SCHEDULE 2 – THE SERVICES

A. Service Specifications

This is a non-mandatory model template for local population. Commissioners may retain the structure below or may determine their own in accordance with the NHS Standard Contract Technical Guidance.

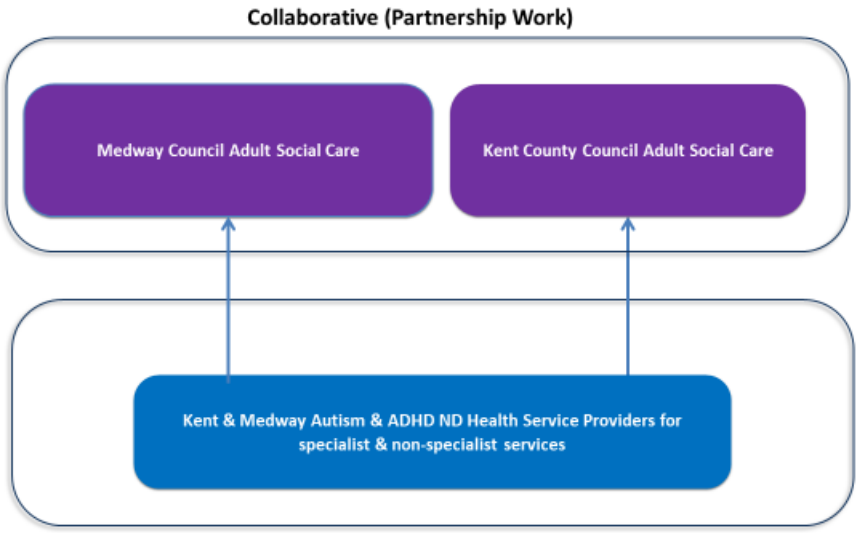
Service Specification No.	Sch2
Service	**Kent and Medway Autism & ADHD Neurodevelopmental Health Service**
Commissioner Lead	
Provider Lead	
Period	**1st October 2020 - 30th March 2025**
Date of Review	**1st 2020**

1. Population Needs

1.1 Autism National/local context and evidence base

This specification describes a Neurodevelopmental (ND) Health Service providing Adult Autistic Spectrum Conditions (ASC) and Attention Deficit Hyperactivity Disorder (ADHD), that encompasses the whole Adult ND pathway from pre-diagnostic, diagnostics, post diagnostic support, prescribing and titration services for people with ADHD and treatment for those presenting with 'Complex Autism' or behaviour that challenges. This service will work in close collaboration with both Kent & Medway Local Authorities Adult Social Care services to develop good partnership practice and wherever possible multidisciplinary teams (MDT) that are in line with NICE (National Institute for Clinical Excellence) clinical guidance on 'Autism Spectrum Disorder in Adults': Diagnosis and Management (NICE, 2012). The service will be known as 'The Kent & Medway Autism & ADHD ND Health Service' and will be a community-based service across Kent & Medway. It is expected that the service will codesign the model of care with other vested stakeholders over the first 1-2 years of contract commencement.

Table.1. Kent & Medway Autism & ADHD ND Health Service



In response to section 2 of the Autism Act 2009, the Department of Health published '**Fulfilling and Rewarding Lives'**, **The Strategy for adults with autism in England (2010)**
The Government's vision is that 'All adults with autism are able to live fulfilling and rewarding lives within a society that accepts and understands them. They can get a diagnosis and access support if they need it, and they can depend on mainstream public services to treat them fairly as individuals, helping them make the most of their talents. It outlines five quality outcomes:
1. Adults with autism achieve better health outcomes
2. Adults with autism are included and economically active
3. Adults with autism are living in accommodation that meets their needs
4. Adults with autism are benefiting from the personalisation agenda in health and social care, and can access personal budgets
5. Adults with autism are no longer managed inappropriately in the criminal justice system

Think Autism, - Fulfilling and Rewarding Lives, the strategy for adults with autism in England: an update (2014)
This update of the 2010 strategy sets out 15 new priority areas and reaffirms the importance of the 5 areas for action identified in the strategy aimed at improving the lives of adults with autism. The 15 priorities are set out as 'I' statements focussing on those with autism being an equal part of their communities; getting the right support at the right time during their lifetime; and people being able to develop their skills and independence and being able to work to the best of their ability, for example:

- "I want a timely diagnosis from a trained professional. I want relevant information and support throughout the diagnostic process" is particularly relevant in that it provides a synopsis of diagnostic requirements.

Building the right support - A national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition (2015)
This policy document sets out the plan to shift money from hospital care to community services in order to reduce use of in-patient beds by 50% by March 2019 and fund the development of a comprehensive range of community services. By the end of 2019 the projected targets of 50% were not achieved and the programme has been further extended with a shift from focussing on planned discharge rates to an investment in community infrastructure plans which will see locally based services and resources in order to support the discharges.

NICE Quality Standards for Autism, (2014)
NICE quality standards are a concise set of prioritised statements designed to drive measurable quality improvements within a particular area of health or care. They are derived from high-quality guidance, such as that from NICE or other sources accredited by NICE. https://www.nice.org.uk/guidance/qs51

Autism: Recognition, Referral, Diagnosis and Management of Adults on the Autistic Spectrum, NICE (2012)
These guidelines recommended that all local authorities should establish a specialist community based multidisciplinary team. It recommended that a range of professionals should be involved including clinical psychologists, social workers, psychiatrists, nurses, occupational therapists and speech and language therapists.

Extract from NICE guidance below. Refer to full guidance (as linked above) for exact detail. Comprehensive assessment of suspected autism should:

- Be undertaken by professionals who are trained and competent
- Be team-based and draw on a range of professions and skills
- Where possible involve a family member, partner, carer or other informant or use documentary evidence.

To aid more complex diagnosis and assessment for adults, consider using a formal assessment tool, such as:

- Adult Asperger Assessment (AAA; includes the Autism-Spectrum Quotient [AQ] and Empathy Quotient [EQ]) [6]
- Autism Diagnostic Interview – Revised (ADI-R) [7]
- Autism Diagnostic Observation Schedule 2 – (ADOS-2) [8]
- Asperger Syndrome (and high-functioning autism) Diagnostic Interview (ASDI) [9]
- Ritvo Autism Asperger Diagnostic Scale – Revised (RAADS-R)[10]

The recommended approach is via MDT and Multimodal:

1) Development history i.e. ADIR, 3Di, Disco or if lack of informants (family, friends etc) then comprehensive psychological assessment detailing what developmental history we do know
2) Direct Assessment of person (ADOS2) and similar
3) Independent reports – Care Act assessment, educational assessment, other health reports.

The process should be:

i) Accessible information, guidance & advice available
ii) Initial phone consultation
iii) Screening tools
iv) Assessment process
v) Report
vi) Feedback
vii) Follow up if necessary

Autism NICE Quality Standard 51 – outlines what quality provision should look like through provision of quality statements and measures. Guidance to be used in conjunction with the Autism Strategy. Full Quality Standard available at https://www.nice.org.uk/guidance/qs51

Statutory Guidance for Local Authorities and NHS Organisations to Support Implementation of the Adult Autism Strategy (2015)
The guidance focuses on the areas which section 2 of the Autism Act 20097 requires organisations to be addressed, in each case identifying what Local Authorities, Foundation

Trusts and NHS bodies are already under a duty to do under legislation, what they are expected to do under other existing guidance, and what they should do under this guidance.

The Kent & Medway Complex Autism Service (KAMCAS). In 2017 Commissioners from Kent and Medway secured match funding from NHSE and Kent County Council to develop plans for a comprehensive integrated multi-disciplinary service for people with Complex Autistic Spectrum Conditions (ASC) in order to meet the obligations set out in legislation and guidance; Transforming Care required local areas to put in place a comprehensive range of services by March 2019 that would reduce reliance on specialist in-patient services for people with complex autism who formed part of the transforming care cohort. Whilst local plans for neurodevelopmental conditions, which included formal procurement of services, could not meet the March 2019 timeframe, NHSE required specialist services to be put in place within that timeframe that would see a reduction in the number of people with ASC who are in specialist in-patient units and/or a reduction in numbers admitted to such units. The interim pilot service called KAMCAS was commissioned to underpin Kent & Medway's wider Transforming Care Programme (TCP) objectives and Sustainability & Transformation Plan (STP).

1.2 ADHD – National and Local

Like autism, ADHD during adulthood is often not identified. However, ADHD is a neurodevelopmental disorder that for many people persists into adulthood. It is associated with difficulties with attention, hyperactivity and impulsivity. The costs of untreated ADHD during adulthood are high, and include poor educational outcomes, unemployment, failed interpersonal relationships, increased illicit drug use, and increased forensic behaviour. Fortunately, ADHD is amenable to effective treatment during adulthood, leading to decreased costs for the individual and society, and this is reflected in the recent NICE guidelines. It is estimated that approximately 3% of the adult population suffers from residual symptoms of ADHD during adulthood. Advantages of identification of ADHD during adulthood include decreased health and economic costs to the individual and society.

Attention deficit hyperactivity disorder: diagnosis and management NICE, 2018 (NG87). Recent updated new recommendations have been added on recognition, information and support, managing attention deficit hyperactivity disorder (ADHD; including non-pharmacological treatment), medication, follow-up and monitoring, adherence, and review of medication and discontinuation. Local services should:

- Pre-diagnostic, diagnostic, treatment and consultation services for people with ADHD who have complex needs, or where general psychiatric services are in doubt about the diagnosis and/or management of ADHD
- Work with Medicines management / CCGs to develop local protocols for LES / shared care arrangements with primary care providers, and ensure that clear lines of communication between primary and secondary care are maintained

For a diagnosis of ADHD, symptoms of hyperactivity/impulsivity and/or inattention should:

- meet the diagnostic criteria in DSM-5 or ICD-10 (hyperkinetic disorder), and
- cause at least moderate psychological, social and/or educational or occupational impairment based on interview and/or direct observation in multiple settings, and
- be pervasive, occurring in two or more important settings including social, familial, educational and/or occupational settings.
- As part of the diagnostic process, include an assessment of the person's needs, coexisting conditions, social, familial and educational or occupational circumstances and physical health.

Transition from Children's to Adult Services

The development of a transition list of young people (17-17.5yrs old) moving from child to adult services helps to identify their needs in terms of ADHD and or ASD as they transfer to Adult Services.

Providers will work with commissioners and system providers to understand the needs, seamless processes in order to transfer young persons, where there is an ongoing need evident to adult providers that these young people require a continuation of treatment. Where the need is not apparent for that YP during the transition age, but occurs later - it will be incumbent on the provider to develop, in conjunctions with partners an agreed pathway that supports efficient access back into core adults' services

When young people leave children's services, their neurodevelopmental difficulties often persist (this is always the case in autism); however, they may not have access to adult services as they may not meet the threshold for secondary care services. As such, parents, children and carers often experience a sudden vacuum of support at this time of transition. It is appropriate for young people in this transition to undergo diagnostic review by the current provider to establish their continued treatment needs (e.g. stimulants for ADHD), a needs assessment (ASD and ADHD) and timely signposting to all appropriate adult services. Adult services accepting transfers from children's services should ensure seamless transfer across without delay or disruption to treatment (inc appropriate prescribed medication continuation).

Autism Transition

People with ASC experience very high rates of comorbidity which is often undetected and is reversible in both childhood and adulthood. Children are often in touch with CHYPS services and in receipt of appropriate treatment, but - as with ADHD - experience a 'cliff edge' in the provision of services at the point of transition to adulthood. It is therefore important to ensure at the point of entry to adult services that patients are reviewed for comorbidity by the most appropriate professional/s to enable them to access on-going treatment, or are signposted to appropriate support services. It is also important to note that many people with ASC will not require or wish for continued medical intervention, so a review at transition also provides for the giving of a 'clean bill of health' to this group and the provision of information regarding how to access support should this be necessary in the future.

ADHD Transition

ADHD is increasingly a focus of treatment during childhood. It leads to difficulties in schooling and at home and is often associated with education and social underachievement. Treatment with stimulant drugs significantly lessens this disease burden, however, such treatment is typically unavailable after 18 years of age, which leads to spiralling health and economic costs. It is therefore important to ensure that services exist which continue to meet the needs of this group during transition and early adulthood, and that can prevent mental ill-health and social morbidity.

NHSE Long Term Plan 2019 - Autism and ADHD (p.52)

The LTP states commitment to improvements across the system in the areas of:

- 3.31. Action will be taken to tackle the causes of morbidity and preventable deaths in people with a learning disability and for autistic people.
- 3.32. The whole NHS will improve its understanding of the needs of people with learning disabilities and autism and work together to improve their health and wellbeing.
- 3.33. Children and young people with suspected autism wait too long before being provided with a diagnostic assessment
- 3.34. Children, young people and adults with a learning disability, autism or both, with the most complex needs, have the same rights to live fulfilling lives.
- 3.35. Increased investment in intensive, crisis and forensic community support
- 3.36. We will focus on improving the quality of inpatient care across the NHS and independent sector.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

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

2.2 Local defined outcomes

Required Outcome Evidence that the Service User:	**Key processes to support outcome** To enable the achievement of the outcome the provider must:
Pre-diagnostic support is available.	Individuals have access to I&A and signposting prior to any assessment or diagnosis.
1. Undergoes comprehensive assessment and treatment of their autism (ASC needs/autistic needs) and or ADHD needs. (use of a standardised referral screening tool)	Adhere to the Standard Operating Policy (SOP) which outlines procedures for: • Referral and transfer of (shared) care • Assessment using a multi – disciplinary approach with the ASC social care element including Occupational Therapists and Social Workers. • Producing a recommendation report (management plan) which includes multi-disciplinary clinical formulation and treatment plan (including diagnosis) for each patient in conjunction with the patient and other professionals involved in the patients care. • Providing the patient with information about their condition and treatment in an accessible format • Ensuring Interventions comply with all statutory, regulatory and good practice standards (CQC Essential Standards of Care and Safety, NICE guidelines) • Adhere to the timeframe (NICE guidelines / 13wks) for achievement of the above QUERY what the 13 week refers to. What does it include and where does 13 weeks start exactly? Needs to • Share information between all professionals and agencies involved in the patients care (e.g. frequency of contact). Any patient identifiable correspondence to be in accordance with GDPR / DPIA / IG guidelines, e.g. through .nhs.net to .gcsx secure email accounts. • Triage waiting list for those awaiting assessment which incorporates completion of referral form, patient's questionnaire, psychometric tests (e.g. DISCO, AQ,

	Cambridge Behaviour Scale) to inform and assist with diagnosis (compliant with current NICE guidance) • Maintain eligibility prioritisation of access where waits occur for those most at risk
2. Receives care in an environment which is safe	Policies and procedures that comply with all legislation and guidance including but not restricted to • Complaints • Safeguarding • Clinical Governance & Prescribing Policy / Shared Care Protocol (or equivalent policies) • Equality and Diversity • Information Governance • CQC Registered • CPD / Training & Development • Mental Capacity (including presumption of capacity) • Whistleblowing • Continuing Professional Development (CPD) • Clinical supervision and appraisal.
3. Have their physical health needs properly assessed as part of the autism (ASC needs/autistic needs) assessment and treatment process *and* Has been referred to the relevant general medical service(s) for further investigation and management as indicated.	Protocols in place that include: • Baseline physical health evaluation by primary care services (where necessary) / relevant medical history • Relevant monitoring to be undertaken in relation to any specific treatments prescribed • Action to be taken where physical health needs have been identified that require further investigation and management, e.g. detail included within recommendation report (management plan) to highlight to GP/Consultant alongside recommendation to patient.
4. Providers evidence of policies for detailed assessment of risks to themselves and others.	• Ensure staff are trained in Risk Assessment and Management • Have robust links to other specialist Mental Health community and inpatient services for the purpose of sharing information and for obtaining opinion/ advice on specific issues. • Policy of any lone working risks which may be highlighted during referral and ensuring appropriate steps are taken to avoid risk to individuals, colleagues, patient and members of the public.
5. Experiences continuity of care when moving between services.	• Secure IT systems for the sharing of information within the service, fulfilling (or as a minimum having a plan in place) to meet IG / GDPR / DPIA requirements. • Clear transfer procedures outlined within the Operational policy that details relapse indicators, crisis and contingency plans • Clear procedures for seeking and recording the Service User's consent for the sharing of information • Ensure that information about services is available to the client in an accessible format.

	• Transparency in any communications to patients/representative, including information in relation to timescales, to help manage their expectations. • pass original referral to alternate providers when required, when responsible commissioners deem it appropriate to secure additional capacity from additional registered and accredited providers. Adhering to, and helping to develop, a robust process in these circumstances. • Be aware of all pathways / services incl criminal justice system providers, forensic services etc.
6. The patient's relative and/or carer, subject to service user's consent, (as appropriate) are consulted about the care they receive.	• Gain explicit patient/representative consent for the purpose of assessment, diagnosis and onward referral (when appropriate). Gather and retain information, which is deemed relevant, appropriate and not excessive and clearly identifies the parties involved and their role. • Ensure that the service user's known preferences for sharing information are clearly documented in their records and that these are respected where this is compatible with assessed risks to self or others. • Ensure that when the service user does not have the capacity to give consent, the appropriate steps to arrive at a 'Best Interest' decision have been taken and recorded and agreed by the MDT working with the patient
7. Is offered access to advocacy services including, where appropriate, IMCAs and IMHAs.	• All practicable steps are to be taken to include patient representative/family/carer/advocate is included and present during assessment and able to contribute where appropriate. • Ensure that information on advocacy, IMCA and IMHA is displayed and is available in a variety of appropriate formats • Implement appropriate systems for recording whether a client is 'befriended' under the terms of the Mental Capacity Act • Provide awareness training for all staff in relation to the relevant legislation.
8. Is treated with dignity and respect.	Ensure all staff have a range of training at the required levels that is in line with the 'Core capabilities frameworks for supporting autistic people and people with a learning disability', Skills for Health, 2019. Including clear adherence to policy on: • Equality and Diversity (reasonable adjustments) • Information Governance. Take all steps to accommodate any patient and/or representative requirements. Have a process in place allowing for patient and/or representatives feedback to be collected, collated and reported upon (Friends & Family Test)
9. Is safely prescribed the medication to address their ADHD needs	Prescribing pathways to be agreed with the provider and commissioners: • Providers will prescribe ADHD medication as per the Kent and Medway formulary with a preference for any cost-effective options that are agreed by the K&M APC, as outlined in section 3.5

	• The provider & commissioners will ensure the implementation of a Shared Care Protocol for / across Kent & Medway • The protocol is to be developed with Medicines Management Leads / commissioner support and embedded across Kent & Medway for the ongoing prescribing of ADHD medication post titration and stabilisation from the core service. • Providers will liaise, providing accessible consultancy / training to primary care GPs around any issues with ongoing prescribing for ADHD medication. Ongoing support from core service to primary care providers is essential when transferring care and must remain open between the primary care provider & the core service. Shared care should be obtained with explicit consent. • Where GPs feel it appropriate to do so, core service providers will accept transfers back from primary care to core service for prescribing stabilisation in line with the new shared care protocol / LES arrangements
10. Training & Consultancy	• Core service providers will work within current NICE guideline parameters around prescribing of medication for ADHD. Training and consultancy will be provided to all primary care (GP) providers who take part in the new shared care arrangements (LES) • A comprehensive package of training / documentation should be developed by core service providers to primary care providers along with clear systems & processes for accessible consultancy from core providers. • Training should be compliant and meet the published national competency framework (Skills for Health, 2019).

3. Scope

3.1 The Kent & Medway ND Autism & ADHD Service
Will provide **a service** for screening, assessing and diagnosing referrals, providing post diagnostic support, specialist care for those presenting with complex autism and prescribing and titration for ADHD; forming MDT functionality between health and social services across Kent & Medway, working in partnership with social care who provide community care assessments and/or information and advice, support care packages and other commissioned care options, for those eligible.

3.2 Kent Integrated MDT Pathway. The overall aim of the service within a new pathway is to provide a**n** integration of health & social care provision which enables early access / intervention and treatment / support for those individuals in need, reducing demands on the wider system and promoting independence, thus reducing longer-term dependencies. The draft pathway below is subject to further codesigned with all system providers to ensure a robust model of care is developed over the first 1-2 yrs. of the new health service being implemented.

KENT MDT INTEGRATED ADULT PATHWAY

		ACCESS TO SERVICES THE SERVICE USERS JOURNEY			THE SERVICE USERS JOURNEY
TIERED SYSTEM	HEALTHCARE	GP REFERRALS INTO SINGLE POINT OF ACCESS (SPA)		SOCIAL CARE	SERVICE USER SUSPECTED ASC/ADHD
(T1) TIER 1 PRIMARY CARE GP/	SHORT TERM	REFERRAL VIA TIER's 1-4 VIA SPA		PUBLIC HEALTH UNIVERSAL SERVICES / CHARITABLE/VOLUNTARY SECTOR/ SOCIAL CARE GRANT DELIVERY/WIDER SYSTEM	STEP 1 – ACCESS TO SERVICE SELF-REFERRAL OR TIER's 1-4
(T2) TIER 2 SPECIALIST SERVICES , LOW LEVEL NEED / EARLY INTERVETION	SHORT TERM	TRIAGE	(T2) SCREENING ASSESSMENT & SUPPORT LOW LEVEL – PRE/POST DIAGNOSTIC INTERVENTIONS SOCIAL CARE ENABLEMENT OFFER (OT) SHORT TERM SOCIAL SOLUTIONS (WHERE TIER 1 OFFERS NOT SUFFICIENT) (EMPLOYMENT/HOUSING, CARERS ETC)	CARE ACT ASSESSMENT (2014) SHORT TERM SOLUTIONS - ASC TEAM	STEP 2 SCREEN – ASSESS – SUPPORT (ASC/ADHD)
		COMMUNITY INTEGRATED MDT	1 x MDT COVERING TIERS 2-3 OF SYSTEM (30%+ COMPLEX CASE MANAGEMENT)	STAFF MIX SUBJECT TO CO-DESIGN	STEP 3 – Dx, PRESCRIBING, CBT / CASE MANAGEMENT STEP 4 – LONG TERM NEEDS IDENTIFIED
(T3) TIER 3 SPECIALIST SERVICES HIGH COMPLEX NEED / TC RISK REGISTER	SHORT - MEDIUM TERM INTENSIVE	COMPREHENSIVE	(T3) COMPREHENSIVE ASSESSMENT FOR DIAGNOSIS, PRESCRIBING SPECIALIST COMPLEX & CHALLENGING BEHAVIOUR MDT ENABLEMENT – SOCIAL, SENSORY, FUNCTIONAL, ADAPTIVE PSYCHOLOGY: COMPLEX SOCIAL WORK OT HEALTH / OT SOCIAL CARE PSYCHOLOGY CBT CONSULTANCY / TRAINING	LONG TERM ASC TEAM ENABLEMENT SPECIALIST COMMUNITY SPECIALIST TEAM – IN REACH CAPACITY TEAM	STEP 5 – MULTI-AGENCY CARE COMPLEX NEEDS E.G. CMH TEAM, SOCIAL SERVICES, CJS LD TEAMS
(T4) TIER 4 TRANSFORMING CARE COHORT RESIDENTIAL/CJS	TIME DEPENDENT		WATERSTONE – COMMUNITY REHAB	INPATIENT - NAU / NHSE SPEC COM / CCG / PRISON	

The draft pathway service model comprises of bespoke clinical MDTs for ASC diagnostics and post diagnostics, Complex ASC, ADHD diagnostics and prescribing and should be based within the community to receive referrals from either primary, secondary or tertiary health care providers (GPs, CMHTs, ND Consultants, social care & other professionals) for assessment and or diagnosis of Autism and or ADHD neurodevelopmental conditions in the absence of a learning disability and make recommendations / partnership working or signpost to other providers: The service should access existing resources in mental health services for identified needs, make suggestions about how these needs could be met if existing services are not able to provide the service needed, and make recommendations about processes and staffing requirements in line with the NICE guidance on Autism Spectrum Conditions and ADHD.

3.3 Aims of Diagnostic & Post Diagnostic Support Services

- Achieve National Targets for waiting times
- Access to diagnostic services for those with suspected ASC and or ADHD
- Access to treatment for those with ADHD and ASC, including post diagnostic support
- Access to medication, where appropriate for those with ADHD
- When non-pharmacological treatment is indicated for adults with ADHD, offer the following as a minimum: a structured supportive psychological intervention focused on ADHD regular follow-up either in person or by phone
- Provision of a local ASC and ADHD assessment diagnosis, prescribing (ADHD) and titration service with post diagnostic sessions for those in need, including ASC CBT, OT & SaLT.
- Ensure effective multi-disciplinary working with Social Care services.
- Improved understanding of the needs of people with ASC and or ADHD, by those supporting them to live in the community through link working, information sharing and recommendations from the dedicated assessment and diagnosis service.
- Improved care co-ordination and information between primary care, secondary and voluntary sector providers
- Appropriate signposting to voluntary and third sector organisations.
- Client shows clear understanding of diagnosis provided.

3.4 Objectives of Diagnostic & Post Diagnostic Support Services

- Service provision which accounts for individuals' preferences, i.e., communications, disabilities, cognitive function.
- Diagnosis provided with clear reasoning behind decision reached.
- Community (accessible) based assessment and diagnosis
- Incorporation of family/representative views and individual's developmental history and context.
- Timely response in accordance with NICE Quality Statement 51 and guidance.
- Service users and/or representatives feel informed of concise and consistent process, what it involves, and on what approximate timescale through formal correspondence.
- Complaints process established, conveyed to client (and/or representative) and handled in accordance with NHS complaints procedure.
- Seamless transition from referral, diagnosis, signposting and ongoing support.
- Data collected and conveyed in accordance with patient consent.
- As part of an integrated service, ensuring effective working practices with the social care element of the service.
- Fulfil commissioner reporting requirements as detailed in section 6 of this service specification (Activity).

3.5 Medicines Optimisation

The provider will ensure that all prescribing is in line with local formularies across Kent and Medway. GPs will not routinely issue non-formulary items. Providers will support the review and delivery of clinical treatment pathways utilising the most cost-effective medicines.

- The provider will support the joint development of shared care protocols and fulfil responsibilities outlined in shared care agreements to enable safe and effective treatment and monitoring of patients with a stable and well controlled condition. All shared care protocols must be reviewed and approved by the relevant Area Prescribing Committee (or equivalent).

- Shared care arrangements for ADHD prescribing will ensure initiation, titration and prescribing by the provider until the patient is stable (minimum of 3 months).

- Providers will work with CCGs to identify opportunities that will support savings and obtain the best value from medicines across the local health economy. This will include (but not limited to) the identification of savings that will be delivered on the introduction of relevant generic products to achieve the greatest cost benefit in accordance with local and national recommendations.

- Providers will work with the CCG to ensure that the impact of all new NICE technology appraisals and policies are evaluated for impact and pathway update to ensure robust and effective implementation.

The provider will adhere to interface prescribing / medicines optimisation agreements which include but are not limited to:

- Patients should receive a prescription or supply from the provider for a minimum of 14 days. A longer supply may be indicated e.g. where a shared care arrangement states otherwise, where the dispensed pack cannot be easily divided or where patient treatment requires stabilisation over a longer period.
- Hospital / Specialist only medicines as identified in the interface formulary or in national guidance; medicines requiring continued monitoring or where an agreement to shared care is pending; medicines supplied as part of provider based clinical trials will be provided in its entirety by the provider.
- GPs should not be asked to prescribe medicines which are intended to be used/administered in Provider clinics.
- All specially formulated, unlicensed medicines or 'specials', named patient medicines and medicines used as part of clinical trials are NOT to be prescribed or recommended, unless sanctioned by the Area Prescribing Committee (or equivalent).
- New medicines entering the market must be reviewed and approved by the Area Prescribing Committee (or equivalent).
- The provider must submit their prescribing data to the CCG upon request or as per agreed timescales.

The provider must ensure they demonstrate robust processes to ensure the safe and secure handling of medicines and medicines related processes (including transfer of information on medicines) that comply with relevant legislation, national and local guidance.

"Stopping over medication of people with a learning disability, autism or both (STOMP) and Supporting Treatment and Appropriate Medication in Paediatrics (STAMP)"

The provider will adopt the NHS England STOMP-STAMP health care pledge available via england.wesupport.stomp@nhs.net. The provider will adhere to the principles of the pledge below and will complete the NHSE action plan and self-assessment which will be made available to commissioners if requested.

- We will actively explore alternatives to psychotropic medication
- We will ensure people with a learning disability, autism or both, of any age and their circle of support are fully informed about their medication and are involved in decisions about their care

- We will ensure all staff within the organisation understand psychotropic medication including why it is being used and the likely side effects
- We will ensure all people are able to speak up if they have a concern that someone is receiving inappropriate medication
- We will maintain accurate records about a person's health, wellbeing and behaviour
- We will ensure that medication, if needed, is started, reviewed and monitored in line with the relevant NICE guidance
- We will work in partnership with people with a learning disability, autism or both, their families, care teams, healthcare professionals, commissioners and others to stop over medication.
- We pledge to ensure that young people with a learning disability, autism or both are able to access appropriate medication (in line with NICE guidance,) but are not prescribed inappropriate psychotropic medication. Regular and timely reviews should be undertaken so that the effectiveness of the medication is evident and balanced against potential side effects. This will mean that children and young people are only getting the right medication, at the right time, for the right reason.
- We pledge to work together with young people with a learning disability, autism or both and their parents, carers and families, to take measurable steps to ensure that children and young people only receive medication that effectively improves their lives.
- We pledge to set out the actions that our individual organisations will take towards this shared aim and report regularly on the progress we have made, ensuring that we can be held to account.

3.6 Aims of Complex Autism Services

Support achieving the overall aims of Transforming Care in Kent and Medway which are:

- To work in partnership with individuals with ASC and their families and with wider stakeholders to define what good person-centred care and support looks like and to develop systems and processes that will deliver it.
- To change how services are provided in order to enable people with ASC to experience truly integrated and well-coordinated health and social care that delivers improved outcomes throughout their lives.
- To ensure that integrated health and social care interventions that are provided enable people to live safe and fulfilling lives in their local community, close to the people who are important to them.
- To focus on early intervention and prevention to ensure that people's needs do not increase over time and intensive support to individuals with more complex needs or to those who are in crisis.
- To support the continuing development of a skilled and dedicated workforce through the sharing of knowledge and best practice.

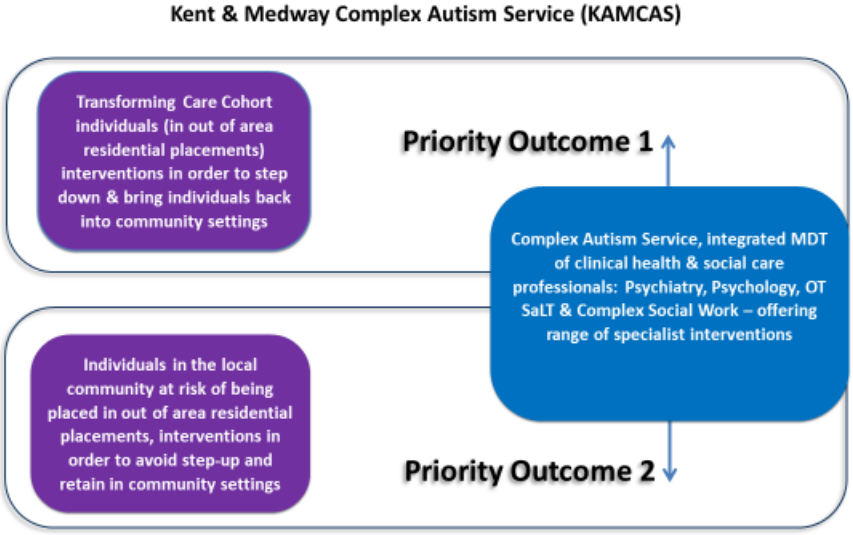
3.7 Objectives of Complex Autism Service

- To reduce the number of people from Kent and Medway who are in-patients in specialist ASC hospitals by offering a local community-based model of care as an alternative to in-patient care.
- To reduce admission rates to specialist ASC hospitals by offering a range of clinical interventions in conjunction with existing health and social care services as part of a comprehensive package of support and treatment for people with the most complex needs
- To support complex case management by providing clinical intervention for those considered as 'highly complex with behaviour that challenges' and at risk individuals open to adult social care within a multidisciplinary team (MDT)
- To support the development of an effective and efficient care pathway and model of integrated care and treatment for all people with ASC
- To contribute data, information and knowledge to support the development of comprehensive commissioning plans for people with ASC.

3.8 Outcomes of Complex Autism Service

The essential outcomes required for the Kent & Medway Transforming Care Programme are to reduce the current numbers of in-patients in out of area placements (known as the transforming care cohort) by ensuring there is sufficient community provisions available locally to meet their needs and to reduce the need to use / place individuals in out of area unit (high-cost) placement settings.

The service will be expected to provide the clinical element of this provision by:
Outcome 1.
To offer an alternative specialist clinical provision for those individuals (who are clinically assessed as ready to step-down) currently in – inpatient settings (transforming care cohort) due to their presenting complex ASC
Outcome 2.
To offer an alternative specialist (community-based) clinical provision for those individuals at risk of out of area – inpatient stays (who are clinically assessed as requiring in-patient treatment) due to their presenting complex ASC.
Table 3. KAMCAS



The provider will do this by:

- Offering sustainable (ongoing where needed), accessible and appropriate clinical support / specialist ASC treatments within a supported residential community setting
- Clinical interventions that encompasses best practice within NICE guidance and known frameworks for use with complex ASC
- Appropriate prescribing within NICE (2014) Guidance
- Function within a multidisciplinary team (MDT*) to ensure no silo working takes place
- Offer appropriate clinical assessments of individual needs
- Develop with a wider MDT a comprehensive plan of care (care plan) suited to the individuals needs
- Be the named care coordinator, or part of a care coordinated agency plan for the individual
- Review care plans for individuals on agreed basis (minimum of 6-12 weeks)
- Care Plan closure and or transfers of care

Benefits to service users:

- Promote holistic wellbeing and a sustainable benefit to the individual that supports the current placement setting (eg within supported accommodation or residential rehabilitation)
- Promotes a person-cantered approach to caring for the individual
- Promotes a stability of individual's ASC impacting on lifestyle for future progress onto / into a lower level need for supported accommodation for the future (further step-down provisions)
- Reduction in dependence for individuals in requiring higher level complex need interventions on an on-going basis

3.9 Service description/care pathway

The service will provide a timely, integrated, person-centered diagnostic and assessment for ASC and or ADHD, post diagnostic ASC support in the form of OT interventions and or adapted CBT, ADHD prescribing and titration/medication review and provide consultancy to primary care ongoing prescriber where required within a shared care protocol.
Where eligible, provide Complex ASC provision for adults who present with complex needs and or behavior that challenges, offering step down provision for transforming care cohort or step up avoidance.

3.10 Population covered

Adults aged 18 and over and transitional YP's from 17.5 years as part of a transition arrangement who are registered with a GP in Kent or Medway CCG's and who do not have a learning disability.

Individuals with a confirmed learning disability receive services from Integrated Teams for People with Learning Disability.

3.11 Acceptance and Exclusion Criteria and Thresholds

3.12. Diagnostic & Post Diagnostic Services Acceptance criteria:

- Adults aged 18 years and over
- Adults aged 17.5 years (transitional CYPs)
- Adults without a confirmed learning disability
- Adults for whom assessment for concurrent mental health problems has been undertaken by the individual's local community mental health team, where appropriate.
- Adults whose local GP and or mental health team are aware of the onward referral.
- Where there is dispute with Learning Disability teams over eligibility, it is expected that both the ND Service and LD Teams will discuss the referral and decide which service is best suited to meet the needs of the individual within 4 weeks of receipt of referral.

3.13 Complex Autism Services Acceptance criteria:

- Have a diagnosed Autistic Spectrum Condition without a diagnosed Learning Disability (LD); (borderline LD cases will be considered on a case by case basis)
- Are currently an in-patient in local mental health units or in specialist out of area ASC beds
- Have been referred or are at imminent risk of admission to in-patient services for assessment and interventions for ASC and co-morbid conditions
- Will benefit from community-based assessment and interventions as an alternative to in-patient care and treatment.
- Are open to adult social care service and present with highly complex and or behaviour that challenges

3.14 Complex Autism Services Exclusions:

- Have a diagnosis of Learning Disability
- Are under 18 years of age (exceptions may be agreed with Commissioners if the individual is approaching 18 years old in a Tier 4 Children and Young Person bed and will transition to an adult ASC bed at age 18)
- Clearly meet the criteria for detention under the Mental Health Act regardless of the availability of community-based assessment and interventions.

1. Referral Processes and Response Times

4.1 Referral routes into the diagnostic and post diagnostic services will receive referrals from GPs, social services, secondary care mental health services.

4.2 Referral routes to complex autism services will receive referrals from the core ND health service, Kent ASC Social Care Team, Medway Social Care Teams, CMHTs, Out of Area Treatment Panels (OATs) or via CTR's Care and Treatment Review Panels and NHSE (Spec Comm). GP referrals or self-referrals will not be accepted because individuals with complex needs will be referred initially to generic health and social care services.

4.3 Where an individual is identified as having moderate to severe mental health co-morbid requirements then referral to the Community Mental Health Teams may be required. Where the individual exhibits behaviour which places him/her at risk of offending then onward referral to the local forensic service for assessment may be required.
Where presenting autistic behavior is complex and or challenging and the individual is at risk of inpatient and or out of area treatment then the Complex Autism Service will assess and or treat individuals without an associated learning disability.

4.4 Recommendation (management) Report: As part of an integrated diagnostic and assessment pathway, following the completion of a Recommendation Report, copies will be provided to the referred and the referrer, allowing the individual to be referred and or signposted to the most appropriate service to meet their needs. Where a positive diagnosis is made this may necessitate a need for structured support and or assessment for eligibility of social care needs, if appropriate the individuals GP will be informed and the relevant social care team will provide a support service; community care assessments, and/or information and advice. Where concurrent mild to moderate mental health problems are identified then the individual will be referred into Primary Care Mental Health Services, e.g. IAPT Service.

4.5 Kent and Medway Joint Working Protocol for Adults with Co-existing Mental Health and Neurodevelopmental Conditions defines collaboration and joint working between MH and ND services, outlining key roles and responsibilities to ensure service users, where eligible should receive treatment appropriate to their needs from all commissioned providers.

4.6 All referrals will be received by a Single Point of Access (SPA). Referrals must be copied to the individual's GP and any relevant professionals e.g. social worker advising of the referral.

4.7 A response to the initial referrer must be confirmed within 2 weeks and an initial assessment date offered. The initial assessment will aim to be undertaken within 3 months of the referral letter (in accordance with NICE Quality Standard (QS51), dependent on demand. There will be a maximum of 4 weeks from completion of assessment to the provision of a written report with recommendations which incorporates:

- Patient details
- Report author, date and those present during assessment
- Documents seen before and during assessment
- Diagnostic tools used, purpose and respective contributors
- Referee history (e.g. developmental, family, educational)
- Referee presentation (e.g. appearance, communication, empathy)

- Diagnosis (e.g. meeting criteria, traits contributing to diagnosis, severity, further information required)
- Recommendations (e.g. Psychological and Pharmacological Interventions, further assessments, signposting).
- Treatment planning and expected timeframes.
- Sign off and assessor declaration.

In the event the patient does not attend a scheduled assessment, the provider will escalate a response through a standard procedure of 2 phone calls and 2 letters to the patient before removing the person from the waiting list.

4.8 Waiting List & Priority Criteria

Where service demand outstrips capacity waiting lists may be implemented. In such cases waits for access to diagnostic services should be kept to a minimum, targeted waiting times are 12 weeks. Priority criteria should be implemented across all waiting lists within CCG areas. The provider should present and discuss a list of priority criteria applied with the commissioner to ensure efficacy of services. Criteria of selection should include those who present with:

- Social Services CP involvement and or safeguarding risks
- Complex comorbid MH
- Criminal Justice System (CJS) involvement
- Significant and or debilitating physical LTCs

4.9 Interdependence with other services/providers

Partnership / Integrated MDT working with KCC ASC Social Care and Medway Social Care for people with ASC will be important. Assessing, diagnosing and providing recommendations for individuals is important but being able to subsequently signpost people onto a range of enablement orientated and commissioned support services (such as supported employment) in social care settings and from the voluntary and third sector will be imperative in order to assist people in achieving their optimum level of functioning and their life aims and ambitions. Close working with local voluntary sector and bespoke commissioned services will be imperative for good Service User outcomes.

4.10 Training Sessions

Will be provided regularly for GPs within the shared care /LES arrangements to assist them in safely providing on-going prescribed ADHD medication, after stabilisation. Where there are GP concerns, consultancy will be available and if required patients may be transferred back to the specialist core service.

5. Applicable Service Standards

5.1 Applicable National Standards (e.g. NICE)

The staff in this service must adhere to their Professional Codes of Conduct and ensure that they are up to date with current methodologies, approaches and validated tools used to assess and diagnose people with ASC in the absence of a learning disability. Individuals must be able to demonstrate core competencies in their chosen professional field in the assessment and diagnosis of Autism and or ADHD.

5.2 NICE Quality Standard for Autism (QS51)

1) People with possible autism who are referred to an autism team for a diagnostic assessment have the diagnostic assessment started within 3 months of their referral.
2) People having a diagnostic assessment for autism are also assessed for coexisting physical health conditions and mental health problems.
3) People with autism have a personalised plan that is developed and implemented in partnership between them and their family and carers (if appropriate) and the autism team.
4) People with autism are offered a named key worker to coordinate the care and support detailed in their personalised plan.

5) People with autism have a documented discussion with a member of the autism team about opportunities to take part in age-appropriate psychosocial interventions to help address the core features of autism.
6) People with autism are not prescribed medication to address the core features of autism.
7) People with autism who develop behaviour that challenges services are assessed for possible triggers, including physical health conditions, mental health problems and environment factors.

People with autism and behaviour that challenges services are not offered antipsychotic medication for the behaviour unless it is being considered because of psychosocial or other interventions are insufficient or cannot be delivered because of the severity of the behaviour.

5.2.1 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

The Royal College for General Practitioners has set autism as a clinical priority for 2014-17 to ensure that doctors and clinicians have appropriate training as detailed in the Autism Strategy for England.

The Adult Autism Strategy for England 2010 key recommendations and duties are: -

1. Improved training of professionals in autism
2. The recommendation to develop autism teams
3. Actions for better planning and commissioning of services, including people with autism their parents/carers
4. Actions for improving access to diagnosis and post diagnostic support.
5. Leadership structures at national, regional and local levels for delivery.

Proposals for reviewing the strategy to make sure that it is still working

5.2.2 Applicable local standards

- Maximum 3 month wait from referral to assessment to commence dependent on demand (in accordance with NICE Quality Statement 51).
- Maximum of 4 month wait from referral to completion of assessment dependent on demand
- Maximum of 4 weeks from completion of assessment to provision of written report with recommendations
- Assessments are to follow agreed protocol detailed in the Standard Operating Policy and Process documentation (providers own policies & procedures).
- The quality and consistency of assessments and recommendation reports may be subject to audit to ensure quality standards are evidenced and maintained.
- Responsive to commissioner requests in relation to quality assurance.
- Key Performance Indicators (KPIs), as detailed in section 6.3, are to be reported to commissioners on a quarterly basis. These KPI submissions will be a standing agenda item on the regular contract performance meetings.
- Patient satisfaction feedback to be used to inform service improvements and developments in partnership with commissioners. As set out in the NHS Friends & Family Test Guidance documentation.

5.2.3 Applicable Standards for Complex Autism Services

The Service will function within an evidenced-based core Clinical Model of Care, using a framework of Positive Behaviour Support Approach and Values, that is Person-Centred and supports individuals in the therapeutic delivery of:

- TEACCH (teach, expand, appreciate, collaborate, cooperate & holistic)
- SPELL (structure, positive, empathy, low arousal & links)
- PBS (Positive Behaviour Support)Values (theories and evidence base)
- Sensory Sensitivities
- Work with specialist Mental Health services for Comorbid Mental Health conditions

- Identifies and mitigates Risks & Risk Management planning
- Where appropriate, support service user involvement / development and carer involvement within care plans

The service will deliver (and or support) the functions and following processes:

- Staff training programmes (CPD) specific to the needs of the service
- Offer advice and consultancy to partner agencies who are joint working with individuals within the service
- Work within a multidisciplinary team of wider health and social care professionals where lead care coordination will be based on severity of presenting needs
- Use approved referral care pathways across Kent & Medway
- All NICE Quality Standard for Autism (QS51).

6. Applicable quality requirements and CQUIN goals

TBD

7. Location of Provider Premises

The provider/s will source suitable accommodation across Kent & Medway in order to deliver accessible services.

Hub & outreach spoke models of coverage should be defined and agreed with commissioners and subject to codesign changes

8. Individual Service User Placement

7.1 **Complex Autism Services**

The Kent and Medway Transforming Care Partnership (TCP) had a total of 78 adults in specialist CCG or NHSE commissioned in-patient beds on 31 January 2018. More than a quarter of these (N=21) had a primary diagnosis of ASC.

- CCG commissioned in-patients = 7 (Inc. 1 from Medway)
- NHSE commissioned in-patients = 14 (Inc. 3 from Medway)

Whilst it is a key objective of the Kent & Medway TCP to reduce the above numbers in treatment, this transformation is expected to take place only where individuals are ready to be returned to community settings. Clinical expertise and individual / carer and family wishes are all incorporated into any decisions taken.

7.1.2 The complex autism service & specialist rehabilitation providers:

Waterstones (Stonebridge House)

- Clinical interventions of the MDT on an ‘in-reach’ basis to individuals from Kent and Medway who are placed with the Waterstone (Stonebridge House) complex autism bespoke Residential Assessment/Rehabilitation Accommodation.
- Where the residence of Waterstone in Maidstone is required for treatment / placement stays - the clinical lead will take any final decisions on the safeguarding practice for the placement of individuals within the residential treatment unit of Waterstone. This is to ensure that any individuals are not placed ‘at risk’ within this residence and or placement would lead to the detriment of current and or future placement needs.

- Funding decisions on placements will be followed in line with set protocols, shared and or split cost arrangements between heath & social care will be followed and authorisation will come from CCG commissioners (for health) or social care placements (via social care authorised manager)

The complex service MDT combined with bespoke placements are expected to provide a comprehensive local alternative to ongoing hospital care or hospital admission for people with ASC.