Freedom of Information Request

Reference Number: EPUT.FOI.24.3553
Date Received: 30 May 2024

Information Requested:

I would **like information regarding attention deficit hyperactivity disorder (ADHD) and Autism services and pathways at EPUT (regarding Mid Essex catchment region and others)**. I would be grateful if you would answer the following questions that are relevant as of today (30/5/24 at time of sending) or within 3 months of. Please answer the questions for **both children and adult services.** Please answer in most suitable format should that be free text or fill in the boxes format suggested below:

1. What catchment (or catchments) does your provide/offer assessment, diagnosis and ongoing support for ADHD and Autism under the local NHS pathway? Please answer based on towns and/or ICB catchment

Services providing support	Adults	Children
Autism	NE Essex and South East/South West Essex	South East Essex
ADHD	NE & West and MSE Essex	South East Essex

2. What are the approximate wait times for assessment / diagnosis for ADHD and Autism? How many individuals are on the waitlist awaiting assessment? Please also answer per catchment/town if the waitlists are separated (can estimate based on current number on the waitlist vs current slot allocations for assessment).

Children: Wait times are based on number of weeks from being placed on pathway to completion of diagnostic assessment Jun 2023 to May 2024. Number of wait list is the number open as at 31st May 2024

Wait times for adult ADHD – there are different stages for the assessment so the initial assessment and informant contact and then the diagnostic assessment.

Assessment / Diagnosis	Adults	Children
Autism	South Essex Approx. Wait time: 4 years Number on list: 873 NE Essex Approx. Wait time: 18 months Number on list: there are 355 for an initial assessment and 112 on the waiting list for a diagnostic assessment	Approx. Wait time: 39 weeks Number on list: 130
ADHD	Approx. Wait time:	Approx. Wait time: 49 weeks

	NE/West and MSE 2yrs for initial assessment and then a further 2 years for the diagnostic assessment Number on list: MSE 312 on WL for diagnostic assessment but 5392 awaiting initial assessment and informant contact NE/West 217 on WL for diagnostic assessment but 2337 awaiting initial assessment and informant contact.	Number on list: 149

3. What are the approximate wait times for reviews / follow up ? Please also answer per catchment/town if the waitlists are separated
(This would include those diagnosed within this service or those transferred to these services with a prior diagnosis such as RTC.)

Reviews / Follow up	Adults	Children
Autism	(If applicable) Approx. Wait time: Number on list: N/A – we offer a follow up appointment after a diagnosis is given there would not be a wait time for it	(If applicable) Approx. Wait time: Number on list: 0
ADHD	Approx. Wait time: Number on list: : Once a diagnostic assessment has been completed the individual is offered a place on our group and then a follow up is offered after the group completion. They will go on the WL for a pharmacology assessment and possible initiation – the waiting time for these appointments is currently approximately 2 years.	Approx. Wait time: 8weeks Number on list: 1171

4. (After medication titration) For ADHD and medications reviews under the local NHS service/s are they meeting the current NICE guidelines of yearly reviews? What proportion of individuals under the local services are reviewed yearly in line with the

NICE guidelines? (See GP response regarding shared care below) - see disclosure below

Medication Annual Review	Adults	Children
Autism	Not applicable	Not applicable
ADHD	Yes / No.	Yes / No _ 80% diagnosed ADHD fulfil annual reviews per NICE guidelines -10% reach 18yrs annual reviews then discharged to ADHD Adult Service. - 10% not on medication

If no to the above, what is being done by the ICB and local services to address this?

5. How is EPUT ADHD services (and/or ICB) managing the ongoing medication shortages? Has their been a position statement or contingency plan should these shortages continue or reoccur? Given long wait times

Management of ADHD medication shortages	Adults	Children
Autism	Not applicable	Not applicable
ADHD	Liaison across the ICBs and EPUT pharmacy directorate/ADHD services to have a joined up plan. Previously an information document and support for GPs, this piece of work is underway currently. Prescribers are checking around medication availability prior to prescribing.	Daily Duty Clinics Setup

6. After receiving an Autism and/or ADHD diagnosis are individuals and their families offered follow up review by the local NHS service? What support is offered after diagnosis? This maybe especially important after just receiving a 'lifelong' neurodevelopmental 'disorder' diagnosis, some individuals and families may need support to process and accept this diagnosis.

Follow up post diagnosis (with or without medication)	Adults	Children
Autism	NE Autism service, signposting and outcome appointment completed to share this information and consider any appropriate	Pre& Post diagnostic Sessions across South East Essex / We offer one to one for YP or Parents working

	referrals. South Autism service signposting and outcome appointment. In the South service there are also groups offered to individuals following diagnosis within the service as well as for those who have an existing diagnosis. The groups are an anxiety and managing social situations group, a practical coping skills group and a social group. The service also offers limited individual support.	
ADHD	NE & West, MSE services both offer a psychoeducation group following diagnosis and a group is in planning for those on the waiting list for a diagnostic assessment. Due to volume of referrals there is no capacity currently for individual support.	Pre& Post diagnostic Sessions across South East Essex / We offer one to one for YP or Parents working

7. Given the higher prevalence of comorbidities associated with Autism and/or ADHD that may affect movement, eating, speaking, language and mood, are there provisions for allied health services to support in management of these comorbidities if required? Who provides these service/s? – Please see my disclosure

Support for comorbidities	Adults	Children
Dietitian	Yes / No / per need Services provided by:	Yes / No / per need Services provided by:
Speech and Language Therapist	Yes / No / per need Services provided by:	Yes / No / per need Services provided by: Children's Speech and Language Therapist
Physiotherapist	Yes / No / per need Services provided by:	Yes / No / per need Services provided by: Physiotherapist
Occupational Therapist	Yes / No / per need Services provided by: The South Autism service (only) has a part-time OT within the team. This individual sometimes offers consultation/advice to the NE Autism service.	Yes / No / per need Services provided by: Occupational Therapist

Psychology	Yes / No / per need Services provided by: both the ASD (NE and South) and ADHD services (NE&West and MSE) have qualified psychologists within the teams.	Yes / No / per need Services provided by: ASD- South East Essex

8. Please provide current documents on local policies / pathways or weblinks to such for both ADHD and Autism for both Adult and Children's services.
   Please see attached.

   We have Operational Policies for the Adult ADHD and ASD services and service specs.

Publication Scheme:

As part of the Freedom of Information Act all public organisations are required to proactively publish certain classes of information on a Publication Scheme. A publication scheme is a guide to the information that is held by the organisation. EPUT's Publication Scheme is located on its Website at the following link https://eput.nhs.uk

Service Specification No.	12 (2015-16 v2)
Service	Asperger's Service
Commissioner Lead	Sipho Mlambo
Provider Lead	Sharon Allison
Period	1st April 2015 – 31st March 2016
Date of Review	Feb 2015

1. Population Needs

1.1 National/local context and evidence base

Recent years have seen an increased focus on the difficulties experienced by people with Autistic Spectrum Disorders (ASD), (Barnard et al 2001; DOH 2006). Autistic Spectrum Disorders are developmental in origin and lifelong. Boys have usually been seen as at higher risk but there is now some suggestion that girls with AS are overlooked (Gould 2009).

Characteristics of all ASD are impairment in social interaction, in social communication and the presence of repetitive, stereotyped behavior's with a limited range of interests. Typically people with autism have an associated learning disability and are therefore seen within learning disability services.

People with Aspergers Syndrome, however, usually have average or above average cognitive functioning and are not, therefore, eligible for ALD services, (nor, indeed, would wish to use such services). Equally AMH services have also, traditionally excluded people with AS from their eligibility criteria. Consequently people with AS have often "fallen through the net" and experience additional problems with depression, anxiety and social exclusion

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain	Description	
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 agreed defined outcomes

South Essex Joint Mental Health Strategy

Outcomes	Statement	
1	People will have good mental health	X
2	People with mental health problems will recover	X
3	People with mental health problems will have good physical health and people with physical problems will have good mental health	X
4	People with mental health problems will have the best quality of life	X

3. Scope

3.1 Aims and objectives of service

To provide access to a diagnostic assessment and intervention service for young people (18-30 years)

To provide access to an assessment for those over 30 years of age to assist in establishing a differential diagnosis.

To ensure that young people who do have AS have access to:-

- group work particularly to address social functioning
- Family therapy
- Vocational support and employment opportunities
- Individual work to address for e.g. anxiety, low mood

3.2 Service description/care pathway

Scope

The Service is based in the Basildon Community Resource Centre but where possible individuals are offered appointments in other settings in their local areas as well as home visits also. As the Service develops further community bases may be utilised so as to provide services across the Trust area.

The Service is a two tier service, providing assessment; and where a diagnosis of Aspergers Syndrome, is made, access to a range of support including occupational therapy, family therapy and individual psychology services.

People over the age of 30 will be offered an assessment only, as the service develops this may be reconsidered.

Referrals

Referral may be made in writing by a consultant psychiatrist in order to ensure that the Service receives a full history on the individual being referred and that any mental health problems can be excluded prior to the referral being made. In view of the recent changes in the way in which AMH services are accessed these referral may come through the First Response Team following discussion with the Consultant Psychiatrist

As the Service develops further referrals for an assessment may be accepted from other health professionals (OT, psychology, care coordinators) to assist in care planning.

Care Planning

All Service users will receive an individual care plan but will not, normally be subject to CPA.

Where people are referred from the CMHT care planning will remain within the CMHT and staff within the AS Service will contribute

Where the client is open to the AS Service a coordinator will be agreed within the Service.

Clients over 30 referred for an assessment only will receive a standard care plan and remain the responsibility of the relevant RMO.

The following interventions will be available:-

Individual therapeutic work

With Psychology to address specific problems, e.g. social anxiety, relationships. The work will be based on a formulation agreed with the client and is likely to be CBT in orientation. Work will be undertaken either in a clinic, the community or the client's home (subject to a risk assessment). Such work is likely to be up to 6 months in length but depending on the individuals needs may be extended beyond this period of time.

Systemic family therapy

Systemic family therapy will be available each week so that this therapeutic modality can be offered to assist families as a whole.

Vocational intervention

This support will be provided through Occupational Therapy support initially with referrals being made to the Employment Specialists where appropriate for more direct employment related intervention

Group work has been developed in the 2nd-3rd year of the Service and includes sports related social groups (a confidence in sports groups and a confidence in running group) as well as a reading group

It was anticipated that engagement with this Service would be time limited up to 1 year, however there are some individuals who require a greater level of support and who do not meet the criteria for either LD or AMH services. Discharge planning will begin immediately.
The care plan will be formally reviewed after 6 months.
The individual will also be introduced to local self-help groups in the voluntary sector.
At this stage there is no formal input from social care staff.

Currently the Diagnostic Interview for Social and Communication Disorders (DISCO) is

used and will be undertaken by a licensed user.

Assessment

Assessment is generally a time limited, albeit lengthy, process. Other assessments may include:-

- Assessment of cognitive function
- Assessment of executive functioning
- Assessment of memory
- Assessment of social functioning
- Assessment of risk (especially for community based work)

Further assessment will be undertaken if a specific need is identified during the DISCO assessment.

Those between 18 and 30 years who receive a positive diagnosis of AS will be invited to a case review to agree a care plan.

The Service will therefore be a two tier service, providing assessment; and where a diagnosis of Aspergers Syndrome, is made, access to a range of support including vocational support, family therapy and individual psychology services.

People over the age of 30 will be offered an assessment only, as the service develops further this may be reconsidered.

Staffing

- Consultant clinical psychologist 0.4 wte
- Assistant Psychologist 1 wte
- Occupational Therapist 0.43 wte
- Systemic family management 0.1 wte

Training

All staff will undertake the mandatory training as required by the Trust.

Specialist training will be undertaken as required but is likely to include the following:-

- The consultant clinical psychologist received training in the use of DISCO, the Diagnostic Interview for Social and Communication Disorders

- Other staff may also require DISCO training as the Service develops

- The assistant psychologist will need training in the use of psychometric assessments. This will be provided within the Trust

- All staff will need training in the ways of working with people with AS. As staff acquire expertise this will be provided within the Service

- The psychologists within the Service may require further training in CBT.

3.3 Population covered

Patients registered with a South Essex GP and living in the South Essex geographical boundaries.

3.4 Any acceptance and exclusion criteria

3.4.1 Inclusion Criteria

The Service is available to individuals living within the geographical area of South Essex.

Individuals between the ages of 18 to 30 years may be referred into the Service. Referrals should by consultant psychiatrist but this may come through the First Response Teams.

Where a younger adult or older child requires an assessment the most appropriate route of referral will be determined in conjunction with the transition protocol and may involve joint working with CAMHS.

Referrals of people over the age of 30 will be accepted for an assessment at the request of a consultant psychiatrist and with the aim of assisting in the diagnostic process.

3.4.2 Exclusion Criteria

- This service is not commissioned for service users whose conditions fall within PbR Clusters 1, 2 and 3

- People who have an established diagnosis of AS and whose needs are already being met by other sources.

- People eligible for ALD services.

- People who have not been seen by psychiatry (to exclude underlying MH problems).

3.5 Interdependencies with other services

The Service will work closely with SAFE – Supporting Aspergers Families in Essex www.aspergers.org.uk

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

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

There is currently a consultation on NICE guidance (2012) – Autism; Recognition, referral, diagnosis and management of adults on the autism spectrum.

The Autism Act (2009) necessitates that health and social care systems have pathways for

ASD.

The Autism Strategy (2010) sets out the direction of travel.

4.3 Applicable agreed local standards

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements See Schedule 4 A-D

5.2 Applicable CQUIN goals See Schedule 4 E

6. Location of Provider Premises

The Provider's Premises are located at:

The Service is based at the
Basildon Resource Centre, Basildon Hospital, Nethermayne, Basildon, Essex.

Further community bases are utilized in order to provide services across the Trust area.

7. Individual Service User Placement

CYP ADHD 6yrs + Pathway – Southend &Essex

NHS
Essex Partnership University
NHS Foundation Trust

Pre-Referral

Please be aware we do not accept referrals for children under the age of six (6)
Identification Concern - Referral from Southend & School Nurses, CAMHS, Education, GP's

Screening/ Triage Allocation

Lighthouse Single Point of Access (SPA) Referral from Essex School Nurses, CAMHS, Education
via epunft.seechs.singlepointofaccess@nhs.net and GP SystmOne e-Referral

ADMIN
Starts 18 Weeks RTT

Acknowledgement of referral-Parent / Referrer

Clinician Triage
MDT Case Discussions

Information Gathering

ADMIN ADHD Questionnaires & Developmental history Sent to Parents/School. **Complete and Return within 4wks**

Time period for return of screening form will be delayed during school holiday. DON T send screening packs during last two weeks of School term. Inform families there will be delay.

ADMIN ADHD Questionnaires & Developmental history, Sent to Parents & School, **Complete and Return within 4wks**

ADHD Questionnaires - **Received & Graded**
If there is sufficient information to suggest ADHD diagnosis

Meets Criteria "NO"
ADMIN Letter to referrer/parents why CYP not meeting criteria
Sign post to Public Health Nursing & local groups

Meets Criteria "Yes"
ADMIN Letter to acknowledge next stage of pathway
If Classroom/Playground observations needed

Psycho-Education

Psycho-education - Parents will be invited to the ADHD **Parent Information Session**
Virtual or according to CYP Individual needs

Led By Clinician ADMIN Stops Clock RTT First definitive treatment

QB Test Screening Appointments

If a **comorbid** difficulty is identified and/or information suggests a different neurodevelopmental diagnostic process is also helpful then internal referral will be offered for an assessment where a care plan will created.

This can run alongside the ADHD pathway

Health care staff will weigh and measure your child and make some basic physical observations.

School Observations if required.

QB Test Screening

A letter will be sent to Parent

To aid diagnosis child will be offered a **QB test** (objective computer test for ADHD).

Responsibility of care and risk management

Psycho-Education

Psycho-education - Parents will be invited to the ADHD **Parent Information Session**
Virtual or according to CYP Individual needs

ADMIN RECALLS 52 weeks Escalate

Assessment & Diagnostic Feedback

Diagnostic Feedback Assessment and Management Plan & **Psycho-education**

NO ADHD | ADHD Moderate | Moderate / Severe ADHD | Severe ADHD,ADD & Mental Health Co-occuring LD/ ODD/ASD/OCD

Child discharged from pathway. A copy of the discharge letter will be sent to the GP

Medication prescribed if required Initiate Monitor 3 mths - **Psycho-education**
Shared Care with GP Medication Follow Up Health Review
6 months review / Psycho-education

Refer to SET CAMHS or Joint clinics

Transition
14-16 years – (if 16 years and on Medication) Transfer to **ADHD ADULT** Services
Ready Steady Go

Psycho-Education

Psycho-education - Parents will be invited to the ADHD **Parent Information Session**
Virtual or according to CYP Individual needs

Essex Partnership University
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OPERATIONAL GUIDELINES
Adult ADHD SERVICE
MID AND SOUTH ESSEX

CLINICAL GUIDELINE NUMBER:	
VERSION NUMBER:	
AUTHOR:	Sharon Allison
CONSULTATION:	
IMPLEMENTATION DATE:	July 2022
AMENDMENT DATE(S):	
LAST REVIEW DATE:	November 2022
NEXT REVIEW DATE:	
APPROVED by TASK AND FINISH GROUP	

1.0 STAFFING

1.1 The Adult ADHD service will be offered across Mid and South Essex and will integrate with the PCN MH teams across South Essex. In addition to this there will be links with community paediatric services across both areas as a route into the service to continue, where appropriate medication monitoring for those CYP who are 18 and over. Post diagnostic support routes will be explored and links made with relevant services and agencies including IAPT, social care, GPs, voluntary sector, advocacy services.

1.2 The service will be provided by an MDT consisting of a psychiatrist (0.5wte), clinical psychologist (1wte band 8b, 1wte band 8a), nurse prescriber (2wte band 7), pharmacist (0.2wte), assistant psychologists (4wte) and admin support (0.5wte).

2.0 SERVICE DELIVERY

2.1 The Service strives to ensure timely access to standardised diagnostic assessment, access to both non pharmacological (evidence based) and pharmacological treatment and interventions for adults referred into the service. In addition, and where appropriate, consultation will be provided in relation to patients or for services where support is required from a specialist team and training will be offered. The service will work in line with a capacity model and does not hold waiting lists (this is obviously not the current circumstance as we inherited the Mid waiting list and volume of referrals exceeds what was originally considered).

2.2 The team will provide management and support around both pharmacological (psychiatrist, nurse prescribers and pharmacist) including prescription and titration of medication as well as non pharmacological (psychologists, assistant psychologists) and nurses) management and support

2.3 All MDT members will have clear job plans, outlining activities and caseloads to ensure optimal capacity and service planning.

3.0 MDT MEETINGS

3.1 Whenever possible, decisions will be made regarding whether or not a patient will be accepted into the Service in the MDT meeting following discussion with other involved services where appropriate. There will be discussion of CYP transitioning to adult services and planned MDT/service clinics to facilitate this process.

3.2 Where there are individuals with a complex presentation these will be discussed within the MDT forum and plans for care/intervention considered in addition to discussions and liaison with services already involved.

4.0 REFERRALS PATHWAY

4.1 GP referrals will currently come directly through to the team. These referrals will be in order to access an assessment for ADHD or if an existing diagnosis exists to access psychological input and/or exploration around medication stabilisation and titration.

4.2 Children and young people aged 18 years who are stabilised and titrated without any secondary mental health needs who require transition to specialist services for annual review under a shared care protocol agreement will be referred into the service. This referral route will be through arranged joint clinics between paediatrics and the ADHD service.

4.3 All referrals to the ADHD Service will be paper screened and then decisions made with regard to initial assessment and informant contact discussed within the multi-disciplinary Team (MDT) and/or clinical supervision to then be accepted by the team if appropriate. Referrals will be acknowledged in writing within 4 weeks and informed that they will be contacted for an initial assessment when an appointment is available. They will be invited to an assessment appointment with one of the MDT or a combination of the team as appropriate and decided within the MDT referral meetings/clinical superivison. (Pathway in Appendix)

4.4 The service will offer a comprehensive assessment either on a diagnostic basis or to review treatment options within a specified time period of 28 working days from receipt of referral. (This timescale is not currently achieveable due to staffing and volume of referrals)

4.5 Recommendations for an individual intervention plan, access to the service psychoeducation group, individual therapy or signposting to other services/resources will be informed by the assessment. Joint pathways with primary care IAPT services (Therapy for You-T4U, Inclusion, Health in Mind and Vitaminds) are being developed to ensure more integrated and seamless care for the patients who require additional support to maintain progress following discharge from the service.

5.0 CONTACTS WITH THE PATIENT FOLLOWING REFERRAL

5.1 Written acknowledgement of the referral to the service will be sent within 4 weeks of receipt sharing information about next steps.

5.2 Where individuals are referred through the community paediatric teams, arrangements will be made for them to attend a joint clinic prior to their discharge to plan contact and input from the ADHD service.

5.3 An assessment slot will be offered within 28 working days of acceptance of the referral by the assessing clinican(s) by phone and followed up with a letter. (this is currently not achieveable due to volume of referrals and staffing)

5.4 After assessment all cases will be discussed within the MDT and an appropriate care pathway considered, whether individual support, access to the service psychoeducation group, or signposting to other services as well as consideration around pharmacological input.

5.5 An appointment will be offered when the group or individual intervention slot becomes available. The clinican will telephone to arrange a convenient appointment time and follow up with a confirmation letter.

5.6 In all instances, correspondence will be sent to the referrer, GP and patient (if they consent to this). An assessment report and therapy/assessment discharge report (if offered intervention) will be required for all patients.

5.7 Where an individual is begun on medication this will be shared with the GP and notification regarding the Continuing Care agreement provided. Once an individual's medication has been titrated and stabilised the written agreement with the GP will be formalised in writing.

6.0 RISK ASSESSMENT AND MANAGEMENT

6.1 All patients, will have a brief risk assessment completed and a further full risk assessment if there is indication of the presence of any historical or current risks.

7.0 INDIVIDUAL INTERVENTIONS

7.1 Individual/access to group support will be provided to individuals following discussion and agreement at the MDT. In terms of the allocation of individual treatment, the team will work to a capacity model. All individual and group interventions will be formulation driven and goal oriented. The service aims to work with individuals over a 6 to 8 month period and then discharge back to the GP under a continuing care agreement if medication has been prescribed or signpost to other support as appropriate. Any extension to this will be considered on a case by case basis and in discussion with the MDT.

7.2 The patient, GP and referrer will be informed of the progress the patient has made, along with the next course of action as appropriate.

7.3 Qualified psychologists and nurses will provide individual and group intervention. Where there are staff undergoing training within the service, such as Trainee Clinical Psychologists, Assistant Psychologists, medical trainees, student nurses, their work with individuals will be monitored under close supervision.

7.4 Interventions provided will be in line with evidence based practice and, where resources allow, in line with NICE recommendations. Sessions will work towards therapy goals identified from a patient's individualised formulation.

Review of goal attainment is measured using the Goal Attainment Scale (GAS) incorporating appropriate quality of life and ADHD specific outcome measures where relevant.

7.5 Sessions that are cancelled can be rescheduled, however sessions where patients DNA will count toward the treatment intervention. Cancelled or DNA'd sessions will be explored taking into consideration the individuals circumstances as it is recognised that planning and organisation are difficulties encountered by those who have ADHD.

8.0 GROUP/MANUALISED INTERVENTIONS

8.1 Group interventions will be based around evidenced based approaches utilising for example CBT, ACT and CFT principles. There will be a psychoeducation element to these interventions as well.

8.2 Upon completion of group intervention, patients will be offered a review appointment with a member of the MDT to discuss the outcome and consider the need and the appropriateness of offering an individual therapy intervention.

8.3 Group programmes will be offered on a rolling basis which will either be a series of topic based sessions that individuals can join at any point in the programme or a closed group approach so that individuals are started on the next available one.

9.0 DNA, FAILURE TO OPT IN

9.1 All DNA's to the service will be discussed as an MDT process and discharge discussed on a case by case basis.

9.2 As per pathway if the individual does not attend their first two sessions offered without prior contact, discharge will be considered taking into account circumstances. All other professionals involved in their care will be informed of this outcome, and any known risk factors highlighted and discussed further with the wider care team.

9.3 If the patient DNA's a session once treatment has begun we will attempt to contact them via telephone. If reachable, we will offer them an alternative appointment over the phone. If not reachable, a letter will be sent asking them to make contact with the service to arrange another appointment within 14 days. No contact within this time-frame will result in discharge.

9.4 Discharge due to DNA/disengagement will always be discussed with the MDT, taking into account the patients clinical presentation.

9.5 All discharges would be communicated in writing to the patient (if opted in to receive correspondence), GP, and referrer

10.0 TRANSFER TO OTHER EPUT SERVICES

10.1 If during the course of treatment by the MDT it is identified that the patient's needs would be better met elsewhere staff will review this with the individual and other professionals involved in the first instance. Alternatively the individual will be brought up for discussion within the MDT, and then actioned appropriately.

11.0 SPECIALIST COGNITIVE ASSESSMENTS

11.1 Any need for a cognitive assessment to be undertaken will be considered as part of the overall specialist assessment. The nature of the assessment process for ADHD is comprehensive and may include investigation of other aspects of an individual's presentation taking into consideration clarity about how this could inform clinical care and treatment planning.

12.0 CONSULTATION WITH OTHER PROFESSIONALS

12.1 Consultation clinics/sessions will be made available to other teams within EPUT for discussion of individuals where there are queries about a possible ADHD.

13.0 SUPERVISION AND CPD

13.1 All the MDT members in the service engage with appropriate supervision. For unqualified and newly qualified psychologists this is scheduled weekly, and for band 8a and above fortnightly/monthly. In line with Trust policy and professional requirements this robust supervision process ensures both clinical governance and professional development.

13.2 Where appropriate all team members will also meet regularly with their identified operational managers (if this sits outside the team), to review the function of provision within the MDT.

13.3 All team members engage with an annual appraisal, jointly led by both the professional manager and the operational manager as appropriate.

14.0 AUDIT AND SERVICE DEVELOPMENT – need to develop.

14.1 Outcome measures and a brief patient satisfaction questionnaire will be developed to be employed in evaluating the effectiveness of our service and the interventions provided. Measures will be collected at pre and post therapeutic intervention and at assessment

14.2 The ADHD Service is committed to developing its resource and providing the highest quality input to individuals accessing the service and stakeholders. The MDT and where possible student psychologists, supported by qualified clinicians, will undertake focused audit projects in relation to the delivery of care in order that adaptive changes can continue to evolve. Service data will be routinely collected at the point of discharge and analysed to profile a number of service variables, including the presenting problems being addressed in therapy, number of sessions offered and attended and clinical outcomes. This data supports the evaluation of our pathway and reviews quality and efficiency of service delivery.

15.0 TEACHING

15.1 The ADHD Service is keen to facilitate training and teaching forums to colleagues. Teaching, and associated support, can be available to the MDT.

15.2 Where appropriate teaching sessions will be made available to the Doctorate Clinical Psychology training programmes in Essex and Hertfordshire.

16.0 ANNUAL LEAVE/SICKNESS

16.1 Staff will follow the Trust policies for requesting annual leave and get permission from their manager/operational lead to ensure the continued delivery of services in their area.

16.2 Individual staff are responsible for making arrangements for their clinical commitments when on annual leave.

16.3 The operational manager and the MDT will manage the clinical caseload, and re-allocate the work where appropriate, whilst a member of staff is off sick.

17.0 ADMIN

17.1 All aspects of admin will be provided to the MDT through the identified ADHD admin support.

17.2 It is understood that the process of informing patients in writing and documenting each step of the process will be completed by admin staff who will be given all the template letters accessed through Systmone to complete these tasks.

17.3 Admin will input all information as required and within the remit of the admin staff

Essex Partnership University
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OPERATIONAL GUIDELINES
Adult ADHD SERVICE
NORTH EAST AND WEST ESSEX

CLINICAL GUIDELINE NUMBER:	
VERSION NUMBER:	3
AUTHOR:	Sharon Allison
CONSULTATION:	
IMPLEMENTATION DATE:	July 2021
AMENDMENT DATE(S):	
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NEXT REVIEW DATE:	
APPROVED by TASK AND FINISH GROUP	

1.0 STAFFING

1.1 The Adult ADHD service will be offered across NE and West Essexand will integrate with the PCN MH teams in NE Essex and the SPA team in West as a referral route. In addition to this there will be links with community paediatric services across both areas as a route into the service to continue, where appropriate medication monitoring for those CYP who are 18 and over. Post diagnostic support routes will be explored and links made with relevant services and agencies including IAPT, social care, GPs, voluntary sector, advocacy services.

1.2 The service will be provided by an MDT consisting of a psychiatrist (0.5wte), clinical psychologist (1wte band 8a), nurse prescriber (2wte band 7), pharmacist (0.2wte) and admin support (0.5wte).

2.0 SERVICE DELIVERY

2.1 The Service strives to ensure timely access to standardised diagnostic assessment, access to both non pharmacological (evidence based) and pharmacological treatment and interventions for adults referred into the service. In addition, and where appropriate, consultation will be provided in relation to patients or for services where support is required from a specialist team and training will be offered. The service will work in line with a capacity model and does not hold waiting lists.

2.2 The team will provide management and support around both pharmacological (psychiatrist, nurse prescribers and pharmacist) including prescription and titration of medication as well as non pharmacological (psychologist and nurses) management and support

2.3 All MDTmembers will have clear job plans, outlining activities and caseloads to ensure optimal capacity and service planning.

3.0 MDT MEETINGS

3.1 Whenever possible, decisions will be made regarding whether or not a patient will be accepted into the Service in the MDT meeting and following discussion with the local PCN MH/SPA team. There will be discussion of CYP transitioning to adult services and planned MDT/service clinics to facilitate this process.

3.2 Where there are individuals with a complex presentation these will be discussed within the MDT forum and plans for care/intervention considered.?

4.0 REFERRALS PATHWAY

4.1 GP referrals will come through the PCN MH teams for both the North East of Essex and West Essex and where appropriate be referred in to the ADHD Service. These referrals will be in order to access an assessment for ADHD

or if an existing diagnosis exists to access psychological input and/or exploration around medication stabilisation and titration.

4.2 Children and young people aged 18 years who are stabilised and titrated without any secondary mental health needs who require transition to specialist services for annual review under a shared care protocol agreement will be referred into the service. This referral route will be through arranged joint clinics between paediatrics and the ADHD service.

4.3 All referrals to the ADHD Service will be discussed within the multi-disciplinary Team (MDT) and accepted by the team if appropriate. Once the referral is accepted the patient will be contacted via telephone within 1 week and informed that an information form will be sent out to them for completion and return (is this something admin could do???). If there are any difficulties in completing the form in this way then the individual will be triaged over the phone by one of the MDT. They will be invited to an assessment appointment with one of the MDT or a combination of the team as appropriate and decided within the MDT referral meetings. (Pathway in Appendix)

4.4 The service will offer a comprehensive assessment either on a diagnostic basis or to review treatment options within a specified time period of 28 working days from receipt of referral.

4.5 Recommendations for an individual intervention plan, whether stabilisation work, group therapy, individual therapy or signposting to other services/resources will be informed by the assessment. Joint pathways with primary care IAPT services (Therapy for You-T4U and Vitaminds in West Essex) will be developed to ensure more integrated and seamless care for the patients who require additional support to maintain progress following discharge from the service.

5.0 CONTACTS WITH THE PATIENT FOLLOWING REFERRAL

5.1 Telephone contact will be made with the patient within one week of the patient being referred through the PCN MH Teams to inform of completion of a further information form. If needed this form can be completed by phone with one of the MDT. On receipt of the further information and discussion within the team a letter will be written informing that they have been accepted into the service

5.2 Where individuals are referred through the community paediatric teams, arrangements will be made for them to attend a joint clinic prior to their discharge to plan contact and input from the ADHD service.

5.3 An assessment slot will be offered within 28 working days by the assessing clinican(s) by phone and followed up with a letter.

5.4 After assessment all cases will be discussed within the MDT and an appropriate care pathway considered, whether individual therapy, group

therapy, or signposting to other services as wel as consideration around pharmacological input.

5.5 A therapy appointment will be offered when the group or individual intervention slot becomes available. The clinican will telephone to arrange a convenient appointment time and follow up with a confirmation letter.

5.6 In all instances, correspondence will be sent to the referrer, GP and patient (if they consent to this). An assessment report and therapy/assessment discharge report (if offered intervention) will be required for all patients.

5.7 Where an individual is begun on medication this will be shared with the GP and notification regarding the Shared Care agreement provided. Once an individual's medication has been titrated and stabilised the Shared Care agreement with the GP will be formalised in writing.

6.0 RISK ASSESSMENT AND MANAGEMENT

6.1 All patients, will have a brief risk assessment completed and a further full risk assessment if there is indication of the presence of any historical or current risks.

7.0 INDIVIDUAL INTERVENTIONS

7.1 Individual/group therapy will be provided to patients following discussion and agreement at the MDT. In terms of the allocation of individual treatment, the team will work to a capacity model. All individual and group interventions will be formulation driven and goal oriented. The service aims to work with individuals over a 6 month period and then discharge back to the GP under a shared care agreement if medication has been prescribed or signpost to other support as appropriate. Any extension to this will be considered on a case by case basis and in discussion with the MDT.

7.2 The patient, GP and referrer will be informed of the progress the patient has made, along with the next course of action as appropriate.

7.3 Qualified psychologists and nurses will provide individual and group intervention. Where there are staff undergoing training within the service, such as Trainee Clinical Psychologists, Assistant Psychologists, medical trainees, student nurses, their work with individuals will be monitored under close supervision.

7.4 Interventions provided will be in line with evidence based practice and, where resources allow, in line with NICE recommendations. Sessions will work towards therapy goals identified from a patient's individualised formulation. Review of goal attainment is measured using the Goal Attainment Scale (GAS) incorporating appropriate quality of life and ADHD specific outcome measures where relevant.

7.5 Sessions that are cancelled can be rescheduled, however sessions where patients DNA will count toward the treatment intervention. Cancelled or DNA'd sessions will be explored taking into consideration the individuals circumstances as it is recognised that planning and organisation are difficulties encountered by those who have ADHD.

8.0 GROUP/MANUALISED INTERVENTIONS

8.1 Group interventions will be based around evidenced based approaches utilising for example CBT, ACT and CFT principles. There will be a psychoeducation element to these interventions as well.

8.2 Upon completion of group intervention, patients will be offered a review appointment with a member of the MDT to discuss the outcome and consider the need and the appropriateness of offering an individual therapy intervention.

8.3 Group programmes will be offered on a rolling basis which will either be a series of topic based sessions that individuals can join at any point in the programme or a closed group approach so that individuals are started on the next available one.

9.0 DNA, FAILURE TO OPT IN

9.1 All DNA's to the service will be discussed as an MDT process and discharge discussed on a case by case basis.

9.2 As per pathway if the individual does not attend their first two sessions offered without prior contact discharge will be considered taking into account circumstances. All other professionals involved in their care will be informed of this outcome, and any known risk factors highlighted and discussed further with the wider care team.

9.3 If the patient DNA's a session once treatment has begun we will attempt to contact them via telephone. If reachable, we will offer them an alternative appointment over the phone. If not reachable, a letter will be sent asking them to make contact with the service to arrange another appointment within 1 week. No contact within this time-frame will result in discharge.

9.4 Discharge due to DNA/disengagement will always be discussed with the MDT, taking into account the patients clinical presentation.

9.5 All discharges would be communicated in writing to the patient (if opted in to receive correspondence), GP, and referrer

10.0 TRANSFER TO OTHER EPUT SERVICES

10.1 If during the course of treatment by the MDT it is identified that the patient's needs would be better met elsewhere staff will review this with the individual and other professionals involved in the first instance. Alternatively the individual will be brought up for discussion within the MDT, and then actioned appropriately.

11.0 SPECIALIST COGNITIVE ASSESSMENTS

11.1 Any need for a cognitive assessment to be undertaken will be considered as part of the overall specialist assessment. The nature of the assessment process for ADHD is comprehensive and may include investigation of other aspects of an individual's presentation taking into consideration clarity about how this could inform clinical care and treatment planning.

12.0 CONSULTATION WITH OTHER PROFESSIONALS

12.1 Consultation clinics/sessions will be made available to other teams within EPUT for discussion of individuals where there are queries about a possible ADHD.

13.0 SUPERVISION AND CPD

13.1 All the MDT members in the service engage with appropriate supervision. For unqualified and newly qualified psychologists this is scheduled weekly, and for band 8a and above fortnightly/monthly. In line with Trust policy and professional requirements this robust supervision process ensures both clinical governance and professional development.

13.2 All team members also meet regularly with their identified operational managers, to review the function of provision within the MDT.

13.3 All team members engage with an annual appraisal, jointly led by both the professional manager and the operational manager as appropriate,

14.0 AUDIT AND SERVICE DEVELOPMENT – need to develop.

14.1 Outcome measures and a brief patient satisfaction questionnaire will be developed to be employed in evaluating the effectiveness of our service and the interventions provided. Measures will be collected at pre and post therapeutic intervention and at assessment

14.2 The ADHD Service is committed to developing its resource and providing the highest quality input to individuals accessing he service and stakeholders.

The MDT and where possible student psychologists , supported by qualified clinicians, will undertake focused audit projects in relation to the delivery of care in order that adaptive changes can continue to evolve. Service data will be routinely collected at the point of discharge and analysed to profile a number of service variables, including the presenting problems being addressed in therapy, number of sessions offered and attended and clinical outcomes. This data supports the evaluation of our pathway and reviews quality and efficiency of service delivery.

15.0 TEACHING

15.1 The ADHD Service is keen to facilitate training and teaching forums to colleagues. Teaching, and associated support, can be available to the MDT.

15.2 Teaching sessions will be made available to the Doctorate Clinical Psychology training programmes in Essex and Hertfordshire.

16.0 ANNUAL LEAVE/SICKNESS

16.1 Staff will follow the Trust policies for requesting annual leave and get permission from their manager/operational lead to ensure the continued delivery of services in their area.

16.2 Individual staff are responsible for making arrangements for their clinical commitments when on annual leave.

16.3 The operational manager and the MDT will manage the clinical caseload, and re-allocate the work where appropriate, whilst a member of staff is off sick.

17.0 ADMIN

17.1 All aspects of admin will be provided to the MDT through the identified ADHD admin support.

17.2 It is understood that the process of informing patients in writing and documenting each step of the process will be completed by admin staff who will be given all the template letters accessed through Systmone to complete these tasks.

17.3 Admin will input all information as required and within the remit of the admin staff

Essex Partnership University
NHS Foundation Trust

OPERATIONAL GUIDELINES
Adult ASD SERVICE
NORTH EAST ESSEX

CLINICAL GUIDELINE NUMBER:	
VERSION NUMBER:	1
AUTHOR:	Sharon Allison
CONSULTATION:	
IMPLEMENTATION DATE:	September 2022
AMENDMENT DATE(S):	
LAST REVIEW DATE:	
NEXT REVIEW DATE:	
APPROVED by TASK AND FINISH GROUP	

1.0 STAFFING

1.1 The Adult ASD service will be offered across NE Essex and will integrate with the PCN MH and SPA teams as a referral route. In addition to this there will be links with community paediatric services across both areas as a route into the service where an individual is late to diagnosis for those CYP who are 18 and over. Post diagnostic support routes for signposting, including Summit (local advocacy service who support individuals with ASD and through the assessment process), will be explored and links made with relevant services and agencies including IAPT, social care, GPs, voluntary sector, advocacy services.

1.2 The service will be provided by an MDT consisting of 2 qualified clinical psychology posts (1wte band 8b and 1wte band 8a), 1wte CAP or trainee counselling psychology post (start at band 5 and progress to band 6) and admin support (0.5wte).

2.0 SERVICE DELIVERY

2.1 The Service strives to ensure timely access to standardised diagnostic assessment for adults referred into the service and signposting recommendations made post diagnosis. In addition, and where appropriate, consultation will be provided in relation to patients or for services where support is required from a specialist team and training will be offered. The service will work in line with a capacity model and does not hold waiting lists.

2.2 All MDT members will have clear job plans, outlining activities and caseloads to ensure optimal capacity and service planning.

3.0 MDT MEETINGS

3.1 Whenever possible, decisions will be made regarding whether or not a patient will be accepted into the Service in the MDT meeting and following discussion with the local PCN MH/SPA team. There will be discussion of CYP who need to transition to adult services for diagnostic assessment and planned MDT service links to facilitate this process.

3.2 Where there are individuals with a complex presentation, these will be discussed within the MDT forum and plans for diagnostic assessment or ongoing appropriate care/intervention considered from within other services.

4.0 REFERRALS PATHWAY

4.1 GP referrals will come through the SPA team and, where appropriate, be referred in to the ASD Service. These referrals will be in order to access an assessment for ASD.

4.2 Children and young people aged 18 years who have been referred into paediatric services and are still awaiting a diagnostic assessment will be referred through MDT cross service discussion.

4.3 All referrals to the ASD Service will be discussed within the multi-disciplinary Team (MDT) and accepted by the team if appropriate. If the referral is not to be accepted a letter will be written to the individual with a copy to the GP detailing reasons why and signposting to appropriate resources or services to address the issues being raised.

4.4 Once the referral is accepted, the patient will be contacted via telephone within one week and informed that an information form will be sent out to them for completion and return. The individual will be advised of support to complete this information through the ASD service directly as well as Summit Advocacy Service. Once this information is received, the individual will be invited to an assessment clinic appointment. This appointment will be offered within a specified time period of 28 working days from receipt of referral into the service, with either the AP or the CAP/Counselling Psychology Trainee as appropriate and decided within the MDT referral meetings. (Pathway in Appendix)

4.5 The service will offer a further assessment on a diagnostic basis to conclude the process with a member of the MDT as appropriate and decided within the MDT referral meetings.

4.6 Following the diagnostic assessment and discussion within the MDT, arrangements will be made for an outcome appointment with the individual and a family member, carer or advocate at their discretion. These outcome appointments will take place for all individuals whether a diagnosis of an ASD is being given or not. During this appointment recommendations for the specific individual and onward referrals or signposting will be discussed as informed by the assessment. Joint pathways with, for example, primary care, IAPT services (Therapy for You) will be developed to ensure more integrated and seamless care for the patients who require additional support to maintain progress following discharge from the service.

5.0 CONTACTS WITH THE PATIENT FOLLOWING REFERRAL

5.1 Telephone contact will be made with the patient within one week of the patient being referred through the SPA Team to inform of completion of further assessment forms. If it is not possible to contact the individual by phone a letter/email (this information is requested on the referral form) will be sent requesting the individual makes contact with the service. These forms will be sent with a letter explaining alternate ways to complete with a member of the service directly by phone as well as through the support of Summit (local advocacy service). On receipt of the further assessment forms and discussion within the team a letter will be written informing whether or not they have been accepted into the service and if not the letter will detail the reasons for this.

5.2 Where individuals are referred through the community paediatric teams, arrangements will be made for the necessary information to be gathered to ensure the referral process can be followed.

5.3 An initial assessment clinic slot will be offered within 28 working days by the assessing clinican(s) by phone and followed up with a letter.

5.4 After assessment all cases will be discussed within the MDT and an appropriate care pathway considered and onward referrals discussed for , signposting to other services as appropriate.

5.5 In all instances, correspondence will be sent to the referrer, GP and patient (if they consent to this). An assessment report will be required for all patients.

6.0 RISK ASSESSMENT AND MANAGEMENT

6.1 All patients, will have a brief risk assessment completed and a further full risk assessment if there is indication of the presence of any historical or current risks.

7.0 INDIVIDUAL INTERVENTIONS the service is not currently set up to provide this input but this will be considered as a development step. At this point any intervention will be considered as an onward referral.

7.1 The service currently does not provide Individual/group therapy as this is for further development. This element will be relevant/necessary when this change is made and until this point onward referrals and other services will be considered as appropriate to provide input to individuals accessing a diagnostic assessment. Individual/group therapy will be provided to patients following discussion andagreement at the MDT. In terms of the allocation of individual treatment, theteam will work to a capacity model. All individual and group interventions willbe formulation driven and goal oriented. The service aims to work with individuals over a 6 month period and signpost to other support as appropriate. Any extension to this will be considered on a case by case basis and in discussion with the MDT.

7.2 The patient, GP and referrer will be informed of the progress the patient has made, along with the next course of action as appropriate.

7.3 The service will provide individual and group intervention with decisions being made within the MDT as to which member of the team will provide this input. Where there are staff undergoing training within the service, such as Trainee Clinical Psychologists or Assistant Psychologists their work with individuals will be monitored under close supervision.

7.4 Interventions provided will be in line with evidence based practice and, where resources allow, in line with NICE recommendations. Sessions will work towards therapy goals identified from a patient's individualised formulation. Review of goal attainment is measured using the Goal Attainment Scale (GAS) incorporating appropriate quality of life and ASD specific outcome measures where relevant.

7.5 Sessions that are cancelled can be rescheduled, however sessions where patients DNA will count toward the treatment intervention. Cancelled or DNA'd sessions will be explored taking into consideration the individuals circumstances as it is recognised that planning and organisation are difficulties encountered by those who have ASD.

8.0 GROUP/MANUALISED INTERVENTIONS as above

8.1 Group interventions will be based around evidenced based approaches utilising for example CBT, ACT and CFT principles. There will be a psychoeducation element to these interventions as well.

8.2 Upon completion of group intervention, patients will be offered a review appointment with a member of the MDT to discuss the outcome and consider the need and the appropriateness of offering an individual therapy intervention.

8.3 Group programmes will be offered on a rolling basis which will either be a series of topic based sessions that individuals can join at any point in the programme or a closed group approach so that individuals are started on the next available one.

9.0 DNA, FAILURE TO OPT IN

9.1 All DNA's to the service will be discussed as an MDT process and discharge discussed on a case by case basis.

9.2 As per pathway if the individual does not attend their first two sessions offered without prior contact, discharge will be considered taking into account circumstances. All other professionals involved in their care will be informed of this outcome, and any known risk factors highlighted and discussed further with the wider care team.

9.3 If the patient DNA's a session once treatment has begun we will attempt to contact them via telephone. If reachable, we will offer them an alternative appointment over the phone. If not reachable, a letter will be sent asking them to make contact with the service to arrange another appointment within 1 week. No contact within this time-frame will result in discharge.

9.4 Discharge due to DNA/disengagement will always be discussed with the MDT, taking into account the patients clinical presentation.

9.5 All discharges would be communicated in writing to the patient (if opted in to receive correspondence), GP, and referrer

10.0 TRANSFER TO OTHER EPUT SERVICES

10.1 If during the course of assessment by the MDT it is identified that the patient's needs would be better met elsewhere staff will review this with the individual and other professionals involved in the first instance. Alternatively the individual will be brought up for discussion within the MDT, and then actioned appropriately.

11.0 SPECIALIST COGNITIVE ASSESSMENTS

11.1 Any need for a cognitive assessment to be undertaken will be considered as part of the overall specialist assessment. The nature of the assessment process for ASD is comprehensive and may include investigation of other aspects of an individual's presentation taking into consideration clarity about how this could inform clinical care and treatment planning.

12.0 CONSULTATION WITH OTHER PROFESSIONALS

12.1 Consultation clinics/sessions will be made available to other teams within EPUT for discussion of individuals where there are queries about a possible ASD.

13.0 SUPERVISION AND CPD

13.1 All the MDT members in the service engage with appropriate supervision. For unqualified and newly qualified psychologists this is scheduled weekly, and for band 8a and above fortnightly/monthly. In line with Trust policy and professional requirements this robust supervision process ensures both clinical governance and professional development.

13.2 All team members also meet regularly with their identified operational managers, to review the function of provision within the MDT.

13.3 All team members engage with an annual appraisal, jointly led by both the supervisor and the operational manager as appropriate,

14.0 AUDIT AND SERVICE DEVELOPMENT – need to develop.

14.1 Outcome measures and a brief patient satisfaction questionnaire through 'I want great care' will be developed to be employed in evaluating the

effectiveness of our service and the interventions provided. Measures will be collected at pre and post assessment

14.2 The ASD Service is committed to developing its resource and providing the highest quality input to individuals accessing the service and stakeholders. The MDT and where possible student psychologists, supported by qualified clinicians, will undertake focused audit projects in relation to the delivery of care in order that adaptive changes can continue to evolve. Service data will be routinely collected at the point of discharge and analysed to profile a number of service variables, including the presenting problems being addressed in therapy, number of sessions offered and attended and clinical outcomes. This data supports the evaluation of our pathway and reviews quality and efficiency of service delivery.

15.0 TEACHING

15.1 The ASD Service is keen to facilitate training and teaching forums to colleagues. Teaching, and associated support, can be available to the MDT.

15.2 Teaching sessions will be made available to the Doctorate Clinical Psychology training programmes in Essex and Hertfordshire.

16.0 ANNUAL LEAVE/SICKNESS

16.1 Staff will follow the Trust policies for requesting annual leave and get permission from their manager/operational lead to ensure the continued delivery of services in their area.

16.2 Individual staff are responsible for making arrangements for their clinical commitments when on annual leave.

16.3 The operational manager and the MDT will manage the clinical caseload, and re-allocate the work where appropriate, whilst a member of staff is off sick.

17.0 ADMIN

17.1 All aspects of admin will be provided to the MDT through the identified ASD admin support.

17.2 It is understood that the process of informing patients in writing and documenting each step of the process will be completed by admin staff who will be given all the template letters accessed through Systmone to complete these tasks.

17.3 Admin will input all information as required and within the remit of the admin staff

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Pre-School Autistic Spectrum Disorder Pathway

Pre-Referral

Concerns Identified from Southend & Essex Health Visitors, School Nurses, CAMHS, Education, GP's

Lighthouse Single Point of Access (SPOA) Referral from via epunft.seechs.singlepointofaccess@nhs.net **and GP SystmOne e-Referral**

Screening/Triage Allocation

18 Weeks RTT Clock Starts

Referral to Multi Agency Core Referral Team (MACRT)

Sometimes further information is requested to help decide whether assessment is appropriate

New referrals received and accepted

Not enough Information

Expected Pre-referral Information received

Acknowledgement of referral to Parent / Referrer that child has been placed on the **ASD pathway**

Information Gathering

Information Gathering - Questionnaires Sent to Parents & Nursery Return within **4 wks**
ASD under 5s Questionnaires - Received & **Graded/Scored**

Psycho-Education

Does Not Meet Criteria
Letter to referrer/parents for why CYP does not meet criteria. Watchful Wait /End Referral /discharge

Sign Post to Public Health Nursing 0-19 for support / Local Offer for Support

Meets Criteria
Referral Accepted
Letter to referrer/parents

First Definite Treatment Clocks Stop

Individual based Intervention or Pre – Psycho education

Health care staff will weigh and measure your child and make some basic physical observations.

Child invited to an **Initial Appointment**

Assessment Appointments

Pre – Observation Assessment Support

Speech and Language, Occupational Therapist, Clinical Psyc, SHV, Dev Pract /Sleep Advisor

Communication, Challenging behaviour, Sensory, Development & Play

Community Paediatrician - *Developmental History/ Full Examination / any investigations.*

For a few children the paediatrician will be able to make a diagnosis at this appointment, in other cases they might need more information. , Paediatrician refers to MDA team for assessment.

Multidisciplinary Assessment - MDA Discussion
MDA team decides understands child's strengths and difficulties
A formal assessment - ADOS Assessment or ADI

Diagnosis

Feedback/Review Meeting - Discuss assessment findings with parent and any support that may need

Where a particular diagnosis is identified as relevant, this should be made with reference to DSM or ICD criteria

ASD diagnosis confirmed

Joint **Reports** - relevant professionals to develop an appropriate intervention package including educational support, sleep, behaviour & sensory recommendations

ASD Not Confirmed

Child with co-existing /Complex Cases for one or more of neurodevelopmental disorders (CARE PLANING) or offer second opinion

Psycho-Education

ADMIN **Invites Parent to Post – Diagnostic Support Sessions**

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School Age Autistic Spectrum Disorder Pathway

Pre-Referral

Concerns Identified from Southend & Essex Health Visitors, School Nurses, CAMHS, Education, GP's

Lighthouse Single Point of Access (SPOA) Referral from via epunft.seechs.singlepointofaccess@nhs.net **and GP SystmOne e-Referral**

Screening/Triage Allocation

18 Weeks RTT Clock Starts

Referral to Multi Agency Core Referral Team (MACRT)

Sometimes further information is requested to help decide whether assessment is appropriate

New referrals received and accepted

Not enough Information

Expected Pre-referral information received

Acknowledgement of referral to Parent / Referrer that child has been placed on the **ASD pathway**

Time period for return of screening form will be delayed during school holiday. DON'T send screening packs during last two weeks of School term. Inform families there will be delay.

Information Gathering

Information Gathering - Questionnaires Sent to Parents & School Return within **4 wks**
ASD Over 5s Questionnaires - Received & **Graded/Scored**

Psycho-Education

Does Not Meet Criteria
Letter to referrer/parents for why CYP does not meet criteria. End Referral /discharge

Sign Post to Public Health Nursing 0-19 for support / Local Offer for Support

Meets Criteria
Referral Accepted
Letter to referrer/parents

Individual based Intervention or Pre – Psycho education

First Definite Treatment Clocks Stop

Health care staff will weigh and measure your child and make some basic physical observations.

Assessment Appointments

Child invited to an
Initial Appointment

Community Paediatrician - *Developmental History/ Full Examination / any investigations*. If ASD symptoms are present, Paediatrician refers to MDA team for assessment.

Multidisciplinary Assessment - MDA Discussion
A formal Multidisciplinary Assessment (Speech and Language, Occupational Therapist, Clinical Psyc, Specialist HV)
ADOS Assessment or an Autism Diagnostic Interview (ADI)

Diagnosis

Feedback/Review Meeting - Discuss assessment findings with parent and any support that may need

Where a particular diagnosis is identified as relevant, this should be made with reference to DSM or ICD criteria

ASD diagnosis confirmed

Joint **Reports** - relevant professionals to develop an appropriate intervention package.-

Follow Up meeting to discuss adjustment to child's diagnosis

ASD Not Confirmed

Child with co-existing /Complex Cases for one or more of neurodevelopmental disorders (CARE PLANING) - Specialist Services or offer second opinion

Psycho-Education

ADMIN **Invites Parent to Post – Diagnostic Support Sessions**