Neurodiversity partnership delivery plan 2025/2027

NHS
Frimley
Integrated Care Board

Contents

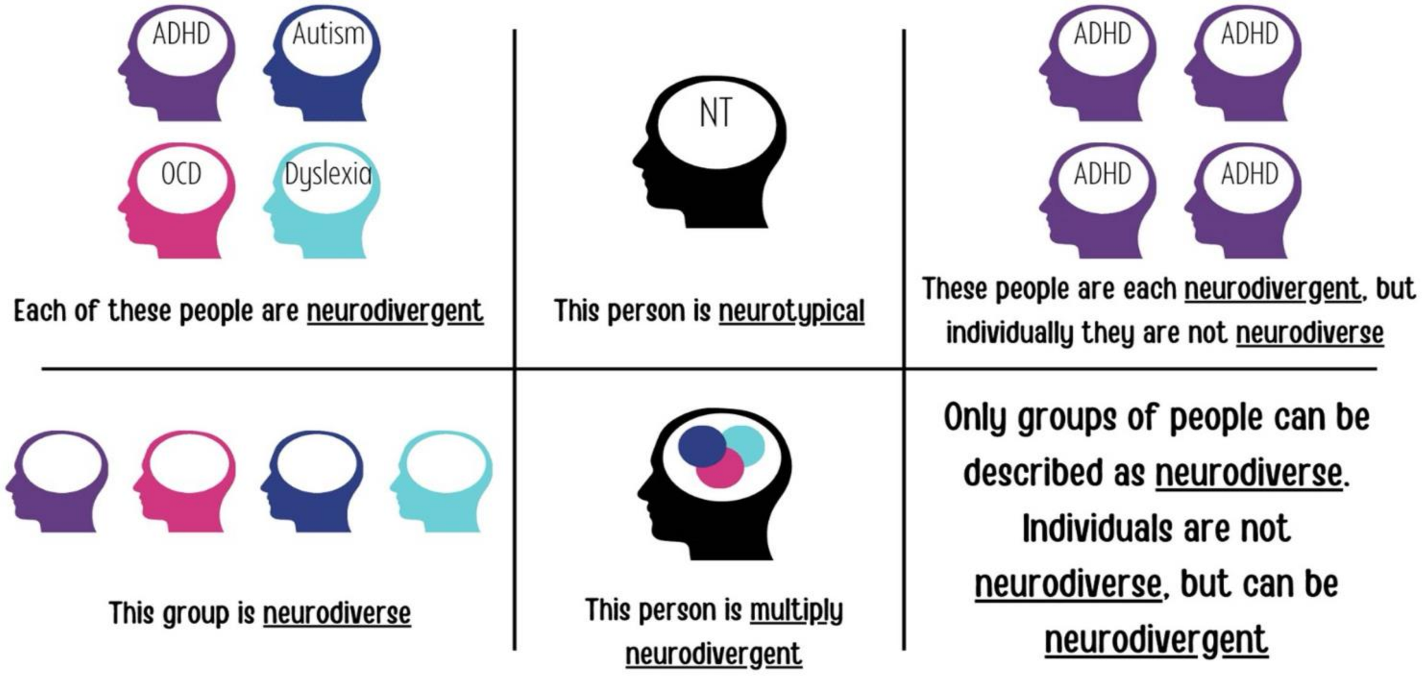
Vision & Journey

A note on language

Throughout this document, we use the term ‘**neurodiversity**’ to encompass people of all neurotypes, including those who are neurotypical. Neurodiversity is the concept that everyone’s brain is unique. It recognises the biological fact that we are a diverse society – we all think, learn, and act differently, and we all have different strengths. Neurodiversity recognises and celebrates the value that these different strengths can bring.

We use the term ‘**neurodivergent**’ to describe those who have a neurodevelopmental difference, which may or may not include a formal diagnosis.

Neurodivergence includes but is not limited to: ADHD, autism, dyslexia, dyspraxia, dysgraphia, dyscalculia, developmental language disorder, foetal alcohol syndrome, and other forms of developmental learning differences and needs.



Each of these people are neurodivergent

This person is neurotypical

These people are each neurodivergent, but individually they are not neurodiverse

This group is neurodiverse

This person is multiply neurodivergent

Only groups of people can be described as neurodiverse. Individuals are not neurodiverse, but can be neurodivergent

https://parentingspecialchildren.co.uk/resources/find-out-about-neurodivergence/

Vision of neurodiversity plan

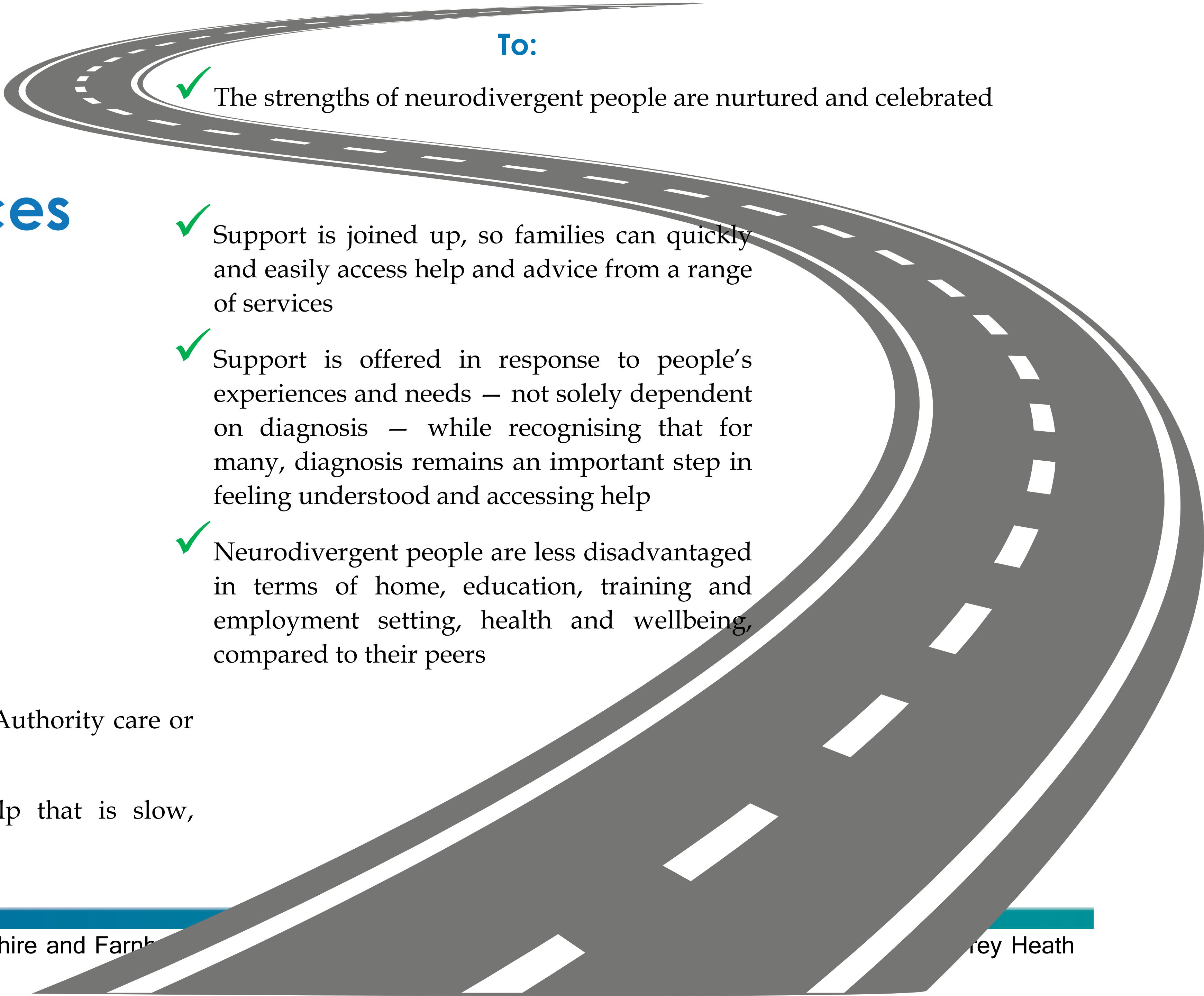
What is the vision for Frimley population?

> *"We aspire to meet the needs of our **Neurodivergent** population, and support them to thrive at all stages of life"*

Frimley Transforming neurodiversity logic model

Please see Appendix 2 for logic model (slide 35)

Transforming services



From neurodivergent people:

- ✗ Facing multiple inequalities
- ✗ Being at greater risk of coming into Local Authority care or lengthy mental health inpatient care
- ✗ Experiencing assessment, support and help that is slow, fragmented and hard to navigate

To:

- ✓ The strengths of neurodivergent people are nurtured and celebrated
- ✓ Support is joined up, so families can quickly and easily access help and advice from a range of services
- ✓ Support is offered in response to people’s experiences and needs – not solely dependent on diagnosis – while recognising that for many, diagnosis remains an important step in feeling understood and accessing help
- ✓ Neurodivergent people are less disadvantaged in terms of home, education, training and employment setting, health and wellbeing, compared to their peers

Drivers & Context for plan development

Context for the Frimley Neurodiversity partnership plan

A case for change:

Too many CYP, families and adults are struggling to get the help they need, when they need it or believe they can’t access support without a formal diagnosis.

Services across the NHS, local councils, and education are under pressure and not keeping up with growing needs. There are also big differences in the kind of help available depending on where you live, across the country creating inequity and unfairness.

In East Berkshire, families are telling us they feel unheard and frustrated. Many say they feel blamed instead of supported, and they often have to repeat their story again and again when moving between schools or services. Transitions—such as changing schools or moving from children to adult services—are especially tough.

Delays in support can lead to worse outcomes. We’re seeing:

- A rise in emotionally based school avoidance among neurodivergent young people
- High rates of school suspensions for neurodivergent pupils
- More children and young people in mental health crisis, and more being admitted to hospital
- A growing number of neurodivergent students in mainstream schools who aren’t getting the help they need
- A significant increase in Education, Health and Care Plans (EHCPs) with neurodivergence as the primary need
- Only 26% of autistic students report feeling happy at school (NAS Report, 2024)

Education settings are doing their best but face challenges too—like not having the right training, support, or resources. Stronger partnerships between schools, health services, and families are urgently needed.

At a time when public services are under financial pressure, we need to act early, fairly, and in a joined-up way—so that all our neurodivergent population can thrive.

Alignment with local and regional plans

Existing National, Regional and Frimley specific strategies, plans and workstreams

Relevant national and local strategies and plans

As we develop delivery and commissioning models, we will align with relevant local and regional strategies to ensure that services and support are inclusive of neurodivergent people and responsive to population needs. This work will build on and complement existing priorities within Frimley ICB's Mental Health transformation programme, including:

- Tackling health inequalities
- Strengthening early support
- Improving community-based care
- Enhancing urgent and emergency care

We will also take into account existing strategic plans and frameworks across the system, including:

- National strategy for autistic children, young people and adults: 2021 to 2026
- Frimley Mental Health Inpatient Services Plan (MHIP) – 3-year plan
- Berkshire Healthcare NHS Foundation Trust Neurodiversity Strategy
- Slough adult autism strategy 2024-2029
- Surrey all age autism strategy 2021-2026
- Hampshire all age autism strategy 2023
- Bracknell Forest all age integrated autism strategy 2025-2030 (draft for consultation)
- Surrey Heartlands ICB's, and Hampshire and Isle of Wight ICB's Neurodevelopmental Transformation Plans

Region- Southeast All-age Neurodiversity Programme

This plan aligns with the broader South East Neurodiversity Transformation Programme, which includes a focus on reducing diagnostic waiting times, developing strengths-and-needs-led support frameworks for both children and adults, and supporting access to early help without being dependent on a formal diagnosis. We are mindful of the shared aims across the region and will ensure our local work complements and builds on this strategic direction. (Further detail available on request or via regional programme documents.)

Population

Context- Frimley Region

Population catchment and working ICB Partners

- The Frimley ICB is part of the wider Frimley Integrated Care System (ICS) that covers a significant part of the geography of the South East Region (as shown in the map on slide 5).

Frimley ICB comprises of five Places:

- Bracknell Forest
- North East Hampshire & Farnham
- Royal Borough Windsor & Maidenhead
- Slough
- Surrey Heath

Around 810,000 people are registered with 72 GP practices in the Frimley system.

The ICB is bordered by three ICBs, with who we work closely with:

- Buckinghamshire, Oxfordshire and West Berkshire (BOB) ICB
- Surrey Heartlands ICB
- Hampshire & Isle of Wight ICB

Frimley System Map

Autism and ADHD prevalence

Children and young people (up to 25) data

Place	Total Population 0-25	Population 0-25 ADHD	Prevalence ADHD %	Population 0-25 Autism	Prevalence Autism %
Bracknell Forest	34099	1116	3.3	1568	4.6
North East Hampshire & Farnham	66235	2291	3.5	2756	4.2
Royal Borough Windsor & Maidenhead	52734	1692	3.2	1772	3.4
Slough	62120	562	0.9	1651	2.7
Surrey Heath	26557	895	3.4	1028	3.9
Total	241745	6556	2.71	8775	3.62

Data from connected care January 2025 based on patients with GP coding of Autism and or ADHD.

Adults (18-90+) data

Place	Total Population 18-90+	Population 18-90+ADHD	Prevalence ADHD %	Population 18-90+ Autism	Prevalence Autism %
Bracknell Forest	92061	1788	1.94%	1200	1.30
North East Hampshire & Farnham	177041	2756	1.56%	1680	0.95
Royal Borough Windsor & Maidenhead	140520	2480	1.76%	1335	0.95
Slough	133681	944	0.71%	759	0.57
Surrey Heath	75948	1131	1.49%	565	0.74
Total	619251	9099	1.46	5539	0.89

Data from connected care June 2025 based on patients with GP coding of Autism and or ADHD.

Scope

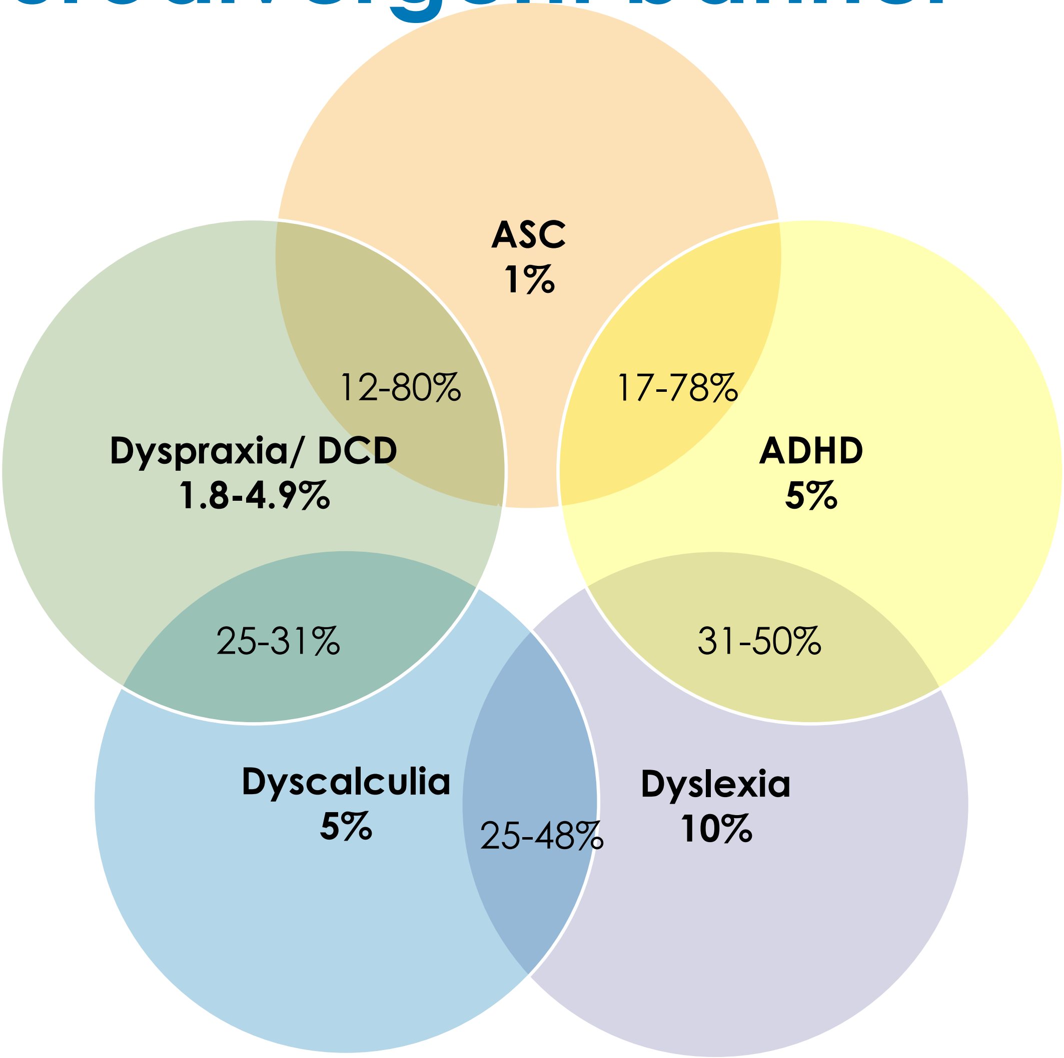
Vision is for all under the Neurodivergent banner

Our long-term vision is to build a system that recognises and supports the full diversity of neurodivergent people — across all ages, diagnoses and lived experiences.

This initial plan focuses on Autism Spectrum Condition (ASC) and Attention Deficit Hyperactivity Disorder (ADHD). These areas have been prioritised due to current diagnostic pressures, local strategy commitments, and opportunities for early progress.

During this phase, we will begin by understanding lived experiences, mapping existing provision, and exploring more joined-up, needs-led ways of offering support.

Learning from this work will lay the foundation for wider inclusion in future phases — ensuring the system grows to support all under the neurodivergent banner.



Co-occurrences of Neurodiversity (general population) (Kirby and Cleaton 2019

Approach

Core approaches

Strength based and needs led approach (informed by THRIVE principles)

We are moving away from a medical model toward an approach that puts the individual at the centre – focusing on what matters to them, not just what's 'wrong'. This is aligned with the THRIVE Framework, a model used in children's mental health services that emphasises early help, needs-led responses, and working across the whole system.

This approach includes:

- Identifying and meeting needs early
- Working with those who know the person best
- Joined-up support from health, education, social care, and community

The goal is to create environments where people can thrive – not just cope.

Underpinned by:

- The THRIVE Framework for System Change (Wolpert et el.,2019.)
- The Social Model of Disability The Social Model of Disability short
- The Graduated Approach (Ch 6, SEND code of practice 0-25 2015), and Ordinarily Available Provision
- Our logic model (Slide 35)

Neurodivergent CYP and adults experience an environment where needs are identified, understood and met. They are well supported by family, friends, local community, education or employment settings.

Shifting the Model

From Diagnosis-First to Needs-Led Support:

The way we think about neurodivergence is changing. We're moving away from a medical model and towards one that focuses on strengths, needs and early support. Here's how that shift looks in practice:

Medical Model/Deficit Based

- Focuses on diagnosis as the gateway to support
- Often delays help until clinical thresholds are met
- Views the individual in isolation, not in context
- Assumes something is 'wrong' that needs fixing
- Access to support is often based on labels, not lived experience
- Reactive – support comes when things reach crisis

New Model: Strengths-Based and Needs-Led

- Focuses on what matters to the person, not just what's 'wrong'
- Offers support based on need – not diagnosis alone
- Works alongside the individual, their families, carers and trusted adults
- Sees the person in context – including strengths, identity and environment
- Encourages early help to prevent crisis
- Support is proactive, personalised and co-produced

Workstreams

Workstreams overview and indicative timeline

Supporting enablers

Berkshire strengths and needs tool development: April 2025 to September 2026

Model of care development and strategic commissioning: January 25-March 2027

Right to Choose (RTC): October 2024 to April 2026

Partnership for Inclusion of Neurodiversity in Schools (PINS): April 2024-March 2026

Adults: July 2025- April 2027

Berkshire strengths and needs tool evaluation and development

Overview

The earlier we can recognize a child's neurodivergence, the better we can support them in school and at home. Locally, the healthcare system has relied on traditional medical assessments, where children often wait up to two years to be evaluated. After the assessment, families often find that there's little additional support to help them manage their child's needs.

The proposed solution is to work pan Berkshire to focus on improving the identification and support of neurodivergent children, with a clear plan for how things will be done consistently across the region. The goal is to create a system where neurodivergence is recognized early and to focus on early, preventative support instead of waiting for formal diagnoses.

The idea is to use neurodivergent strengths and needs tools to identify children who may need support early. To evaluate and promote whole system use of a tool to provide a holistic view of a person's needs (as early as possible, whether they have received a medical diagnosis or meet the criteria for one), celebrate the strengths and positives of what is working well and suggests types of strategies that can be put in place to help manage those needs in different areas of life.

Learning from best practice elsewhere, for example a model from Portsmouth has been successful in reducing the demand for medical diagnoses by 65%.

Creating a collaborative approach involving families, school leaders, social care providers, and other partners to implement neurodivergent early identification across Berkshire. The process will involve:

- **Communication**: Informing local families and schools about the proposed changes.
- **Planning**: Setting up a steering group to oversee the changes and review tools that could work best for Berkshire.
- **Testing**: Running workshops in each local area to test how the tools work and adjusting them to fit local needs.
- **Training**: Providing training for educators and other professionals on how to use the strengths and needs tool.
- **Implementation**: Rolling out the new approach across Berkshire, with close monitoring of how it's working and making adjustments as needed.

Model of care development

Overview

We are developing and delivering new neurodivergence centred support models across the Frimley system. This involves setting out clear commissioning intentions and, where appropriate, taking services through a procurement process.

Phase 1 – Mapping and Engagement

To start by mapping existing services for children, young people, and adults across Frimley to build a shared understanding of:

- The full neurodevelopmental pathway – from early identification through to assessment, ongoing support, and crisis intervention
- All commissioned and funded services, including subcontracted and grant-funded offers across Health, Social Care, Education, and the Voluntary, Community, and Social Enterprise (VCSE) sectors
- the access thresholds and criteria currently used by services

Phase 2 – Gap Analysis and Model Development

Using insights from the mapping and stakeholder engagement, we will improve and align services to:

- Eliminate duplication
- Identify and address gaps in service delivery
- Support early identification, timely assessment, and appropriate crisis responses
- Ensure best value across all commissioned and funded services
- Define clear access criteria and improve signposting for individuals and families
- Set up evaluation processes to measure impact and return on investment
- Gather meaningful data and feedback for continuous improvement and assurance

ND centered delivery and commissioning model

Model of care development

Commissioning Intentions

To support delivery of the new model, we plan to commission:

- **Community-based support offers**, including a dedicated **sleep support service**
- A pan Berkshire **specialist support service** (name to be confirmed post co-production) offering targeted interventions for individuals and families

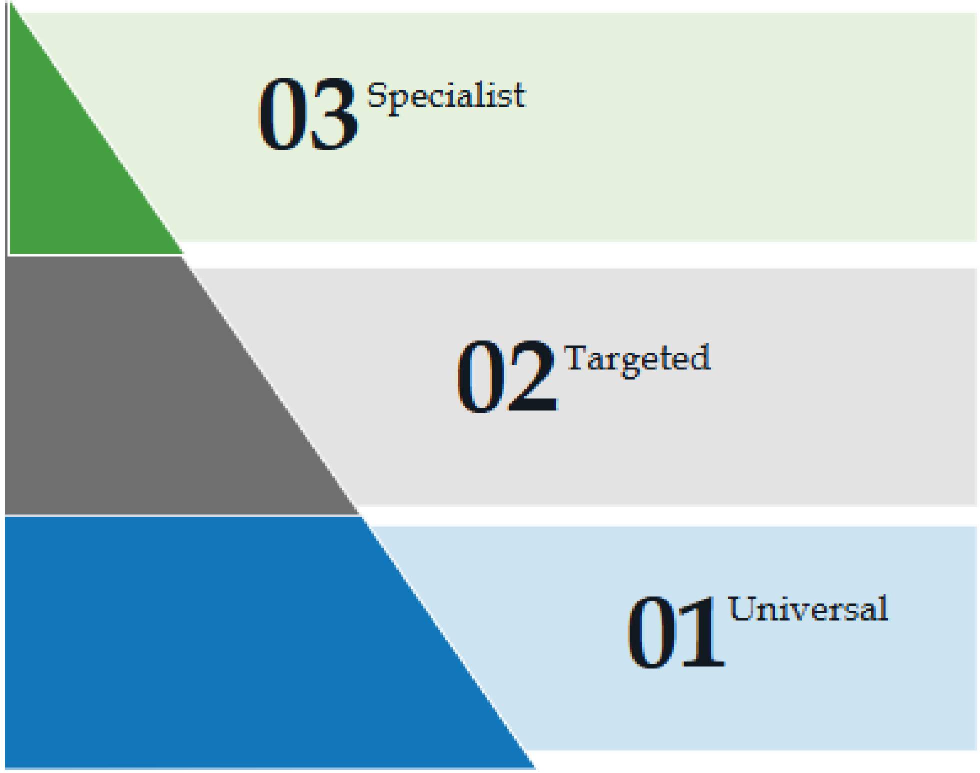
Key Interdependencies

The model will be designed in close coordination with existing initiatives and services, including:

- **Support for parents, carers, and individuals** – including current provision from services such as SEND Information, Advice and Support Service, Parent Carer Forums, GEMS support programme (East Berkshire), Barnardo's (Surrey), Autism Berkshire's adult autism support service (East Berkshire), National Autistic Society (Surrey) – as well as emerging insights from Hampshire's new Multi-Disciplinary Team (MDT) model.
- The **strengths and needs tool**, to support timely and appropriate recognition of needs.
- The **key worker service and dynamic support register**, providing personalised support to families navigating complex systems and to help prevent crisis.
- **PINS (Partnership for Inclusion of Neurodiversity in Schools)**, which supports inclusive practice within primary educational settings.
- Local Authority **Delivering Better Value (DBV)** programmes that enhance school-based SEND support.

These interdependencies are critical to delivering a joined-up, person-centred system of care and education for neurodivergent individuals and their families.

Model of Care to be refined using co-production



Right to Choose (RTC)

Developing a Clear, High-Quality Pathway for Autism and ADHD Services Under Patient Choice

Overview

People have a legal right to choose their healthcare provider – including for autism and ADHD assessments – under the **Right to Choose (RTC)**. This means they can request care from any provider that meets NHS standards and is willing to work under local NHS contracting arrangements.

However, the quality and cost of these services can vary widely between providers. This has important implications for both patients and the Frimley Integrated Care Board (ICB), including concerns about clinical standards, waiting times, consistency of care, and financial sustainability.

Frimley Position (2024–25)

- **RTC activity**: At least 14 different providers have delivered autism and ADHD services via RTC referrals this year.
- **Primary care support**: We have issued guidance to GP practices to help them make informed RTC referrals.

Our Response and Plan (Looking Ahead to 2025–26)

We propose to go out to market in **summer 2025**, aiming to put new contracts in place by **April 2026**. This will allow us to:

- **Accredit providers** based on a clear Frimley-wide service specification and eligibility criteria
- **Establish consistent quality standards and care pathways** for both children and adults
- **Improve reporting and visibility**, so we understand how services are being used
- **Reduce non-contracted activity (NCA) spend** by agreeing prices in advance
- **Increase the number of contracted providers**, helping to reduce long waiting times
- **Support GPs with shared care** decision saround medication prescribing for ADHD particularly when patients are referred to RTC providers

Next Steps

- **Finalise and approve all age service specifications** (setting out what good care looks like and learning from other areas
- **Set up a procurement process** to formally appoint and contract providers
- **Establish a transparent accreditation process**, so providers can apply to deliver care under local agreements
- **Engage with stakeholders** – including GPs, patients, parents/carers, and schools – to communicate clearly about changes and support shared decision-making

Partnership for Inclusion of Neurodiversity in Schools (PINS)

Overview

National programme for financial years 24-25 and 25-26 with funding from the Department for Education and NHS England. To bring health and education specialists and expert parent/carers into mainstream primary settings to deliver whole school approaches that support the needs of neurodivergent children. Initially time limited until March 2026. Access to support provided through the PINS Programme is not dependent on any formal diagnosis or assessment.

PINS addresses challenges in school by:

- Enhancing school staff skills and confidence.
- Strengthening school-parent/carer partnerships.
- Creating inclusive, sustainable school environments.

PINS recognises that many of the approaches and interventions promoted through the programme will be of benefit to all children attending a setting, including those who may have other types of special educational need, mental health needs or learning difficulties.

Local delivery is taking place across mainstream primaries (pilot schools) across East Berkshire

Learning from PINS to consider as part of Frimley plan

- Holistic view of how evidence, evaluation and learning from PINS can inform and shape transformation and a needs led approach
- Identification of tools, resources and strategies that can be maintained and sustained after March 26
- Opportunities to test hypotheses about inclusion, skills and knowledge in schools and identify new ways of working
- Input from broad and representative groups of parents and carers
- Increased opportunities to hear pupil and parent/carer voice and establish children and parent/carers as experts in 'what works'

Adult workstream

Collaboration with BOB ICB’s ADHD Task and Finish Steering Group

Overview

We plan to actively collaborate with the Buckinghamshire, Oxfordshire, and Berkshire (BOB) Integrated Care Boards’ ADHD Task and Finish Steering Group. This group oversees several key workstreams focused on improving ADHD services, including:

- Communication and engagement with patients and stakeholders
- Developing a commissioning framework that supports Right to Choose (RTC)
- Defining clear patient pathways and access criteria for assessments
- Establishing effective shared care protocols
- Liaison with mental health services
- Liaison with primary care

Plan developed from mapping and engagement

We will ensure that support services are sufficient, accessible, and include robust crisis prevention measures.

Additionally, we will consider transition arrangements to provide seamless support as patients move from child to adult services, ensuring continuity of care throughout this critical period.

Enablers and Measures of success

Factors for success

Enablers

- A shared vision and common language agreed across the whole system
- Flexibility in the system to meet neurodivergent needs and build on individual strengths
- Redesigning pathways together with input from all stakeholders, especially those with lived experience (co-production)
- Developing a clear communication plan and strategy aimed at neurodivergent age groups, their parents/carers, and professionals including primary care and education settings
- Improved signposting that includes busting myths (e.g., about access to support not being diagnosis dependent) and guiding people to self-help resources
- Strong partnerships with Local Authorities
- Collaboration with community leaders
- Working closely with the voluntary sector
- Commissioning and delivering services based on identified needs (needs-led model)
- Efficient use of existing service capacity to meet demand
- Established mature governance structures with active stakeholder participation
- Developing a performance and impact framework to measure success
- Providing relevant training to staff and partners
- Mapping existing services to understand gaps and overlaps

Measures of Success Overview

Co-produced at April 2025 stakeholder's workshop:

1. People with Lived Experience *(including children, young people, and parent carers where appropriate)*

Success means people:

- **Are listened to and consulted** – Their voices help shape support and services.
- **Feel supported** – They get help that is consistent, caring, and useful.
- **Have their needs met** – Services respond to what matters most to them.
- **Are well informed** – They understand their rights, options, and the support available.
- **Are clearly signposted** – They know where to go and how to access help.
- **Find support accessible** – Services are easy to reach and inclusive.
- **Get support in good time** – Help is available when it's needed, without unnecessary delays.

2. Workforce

Success means professionals:

- **Are consulted** – Their knowledge and experience inform service development.
- **Feel supported** – They have the training, resources, and emotional support they need to do their jobs well.

3. How We Measure and Monitor Success

We will use both data and personal feedback to track progress over time. This includes:

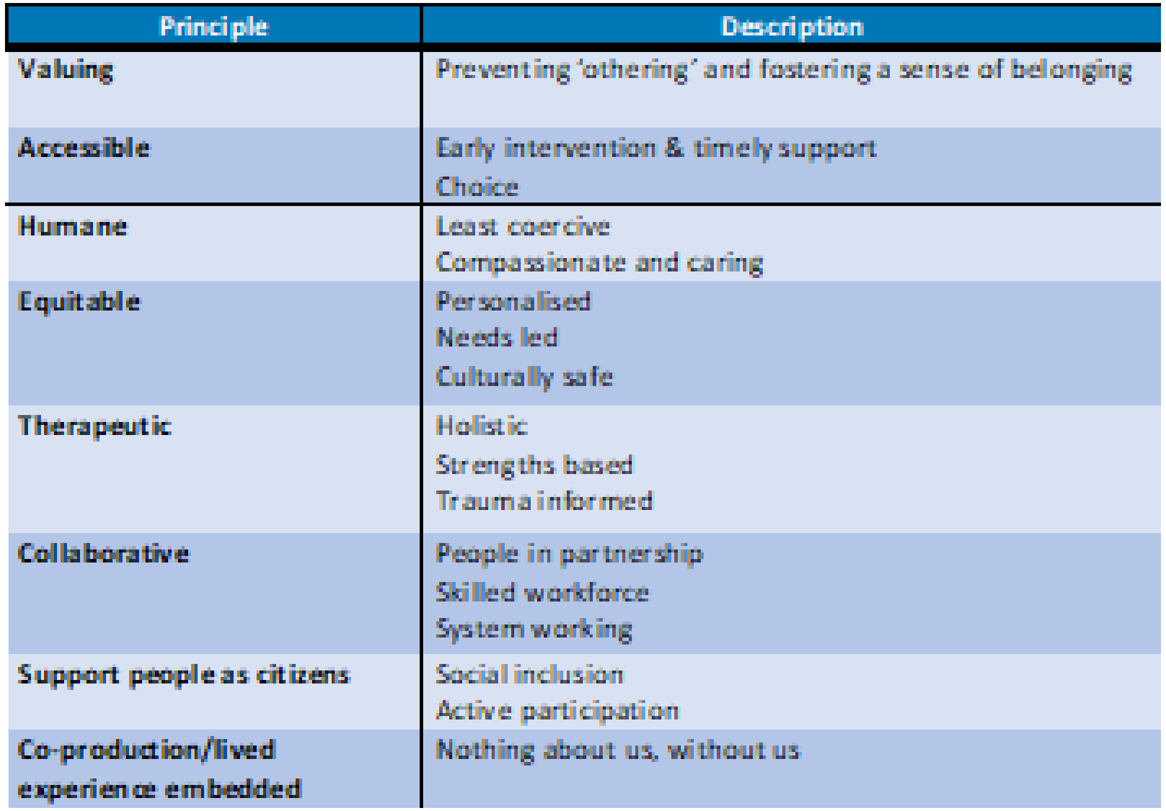
- **Quantitative Measures (Data & Performance Monitoring)**
- **Performance data**, such as:
    - Waiting times
    - Local Authority (LA) data
- **Education-related outcomes**:
    - Reduction in permanent exclusions
    - Fewer children and young people not in education, employment or training (NEET)
    - Improved school attendance
- **Justice system**:
    - Reduction in the number of young people entering the justice system
    - Qualitative Measures (Experiences & Outcomes)
- **Surveys and feedback** from people with lived experience and the workforce
- **Baseline and follow-up tracking**, including emotional wellness, reduction in crisis situations, reduction in inpatient admissions, reduction in sectioning under the Mental Health Act, employment rates and job satisfaction.

Measures of Success Overview

Cross cutting themes

These measures apply across all groups and services:

- **Timeliness** – Support is available when needed.
- **Accessibility** – Everyone can get the help they need, without barriers.
- **Co-production** – People with lived experience and professionals work together to design and improve support.
- **Wellbeing** – Focused on both mental and emotional health.
- **Inclusion and equity** – Services are fair, inclusive, and culturally appropriate.



Principle	Description
Valuing	Preventing 'othering' and fostering a sense of belonging
Accessible	Early intervention & timely support Choice
Humane	Least coercive Compassionate and caring
Equitable	Personalised Needs led Culturally safe
Therapeutic	Holistic Strengths based Trauma informed
Collaborative	People in partnership Skilled workforce System working
Support people as citizens	Social inclusion Active participation
Co-production/lived experience embedded	Nothing about us, without us

Phases of ND Plan development & delivery

Neurodiversity Partnership Plan 2025/2027

PHASE 1

Governance

- Affirm Frimley ICB internal governance for neurodiversity programme
- Affirm Frimley ICB internal capacity for neurodiversity programme
- Stakeholder analysis for engagement and collaboration phase
- Align governance and work with BOB ICB to maximise delivery and shared learning
- Align work with Surrey Heartlands ICB & Hampshire IOW ICB to maximise delivery and shared learning

Collaboration

- Test and refine vision (workshop)
- Agree quality, patient and staff experience and clinical outcomes measures (workshop)
- Develop detailed plans through co-production with people with lived experience of services and those who deliver services
- Agree core set indicators and associated data sources to track the measures of success
- Develop and share best practice across the three ICBs to benefit population

PHASE 2

Initial Delivery (Year 1)

Delivery of plan workstreams:

1. Developing models of care and associated strategic commissioning
2. Early identification tool development
3. Adult workstream
4. Partnership for Inclusion of Neurodiversity in Schools
5. Right to Choose

- Embed and monitor changes (inc signposting) with stakeholders at pathway and governance levels
- End of year 1 assess impact and priorities for year 2

PHASE 3

Delivery as Business as Usual

- Ensure commissioning contracts and relevant planning is in place
- Review priorities and allocation of resources for neurodivergent population
- Share learning and embed in other pathways where appropriate
- End of year 2 carry out formal review of changes with stakeholders across plan
- Revisit collaboration stage and refresh plans for 2027 onwards

Governance

Neurodiversity Plan SRO, Approval Route & Monitoring

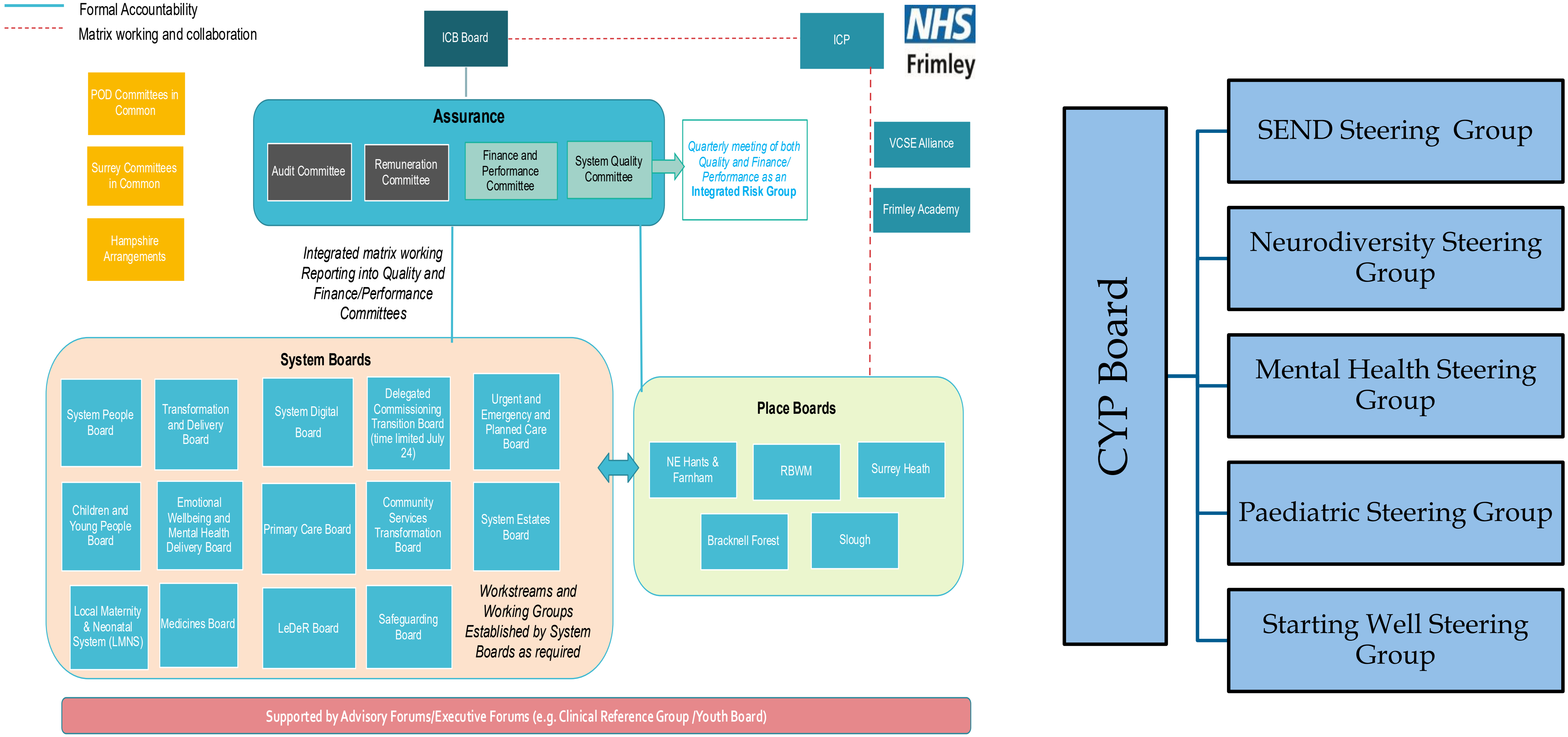
- The Frimley ICB Senior Responsible Officer (SRO) with dedicated capacity for MH Neurodiversity is Tracey Faraday-Drake, Director for Children, Mental Health, and Learning Disabilities with dedicated support capacity from the Transforming Community Care team.

- The developed plan will be formally signed off and monitored by the Frimley ICB Neurodiversity Steering Board, supported by the relevant PMO and collaboration with other commissioning ICBs where appropriate (Surrey Heartlands ICB, Hampshire and Isle of Wight ICB and Berkshire West as part of The Buckinghamshire, Oxfordshire and Berkshire West ICB).

Data and monitoring

- Frimley ICB will work with other ICBs to ensure that quality, patient, staff experience and clinical outcomes can be measured with core set indicators to track the success deliverables.
- Frimley ICB data collection and analysis are provided by South, Central and West Commissioning Support Unit (SCW CSU) with relevant capacity dedicated to supporting the MH Programme.
- Additional engagement with local authorities and relevant data capture and monitoring to be established to aid measuring of success

Portfolio governance including ND and CYP



Formal Accountability

Matrix working and collaboration

POD Committees in Common

Surrey Committees in Common

Hampshire Arrangements

ICB Board

ICP

NHS Frimley

Assurance

- Audit Committee
- Remuneration Committee
- Finance and Performance Committee
- System Quality Committee

Quarterly meeting of both Quality and Finance/ Performance as an **Integrated Risk Group**

VCSE Alliance

Frimley Academy

Integrated matrix working Reporting into Quality and Finance/Performance Committees

System Boards

- System People Board
- Transformation and Delivery Board
- System Digital Board
- Delegated Commissioning Transition Board (time limited July 24)
- Urgent and Emergency and Planned Care Board
- Children and Young People Board
- Emotional Wellbeing and Mental Health Delivery Board
- Primary Care Board
- Community Services Transformation Board
- System Estates Board
- Local Maternity & Neonatal System (LMNS)
- Medicines Board
- LeDeR Board
- Safeguarding Board

Workstreams and Working Groups Established by System Boards as required

Place Boards

- NE Hants & Farnham
- RBWM
- Surrey Heath
- Bracknell Forest
- Slough

Supported by Advisory Forums/Executive Forums (e.g. Clinical Reference Group /Youth Board)

CYP Board

- SEND Steering Group
- Neurodiversity Steering Group
- Mental Health Steering Group
- Paediatric Steering Group
- Starting Well Steering Group

Appendix

Appendix 1: Acknowledgements & Useful links

Acknowledgements

- Frimley ICB Neurodiversity Steering Group
- Attain Health management

Useful links

- The Neurodiversity (ND) Profiling Tool < Portsmouth Local Offer
- About - PINS : PINS (East Berkshire)
- Learning About Neurodiversity at School (LEANS) | Salvesen Mindroom Research Centre
- Centre for Autism (University of Reading)
- The Oliver McGowan Mandatory Training on Learning Disability and Autism - elearning for healthcare
- Autism Berkshire
- Autistica
- National Autistic Society
- Autism Central - peer education programme
- ADHD UK
- ADDitude
- Frimley Healthier Together Neurodiversity Support Hub
- Home - Gems4health (East Berkshire)
- How to access the Mindworks Neurodevelopmental pathway :: Mindworks Surrey
- Parent or Carer :: Mindworks Surrey
- Neurodevelopmental needs :: Mindworks Surrey
- Professionals - guidance to our request for help process | Children Young People and Families Online Resource (Berkshire)
- Parents and carers - how to request help for possible autism and/or ADHD | Children Young People and Families Online Resource (Berkshire)

Appendix 2: Transforming neurodiversity services logic model

With these **INPUTS**	we carry out the following **ACTIVITIES**	creating the following **OUTPUTS**	to deliver the following **OUTCOMES**	with these long-term **IMPACTS**
• Cross-sector leadership through the Neurodiversity Partnership Group. • Neurodiversity Transformation Lead and supporting roles. • Existing budgets, data and local service infrastructure. • Established and developing workforce training programmes. • Neurodivergent needs and strengths tools • Lived experience and insight from neurodivergent people of all ages, families and practitioners. • Collaboration across education, health, care, community and voluntary sectors.	• Co-produce with neurodivergent people, families and professionals to identify barriers and priorities. • Map capacity, demand and resources across education, health, care and community settings. • Develop and embed the Neurodivergent Voices Network to connect community insight with system leaders. • Review and learn from good practice across other regions. • To co-design a neurodivergent needs and strengths led systems change • Align service specifications (including CAMHS) to be clear, equitable and accessible for all ages. • Create a consistent, transparent pathway offer across the Integrated Care System. • Deliver mandatory neuro-inclusive training (e.g. Oliver McGowan) and embed it into workforce development.	• A co-produced action plan and delivery model reflecting lived experience. • A live Neurodivergent Voices Network connecting communities and system leaders. • Clear, consistent referral and support pathways across the ICS. • Evidence-based mapping report showing current demand, capacity and spend. •Implementation of the Berkshire neurodivergent needs and strengths tool; and an aligned VCS, education, health and care support system • Workforce trained in neuro-inclusive practice (Oliver McGowan and beyond). • Shared resources, tools and guidance on what "good" looks like. • Cross-sector partnerships meeting regularly to review progress.	• Neurodivergent people of all ages and their families feel seen, supported and included. • Waiting times for assessment and support are reduced and publicly shared. • Services use consistent, transparent, neuro-affirming pathways. • Education, health and care teams work together using shared language and tools. • Early help and flexible support prevent breakdowns at home, school or placement. • Neurodivergent people experience greater stability in education, work and community life. • Inequalities in access, outcomes and satisfaction are reduced. • Staff report increased confidence, skills and satisfaction in supporting neurodivergent people. • Tools identify and support the needs and strengths of neurodivergent individuals, enabling tailored adjustments across home, school, and community settings	• The system recognises, values and celebrates neurodiversity across all ages and settings. • Neurodivergent people can access the right support and adjustments without long waits or reliance on diagnosis. • Joined-up pathways make it easy for individuals and families to find the help they need, when they need it. • Fewer neurodivergent people experience crisis, breakdown or exclusion at home, school, work or in the community. • Gaps in opportunity, wellbeing and outcomes between neurodivergent and neurotypical people continue to narrow year on year. • Provision of the right help at the right time, reducing the likelihood of children escalating into specialist services when their needs could have been met through ordinarily available offers

Appendix 3
Previous Roundtable slides
August 2022

Q1. What every day improvements do we want to see in schools and the community for neurodiverse people – across all ages

good awareness and confidence for all students to be themselves

Tolerance, Understanding (greater insight than tolerance), appropriate support, appreciation of positives

Needs based support for each child in a class

I'd like the whole school system reviewed and changed to be more inclusive

Improved acceptance of differences; ability to listen to the individual

Voice of CYP and Wider family

Schools and settings take up the training offer as a whole site including dinner ladies etc so change is embedded and sustained

Needs driven services

Better sensory environment, adaptations based one needs, move away from 'see how they'll get on without support'

A real focus on enabling environments with reasonable and anticipatory adjustments

Improved Training and awareness in all environments. More bespoke therapies

acceptance that school based problems can show themselves at homes and that parents are not fabricating

awareness, compassion and enquiry; environmental improvements to reduce sensory challenges; celebration of difference and children and communities

Improved acceptance of differences; ability to listen to the individual

More training and awareness for teachers and all staff

education for professionals in schools to enable early intervention and increased awareness for the community / workplaces

Adaptions in schools to ensure the environment is more ND friendly

Needs based support for each child rather than diagnosis based

I'd like the whole school system reviewed and changed to be more inclusive

Volunteers - parents and families must be part of the work force It takes a village to raise a child

Training, development and resource

understanding, adaptations to sensory environments, individual adaptations (may be small tweaks) to meet needs

education for professionals in schools to enable early intervention and increased awareness for the community

A foundation of literacy in neurodivergence and a culture of celebration of differences

We need a public health campaign to de-medicalise the many misconceptions about ND

Partnership integrated working

In schools, I think being taught about neurodiversity in PSHE lessons would be helpful

Understanding and acceptance of autism

access to a curriculum and accreditation structure that supports the strengths and skills of the learners

Widely Available early intervention and support

most children with SEND are in mainstream schools so autism awareness sessions aimed at students

knowledgeable and well-trained confident staff team

easily accessible support e.g. Lily' feedback about having a mentor

schools must be held accountable for inappropriate exclusions and those schools that are inclusive rewarded

One stop shop multiagency

Improving understanding and confidence to implement 'ordinarily available provision'

The day to day improvement I would like to see would be more people who are working with those neurodiverse populations better equipped to recognise a person as neurodiverse

Q2. How can we improve access to services which are based on NEED rather than a diagnosis?

This requires the re-education of all service providers to be a 'needs based' service and not diagnostically driven

Listening to young people themselves through meetings (e.g. annual reviews) and not just going by a diagnosis

Let the individual / family make the decision to engage rather than a 'referral'

Stop diagnosis acting as the 'golden key' to access support

We need a culture shift and consistency in message. There are too many professionals (primarily) who say that a diagnosis is needed, when it isn't

get the right support to the person/ CYP and their family at the right time, for no longer than is needed

Voice of CYP and Wider family

Better training for all services as standard, parents/carers to be supported to feel confident to make adaptations which will make a difference but without them feeling they are being fobbed off

Needs driven services/culture shift

I think the wider community needs to change first. If you need a diagnosis to get access to extra support then people will want to wait for that. so we need to change the approach to remove thresholds for educational need, thresholds to get secondary care mental health support first

very simply needs lead rather than diagnosis lead

Listening to young people themselves through meetings (e.g. annual reviews) and not just going by a diagnosis

Better awareness and identification of need to support others' understanding in a more accessible way

Allowing each child to flourish giving them permission to access extra time or whatever is needed for their growth

By truly embracing the concept of neurodiversity and fully realising all of the potential a paradigm shift will bring

Get rid of diagnostic based eligibility criteria/ myth bust where there isn't eligibility criteria

Services / therapies designed around need - extra support within education; OT , physio, SaLT etc. Looking at commissioning models

firstly we need a cultural shift to a needs based approach and away from the medical model where all have confidence that this is how a CYP / adult can be supported

Co-production between services, parents, working with 3rd parties to develop a structure that is strength based

it is a MUST DO for settings- not a "nice thing to do if we had the time"- governance and accountability- perhaps via governing bodies? Green paper linked

Roll out training and awareness across services, review thresholds for access, invest in the voluntary sector which is actually filling in many of the current gaps

Governance, accountability and commissioning

ensure services make clear don't have to be on a pathway to a diagnosis to access support

Early intervention - especially early years

education reshape

Partnership integrated working

Widely Available early intervention and support

Remove the need for a "Diagnosis" from a senior professional to access a service

Understand what people are looking for in a diagnosis. Conversation with primary care about expectations. Central government understanding of the needs and realities of the workforce so that central targets don't become wait time based

Publicity for families and users of services , show them through the maze

multi-agency approach that listens to what is needed and making them more 'visible

By working in partnership with organisations that can provide early help. To enable self/family/carer referrals to early intervention/self-help

Q3. What support is missing for parents/families/carers?

People who listen to them, who take their views and feelings seriously. But also people who can challenge and support to shift styles when things aren't working

Parents, families and carers need information that is strength based in relation to ND - not simply the challenges and difficulties

I think the fundamental support that is missing from parents/families/carers is that the focus of the NHS and other services to neurodiversity is a deficit focussed offer. The rationale for the NHS is seen as being to clinically describe rather than cure (because neurodiversity isn't an illness)

Voice of CYP and Wider family

Family therapy/interventions that help parents understand about their interactions with their child/their child's interactions with the world

Needs led service

we are beneficiary led and provide a range of services which actually work but we are restricted by funding. So would recommend commission organisations like ours and other wonderful local charities that are trusted by families and are making a real difference on the ground

somebody that listens, hears what they are saying and can ACT upon this

Easier to list what is not provided - pretty much everything
Parents have to fight to get support

Personalised and tailored support to understand and meet the specific needs their child is presenting with

A space to talk and share experiences; access to well understood (by others) resources which make a difference; ability to influence local decision makers

Help for parents to access support for their YP with education and other support needs, respite - in it's broadest sense e.g. access to daytime and evening

we need to make the families feel held - workshops - social groups - consider needs of parent

Engagement and skill development in early help initiatives. In more complex cases, a consistent/single-point of contact to support

ongoing post diagnostic supportive contact points when required by the patient/carers, employment support, are pathways into carer assessments clear and accessible as they could be?

Easily accessible services and social opportunities

Peer support, compassionate understanding from society and services. access to tools to help self care/support. psychological support- IAPT services are not set up for neurodiversity and can be an exclusion criteria

Early and ongoing access to drop in/drop out service

Peer support models - expertise!

Early intervention/clear clinical pathways

confidence that a child can access help without a diagnosis/ EHCP. Parents do not trust the current system and this seems to be contributing to demand

practical/ emotional/ peer support as well as training and skills development and sharing their expertise to train others which is hugely empowering; connecting to others and support to navigate and be confident in finding the support you need

Peer Support/support networks

Clear pathways , would be great to have support staff to help people through the systems

'at the end of the phone' support and training that is easily accessible and can provide guidance and help parents navigate their way around services

a network to learn from parent Careers training but just to sit with another parent or carer and go oh wow my son does that too

Q4. With so many children and young people still waiting for a diagnosis – how should/could we best prioritise people on the list?

Older children and young people first, experiences of distress first - but I think we need to look at putting in support so that we wouldn't need to prioritise, so that the diagnosis is the cherry on top, rather than the main aim

easy to say risk...but risk defined how? risk of school exclusion/ home or service breakdown/ societal exclusion? I think offering a support package to all of those on the list to ensure they arrive at diagnosis in the best possible place for them

Age

Nearing continuing transition, clear evidence of crises arising, other disadvantages (such as CIC) might be helpful staring points

Identify children at keys stage transition points for school transfers, across age ranges: cross reference cyp waiting lists to children/young people on Dynamic Support register (DSR) and or in out of area placements, LAC, accessing YOS, so increased risk of greater inequalities across their life span

Prioritise those children who are coming up to A levels and GCSEs

Risk

Tough one. Time on list and /presentation/risk factors, but also... deprivation indicators / SEND provision in / performance of local schools, school/teacher screening

Needs led , those in crisis first and those more likely to have long term issues if not diagnosed but also looking at other avenues for support , eg peer support

Those where there are significant safeguarding concerns e.g self harm also around the age of transition to secondary school - as secondary schools are often far more challenging than primary or indeed university

How the CYP are presenting/challenges/complexity etc

This is difficult- and each child you prioritise means another waits longer! Prioritising for high level of risk BUT also where an assessment can help reduce this risk (people often assume it will but in fact it may be something else that is needed and should be the priority)

Identify CYP who may benefit from medication where ADHD is indicated

Reshape the service

Needs led services with greater understanding of neurodiversity and inclusion so that diagnosis is not considered 'be all and end all'

remove the list !!! embed assessment into mainstream education then work within a needs led framework

What really needs to improve is a needs based better offer of support for everyone whilst they wait

ask families what they hoping to achieve from a diagnosis and then provide family support/advise to help them navigate this support

Are early help and engagement opportunities then missed? Are there other diagnostic tools that are swifter?

Hard to move away from waiting time prioritisation without creating complex and challengeable decision making processes

The diagnostic route/process needs to be re-evaluated not the individual

improve communication with key people involved with the children/young people/families

Often this is defined through the lens of the person / professional - when it needs to be a collective approach where there is clear understanding about what the parents and families can provide, the school and other agencies

decompress by upskilling other services to provide support

Complete shift to prevention

Prioritise prevention before it gets to crisis, as well as what is happening atm

highlights the importance of early support and intervention

Triage

Offer some immediate "self-engagement" tools to scale need (maybe based on Portsmouth guide) and easy-to-access responses (do X, try Y etc) and invite them to share the scores to help establish the priorities

Risk that he who shouts loudest gets the service

prioritising is often informed by support needs so how can we (as with prior discussion) reduce need for this

Maybe have a triage process with clear criteria

ABBREVIATIONS

ASC: Autism Spectrum Condition – a neurodevelopmental condition that affects communication, social interaction, and behavior.

ADHD: Attention Deficit Hyperactivity Disorder – a neurodevelopmental condition marked by persistent inattention, hyperactivity, and impulsiveness.

CYP: Children and Young People – a general term for individuals typically aged 0–18 or up to 25 in some contexts used in services relating to education, health, and social care.

DCD: Developmental Coordination Disorder – a condition that affects physical coordination, also known as dyspraxia.

EHCP: Education, Health and Care Plan – a legal document outlining a child or young person's special educational needs and the support they require.

ICB: Integrated Care Board – NHS bodies responsible for planning and funding local health services in England.

LDA: Learning Disability and Autism – a term used to describe individuals and services relating to people with a learning disability and/or autism.

NEET: Not in Education, Employment or Training – a classification for young people who are not currently engaged in education, work, or vocational training.

NHSE: NHS England – the national body responsible for overseeing the budget, planning, and delivery of healthcare services in England.

PINS: Partnership for Inclusion of Neurodiversity in Schools – a collaborative initiative aimed at improving the inclusion, understanding, and support of neurodivergent children and young people within educational settings.

RTC: The Right to Choose- allows patients to select any qualified and accredited provider for their NHS care, ensuring they have a say in where and from whom they receive treatment.

SEND: Special Educational Needs and Disabilities – a term referring to learning difficulties or disabilities that require special educational provision.

SENDIASS: Special Educational Needs and Disabilities Information, Advice and Support Service- provides free, impartial, and confidential advice to children and young people with SEND, and their families, to help them navigate education, health, and care processes.

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