anticipated that all of the population with autism spectrum condition (ASC) or neurodevelopmental disorders will need or present for a diagnostic or post diagnostic service.  Engagement with experts by experience (service users and family members/carers) has informed this specification. The feedback received included that the service should:   * Be co-produced * Be flexible * Be timely * Be transparent * Make information easily accessible about all aspects of the pathway * Signpost to other sources of information and support * Link well with other services * Support education of other health and social care services to enable those services to make reasonable adjustments for ASC * Include a variety of post-diagnostic support (e.g. user-led groups, practical tips, buddying, 1:1 therapy, etc.) * Provide access to advice to help enable early intervention * It is expected that the service will embody all of these elements. | | |
| **2. Outcomes** | | |
| **2.1 NHS Outcomes Framework Domains & Indicators**   |  |  |  | | --- | --- | --- | | **Domain 1** | **Preventing people from dying prematurely** | **Y** | | **Domain 2** | **Enhancing quality of life for people with long-term conditions** | **Y** | | **Domain 3** | **Helping people to recover from episodes of ill-health or following injury** | **Y** | | **Domain 4** | **Ensuring people have a positive experience of care** | **Y** | | **Domain 5** | **Treating and caring for people in safe environment and protecting them from avoidable harm** | **Y** |   **2.2 Local defined outcomes**  The following indicators will be monitored by the Provider and Commissioners through contract management meetings:   * Number of referrals * Referral sources * Number of inappropriate referrals * Waiting times for assessment * Waiting times for post-diagnostic support * Time within service * Proportion of people who have co-produced personalised plans, clearly outlining their desired outcomes and achievement of these outcomes. It is expected that 100% of people will have a co-produced personalised plan. * Feedback from service users, parents and carers from a variety of sources. 100% of service users will have access to the Friends and Family Test (FFT). The provider will be expected to report the FFT scores for the commissioned service | | |
| **3. Scope** | | |
| **3.1 Aims and objectives of service**  The commissioned provision of a diagnostic and post diagnostic service for people with Autistic Spectrum Conditions (ASC) including Asperger’s Syndrome and related neurodevelopmental disorder, including adult ADHD and pragmatic disorder ensures local compliance with the Autism Act, national strategy, “Fulfilling and Rewarding Lives”, the national Statutory Guidelines, NICE Clinical Guidance 72, 128, 142 and 170, NICE Quality Standards 39 and 51.  In this specification, ‘autism’ refers to ‘autism spectrum disorders or conditions’ (ASD/ASC) encompassing autism, Asperger's syndrome and atypical autism (or pervasive developmental disorder not otherwise specified). NHS Sheffield CCG recognises, however, that different individuals and groups prefer a variety of terms for autism including autistic spectrum difference and neurodiversity. ‘Autism' or ASC is used to cover all of these terms.  **Principles**  **The service should deliver principles outlined within the national strategy, “Think Autism” (including the ‘I statements’ in Appendix A), the Autism Act and NICE Guidance. In outline:**   * Support and care should take into account peoples' needs and preferences, and be fully compliant with the requirements of the Equality Act, for example, relating to additional needs arising out of culture, religion or impairments. * People with autism should have the opportunity to make informed decisions about their care, in partnership with their healthcare professionals. * If adults with autism do not have the capacity to make decisions, healthcare professionals should follow the [Department of Health's advice on consent](http://www.dh.gov.uk/en/DH_103643) and the code of practice that accompanies the Mental Capacity Act. * Good communication between healthcare professionals and people with autism and their families, partners and carers is essential. It should be supported by evidence-based written information tailored to the person's needs. * If the person with autism agrees, families, partners and carers should have the opportunity to be involved in decisions about support and care. * Families, partners and carers should also be given the information and support they need. * Care of young people in transition between paediatric services/child and adolescent mental health services (CAMHS) and adult services should be planned and managed according to best practice guidance. * It is anticipated that through this pathway the multi-disciplinary team (MDT) will be able to record more comprehensive data regarding people with ASC. This will in turn inform the Joint Strategic Needs Assessment (JSNA) for Sheffield and provide better commissioning intelligence for service development going forward.   **3.2 Service description/care pathway**  **3.2.1 Overview**  The Service will lead the development and delivery of the following pathway of care:   * Awareness raising and development of screening tools for universal healthcare and social care professionals, skilling others in working effectively with people with ASC or other neurodevelopmental disorder * Development of clear referral guidelines * A pathway for multi-disciplinary diagnostic assessment and decision making * Post diagnostic support packages and pathways * Promotion of positive interventions, training and support to families carers and individuals with a diagnosis   The service will work collaboratively with other services (e.g. mental health services, substance misuse services and learning disability services), particularly when working with people with comorbidities to ensure effective and coordinated intervention.  The delivery will be provided by a multi-disciplinary team of practitioners and professionals with a wide skill mix. The team will ensure the use of a wide skill mix of practitioners and professionals and ensure that clinical resources are only used at the appropriate time and not throughout the whole pathway of care. This means that a range of practitioners could be involved in pre diagnostic assessment, training, and post diagnostic support services.  The diagnostic and post-diagnostic service should be provided within a multidisciplinary team (MDT) model, potentially as outlined in NICE Guidance 142 (also complying with NICE Guidance 72 for people with potential ADHD and NICE Guidance 128 and 170 for people under 19, working alongside paediatric services as necessary) and including admin support. If a nurse is employed, it is recommended that they also provide ADHD prescribing and offer support on the pharmacological management of adults with ADHD referred to the service. It is expected that psychiatry input into diagnosis will be minimal and that any psychiatry capacity will be used largely in a supervisory capacity to support and enable other team members to manage complex cases.  **Coproduction and delivery**  Recognising the value of the skills and experience of service users and family/carer groups, it is anticipated that the provider may choose to include a wider mix of skills in the delivery model (for example, to include peer support, family therapy, buddying, etc.), to those proposed above. This will be based on the financial envelope available, and the skills required within the service, and the MDT will be NICE guidance compliant.  **LA input into the MDT**  Sheffield City Council social worker(s) and liaison worker(s) will be integrated within the operational delivery of the MDT by the provider, but will not need to be recruited within this procurement by the provider itself.  **The MDT should have a key role in the delivery and coordination of:**   * specialist diagnostic and assessment service (including sensory assessments) for adults with ASC and neurodevelopmental disorders, including new adult ADHD diagnosis * specialist care and interventions, including sensory integration, speech and language therapy and counselling * advice and training to other health and social care professionals on the diagnosis, assessment, care and interventions for adults with autism with or without comorbidities (as not all may be in the care of a specialist team), supporting partner services to be autism aware, autism friendly and to make relevant adjustments * support in accessing, and maintaining contact with, housing, educational and employment services * 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. * Medication prescribing/monitoring as appropriate to support Primary Care will be consistent with current or future relevant Shared Care Protocols or clinical and prescribing guidelines as appropriate ( e.g. ADHD protocol)   These are set out in more detail in the sections below.  **3.2.2 Identification and assessment**  It is expected that the service will work with individual service users to determine their personal goals and desired outcomes and monitor progress against these throughout the person’s pathway of care within the service. The service should offer provide face-to-face pre-diagnostic support to determine the rationale for the diagnosis and outcomes the person is looking to achieve.  Assessment for autism and neurodevelopmental disorders should be provided when a person with suspected ASC or related conditions has one or more of the following *and* where there is not a clear alternative and appropriate diagnosis:   * persistent difficulties in social interaction * persistent difficulties in social communication * stereotypic (rigid and repetitive) behaviours, resistance to change or restricted interests,   **And** one or more of the following in addition to the above criteria:   * problems in obtaining or sustaining employment or education * difficulties in initiating or sustaining social relationships * previous or current contact with mental health or learning disability services in child or adulthood * history of a neurodevelopmental disorder such as attention deficit hyperactivity disorder, pragmatic disorder or other such neurodevelopmental disorder   Adults presenting with symptoms of ADHD who do not have a childhood diagnosis of ADHD, should be assessed for ADHD where there is evidence of typical manifestations of ADHD (hyperactivity/impulsivity and/or inattention) that:   * began during childhood and have persisted through life * are not explained by other psychiatric diagnoses (although there may be other coexisting psychiatric conditions) * have resulted in or are associated with moderate or severe psychological, social and/or educational or occupational challenges .   Adults who have previously been treated for ADHD as children or young people and present with symptoms suggestive of continuing ADHD should be assessed for ADHD where symptoms are associated with at least moderate or severe psychological and/or social or education or occupational challenges.  For all clients, include an assessment of the person’s needs, coexisting conditions, social, familial and educational or occupational circumstances and physical health.  The service must work to a trajectory to ensure people referred for a diagnostic assessment for autism have their diagnostic assessment started within 3 months of their referral in line with NICE guidance. During the time from referral to initial appointment, it is expected that the service will be gathering information from the person and their families to inform the diagnostic assessment.  **The assessment for autism should be informed by the evolving picture of the person (i.e. the level of comprehensiveness should be determined by the evolving picture of the person). A comprehensive assessment for autism should:**   * Be consistent with NICE Clinical Guidance 142 or 128 * Be informed, if possible, by a close observer over time (family/partner etc) and/or use documentary evidence (such as school reports) of current and past behaviour and early development. * Take into account and make a differential diagnosis relating to other neurodevelopmental disorder such as ADHD, dyspraxia, pragmatic disorder and other co-morbidities. * When appropriate, use formal adapted assessment tools for people with mild/ borderline learning disabilities * Assess for comorbidities e.g. mental disorders (for example, schizophrenia, depression or other mood disorders, and anxiety disorders, in particular, social anxiety disorder and obsessive–compulsive disorder) neurological disorders (for example, epilepsy); physical disorders; other communication difficulties (for example, speech and language problems, and selective mutism); hyper- and/or hypo-sensory sensitivities. * Make onwards referrals, signpost to appropriate support alternative support * During a comprehensive assessment, a comprehensive risk assessment should be conducted and the team should develop a 24-hour crisis management plan, where necessary in conjunction with specialist mental health services, as identified within NICE Clinical Guidance 142. * In partnership with the service user and their family and carers (if appropriate), the MDT should develop a person centred care plan based on the comprehensive assessment, incorporating the risk management plan and including any particular needs (such as adaptations to the social or physical environment). * Provide a 'health passport' for adults with autism, which includes information for all staff about the person's care and support needs, with their permission, to improve their access to primary, and secondary care. * Medication prescribing/monitoring to support Primary Care within current or future relevant local Shared Care Protocols and clinical and prescribing guidelines as appropriate (e.g. ADHD protocol) as a further interface between Transitions Clinic and GPs for some individuals whose GP may require further specialist advice and support during the handover transitional period.   **Assessment of behaviour that challenges**  If present, assessment of [behaviour](http://publications.nice.org.uk/autism-recognition-referral-diagnosis-and-management-of-adults-on-the-autism-spectrum-cg142/glossary#challenging-behaviour) that challenges should be integrated into a comprehensive assessment for adults with autism, using a [functional analysis](http://publications.nice.org.uk/autism-recognition-referral-diagnosis-and-management-of-adults-on-the-autism-spectrum-cg142/glossary#functional-analysis) (see NICE Guidance [recommendation 1.5.3](http://publications.nice.org.uk/autism-recognition-referral-diagnosis-and-management-of-adults-on-the-autism-spectrum-cg142/guidance#interventions-for-challenging-behaviour)), assessing for possible triggers, including physical health conditions, mental health problems and environmental factors.  **A comprehensive assessment for ADHD should:**   * Be compliant with NICE guideline 72 * Be undertaken by a specialist team psychiatrist or other appropriately qualified healthcare professional (e.g. a GP with specialist interest in psychiatry) with training and expertise in the diagnosis of ADHD * Be based on a clinical and psychosocial assessment of the person * Include a developmental and psychiatric history * Include observer reports and assessment of the person’s mental state   For a diagnosis of ADHD symptoms should:   * meet the diagnostic criteria in DSM-IV or ICD-10, and * be associated with at least moderate psychological, social and/or educational or occupational challenge based on interview and / or direct observation in multiple settings * be pervasive, occurring in two or more important settings including social, familial, educational and/or occupational settings.   **Discussing and deciding on care and interventions** for people with autism and neurodevelopmental disorder   * Take into account NICE Clinical guidance 142 or 128, when assessing and deciding on options for interventions, including pharmacological interventions for challenging behaviour, ADHD or coexisting mental disorders in adults with autism: * Service users will be supported post-diagnostically according to a personalised care plan that is developed and implemented in a partnership between them and their family and carers (if appropriate) and the team. * People with autism will be offered a named key worker within the team to coordinate the care and support detailed in their personalised plan. * People with autism will have a documented discussion with a member of the team about opportunities to take part in age-appropriate psychosocial interventions to help address the core features of autism * The post-diagnostic support phase will be targeted, with clear objectives and will be time-limited. The support may include signposting to other services, counselling, psychosocial interventions, buddying and peer support. Some of this package may be provided together with partner services. * Following the personalised post-diagnostic support, the person’s progress will be reviewed and their plan will be developed to ensure effective transition to mainstream support.   ***Psychosocial interventions focused on life skills for people with autism in line with NICE Clinical Guidance 142***   * Consider individual or group structured activities as part of a personalised care plan and support plan * If appropriate, offer an anger management intervention, adjusted to the needs of adults with autism, as per NICE Clinical Guidance 142 * Consider anti-victimisation interventions based on teaching decision-making and problem-solving skills if appropriate for the individual, to include: * Identifying and, where possible, modifying and developing decision-making skills in situations associated with abuse * Identifying appropriate personal safety skills training * Referral to an individual supported employment programme (working to support other relevant agencies)   *Treatment of adults with ADHD*   * Drug treatment should be the first-line approach unless the person would prefer a psychological approach and has made this decision aware of the evidence base against first line psychological treatment * Drug treatment for adults with ADHD should be started only under the guidance of a psychiatrist, nurse prescriber specialising in ADHD (working in association with a psychiatrist), or other clinical prescriber with training in the diagnosis and management of ADHD * Before starting drug treatment for adults with ADHD a full assessment should be completed, which should include: * Risk assessment for substance misuse and drug diversion * Full mental health and social assessment * Full history and physical examination * An ECG if there is past medical or family history of serious cardiac disease, a history of sudden death in young family members or abnormal findings on cardiac examination * Drug treatment for adults with ADHD should always form part of a comprehensive treatment programme that addresses psychological, behavioural and educational or occupational needs * When starting drug treatment, adults should be monitored for side effects, and will have their initial drug dose adjusted and response assessed by an ADHD specialist. * For adults with ADHD stabilised on medication but with persisting functional challenges associated with the condition, or where there has been no response to drug treatment, a course of either group or individual CBT to address the person’s functional challenges should be considered. Group therapy is recommended as the first-line psychological treatment. This should be assessed in terms of appropriateness on an individual case basis due to the social challenges involved in attending group therapy * People with ADHD who are taking drug treatment will be offered an appropriate follow up review at least annually to assess their need for continued treatment, in line with current NICE guidance.   *Ongoing support and access to early intervention*   * Providers should link with relevant local services, signposting and supporting referrals where required. Partner services will include: the Department for Work and Pensions, Housing Associations, educational providers, voluntary organisations etc. * If someone with an existing diagnosis of ASC or other neurodevelopmental diagnosis requires access to clinical support or advice, the provider must ensure that this is available. This provision may include telephone advice, packages of psychosocial intervention, signposting/referral to other services or agencies, in line with the person’s needs.   **Patient information**  Providers will ensure patient information is readily available in formats appropriate for and required by service users, in line with Accessible Information Standards, including a well-maintained website. This information will detail the variety of services offered, the types of people working within the service, the assessment process, available post-diagnostic support and self-management advice.  **Service development and patient feedback**  Providers will have in place mechanisms that actively seek and develop responsively to the experiences and views of patients and service users in relation to the provision of the service. There should be a demonstrable commitment by the provider to take follow up action should the patient experience indicators show unsatisfactory results.  **Delivery Plans**   * The provider will produce a Delivery Plan that demonstrates how it will deliver the intended outcomes of the contract and the requirements of the Autism Act, and “Fulfilling and Rewarding Lives”. * The plan will determine working relations between the service and other services provided locally (e.g. within local Mental Health and Learning Disability Services, primary care and other health and social care pathways) consistent with the model outlined in the flow diagram below, to ensure good care coordination and joint working as appropriate. The service will operate a signposting service which ensures that the person is managed on a care pathway between services. * The Delivery Plan should detail plans to manage caseloads and waiting lists as well as procedures for managing patients through the multidisciplinary team pathway. * It should detail how the team will support GPs and other clinicians in the day to day management of the person with ASC. * It should detail how they will improve the ability of other health and social services to better manage the person with ASC. * It will detail the post diagnostic support and interventions that will be offered, including how it will support local user and voluntary sector support groups. * It will detail consultancy available to support other health and social care colleagues   **Assurance**  Providers should have in place systems and processes which are able to provide assurance that they are able to demonstrate delivery of the requirements of the Autism Act, national strategy, statutory guidance and NICE guidance.  **3.3 Population covered**  Adults aged 16 or over who are registered with a Sheffield CCG member practice GP. Not all adults with suspected ASC or neurodevelopmental disorder will require or need to receive a specialist diagnosis or will need ongoing health interventions, they may, however still have entitlement for a care assessment and/or a carers assessment in line with the principles of the 2014 Care Act. It will be determined whether this is conducted by the specialist social worker within the MDT or other appropriate teams.  **3.4 Any acceptance and exclusion criteria and thresholds**  **Acceptance criteria**   * Adults over 16 with suspected ASC or other related neurodevelopmental disorder * People in transitions from children’s services to adult services during a handover period working jointly with appropriate children’s services and transitions clinics to ensure a smooth transfer of care into the service, or into primary care and other services. Previous waiting times to receive an ASC intervention in children’s services will be taken into account and deducted from waiting times within the adult service.   **Exclusion criteria**  People who have co-morbidity of learning disability are not specifically excluded, but there is a commissioned Learning Disability Autism Pathway which is likely to be a more appropriate service. However, the Specialist Autism MDT must work in partnership with other services to ensure the best management of each individual working in collaboration. Where mental health conditions faced by the person with ASC are best managed by locally provided Mental Health Services, the Specialist Autism team would be expected to support colleagues to manage the person with autism effectively, taking into account both conditions together, and offering appropriate consultancy.  **Referral Source**   * Sheffield CCG member practice General Practitioners (GPs) * Clinicians/social workers from other Sheffield services * Self-referral is not permitted   **Location of service**  The service will be based in Sheffield, easily accessible with public transport. The service will broadly be provided Monday-Friday, 9am-5pm with flexibility where needed, to accommodate challenges that individuals or families may have in making appointments within these times. | | |
| **4. Applicable Service Standards** | | |
| **4.1 Applicable national standards**   * Transition: getting it right for young people, DH 2006 * Department of Health published 'Fulfilling and rewarding lives: the strategy for adults with autism in England' (2009) * Autism Act 2009 * DH (2010) Prioritising need in the context of Putting People First: a whole system approach to eligibility for social care - guidance on eligibility criteria for adult social care, England 2010 * DH (2010) – A vision for social care: Capable communities and active citizens * HM Government Think Autism (2014) * Attention deficit hyperactivity disorder: diagnosis and management (2008), NICE CG72 and QS39 * Autism in adults: diagnosis and management (2012), NICE CG142 and QS41 * Autism in under 19s: recognition, referral and diagnosis (2011), NICE CG142 * Autism in under 19s: support and management (2013) NICE CG 170   **4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)**   * Royal College of Psychiatrists (2014) Good practice in the management of autism (including Asperger syndrome) in adults CR191   **4.3 Applicable local standards** | | |
| **5. Applicable quality requirements and CQUIN goals** | | |
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| **6. Location of Provider Premises** | | |
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| **7. Individual Service User Placement** | | |
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Additional Information

As there are waits within the current service, it is assumed that the creativity and innovation in the new service will increase productivity in order to address the existing delays.

The CCG are expecting activity over the two years of the contract to ensure a reduction in waiting times in line with NICE Guidance (i.e. diagnostic assessment to begin within 3 months of referral). Activity will be reviewed on a quarterly basis by the commissioners to ensure provision is continuous and that waiting times are reducing in line with expectations.

The service will be paid for on a cost-per-case basis. A tariff of £914 will be paid for the entire pathway (diagnosis and post-diagnostic support) per patient. Some of the Tariff will be reserved for a Local Quality Incentive Payment. In the first year of the contract, this will be worth 5% and payment of the LQIP will be determined by the following:

- 2.5% of the tariff will be based on positive feedback from service users (minimum of 50% of all service users to provide feedback, minimum 75% report ‘good’ or ‘very good’ experiences).

- 2.5% of the tariff will be paid on evidence that all patients have personalised care plans, developed and implemented in partnership between the service user and their family and/or carers (if appropriate) and the team.

The local incentive will be paid in advance and will be reconciled on a quarterly basis against evidence of performance.

The LQIP proportion may increase in future years.

Appendix A – Think Autism ‘I statements’

An equal part of my local community

1. I want to be accepted as who I am within my local community. I want people and organisations in my community to have opportunities to raise their awareness and acceptance of autism.
2. I want my views and aspirations to be taken into account when decisions are made in my local area. I want to know whether my local area is doing as well as others.
3. I want to know how to connect with other people. I want to be able to find local autism peer groups, family groups and low level support.
4. I want the everyday services that I come into contact with to know how to make reasonable adjustments to include me and accept me as I am. I want the staff who work in them to be aware and accepting of autism.
5. I want to be safe in my community and free from the risk of discrimination, hate crime and abuse.
6. I want to be seen as me and for my gender, sexual orientation and race to be taken into account. The right support at the right time during my lifetime
7. I want a timely diagnosis from a trained professional. I want relevant information and support throughout the diagnostic process.
8. I want autism to be included in local strategic needs assessments so that person centred local health, care and support services, based on good information about local needs, is available for people with autism.
9. I want staff in health and social care services to understand that I have autism and how this affects me.
10. I want to know that my family can get help and support when they need it.
11. I want services and commissioners to understand how my autism affects me differently through my life. I want to be supported through big life changes such as transition from school, getting older or when a person close to me dies.
12. I want people to recognise my autism and adapt the support they give me if I have additional needs such as a mental health problem, a learning disability or if I sometimes communicate through behaviours which others may find challenging.
13. If I break the law, I want the criminal justice system to think about autism and to know how to work well with other services. Developing my skills and independence and working to the best of my ability
14. I want the same opportunities as everyone else to enhance my skills, to be empowered by services and to be as independent as possible.
15. I want support to get a job and support from my employer to help me keep it.

**Appendix B – Local Quality Incentive Programme (LQUIN) and Performance Measures**

| **Category and Performance Requirement** | **Performance Levels/KPI** | **Period of measurement** | **Form of measurement** | **Effect of Failure on Payments** |
| --- | --- | --- | --- | --- |
| **Service Delivery** |  |  |  |  |
| Positive Feedback From Service users | Minimum of 50% Feedback Questionnaires obtained  Minimum of 75% Good or Very Good Experiences | Quarterly | Engagement Feedback and Questionnaires | Retention by Authority or refund by Provider of 2.5% of Total Tariff per patient |
| Personalised Patient Care Plans developed and implemented in partnership between Service Users and Family and/or Carers | 100% | Quarterly | Examination of evidence Audited or spot checked | Retention by Authority or refund by Provider of 2.5% of Total Tariff per missing care plan |