Autism and ADHD assessments services: demand management, clinical categorisation and financial sustainability in Medway

Report for scrutiny and assurance

Title of committee	Health and Adult Social Care Overview and Scrutiny Committee
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Title of report	Autism and ADHD assessment services: demand management, clinical categorisation and financial sustainability in Medway
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Summary

This report provides an update for the Health and Adult Social Care Overview and Scrutiny Committee on Autism and Attention Deficit Hyperactivity Disorder (ADHD) assessment services for children, young people and adults.

The commissioning landscape for these services is complex and challenging. Waiting lists are long and growing, demand continues to exceed planned assessment capacity, data quality is variable across providers, and expenditure is rising quickly. Increased use of NHS Right to Choose pathways has added specific complexity in relation to provider oversight, activity monitoring, data flows and financial management, but the underlying demand and capacity pressures affect the wider autism and ADHD assessment system.

This is not a short-term communications or local issue alone. It reflects a wider and growing national challenge in neurodevelopmental assessment pathways, where demand, provider capacity, patient choice legislation, data limitations and affordability pressures are all interacting. The ICB's response is therefore being taken across two linked timeframes:

- immediate actions for 2026/27 to manage clinical risk, equity, quality, provider oversight and spending; and
- medium-term pathway redesign to improve access, consistency, support while people wait, data quality, clinical oversight and financial sustainability

Indicative Activity Plans are a standard part of NHS contracting and are used to set out the expected level of commissioned activity, associated funding and delivery assumptions. For 2026/27, the ICB is applying IAPs across autism and ADHD assessment services, including providers operating through NHS Right to Choose where relevant. This is intended to support clearer activity planning, financial stewardship, provider oversight and prioritisation of available assessment capacity according to clinical need.

The ICB is not seeking to restrict referrals or remove patients' legal rights to choose a provider where those rights apply. However, providers are expected to operate within contracted activity and budget arrangements. Where available capacity is limited, assessment activity will be prioritised

according to the agreed clinical needs-led categorisation approach, while ensuring escalation routes remain available where individual circumstances change.

For children and young people, Autism and ADHD assessment may interact with education, EHCP decisions, specialist educational placement, social care, safeguarding pathways and family stability. Despite support around these issues often being available based on need rather than diagnosis, it is acknowledged that diagnosis is too often thought of as a gateway to such support.

Immediate to medium term actions:

- Apply Indicative Activity Plans (IAPs) through the standard contracting framework to establish agreed activity levels, financial envelopes and provider delivery assumptions for 2026/27. This will support greater consistency across providers, strengthen financial management arrangements and improve oversight of delivery.
- Implement a clinical needs-led categorisation approach to ensure available assessment capacity is prioritised for individuals with the greatest clinical, safeguarding, educational, social care or vulnerability-related need. As a consequence, some people assessed as having lower levels of need may experience longer waits where capacity is constrained.
- Strengthen provider reporting and payment verification processes to improve assurance regarding activity, waiting lists, outcomes, quality and expenditure. This will enhance transparency, support effective contract management and provide a stronger evidence base for future commissioning decisions.
- Develop a longer-term pathway redesign programme to improve triage arrangements, support while waiting, needs-led interventions, data quality and pathway consistency across Kent and Medway. This work will require partnership working across the system and careful design to ensure patient choice continues to be supported and is not unnecessarily restricted.

Recommendations

The Committee is asked to:

- note the rising demand, long waits and financial risk associated with autism and ADHD assessment services across Kent and Medway, including specific additional complexity arising from increased use of NHS Right to Choose pathways;
- note the ICB’s statutory responsibility to enable patient choice where the legal right applies and its parallel statutory duty to remain within available financial resources;
- note the ICB’s use of Indicative Activity Plans as part of the standard NHS contracting framework, alongside clinical needs-led categorisation, strengthened reporting, provider oversight and payment verification arrangements;
- note the ICB’s pathway redesign work, including triage/screening, needs-led support, clearer pathway management, improved provider oversight and support while people wait;

1.1 Introduction and context

Autism and ADHD assessment services are experiencing significant demand nationally and locally. Demand has risen significantly over recent years and waiting lists have grown across commissioned pathways. Increased use of NHS Right to Choose has added specific complexity in relation to provider oversight, data flows and financial management, but the wider pressure reflects growth in demand that exceeds planned capacity across the system.

The ICB must balance three duties:

- meet appropriately population needs for assessment ensuring that children, young people and adults with the greatest clinical, safeguarding or wider vulnerability-related need are supported appropriately.
- supporting patients' legal right to choose a clinically appropriate provider where the right applies;
- meeting its statutory duty to operate within available resources;

- The commissioning landscape for ADHD and autism assessment is complex and challenging. Waiting lists are long and growing, which reflects a wider national trend and is not unique to Kent and Medway.

Demand for autism and ADHD assessment services has increased significantly over recent years and expenditure has risen accordingly. The ICB has seen sustained growth in referrals, assessment activity and associated costs across both children and adult pathways.

Whilst supporting access to assessment remains a priority, the level of demand currently exceeds the funding available within commissioned budgets. Without intervention, forecast expenditure during 2026/27 would significantly exceed the resources allocated to these services. As the ICB operates within a finite NHS allocation, expenditure above budget in one area reduces the funding available for other NHS services and population health priorities, including those utilised to support autistic people and people with ADHD pre- or post-diagnostically.

Table 2 below sets out the growth in budgets and expenditure from 2022/23 to 2026/27

Financial year	Budget	Spend	Overspend to be found from other budgets
2023//24	£0.00	£643,911.89	- £643,911.89
2024/25	£820,580.00	£5,928,757.00	- £5,108,177.00
2025/26	£5,315,422.00	£28,912,354.00	- £23,596,932.00
2026/27	£18,020,580.00		

In 2026/27 the ICB is managing the potential for significant, multi-million pound overspends in this budget and compared to previous year outturn, funding which would need to be found from elsewhere were it to materialise.

The growth in demand has also coincided with significant changes in the provider landscape. New providers continue to enter the market under Right to Choose arrangements, increasing patient choice but also creating specific challenges for provider oversight, activity monitoring, data quality and financial management.

Inequality in access is evident depending on the provider to which a referral is made. Variations in provider waiting times and capacity, alongside differences in awareness of available options, digital access, and availability of advocacy, mean that individuals and families have differing ability to navigate the system and exercise informed choice. This can result in inequitable access and experience, where those with greater knowledge, confidence, or support are better able to select providers with shorter waiting times, while others may not.

It is therefore important that inequity of access for Medway and Kent residents is minimised as we address differential understandings of how to navigate the current provider market or differing levels of support across education, SEND, social care, safeguarding, primary care, mental health, and

wider services. Addressing these factors is essential to ensure equitable access which should be based on need.

1.2 Clinical need categorisation framework

Over the past two years, the system has developed and implemented a clinical categorisation framework based on need for autism and ADHD assessments for children and young people using the statutory commissioned diagnostic services in Kent and Medway (See Appendix 1). This framework has been co-designed with family carers, parent and carer forums, education partners, and a range of key system colleagues, including the Head of Child Health Commissioning, Public Health Principal and Strategic Head of Public Health Programmes, the Education Commissioning Programme Lead, and the Programme Lead for Partnership Commissioning for Children and Families, Acute and Community Pathways, working across Medway Council and NHS Kent and Medway. The framework has also been refined over the last 24 months in response to lived experience feedback and operational learning. The overarching aim is that all children and young people are categorised according to clinical need, so that those whose circumstances pose the greatest risks to safety, stability or access to essential support are seen first, while everyone remains on the pathway and is ultimately seen.

The children's framework organises referrals into three broad categories, each determined through clinical formulation and an assessment of need, rather than a single risk factor. Category 1 covers children whose current situation creates a significant and immediate risk of harm or placement breakdown, or where an early assessment is likely to have a substantial impact on safety or stability. Category 2 (subdivided into 2A and 2B) covers children whose diagnostic outcome is closely linked to safeguarding decisions, specialist care or educational placement, or where a diagnosis is needed to inform a complex mental health treatment plan or youth justice involvement. Category 3 is the standard waiting list, where children are booked by referral date; this applies where needs, while important, are not currently creating an extraordinary level of risk or requiring urgent diagnostic input, and where support can continue through universal or targeted services while the child waits.

Using this categorisation framework, every child is given a category based on need; no one is left uncategorised. Where clinical judgment and formulation indicate that a child's needs are likely to have a greater impact on safety, family stability, placement, or access to critical treatment or social care, that child will be brought forward relative to routine referrals. Equally, where needs are significant but not extraordinary, and do not place the child or family at clear risk of harm or breakdown, those referrals remain on the standard waiting list with no change in booking order. This represents a deliberate shift away from a purely "first-come, first-served" approach, which does not account for changing need over time, towards a clinically led categorisation model that responds to risk and impact.

An equivalent clinical categorisation framework based on need has now been drafted for adults, using the same principles but tailored to adult circumstances such as safeguarding under the Care Act, risk of exploitation, vulnerability in housing or employment, and the need for a diagnosis to inform mental capacity or parenting assessments. The adult framework is currently in draft and is being reviewed by a similar set of stakeholders, including carers, voluntary sector partners, social care, housing, employment support and clinical teams, recognising that until recently the system did not have statutory adult diagnostic providers and therefore had not required such a framework. In the context of indicative activity plans for all providers, the intention is to embed this categorisation approach within the wider commissioning framework, supporting more consistent application across adults and children, including the all-age 'Right to Choose' offer.

Providers will be expected to review categorisations regularly so that prioritisation remains responsive to changing need. The framework is intended to remain dynamic, with decisions guided by clinical judgement and multi-agency information.

By way of illustration, children at the highest level of need may include those at imminent risk of residential school or foster placement breakdown, those under five who are non-verbal with significant suspected co-morbidities, or those facing instability due to family relocation, including through armed forces postings. Intermediate categories may include children who are looked after or subject to child protection arrangements, where a diagnosis is needed to inform an Education, Health and Care Plan or access specialist support, or where there is prolonged absence from school. Routine need would generally apply where a child's needs are currently being managed through existing educational and community provision, and where diagnosis would not alter immediate risk or treatment. The same principles apply for adults: highest need where there is imminent placement breakdown, homelessness risk or complex safeguarding concerns; intermediate need where diagnosis is required to inform mental capacity, parenting assessments or forensic management; and routine need where circumstances are stable and risk is lower, even where neurodevelopmental assessment remains clinically indicated.

1.3 Legal, policy and partnership framework

The paper is framed by patient choice legislation, ICB financial duties, children and SEND partnership duties, adult social care and safeguarding interfaces, equality and health inequalities duties, and local overview and scrutiny governance. Patient choice rights apply in relevant circumstances, including some mental health referrals to providers holding qualifying NHS Standard Contracts., Any pathway arrangements such as Clinical Assessment Services, Single Points of Access or Referral Management Centres must be designed so they do not obstruct patients' legal rights to choice whilst promoting equity of access based on need.

The ICB is also required to manage public resources within available funding. For children and young people, the approach should align with the Children and Families Act 2014, SEND Code of Practice, Children Act safeguarding framework, Equality Act 2010 public sector equality duty and Armed Forces Covenant where relevant. For adults, the approach should also consider adult safeguarding, mental health, social care, transition, carers and wider vulnerability-related duties and interfaces.

Medway Council's role in SEND, education placement, children's social care and safeguarding makes joint escalation and shared understanding important, especially where a child's circumstances change while waiting or where assessment is needed to inform specialist education placement, social care access or safeguarding risk management.

1.4 Contract, data, payment and pricing controls

The ICB has written to autism and ADHD assessment providers, including directly contracted providers and providers operating through another ICB qualifying contract, to set out the 2026/27 approach to activity planning, clinical categorisation, reporting, payment verification and provider oversight.

Indicative Activity Plans are part of the NHS Standard Contract framework and set out the expected level of activity, associated financial envelope and delivery assumptions. For 2026/27, these arrangements are being used to support clearer activity management, financial stewardship and provider accountability across autism and ADHD assessment services.

Alongside activity planning, the ICB is strengthening reporting and payment verification requirements. Robust and timely provider information is needed to understand referral flows, waiting list position, assessment activity, outcomes, quality, variation in access, costs and the relationship between commissioned capacity and demand.

These controls are intended to support stronger assurance, more effective contract management, clearer financial forecasting and better planning for future all-age autism and ADHD pathways.

1.5 Pathway redesign and future model

Support regardless of diagnostic status

The ICB recognises that many people require support regardless of diagnostic status, and access to support should not depend on a formal diagnosis. Current and future work will therefore strengthen access to practical information, self-management resources, support for families and carers, school and education support, voluntary and community sector offers, adult social care signposting, and mental health support on a needs-led basis. Clear escalation routes will be built into the pathway so that, where need or risk changes, people can be re-categorised or stepped up to more intensive input quickly, rather than waiting for a diagnostic appointment as the only route to help. This is reflected in the ICB's draft commissioning intention: implementing a needs-led support offer for autism and ADHD (page 56 of Kent and Medway's draft commissioning intentions for 2027/28).

Single Point of Access, screening and triage

The ICB is exploring clearer all-age pathway management arrangements, including screening or triage and a Kent and Medway Single Point of Access for neurodevelopmental assessment where appropriate. These arrangements are intended to help people reach the most appropriate service earlier, support lawful patient choice, reduce avoidable variation between providers and give a clearer basis for applying the clinical categorisation framework based on need when prioritising and escalating cases. Any model will need to be designed carefully so that it does not create an additional barrier to lawful choice or delay access to assessment, and there will be ongoing engagement with people with lived experience, carers and providers to test and refine the approach.

Provider management and clinical quality

Provider management will remain central to the future model. Every provider will be expected to operate against a clear Indicative Activity Plan and associated budget allocation, with transparent expectations on activity, reporting, quality, communication and escalation. Clinical quality work will include monitoring diagnosis rates, prescribing and titration activity, shared-care transfer, follow-up rates, and any outlier activity, alongside patient experience and alignment with accepted clinical standards and national guidance. Providers will be expected to use the clinical categorisation framework based on need consistently, to respond promptly when circumstances change, and to co-produce improvements with people with lived experience.

Data and planning for 2027/28

The future pathway will be underpinned by an improved all-age dataset from 2027/28 onwards. This dataset will support a clearer and more rational approach to provider activity monitoring, capacity planning, financial forecasting, waiting list management, application of the clinical categorisation framework, equality monitoring and outcomes tracking. Better data will enable the ICB and partners

to understand where demand is arising, which groups experience the longest waits or poorest outcomes, and where investment or pathway redesign will make the greatest difference to residents, particularly those with higher levels of vulnerability or disadvantage.

1.6 Medway-specific implications

- Children and young people with the highest clinical, safeguarding, educational or social care need will be prioritised using the need-led categorisation framework for available assessment capacity.
- Routine referrals may wait longer where they do not meet the agreed needs-based categorisation criteria and have not already commenced, or been scheduled for, assessment.
- The ICB's approach should support fairer access by reducing unmanaged variation between providers.
- Pathway redesign should strengthen consistent triage, clearer information, and support while waiting.
- Effective joint working with Medway SEND, education placement, children's social care and safeguarding colleagues is essential, especially where children are at the point of an EHCP, at risk of placement breakdown, looked after, adopted, subject to Special Guardianship Order or requiring specialist social care access.
- It is not currently known what proportion of the 30k people on the Right to Choose waiting list is resident in Medway. The ICB's data improvement workstream is prioritising the collection of this information and to ensure we understand the potential for patients to be waiting with more than one provider in a complex provider landscape.

1.7 Equality, quality and safeguarding considerations

The needs-led clinical categorisation approach is intended to reduce unmanaged variation by applying consistent criteria and directing available capacity first towards people with the greatest clinical, safeguarding, educational, social care or vulnerability-related need. In applying the approach, the ICB will need to consider potential differential impacts on groups who may experience additional barriers to access, delay or escalation, including children and adults affected by deprivation, disability, neurodevelopmental need, SEND, looked after status, home education, armed forces family circumstances, safeguarding concerns, housing instability, carer burden, digital exclusion or difficulty navigating services.

The approach has also been developed with quality and safeguarding considerations in mind. This includes ensuring that people with higher levels of need are identified consistently, escalation routes are clear if circumstances change while waiting, and communication with patients, families, carers and partner professionals is clear, accessible and proportionate.

1.8 Communications and engagement

The ICB recognises the importance of clear, transparent and consistent communication with children, young people, adults, families, carers, providers, primary care and system partners. It was unfortunate that a recent provider communication pre-empted the ICB's proactive communications plan in this area. Provider and patient communications have been developed to explain the rationale for the 2026/27 approach, how Indicative Activity Plans operate, how the clinical categorisation framework based on need will be applied, the implications for referrals that remain on the standard waiting list, and the routes available for advice or escalation should individual circumstances change.

Providers have been issued with agreed communications materials and key messages to support consistent conversations with patients and families, ensuring that the rationale for the approach, the impact on assessment activity and the commitment to clinically-led decision making are clearly understood.

In addition, the ICB has written to primary care partners, including GPs and the Local Medical Committee (LMC), to provide assurance on the approach being taken, explain the reasons for the change and ensure that referrers are appropriately informed. This approach is intended to support shared understanding across the system, minimise variation in messaging and maintain confidence that access decisions are being managed in a fair, transparent and clinically appropriate way.

1.9 Conclusion

The ICB recognises the significant impact that autism and ADHD assessment waiting times can have on children, young people, families and carers. The challenges currently facing Kent and Medway reflect national pressures affecting many NHS systems, including rising demand, long waits, data limitations and financial pressures. Increased use of NHS Right to Choose pathways creates additional complexity in specific areas such as provider oversight, activity monitoring, data quality and financial management.

The actions being taken during 2026/27 are intended to ensure that finite funding and associated assessment capacity are directed towards those with the greatest clinical, safeguarding, educational, social care or vulnerability-related need, while maintaining compliance with patient choice legislation and improving financial stewardship. These measures are not a substitute for longer-term pathway reform, but they are intended to manage the immediate issues described in this paper.

Alongside these immediate measures, the ICB is developing a longer-term all-age programme of pathway reform focused on improving equity of access, strengthening support while people wait, enhancing provider oversight, improving data quality, assuring clinical quality and delivering a more sustainable model for the future.

Risk management

Risk	Description	Action to avoid or mitigate risk	Risk rating
Routine referrals wait longer	Children, young people and adults may experience uncertainty while waiting.	Clear patient communication, protected queue position where applicable, support hub information and routes for GP/local NHS escalation if circumstances change.	B/3
High clinical or safeguarding need not identified quickly enough	Risk that individuals with the highest level of clinical need, safeguarding concerns or vulnerability are not identified or prioritised quickly enough.	Explicit clinical categorisation criteria across children, young people and adults; provider routes to identify priority cases; joint escalation with SEND, social care, safeguarding, housing, mental health and other relevant partners.	C/3
Legal challenge or patient choice complaint	Patient choice rights, including NHS Right to Choose where criteria are met, must not be unlawfully obstructed.	Design triage/SpoA so it supports lawful choice, does not obstruct rights, and gives clear information on options and complaints routes.	C/2
Financial overspend reduces ability to fund other services	The ICB must act within available resources and manage finite public funding.	Provider IAPs, prior authorisation, payment verification, price variation, contract management, KPI dashboards and activity forecasting.	B/3
Provider variation or inconsistent patient experience	Families may receive inconsistent information or experience unequal waiting times between providers.	ICB-issued patient communications and agreed provider messaging; active provider management and follow-up where messaging diverges.	B/3
Data gaps limit assurance	The Right to Choose provider market creates a mixed data picture, particularly for provider-level waiting times and activity.	Schedule 6 reporting, activity and finance reports, anonymised patient-level data, dashboards and improved dataset development for 2027/28.	B/3
Equality impact insufficiently understood	Potential for unintended inequality arising from changes to assessment access, prioritisation or waiting time	Equality and Health Inequalities Impact Assessment, ongoing monitoring and review, and engagement with relevant partners to identify and address any emerging impacts.	C/2

Risk rating

Likelihood	Impact
A Very likely B Likely C Unlikely D Rare	1 Catastrophic 2 Major 3 Moderate 4 Minor

Appendices

Appendix A: CYP clinical categorisation criteria for autism and ADHD assessment referrals

Appendix A – Needs led clinical categorisation

Agreed system categorisation already in place for statutory CYP providers is as follows:

Prioritisation Criteria – August 2025

Category 1

- Children or Young People (CYP) whose parents are in the armed forces (Armed Forces Covenant), ensuring they are not disadvantaged; or any children at risk of placement breakdown that causes a safeguarding concern (e.g. residential school placement, fostering placement or specialist educational placement)
- Children under 5 years, if non-verbal or have suspected related co-morbidity (consensus that those under 5 often have a higher level of need and therefore need to have earlier intervention)
- CYP identified as at risk of radicalisation by the Prevent process

Category 2A

- Looked After Children (LAC) / Children Looked After (CLA) (at the point of referral), to include adopted and Special Guardianship Order (SGO)
- CYP who are under child protection arrangements or special guardianship
- CYP post adoption (due to risk of adoption breakdown)
- CYP at the point of an Education, Health and Care Plan (EHCP) being issued where a diagnosis is required to inform specialist educational placement
- CYP who require a diagnosis to access specialist social care teams
- High risk of family breakdown
- Risk of admission
- Eating disorder

Category 2B

- Not in school or educational placement for 12 weeks
- Youth justice / offending team, forensic CYP's services
- Differential diagnosis required for mental health treatment plan

Category 3

Waiting based on referral data