Independent Healthcare Providers Network

Building Better Neurodevelopmental Services

The Role of the Independent Healthcare Sector in Delivering NHS ADHD and Autism Care

July 2026

Executive Summary

This report examines the role that independent healthcare providers play in the provision of NHS neurodevelopmental services, with a focus upon assessment and ongoing support for ADHD and Autism in England.

The report provides:

- An overview of the current provision of NHS neurodevelopmental services;
- An outline of the key challenges which, if addressed, can enable improved partnership working between the independent sector and the NHS for the benefit of patients;
- Examples of innovation and effective partnership working between the independent sector and the NHS;
- A series of recommendations, representing a blueprint for reform.

The current challenges facing NHS neurodevelopmental services are widely publicised and acknowledged. Patients – both children & young people as well as adults - face significant waits for assessment (and where appropriate, treatment) often measured in years and, in some parts of the country, more than a decade.

In addition to long waits, patients are confronted with a highly complex, and variable approach to the commissioning of neurodevelopmental services depending on where they live in England – impacting waiting times, coordination between supportive services and approaches to shared care, as examples. This context is compounded by a wider political debate which has questioned the legitimacy of the growth in presentations for support and of the rate of referrals made by GPs for specialist ADHD and Autism assessments.

The consequences of failing to address these challenges are considerable. The ADHD Taskforce which presented its final report in late 2025, estimated that undiagnosed or unsupported ADHD alone would cost individuals and the government at least £17 billion each year. Meanwhile, only around one-third of working-age adults with Autism are in employment, compared with around 80% of people without a disability. The recently-published interim report of the Milburn Review into 'NEETs', i.e. young people who aren't in education, training or employment, notes that over the past decade, the proportion of those who are NEET due to a work-limiting health condition has increased by 70% - driven by mental ill-health and neurodevelopmental conditions. "A whole system reset", Milburn concludes, "is needed."

The value of specialist assessment capability, for a complex and vulnerable patient cohort - and where there is substantial co-occurrence of psychiatric and neurodevelopmental conditions - should not be lost in any future reforms. Proposals for 'needs led' services must be operationally viable in a context of escalating waiting times. In examining a greater variety of routes to access earlier support – which should be welcomed - the importance and value of specialist assessment capability, for a complex and vulnerable cohort of patients should not be lost. In an environment where there is greater awareness, distress, 'self diagnosis' and poor information online, this justifies the need for high-quality clinical input and specialist assessments to ensure that those seeking support have this need met appropriately.

IHPN's Neurodevelopmental Provider Group

- **IHPN has fourteen members who currently deliver neurodevelopmental services.** Almost all (92%) of these members deliver ADHD assessments for Adults (18+), with over two-thirds (69%) of the membership delivering ADHD assessments to children and young people (CYP) under 18; and just over two-thirds (69%) of this membership delivering assessments for Autism (both Adult and CYP pathways).

- **All of these members deliver NHS-funded services, with the majority - but not all - via the NHS Right to Choose (RTC) framework.** Members also deliver NHS-funded services via formal bids and tenders on block and framework contracts. Some members deliver NHS-funded services exclusively, and do not currently offer privately funded services.

- **All fourteen members are registered with the CQC.** 83% of members who have been inspected achieved an 'Outstanding' or 'Good' overall rating. Only a minority of these members, however, have had services inspected by the CQC.

Against this backdrop, the independent sector represents an essential partner in the delivery of NHS neurodevelopmental services and as a source of expertise for future reform, focused on earlier intervention. IHPN estimate, independent sector providers undertake over 50% of NHS ADHD assessments and over one-third of NHS autism assessments, giving patients greater choice and faster access to diagnosis and support. Some have sought to frame rising NHS expenditure on independent providers, in particular via the NHS Right to Choose (RTC) framework, as "overspending". In reality, spending has increased in alignment with the proportion of activity the sector now undertakes, and the sharp growth in demand for support.

The sector also demonstrates examples of service innovation that could benefit the NHS more broadly. Many providers have pioneered scalable, digital models of care that have helped reduce waiting times and costs compared with many NHS services. The case studies included in this report show how providers are streamlining assessment pathways, using digital tools and artificial intelligence to identify patient safety risks, supporting the professional development of flexible multidisciplinary teams, and working in close partnership with NHS commissioners to increase capacity and improve coordination of care.

Patient choice has brought real benefits to patients who are able to access specialist assessments regardless of where they live in England - but the infrastructure to manage the growth in providers now operating at a national level to effectively deliver on this right for patients is lacking. **The greatest improvement to the provision of NHS neurodevelopmental services in the near-term, therefore, would be to adopt a national approach to enhance consistency and standardisation across a number of priority policy areas.** This includes the development of tariff pricing which supports high quality service provision which should be based upon single service specifications across ADHD and Autism pathways; and the development of nationally agreed frameworks for Shared Care and Electronic Prescribing. These are just some of the areas we identify in our summary of recommendations, detailed at the end of the report.

We suggest a first-of-its-kind Modern Neurodevelopmental Service Framework is developed to support these ambitions - complementing existing and ongoing work on modern service frameworks for children & young people's services and severe mental illness. Reforms must put patients first - providing greater clarity and consistency across England over waiting times through standards that are enforced; through greater transparency and consistency in how neurodevelopmental pathways are designed and function, so that patient choice is supported and strengthened.

With the forthcoming publication of the Independent Review into mental health conditions, ADHD and Autism and the forthcoming Mental Health Strategy – alongside wider reforms to SEND and approaches to tackle NEETs, the coming months represent a 'sliding doors' moment to fix the foundations for NHS neurodevelopmental services. The IHPN and our members stand ready to work in close partnership with NHS commissioners, NHS England, DHSC and other stakeholders to make these proposals a reality.

Building Better Neurodevelopmental Services

In recent years there has been considerable growth in demand for assessment, diagnosis and treatment for ADHD and Autism, with 'escalating' waiting times for NHS services.

Prevalence

3-4%

of all adults in England are estimated to have ADHD

2.5m

people in England are estimated to have ADHD, including those without a diagnosis

Only **1/3**

of those with ADHD have received a formal diagnosis

Just **1.2%**

of people with ADHD have it recorded in their GP record

803,000

People were waiting for an ADHD assessment in March 2026

270,000

people were waiting for an Autism assessment in March 2026

Access to Care

Over 25%

of people waiting for an ADHD assessment have been waiting for

2+ years

Waiting times for assessment exceed

6-10 years

across many NHS ICSs

There is a

4x

difference in pharmacological treatment rates between NHS service provider areas

The Independent Sector

The independent sector delivers

50% of NHS ADHD assessments

33% of NHS Autism assessments

100%

of IHPN members who deliver NHS neurodevelopmental services CQC registered

83%

of IHPN members inspected by CQC are rated "Good" or "Outstanding"

For more information on the independent sector's contribution to NHS neurodevelopmental services go to www.ihpn.org.uk/

Independent Healthcare Providers Network

NHS Neurodevelopmental Services Today

Growth in demand

- In May 2026 it was estimated 2,498,000 people in England had ADHD, including those without a diagnosis. Of these, 741,000 were children and young people (aged 5-24). Only about a third of these individuals have received a formal diagnosis, and just 1.19% have this recorded in their GP record.
- In March 2026, there were 270,701 patients with an open referral for suspected Autism. Of these, 242,708 (89.7%) had a referral that had been open at least 13 weeks. Between June 2024 and June 2025, there was a 14.7% increase in open referrals for an assessment of Autism.
- The majority (>55%) of children and young people awaiting community health services in England are awaiting access to community paediatric services, predominantly for those with developmental problems or disabilities, which includes neurodevelopmental assessments.
- Research, including by the ADHD Taskforce, has demonstrated that recent growth in demand for NHS services has largely been driven by historic under-diagnosis, greater awareness and acceptance of ADHD encouraging more people to seek support.

Geographic variation in access.

- Evidence, shared with IHPN to develop this report by one of our members, suggests that a significant 'treatment gap' exists between ICBs (mapped against ICB footprints in place in 25/26) across England, based upon an analysis of their overall weighted populations, the expected weighted population for those with ADHD (for example) and most recent actual diagnosis rates recorded (combining CYP and adults).
- A further recent study finds that there is up to a 4.6-fold difference in pharmacological treatment rates for ADHD between NHS ICBs.

The link with mental ill-health and wellbeing

These developments are of major concern, given the co-occurrence of neurodevelopmental conditions, mental ill-health and wider impacts on wellbeing.

- Long waits increase clinical risk - including the greater likelihood of self-harm, exclusion, inability to secure reasonable adjustments at school or in the workplace.
- The Health Services Safety Investigations Body (HSSIB) has recently warned of greater safety risks when community neurodevelopmental care access is poor, leading to inpatient escalation.
- There is widespread evidence demonstrating how unsupported ADHD symptoms can predispose young people to wider mental ill-health, leading to negative long-term outcomes such as worse academic and employment opportunities, financial difficulties, higher engagement in criminal activity and increased mortality. For those with Autism, there are higher risks of suicide.
- A recent study in the British Journal of Psychiatry which explored adults diagnosed with ADHD in the UK, reveals an "apparent reduction in life expectancy for adults with diagnosed ADHD relative to the general population was 6.78 years for males, and 8.64 years for females".

Unlocking potential

With timely assessment - and where appropriate, treatment - children and adults alike can unlock their potential - achieving more at school, thriving at work, and enjoying better health and relationships.

- A recent report, developed by Autism Alliance UK, revealed, doubling the employment rate for autistic adults would create up to £1.5 billion of benefit for the economy per year.
- Recent research has shown that effective prescribing of ADHD medication can reduce the risk of suicidal behaviours, substance misuse, transport accidents and criminality.
- Evidence, shared by one of our members who measure the longitudinal impact upon patients further to ADHD treatment, reveals that following a year, 62% of patients reported improved attention and concentration, 82% showed reduced depression symptoms (average PHQ-9 reduction: 5.53 points), 77% reported reduced anxiety (average GAD-7 reduction: 4.42 points) and patients with severe symptoms show the greatest improvements (e.g., PHQ-9 reduction of 12.91 points).
- The ADHD Taskforce evidence summary states that stimulant treatment has one of the highest efficacy effect sizes seen in psychiatry and even in general medicine, at least in the short term. That makes ADHD an unusual area in which high unmet need coincides with unusually strong treatment effects.

Siloed services

There is widespread acceptance that current services are too often siloed and predicated on a diagnostic model, but without sufficient subsequent and integrated support for individuals - particularly for young people and adults.

- This has been a central finding of the ADHD Taskforce, the interim report of the Independent Review into mental health conditions, ADHD and Autism and the Milburn Review into NEETs.

ADHD Taskforce – final report (November 2025): Key findings and recommendations

- Concludes that there is"consistent evidence that ADHD is under-recognised, under-diagnosed and under-treated (including with medication)" in England, but says there are "anecdotal reports of low-quality ADHD assessment and inaccurate diagnosis provided by some ADHD services".
- Calls on the Government to introduce "transparent and clear regulation of ADHD service providers as well as auditable quality control for commissioners", and to "collaborate with NICE to explicitly define what is meant by an appropriately ADHD-qualified healthcare professional". are positions that the IHPN have publicly supported.
- Proposes DHSC should incentivise GP practices to take on aspects of ADHD care and also develop a greater leadership role around ADHD.

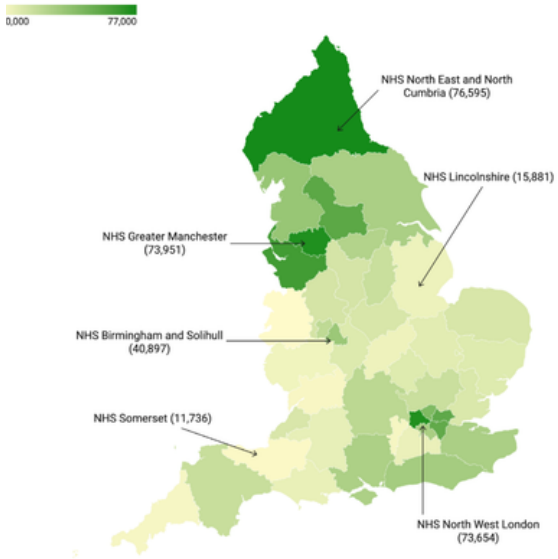
Young people and work – interim report (June 2026) – Key findings

- This review, chaired by Rt Hon Alan Milburn notes that NEETS are now "an interlocked health, disability and participation issue" and that the cumulative cost to the UK of almost 1 million NEET young people at £125 billion a year.
- In 2024/2025, 29.6% of disabled young people were NEET in the UK compared with 8.7% of non-disabled peers, a gap of 20.9 percentage points.
- "Health has become central to who becomes NEET and who stays NEET" – this is, as he puts it, 'a defining shift'. Over the past decade, the proportion who say they are NEET due to a work-limiting health condition has increased by 70%.
- The proportion of disabled NEETs citing mental health as their primary condition has almost doubled to more than four in ten.

Independent Review into mental health conditions, ADHD and Autism – interim report (March 2026) – Key findings

- Concludes "there is credible evidence of increasing psychological distress", but that in ADHD and autism, "rising diagnoses and referrals appear to exceed changes in underlying epidemiological prevalence and are likely to reflect a combination of improved recognition, changing help seeking behaviour, institutional incentives and pressures within existing service pathways".
- Suggests that "across the system, support is too often accessed through pathways that are slow, fragmented and heavily dependent on diagnostic categorisation".
- Notes that these findings "point to a more complex and changing relationship between identification, diagnosis and treatment across different parts of the system" which may "increasing delays between diagnosis and treatment, greater caution in prescribing, changes in case mix, or the growing role of private assessment pathways in which diagnosis does not always lead directly to NHS prescribing".
- It concludes that, "at present, the data do not permit these explanations to be disentangled with confidence"

An Estimation of the ADHD 'Treatment Gap' Across NHS Integrated Care System Footprints in England, Based on Prevalence and Population Data, 2025/2026*



Note: The darker the green, the greater the current likely 'treatment gap'.

*Source(s): Underlying assumptions used to development this data from the following sources: MH weighted populations in annex D from: https://www.england.nhs.uk/publication/supporting-spreadsheets-for-2025-26-allocations/;
Weighted population divided by estimated population size for age cohort in annex A: https://www.england.nhs.uk/publication/supporting-spreadsheets-for-2025-26-allocations/. Diagnostic estimate is based on 1 in 9 people with ADHD being on medication: https://adhduk.co.uk/adhd-diagnosis-rate-uk/ .

The Role of the Independent Sector

IHPN members who deliver NHS neurodevelopmental services do so via the following contractual mechanisms:

- **The Right to Choose (RTC) framework -** representing the vast majority of NHS-funded activity delivered by members: a patient choice mechanism, whereby referrals are made via general practice, and activity is funded by the patients' ICB. Referrals can be received and care delivered via Non-Contracted Activity (NCA).
- **National Framework Agreements -** established under the Provider Selection Regime (PSR) Regulations 2023 with England-wide coverage.
- **Regional Framework Agreements -** which cover an NHS Region footprint.
- **Local procurement & block contracting -** e.g. Backlog Clearance/ Waiting List Initiative/Rapid Delivery. ICBs and Trusts commission time-limited neurodevelopmental backlog reduction programmes with defined volumes and accelerated delivery timescales, enabling systems to address acute waiting list pressure through rapid mobilisation and scaled clinical capacity.
- **Steady-state / service extension contracts -** Some members also deliver services through longer-term contracts that provide ongoing, planned capacity to support business as usual demand. These arrangements are often extensions of existing services or awarded via frameworks, with an emphasis on integration with local pathways.

> "We will not let spare capacity go to waste on ideological grounds. We will continue to make use of private sector capacity to treat NHS patients where it is available, and we will enter discussions with private providers to expand NHS provision in the most disadvantaged areas. Our use of a plurality of providers - from within the NHS, the voluntary sector, the independent sector or social enterprise - will not be limited to elective care. Where there is such rapid innovation taking place today in how services can be transformed through advances in science and technology we want to broaden the eco-system of providers"
>
> DHSC, 10 Year Health Plan (July 2025)

Since the introduction of the RTC framework in particular, there has been a significant expansion in the ability for the patient to choose their provider – enabling improved access to Autism and ADHD assessments through clinically-effective, yet scalable (and often, virtual or hybrid) platforms. RTC is a key example of funding 'following the patient'.

Independent sector providers are playing a significant and growing role in the provision of NHS neurodevelopmental services. IHPN estimate that they deliver more than 50% of all NHS ADHD assessments and more than 33% of all NHS Autism assessments (across both CYP and adults).

ADHD
Adults and CYP
>50%
Of all NHS assessments delivered by independent sector providers

Autism
Adults and CYP
>33%
Of all NHS assessments delivered by independent sector providers

100%
of IHPN members who deliver NHS neurodevelopmental services registered with the CQC

83%
of IHPN members inspected by CQC achieved a Good or Outstanding (Overall) rating.

Note: These estimates are based a combination of IAP data shared by members in confidence with IHPN, combined with published activity data, included in published national published by the Mental Health Services Dataset (MHSDS) and Community Services Dataset (CSDS). Official statistics published by NHS England do not explicitly include cases handled via RTC. One reason for this may be due to variable ICB enforcement of MHSDS reporting by providers.

Challenges and Proposals for Reform

Variability in Activity Management is Creating a Postcode Lottery for Patients

Across England, independent healthcare sector providers currently encounter variation in:

- referral and acceptance criteria;
- commissioner expectations regarding complexity;
- prescribing responsibilities;
- reporting requirements;
- governance standards;
- data collection requirements;
- acceptance of remote and hybrid pathways.

Our membership identifies greater standardisation and the reduction of unwarranted variation in the commissioning of neurodevelopmental services to be a key priority for reform.

All IHPN members recognise the financial pressures facing ICBs at present and the legitimate need for appropriate service demand management. However, the commissioning of NHS neurodevelopmental services has swiftly changed over the past eighteen months, with the introduction of Indicative Activity Plans (IAPs) and the increasing use of Prior Approval mechanisms alongside the use of 'minimum waiting times' changing how the Right to Choose (RTC) framework operates in practice.

The result is greater operational uncertainty for providers and a greater gap emerging between commissioned activity and patient demand.

A recent analysis, based on Freedom of Information requests, published by ADHD UK, reveals that "almost 60% of ICBs have imposed, or are planning to impose, limits on the number of ADHD and Autism assessments" they will fund.

In some cases, ICBs have limited IAPs to those patients who have appointments booked, stating that the risk (clinical and financial) of undertaking activity beyond the IAP will rest with the provider. In other instances, IAP allocation has been based upon provider-reported patients in progress.

Across our membership, for the current financial year 2026/27, members have been set IAPs by around a third of ICBs. Where IAPs have been set, our estimation is that our membership has been allocated activity approximately 33% lower than that delivered during the financial year 2025/26. These allocations are, in many cases, significantly below current referral rates and the level of underlying patient need. As a result, clinical capacity remains unused while waiting lists continue to grow and patients experience longer delays in accessing assessment and treatment.

In addition to financial controls, commissioners are using a range of access policies and approval mechanisms to manage activity within available in-year budgets.

- **Minimum Waiting Times:** We have seen some ICBs propose minimum waiting times of over 52 weeks (and even as long as 104 weeks) "to standardise waits across the system, and bring them closer in line to the local NHS provider where waits for Adult ADHD Assessments are circa 3 years". In the absence of a national waiting time standard, which is scrutinised and enforced, this variation risks exacerbating inequities in access to care across England.

- **Prior Approval Schemes (PAS):** Local commissioning policies and triage/interface services can be legitimate means of ensuring patients with the highest needs are appropriately identified. However, the RTC operates on the basis of a provider following the specification of its host commissioner (with whom it secured a 'qualifying contract') for referrals received from any ICB. We are seeing some ICBs seeking to introduce commissioning policies which would have the effect of requiring the provider to deliver a service differently to that underpinned by the host commissioner's contractual terms. One example of this is where the host commissioner has commissioned a virtual pathway, with another ICB specifying in a PAS that elements of the pathway are mandated to be delivered face-to-face. Fundamentally, these issues could be resolved by a well-designed, evidence-based and uniform service specification.

- **Patient-facing communications which inaccurately characterise RTC or its working.** IHPN has seen a range of communications made either to GPs or directly to patients which make the argument that provider "accreditation is guarantee of quality" thereby implying assessments undertaken by RTC providers who have not been accredited by a particular NHS ICB, may be of lesser quality and "may not be accepted", creating additional complexity for the referrer and the patient.

In practice these developments mean:

- **Significant unused capacity:** As a consequence of the reduction in activity commissioned – and of the rate at which providers can assess patients. One of our member reports that in Q4 2025/26 alone, they estimated that capacity to undertake almost 9,000 initial assessments went unused because of activity-related funding restrictions.
- **Extended waiting times for patients**: With activity limits slowing the rate patients can be assessed. The overall impact on waiting times is difficult to quantify precisely. Unlike traditional contracted services, IAPs are often agreed for a single financial year and can vary substantially from one year to the next. This means providers can usually only give meaningful assurance to patients whose activity sits within that particular financial year
- **Challenges in delivering 'operational transparency' for patients:** The practical effect of some local commissioning behaviours means that patients with similar clinical needs may face different waiting times based solely upon geography. For patients, their statutory right to choose becomes increasingly difficult to exercise meaningfully because waiting time visibility also reduces in this context.

- **Additional friction is built into the pathway:** Owing to changing and variable acceptance rules, approval mechanisms or financial thresholds, the overall 'patient journey' is subject to greater variability across England.

- I**ncrease in overall clinical risk:** Owing to delayed diagnosis, delayed initiation of treatment (in ADHD) with patients waiting longer with unmanaged symptoms, functional impairment, and in some cases, worsening mental health or safeguarding concerns. A number of members have reported IAPs which mean, in practice, they would be unable to carry out assessments for referred patients screened and triaged and deemed 'high risk' or complex until next financial year when activity is reset by IAPs.

In terms of operational management, this variability and volatility makes planning at the provider level increasingly challenging**.** Regardless of whether members have a sessional clinical workforce, or an employed model, predictability is required to recruit, onboard, supervise and retain clinicians effectively.

Evidenced-based Tariff Pricing – Aligned with Clear National Specifications - Can Play a Key Role in Driving Quality

Pricing can be a key mechanism to drive high-quality, innovative provision, when carefully designed and implemented, and we welcome the publication of guide prices for ADHD assessments earlier this year which are a positive first step towards the development of mandatory national tariffs prices in this area.

As it stands, however, the evidence base which underpinned the non-mandatory guide prices which came into effect as of April 2026 has remained unclear, with the cost evidence underpinning it never made available publicly.

Overall, our members reflect that the current non-mandatory guide prices encompass discrete episodes of activity, rather than the full safe clinical pathway, with guide prices, especially for Autism, combined assessments and titration (ADHD pathway) in particular not reflecting the full cost of NICE-compliant care.

It is vital that the introduction of tariff pricing is applicable to all providers of NHS neurodevelopmental services, including statutory providers currently delivering these services predominantly via block contracting arrangements.

As NHSE progresses its work toward the development of mandatory tariff pricing, we recommend the development of:

- National quality standards which are linked to tariff assumptions;
- Differentiated tariffs for patient cohort complexity;
- Explicit recognition of the governance and enabling infrastructure which are required to deliver pathways;
- Pricing assumptions that are based on real-world data (derived from fulsome consultation with all providers);
- Publication of the costing methodology and underlying evidence base;
- Regular review against outcomes and delivery data.

Greater Adoption of Virtual Assessments and Digital Tools to Improve Productivity

There has also been a degree of misalignment between national policy - set out in the 10 Year Health Plan and the NHS Medium Term Planning Framework – and the approach taken by NHSE in the development of non-mandatory guide prices where no prices for virtual assessments for ADHD (CYP pathway) or for Autism (CYP and Adult pathways) were published, implying a preference for the commissioning of in-person assessments.

There is growing evidence, however, to support the position that virtual and hybrid assessments are clinically acceptable when delivered by suitably trained clinicians with robust clinical governance processes:

- A study of service users who undertook assessment by the ADHD and Autism Service at Southwest Yorkshire NHS Partnership Foundation Trust in 2020 completed "found remote telecommunication to be useful, effective, reliable and satisfactory".
- A mixed methods systematic review of autism assessments published in 2025, involving UK clinicians and families found high satisfaction, citing convenience, reduced travel burden, improved access, and faster care, aligning with the international evidence showing diagnostic agreement rates of 80–88.2% between telehealth and in person assessments.
- With specific reference to Autism assessments, whilst some concerns have been raised around the ability to conduct observations, clinicians have also noted the value of the insight into home environment that virtual assessments can bring, noting the ability to examine natural behaviour at home, family dynamics and sensory and environmental triggers. These aspects can enhance assessment quality in some cases, even if other behaviours are harder to observe remotely.

IHPN members have also adopted a wider range of digital tools to meet the needs of a provider accepting referrals at a national level, to boost productivity and to introduce technologies which can improve service provision.

Below we provide three examples: an approach to enhance screening and onboarding; and the effective deployment of an AI-powered capability to enhance safeguarding and patient safety.

Case Study – Psicon: Enhancing Patient Screening and Onboarding Processes

Context

- The management of patient onboarding and referral into neurodevelopmental services can be complex and challenging.
- Patient information can be received in a wide variety of formats and from a range of different sources e.g. from schools or from carers.
- With some providers now handling many thousands of cases each month, this managing onboarding has proven a major logistical challenge.

Approach

- Psicon has developed their own system in-house, utilising Salesforce, which can automate much of what used to be a manual process.
- To achieve this, they have partnered with the author and publisher of the screening tool (Multi-Health Systems) to develop screening tools into a single, coherent platform which can prepare patients within twenty-four hours and provide an automatic acknowledgement of referral.

Impact

- This project is estimated to have saved 40,000 admin hours between January 2025 and October 2025 alone.
- The approach means patients are able to move from referral to a clinically ready triage pathway within 24 hours in most cases, significantly reducing delays at the start of the patient journey.
- Patients can complete onboarding digitally, giving them greater visibility and control over their own care pathway while reducing unnecessary administrative contact.
- Administrative teams are able to spend more time supporting patients with complex queries and less time undertaking repetitive manual processing.
- Clinicians receive structured, validated information earlier in the pathway, supporting more efficient and consistent clinical decision making.

Case Study - Psychiatry UK: Implementing TwynSyght, an AI-powered risk and safeguarding tool to automatically scans patient notes, flag risks, and enable real-time intervention

Context

- Psychiatry UK has implemented TwynSyght, an AI-powered clinical decision support tool to enhance mental health risk screening for NHS patients.
- The system automatically analyses patient-written mental health notes, identifying potential risks such as self-harm indicators or safeguarding concerns, and generates comprehensive risk summaries directly integrated into electronic health records.

Impact

- Between January and August 2025, TwynSyght processed over 570,000 patient notes, highlighting 6,988 apparent risks requiring clinical attention, of which clinicians determined 397 required immediate action.
- The scale of automated screening has enabled comprehensive real-time risk monitoring across Psychiatry-UK's entire caseload, something previously impossible with manual methods.
- Performance data demonstrates consistent, high-volume processing throughout the implementation period, ranging from 58,296 notes in April to 84,612 notes in July.

Lessons Learnt

- Effective implementation of tools can enable improved safeguarding and real-time intervention.
- Vulnerable individuals documenting risks in their notes no longer slip through assessment gaps due to time or capacity constraints – improving the quality of care delivered.

Case Study – Paloma Health: Improving assessment quality and efficiency through an innovative new electronic patient record and AI documentation tool

Context

- High-quality neurodevelopmental assessments include appointments of over an hour in length, where detailed notes need to be taken by the assessing healthcare professional.
- The requirement to focus on note-writing can limit an assessor's ability to pick up the nuances of the presentation and ensure a high-quality assessment. Furthermore, these notes can take significant time to write during and after appointments, reducing the efficiency of service delivery.
- Generic healthcare electronic patient record and AI scribe tools are not designed for neurodevelopmental assessment services, and therefore do not support assessors in the required note taking.

Approach

- They identified the need to develop a tailored electronic patient record system and AI documentation tool for children's autism and ADHD assessments that would free assessors to focus on the parent and child in front of them.
- Paloma Health invested in building an in-house product, engineering, and AI team that worked alongside our senior clinicians to successfully develop our tailored patient record and AI documentation tool (called Loma).

Impact

- Feedback from the assessor team is that the record system and AI tool Loma supports the team to take higher quality notes and significantly reduce the time spent on note taking.
- As each assessment can be delivered more efficiently, theassessor team are able to support more families and help reduce waiting lists.

A clear, Single National Service Specifications and Standards – relating to Clinical Governance, Oversight and Reporting

There has been a lively debate in recent months regarding variable standards in the quality of ADHD and Autism assessments delivered for NHS patients, with the work of the independent sector often referenced.

Positive 'conversion rates' (i.e. diagnosis) has been suggested as one reason for 'overdiagnosis' of neurodevelopmental conditions and has become one area of discussion in relation to quality.

The recent findings of a King's Fund report suggest NHS sites have struggled to collect 'reliable' diagnosis and conversion rate data. Where it is available, it is not clear that high conversion rates are a phenomenon exclusive to the independent sector. For instance, data from the South London and Maudsley NHS Trust – the UK's largest child mental health service –was cited in a recent article in The British Journal of Psychiatry and revealed that "94% of children assessed received a confirmed ADHD diagnosis." An investigation conducted by Autistica in 2024, based upon an FOI exercise suggests significant variation in conversion rates, with significant differences in conversion rates between NHS Trusts, and conversion rates that were not associated with provider type.

There is no literature we are aware of which establishes an optimal positive conversion rate, given conversion rates should be interpreted in the context of a wider needs-based assessment. As such, where higher conversion rates are observed, this may in fact reflect robust pre-assessment screening and filtering processes rather than reduced diagnostic rigour. Care, therefore, is needed in determining appropriate measures of quality.

There is, however, a recognition that quality of neurodevelopmental service provision is variable – across both NHS-funded and privately funded care and that greater consistency in national standards, workforce competencies and expectations as well as transparency over outcomes would be welcome.

NICE Guidelines

Our members reflect that NICE guidelines represent an important and appropriate foundation for ADHD and Autism services. However, they also noted increasing variation in how this guidance is being interpreted and operationalised. Greater clarity in a number of key areas would be helpful, particularly where guidance is currently interpreted inconsistently, namely:

- What constitutes a sufficiently robust multidisciplinary model for ADHD and autism assessments;
- Which healthcare professional backgrounds are 'appropriately qualified' to deliver autism and ADHD assessments as well as what and how long their training should be to operate independently;
- How long (in hours) autism and ADHD assessment appointments should be;
- The distinction between core NICE requirements and examples of good practice;
- Appropriate expectations around ADHD medication follow-up frequency and discharge arrangements;

A Modern Service Framework

The Government has already committed to develop a 'Modern Service Framework' for mental health (including severe and enduring mental illness) and for children and young people.

We recommend that these workstreams are built upon and extended to provide a dedicated focus upon neurodevelopmental conditions – to form a Modern Neurodevelopmental Service Framework. This work could consider:

Overarching standards and expectations:

- Establishing clear and enforceable waiting times targets and expectations for patients;
- Defining clinical approaches to referral, acceptance, triage and prioritisation;
- Management of complexity, including physical health; co-occurring mental health conditions; safeguarding; differential diagnoses; complexity thresholds and escalations.
- Defining assessment modality standards, with agreed rules of the acceptability of remote, face-to-face and hybrid assessments, with clear criteria for when in-person assessments are required.
- A specification which defines the core competencies required to deliver high-quality neurodevelopmental assessments and the professional training which is required.
- This could include minimum qualifications and registration requirements; competencies; supervision standards; Multi-Disciplinary Team expectations; requirements for independent decision-making; escalation and consultation pathways.

Diagnostic reports and clinical outputs

- Improvement and greater consistency in expectations over the contents and quality of outputs to benefit wider systems of support, including GPs, schools and employers.

Prescribing and medication management

- Establishing a common framework would improve continuity, reduce duplication and support safer transfer between providers.

Quality & clinical governance

- Quality expectations should be standardised, and should be applicable to all providers, regardless of whether NHS- or privately funded.
- Data reporting should be standardised with a national minimum dataset focused on activity, waits, outcomes, patient experience, safety, conversion, prescribing and equity measures. This would reduce duplicative local data requests and allow like-for-like comparison.

To inform this report, a number of members shared examples of recent developments to their clinical governance arrangements – and how these had been adapted to accept patients from across England. However, as with the other case studies included in this report, these should be regarded as illustrative of approaches that different providers are taking at present. Their inclusion should not be regarded as representing a sectoral view of how arrangements should be developed, or how standards should be interpreted. We recognise that different providers have adopted different clinical governance arrangements and that what is detailed below may subject to further change with the introduction of new national standards, revised NICE guidelines etc.

Case Study – CARE ADHD: An Example of How Clinical Pathways Can Be Built Around Quality Standards

Context

- Current ADHD care is characterised by long waiting times, inconsistent clinical quality and fragmented pathways, directly impacting patient experience, leading to delays in diagnosis and poorer health and social outcomes.

Approach

- To address these issues, CARE ADHD has redesigned its pathways through an improvement programme with the aim of improving assessment consistency and quality.
- Pathways have been redesigned from NICE and AQAS standards with structured diagnostic tools, developmental history, safeguarding prompts and screening for anxiety, depression and physical health introduced. Documentation, templates and Standard Operating Procedures (SOPs) have also been standardised.
- Clinical decision-making is supported through frequent MDT review, structured supervision and teaching sessions. Findings from a multi-layered audit programme inform supervision, training and service improvement and are discussed in regular Clinical Governance Meetings.
- Investment was required to develop SOPs, templates and audit tools, and to fund senior clinical roles including a Head of Clinical Effectiveness, Associate Director of Quality and to enable dedicated MDT time.

Impact

- Diagnostic accuracy has proven robust across NHS and private pathways, with second opinions low.
- Triage accuracy and treatment compliance with NICE NG87 has been sustained at 100% and Controlled Drug log compliance shows improvement of 96–100% following targeted oversight.
- Use of structured interviews and validated tools (e.g., DIVA-5) has reduced variability and supported AQAS scores of 89–100%.
- Routine MDT discussion ensured shared clinical reasoning, reflected in low second-opinion rates (0–0.5%).

- Patient feedback has also directly informed refinements to communication, report clarity and post-diagnostic support. (This, however, required significant investment in customer service and digital infrastructure to support increased demand and improve patient flow.)
- Waiting times that peaked as high as 25 weeks, have been reduced to 3 weeks for assessment and 6 weeks for titration.

Lessons Learnt

- Quality in neurodevelopmental assessments can be improved when pathways are built directly around NICE guidance and AQAS standards.
- Continuous audit cycles allow early detection of variation and help sustain improvements, even during periods where these is a significant growth in referrals.
- Embedding structured diagnostic tools ensures robust formulation, reduces ambiguity, and supports defensible clinical decision-making.
- Digital systems that reinforce NICE compliance, through templates, prompts or automated audit, can strengthen governance and reliability.

Case Study – ADHD360: An Example of How a Provider Has Developed an Integrated Clinical Governance Framework Across a Group Model

Context

- Following a significant increase in referrals in recent years, a range of measures have been introduced to improve clinical governance and to provide assurance services are delivered consistently across ADHD pathways as well as and wider group services (including Autism and Speech and Language Therapy).

Approach

- ADHD 360 undertook a thorough review and self-audit of practices, consulting across all areas of the business, identifying specialist roles to lead continuous development.
- A unified governance model is in place, which is aligned with:
  - NICE guidance to ensure evidence based clinical practice across neurodevelopmental and communication pathways.
  - CQC regulatory standards, supporting high quality, safe and compliant service delivery.
  - Internal safeguarding, prescribing and escalation policies fully aligned with the Patient Safety Incident Response Framework (PSIRF).
  - Regular clinical audit and peer review processes, ensuring continuous learning, quality assurance and oversight.
  - Proprietary clinical systems that prioritise safeguarding, risk management and defensible clinical decision making across ADHD, Autism, and Speech and Language Therapy services.
- Clinical standards, compliance and governance are monitored through a monthly Clinical Quality, Compliance and Governance Forum, attended by senior clinical leaders.
- Services are designed to equip them with the highest standard of research led assessment and treatment approaches. This includes access to evidence-based tools, structured training pathways, and continuous mentorship from experienced clinical leaders.

Impact

- Medicines management committee responsible for reporting prescribing audit data has led to a reduction in prescribing errors, at a level below the national expected prescribing error rates for community services.
- Robust internal clinical audit programme in which thematic analysis applied to results, informing internal training programmes has led to a steady increase in audit compliance across all internal clinical teams.
- Full adoption of the Patient Safety Incident Response Framework (PSIRF) has ensured a responsive and proactive process to facilitate learning opportunities from incidents and that the service adopts a no blame and continuous improvement culture.
- An integrated structure ensures safe prescribing, strong quality assurance mechanisms, and regulatory compliance at scale, whilst the governance structure has enabled meaningful learning opportunities across the organisation.

The Current Scope of Regulation Across Neurodevelopmental Pathways

All fourteen IHPN members who deliver neurodevelopmental services are registered with the CQC. Of those members whose services which have been inspected, 83% achieved a Good or Outstanding overall rating.

However, there has been greater discussion in recent months over the current scope of formal regulation of neurodevelopmental pathways. Many have drawn attention to current complexity in the interpretation of current regulations, which state: "If you only offer diagnosis of ADHD and autism with no treatment, you do not need to register with CQC."

This – based on our understanding – arises from an interpretation of current regulations which does not include assessment and diagnosis of neurodevelopmental disorders as regulated activities. This therefore appears to leave 'assessment-only' services (i.e. where the provider does not prescribe medication for instance) beyond the scope of CQC registration (and inspection).

The implications of this are a matter which DHSC and CQC should consider. The current scenario means that providers who deliver similar NHS funded pathways may be subject to different levels of statutory oversight depending on the configuration of their service. This inconsistency creates uncertainty for patients, commissioners and referring clinicians, and is misaligned to the aim of ensuring greater consistency in national standards.

IHPN – and our members- are clear on the principle that **all providers delivering neurodevelopmental services should be CQC-registered** and that there should be 'end to end' oversight of the pathway. In practice, we also recognise the complexity of changes to regulations, including the operational impacts of expanding the range and complexity of providers that would fall into scope of regulation by amending either listed professionals or the scope of 'assessment' and 'diagnosis'. Further consultation on the form that regulatory change could take to provide greater confidence and assurance of these services both from DHSC and CQC would be welcome.

Our members also reflect that current regulatory approaches can lack specificity for neurodevelopmental pathways, particularly where services are delivered digitally or across organisational boundaries. Fundamentally, it could be argued that the way that both the current scope of regulation and how services are overseen is out of step with the way in which services are delivered. As further innovation enters the sector e.g. with a greater proliferation of digital diagnostic tools, the case for revisiting the current approach becomes stronger. Over time, more tailored approaches to assessing clinical governance and patient safety across neurodevelopmental pathways 'end to end', rather than via the isolation of service elements, could be explored.

Electronic Prescribing (E-Prescribing) at Scale to Support Providers Operating Nationally

There is currently no nationally consistent approach to the operation of Electronic Prescription Service (EPS) arrangements for medicines prescribed by Right to Choose (RTC) providers. This variation extends to the use of differing terminology and administrative processes. Fundamentally, providers are operating in a context in which there is no common language or unified approach.

Differential solutions have emerged to enable prescribing and reimbursement continuity, but with significant administrative complexity for providers operating nationally. At the centre of these arrangements are:

- Parent Codes – organisational codes that identify the sponsoring NHS organisation within prescribing and reimbursement systems and determine who is responsible for costs in the first instance (i.e. ICB or Provider).
- Cost Centre Codes – codes used to allocate prescribing expenditure to a specific provider.
- Independent Sector Healthcare Provider (ISHP) status – arrangements that enable independent providers delivering NHS-funded care to access NHS prescribing infrastructure.

Whilst the underlying objective is consistent—ensuring NHS-funded medicines can be prescribed and dispensed for RtC patients—the operational models differ substantially.

Each IHSP has a Parent Code (which will be the same as their Organisation Data Service code). Each ICB that commissions the ISHP via direct contract or NCA and wishes to authorise the ISHP to prescribe, completes a Programme Application Form (PAF). This PAF tags the ICB to the Parent Code. On the basis of this, the creation of a Cost Centre under the Parent Code is enabled.

However, instances have emerged in which some ICBs do not enable the creation of a cost centre for a provider, meaning they cannot utilise NHS EPS and therefore, prescriptions are issued and medicines dispensed through private pharmacy arrangements creating additional administrative burdens, higher costs and going against the intent of the 2026/2027 NHS Payment Scheme principles.

In addition to differing operational models, commissioners frequently use differing terminology when discussing: Parent Codes; Cost Centre Codes; Sponsorship arrangements; ISHP status;

The absence of a common language and nationally-agreed definitions can lead to differing interpretations of NHSBSA requirements and inconsistent implementation. As a result, providers operating across multiple ICBs are often required to maintain different prescribing processes for different patient cohorts despite delivering the same clinical service.

Impact on Commissioners, Providers and Patients

The current approach creates inefficiencies and may increase expenditure for commissioners including increased Medicines Costs, administrative complexity, reduced financial transparency and delayed resolution of operational issues.

RtC providers are disproportionately affected by the status quo because they accept referrals from patients across every ICB in England. Issues include having to navigate the use of differing operating models, additional administrative cost and reconciliation activity, as resources are required to validate prescribing activity with costing data.

Although the issues outlined above are principally administrative challenges, the consequences are felt by patients in delayed access to medication and risk to treatment interruptions as well as representing further example of an inconsistent patient experience.

National Oversight and Approach

The issues described above arise primarily from a lack of nationally coordinated policy and operational guidance. To address these issues, some providers have developed a range of pragmatic and collaborative approaches (see Case Study below).

Case Study: Clinical Partners – Enabling Electronic Prescribing Across ICBs

Context

- Clinical Partners held a qualifying contract with Bristol, North Somerset and South Gloucestershire (BNSSG) ICB that included NHS prescribing via an NHS cost-centre code, with BNSSG set as the parent organisation.
- The cost-centre model, however, was not designed for RTC prescribing across multiple ICBs.
- Using the BNSSG ICB-linked cost-centre for RTC patients outside the ICB would mean that NHSBSA would recharge prescribing and medication costs to the ICB for patients who were not within their geographical commissioning responsibility.
- This is an issue which has prevented many independent sector healthcare providers from issuing NHS prescriptions for RTC ADHD patients.
- In practice, providers rely on private prescriptions for NHS patients, which creates avoidable administrative complexity, as well as preventing realisation of the many benefits of the NHS Electronic Prescription Service (EPS). This is something, meanwhile that recently introduced Payment Guidance advises against.

Approach

To address this issue, Clinical Partners implemented a phased approach to maintain continuity for patients while designing a sustainable, scalable NHS prescribing model. This included:

- Interim continuity: A private online pharmacy supplied medication at trade price, with prescribing and delivery fees charged separately. Medication costs passed to ICBs at trade price during the interim period and absorbed the additional pharmacy fees (so they were not passed on to NHS customers). BNSSG ICB agreed contractual provisions to enable this model while a long-term solution was developed.
- Cost-centre redesign to enable cross-ICB RTC prescribing: Clinical Partners worked with BNSSG ICB, Lancashire and South Cumbria ICB and NHSBSA to explore alternative cost-centre configurations which led to Clinical Partners becoming the parent organisation for the cost-centre. This change meant NHSBSA recharged prescribing activity to Clinical Partners directly, allowing accurate recharging to each ICB for its own prescribing activity, rather than misallocating costs to a single ICB.
- NHSBSA developed a new ePACT2 report to break down charges by ICB and GP practice: NHSBSA used available national data sources (including Spine lookups) to validate commissioning responsibility and produce a robust breakdown. This reduced the need for Clinical Partners and partner ICBs to run time-consuming local validation exercises and improved confidence in the recharging mechanism.
- Enabling EPS at scale: Clinical Partners procured EMIS to support the use of EPS, reducing the need for paper FP10 prescriptions (where applicable) and supporting patient choice of pharmacy. EPS enabled standardised, scalable workflows and stronger operational controls, supporting safe expansion of the RTC medication pathway.

Impact

- **Estimated financial impact:** Predicted reduction in cost per prescription: ~£30 (based on moving away from interim arrangements and optimising end-to-end prescribing and fulfilment)
- O**perational outcomes during pilot**
  - Medication incidents: 0
  - FP10 issues/errors: 0
  - Fulfilment issues/redeliveries: 0
  - First-time fulfilment rate: 100%
  - Fulfilment speed: ~400% improvement (pilot period)

Lessons Learnt

- The intervention succeeded because partner organisations were committed to removing an administrative barrier that was limiting access to care.
- Reducing local validation workload (through national reporting and standard lookups) is essential for scalability.
- EPS-enabled workflows support safer, faster and more standardised prescribing pathways for RTC services.

A programme to improve coordination of approach, involving NHSE the NHS Business Services Authority (NHSBSA); ICBs and the Independent Sector (esp. Right to Choose providers) should be launched with the task of establishing a consistent national framework. Some of the key features of this Framework should include A nationally agreed prescribing model which defines sponsorship responsibilities, Use of Parent and Cost Centre Codes, NHSBSA charging mechanisms and data and reporting requirements. There would also be substantial benefit in creating a unified definition of ‘backing data’.

Alignment over Credentials and Standards Required for MDT Workforce Development and Working in ND

Demand for autism and ADHD assessment and treatment continues to exceed specialist workforce supply across a number of professions. Workforce shortages remain acute in psychiatry, clinical psychology, paediatrics, mental health nursing, learning disability nursing, speech and language therapy and occupational therapy.

Within NHS services, clinicians typically work across portfolios of assessment, treatment and intervention. Meeting current levels of neurodevelopmental demand through traditional employed workforce models would require a substantial proportion of specialist capacity to focus predominantly on assessment activity.

Flexible associate and sessional workforce models have therefore become widely used across much (but not all) of IHPN's membership. Many providers have developed models that allow clinicians to contribute specialist neurodevelopmental capacity alongside substantive employment. Many associate clinicians maintain permanent NHS roles whilst undertaking additional neurodevelopmental work outside their core employment.

The sessional model, whilst scalable and able to respond to demand, is also highly sensitive to commissioning uncertainty, such as that described earlier in the report. Recruiting, training and mobilising a specialist workforce takes significant time, whereas activity assumptions may change in far shorter timeframes. This challenge is particularly acute because workforce and operational decisions are often made in advance of formal notification of activity restrictions.

Providers may already have recruited clinicians, mobilised infrastructure, accepted referrals, scheduled assessment activity and committed resource before revised activity assumptions become clear. This creates inefficiency and disruption despite continued underlying patient demand.

For members who have adopted an employed-first model, they reflect that this is only sustainable when there is alignment of employment to demand, with activity levels that are predictable and stable.

Whilst greater consistency in commissioning and appropriate national standardisation would be beneficial for workforce planning, there are real opportunities to draw upon the capacity and capability of the independent sector as a means of enabling improved training and professional workforce development.

A number of members are explicit that all professionals must possess qualifications and experience in ADHD assessment diagnostic tools, with one member noting that clinicians are required to have a minimum of one years' experience conducting ADHD assessments and must be competent in the use of DIA, Young DIVA, and Conners tools (depending on whether they are assessing adults or CYP).

There is, however, variability in the qualifications and experience of clinicians carrying out ADHD and Autism assessments both within the NHS and across the independent sector. This can create difficulties for patients where assessments are later challenged or not accepted by schools, universities, employers, insurers, or NHS services.

Greater clarity around minimum professional standards, governance expectations, and report quality requirements would therefore be beneficial across both NHS and private pathways. The qualifications, training, and supervision requirements for assessors and prescribers should be clearer and more consistently applied.

There is an opportunity for DHSC/NHS England to develop a training programme for Autism and ADHD assessments, which should be developed with and based upon partnership with independent sector providers who are able to contribute and co-deliver a programme.

Case Study: RTN Mental Health – Developing Multi-Disciplinary Workforce Leadership to Enable Differential Diagnoses and Onward Referrals

Context

- The current model of diagnosis across neurodevelopmental services can too often be siloed, limiting the ability for differential diagnosis or onward referral.
- Optimal patient outcomes would include scope for the independent sector to offer differential diagnoses and appropriate treatment or recommendations, - or for there to be clearly defined and integrated pathways for onward referral within NHS pathways.

Approach

- RTN's recent expansion of their clinical leadership team has been underpinned by the appointment of multi-disciplinary clinicians to coordinate workforce development and to enable differential diagnosis and onward referral.
- RTN's MDT is qualified to diagnose and treat other ND or mental health conditions, which can often be identified through an Autism/ADHD MDT model.
- RTN has commenced work to enable this approach through cooperation with commissioners across other pathways (e.g., we are supporting Devon ICB with their anti-psychotic pathway).

Impact

- Senior clinical leadership has established RTN as an independent NHS Training site, enabling the offer of trainee placements and support assistant psychologists on their pathway to completing a clinical doctorate.
- The approach has helped to attract talent and to consider and implement a more cost-effective clinical model that utilises a broad range of allied health professionals, such as nurses and pharmacists, that also broadens our MDT skill spread.

A National Agreement to Support Shared Care Arrangements (SCAs)

A shared care agreement (SCA) – in the context of ADHD pathways - is a formal arrangement where responsibility treatment is shared between a specialist and the patient's GP. After a patient has been stabilised on medication following a formal diagnosis, they have initiated medication and it has been adjusted the dose until working safely and effectively (through a process called titration) so a patient is stabilised on that medication, the specialist may ask your GP to enter into a shared care agreement.

Under shared care, the GP will issue repeat prescriptions, carry out physical monitoring (such as blood pressure, pulse, and weight) and communicate with the specialist so that they can review the patient at appropriate intervals and advise on any changes to medication. Where shared care functions effectively, it provides a convenient means of continuing treatment and enables continuity to be provided through the patient's GP.

However, our members reflect a clear trend over the last year to eighteen months, towards GPs no longer accepting shared care agreements for ongoing ADHD prescribing. Members estimate that as recently as eighteen months ago, c. 70% of GPs accepted SCAs, but now the sector benchmark is ~50% of GPs accepting SCAs.

Current data on GP shared care acceptance, based upon data shared with IHPN (data represents current acceptance rates across 8/14 members).

Range (% Accepting Shared Care Agreements, (SCAs))	Mean
48-75%	62%

The practical reasons for non-acceptance include: concerns over a growth in prescribing costs which accrue to GP budgets; inconsistent shared-care policies developed at local and system levels; concerns about professional liability in the management of controlled drugs; variation in local GP confidence in the quality of assessments (including those undertaken via RTC); and differing views on whether patients entering via RTC or private routes should be treated equally to patients diagnosed on an NHS provider pathway.

For patients, the consequences can be significant, including interruptions to medication continuity, meaning they may be left to shoulder the cost of private prescriptions. Breakdowns in shared care can also duplicate NHS efforts, because patients may be returned for re-assessment from an NHS provider to reassure some GPs, even where a high-quality diagnostic and treatment process has already taken place.

The most effective solution would be the development of a nationally agreed Shared Care Framework for neurodevelopmental services, supported by standardised documentation, nationally approved clinical protocols, and clear guidance regarding the responsibilities of specialist providers and primary care.

This framework should apply consistently to NHS-funded services irrespective of whether they are delivered through local contracts or NHS RTC. Adopting a national, standardised approach would provide greater confidence to GPs, reduce variation between localities, improve patient understanding, strengthen clinical governance and reduce unnecessary duplication of effort. It would also support more effective workforce utilisation by ensuring specialist services can focus on activities requiring specialist expertise, whilst enabling appropriately supported transfer of stable patients into Primary Care.

It is important to note that the position for privately funded patients is also complex. Patients increasingly 'mix and match' who provides their care – particularly in a context of long waiting times for assessment and treatment across neurodevelopmental pathways.

Whilst the NHS Constitution for England states that patients should not be denied NHS care because they have chosen to fund services privately, there remains considerable variation in how both ICBs and GP practices approach Shared Care for patients who have received a diagnosis via a privately funded assessment. In practice, many patients who have self-funded are required to re-enter NHS pathways and undergo further review before Shared Care is considered. This means patients face a secondary wait before they can access NHS prescribing arrangements. They may need to continue funding specialist reviews, private prescriptions, medication costs and pharmacy dispensing fees.

There are also practical limitations associated with private prescribing. Controlled drugs prescribed privately cannot routinely be issued through NHS electronic prescribing systems. Instead, providers are required to issue paper prescriptions needing wet signatures, which must be delivered to patients and pharmacies. This creates an administrative burden, increases costs and introduces avoidable risks associated with lost, delayed or misdirected prescriptions. Patients are also required to pay the full private cost of medication and pharmacy dispensing fees, which can represent a substantial ongoing financial burden

Summary of Recommendations

1. A first-of-its-kind Modern Neurodevelopmental Services Framework

The Government has already committed to develop a 'Modern Service Framework' for mental health (including severe and enduring mental illness) and for children and young people. We recommend that these workstreams are extended to ensure a dedicated focus upon neurodevelopmental conditions. This work could consider:

Overarching standards and expectations:

- Establishing clear and enforceable waiting time targets and expectations for patients;
- Defining clinical approaches to referral, acceptance, triage and prioritisation;
- Management of complexity, including physical health; co-occurring mental health conditions; safeguarding; differential diagnoses; complexity thresholds and escalations.
- Defining assessment modality standards, with agreed rules of the acceptability of remote, face-to-face and hybrid assessments, with clear criteria for when in-person assessments are required.

Workforce training and development

- A specification which defines the core competencies required to deliver high-quality neurodevelopmental assessments and the professional training which is required.
- This could include minimum qualifications and registration requirements; competencies; supervision standards; MDT expectations; requirements for independent decision-making; escalation and consultation pathways.

Diagnostic reports and clinical outputs

- Improvement and greater consistency in expectations over the contents and quality of outputs to benefit wider systems of support, including GPs, schools and employers.
- Prescribing and medication management
- Establishing a common framework would improve continuity, reduce duplication and support safer transfer between providers.

Quality & clinical governance

- Quality expectations should be standardised, and should applicable to all providers, regardless of whether NHS- or privately funded.
- Data reporting should be standardised with a national minimum dataset focused on activity, waits, outcomes, patient experience, safety, conversion, prescribing and equity measures. This would reduce duplicative local data requests and allow like-for-like comparison.

2. A National Tariff for NHS neurodevelopmental services with mandatory prices for ADHD and Autism screening, assessments and ongoing care.

This would ensure value for money and that both NHS and independent providers are paid fairly and transparently.

- Over the coming financial year, NHS England should consult widely and draw upon evidence from providers of all types to develop a robust currency model which accurately reflects the requirements to deliver high-quality, modern neurodevelopmental services.
- This work should proceed in tandem with the development of a Modern Neurodevelopmental Services Framework and, in particular, service specifications for ADHD and Autism, so that prices are informed by the requirements (both clinical and non-clinical) for the delivery of high-quality services.
- The National Tariff, when introduced, should apply to all providers of NHS neurodevelopmental services, equally.

3. A nationally-agreed Shared Care Framework for neurodevelopmental services

- This should be supported by standardised documentation, nationally approved clinical protocols, and clear guidance regarding the responsibilities of specialist providers and primary care.

4. A National Framework for Electronic Prescribing

- Improved coordination of approach would reduce administrative complexity and cost.
- Some of the key features of this Framework should include the development of a Prescribing Model defining sponsorship responsibilities, use of Parent and Cost Centre as well as reporting requirements. Other key features of standardisation could include introducing a single clear definition of ‘backing data’

5. DHSC/NHS England training programme to enhance MDT Neurodevelopmental Service Provision

- This should be developed with independent sector providers who are able to contribute and to co-deliver the programme.

6. CQC reform of the current scope of regulation for neurodevelopmental pathways.

- As a consequence of both the growth and the nature of how neurodevelopmental services have evolved, particularly through the use virtual and hybrid modalities of care, questions are being asked about whether the current scope of regulation is sufficient.
- As part of a review, the CQC could examine both the 'listed professionals' as well as the current scope of regulated activities, including 'assessment' and 'diagnosis' to inform possible changes to current regulations.
- IHPN support the principle that all providers delivering neurodevelopmental services whether to NHS or private patients, should be CQC registered and that pathways should be subject to 'end to end' oversight.

7. NICE to clarify current wording in guidance for both ADHD and Autism

- Referring to the "appropriately qualified healthcare professional" (s) able to diagnose ADHD and Autism to bring greater clarity, following a recent recommendation from the ADHD Taskforce.

8. Improve understanding of the impact of neurodevelopmental services

A a standardised collection and reporting of measures developed by DHSC/NHSE in partnership with all providers, relating to:

- quality of life and functioning;
- participation in employment, education and training;
- anxiety and depression symptoms over time;
- crisis reduction and use of urgent/emergency services;
- medication adherence and treatment continuity;
- patient-reported experience;
- longitudinal economic value, including reduced downstream health and social cost where possible.

9. Analyse current approaches to pre and post diagnostics assessments

DHSC/NHSE – in collaboration with the independent sector – should analyse current approaches to pre- and post- diagnostic assessment across neurodevelopmental pathways to support an expansion of evidence-backed support for patients.

Conclusions

This report has examined the contribution that the independent sector providers make to the provision of NHS neurodevelopmental services today in England. It has provided a portrait of current provision; contextualised the key challenges currently impeding improved partnership with the NHS; profiled examples of best practice and innovation from across the independent sector; and set out a number of recommendations, representing a blueprint for reform.

The capacity and capability of independent sector providers represent a core part of the solution to tackling significant current unmet demand, in mitigating harm and in partnering to develop 'needs-led' approaches to the provision of neurodevelopmental services. IHPN estimate that in 2025/2026, the independent sector delivered more than 50% of all NHS-funded ADHD assessments and more than 33% of all NHS-funded Autism assessments in England (with IHPN members delivering the majority of this activity). Independent healthcare providers have enabled NHS patients - regardless of where they live across England - to access care further to referral from their GP, where the alternative would be unacceptably long waits and likely further deterioration in health and wellbeing. The independent sector, moreover, has been responsible for considerable innovation in service delivery – particularly in the development of scalable, digital access models – which have enabled reduced waiting times on average, compared to NHS providers, as per recent comments made by the most recent, former Minister.

There are many features of our current systems of support for neurodevelopmental conditions which contribute to a lack of coherence for patients at present. This lack of coherence arises from: variable pricing for assessments across providers; variable commissioning behaviours in setting activity levels and thresholds for assessment; significant variation in specifications used by ICBs for ADHD services; inconsistency in requests for data across commissioners; the inconsistent acceptance (or rejection) of Shared Care by GP practices for ongoing prescribing of ADHD medication. IHPN are of the view that a focus on developing clear national specifications, clarifying standards applied uniformly will improve coherence and confidence in the system.

The value of specialist assessment capability, for a complex and vulnerable patient cohort, and where there is substantial co-occurrence of psychiatric and neurodevelopmental conditions, should not be lost in any future reforms. Proposals for 'needs led' services must be operationally viable in a context of 'escalating' waiting times. In examining a greater variety of routes to access earlier support – which should be welcomed - the importance and value of specialist assessment capability, for a complex and vulnerable cohort should not be lost. In an environment where there is greater awareness, distress, 'self diagnosis' and poor information online, this merely justifies the need for high-quality clinical input and specialist assessments to ensure that those seeking to support have this need met appropriately.

There are significant opportunities to consider how the impact and value of current interventions made by neurodevelopmental services can have far-reaching and long-lasting impacts for patients enabling improved quality of life reducing downstream public expenditure. For instance, there is a strong case for more comprehensive and systematic analysis of the comparative effect size and downstream economic impact of interventions via neurodevelopmental services. Moreover, in addressing a number of cross-Governmental challenges, including the recent growth in young people of NEET status, driven by poor health, there would be broader value in exploring outcomes beyond activity alone, to include employment, school attendance and attainment, NEET status, crisis use, offending, and long-term health outcomes.

With the forthcoming publication of the Independent Review into mental health conditions, ADHD and Autism and the forthcoming Mental Health Strategy – alongside wider reforms to SEND and approaches to tackle NEETs, the coming months represent a 'sliding doors' moment to fix the foundations for NHS neurodevelopmental services. IHPN and our members stand ready to work in close partnership with NHS commissioners, NHS England, DHSC and other Governmental stakeholders to make these proposals a reality.

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