Briefing for the All-Party Parliamentary Group on ADHD

Matthew's Law

Earlier identification.
Timely, effective care.

A refined, costed route from the first concern to appropriate assessment, treatment and follow-up.

12 October 2026 | England demonstration programme | Version 1.0 for discussion

The proposition

Find possible ADHD earlier, protect access to a full clinical assessment, and fund the care that follows. Do not ask people to reach crisis before their needs count.

6,000

People supported

A planned cohort, not a forecast of diagnoses.

6 sites

Diverse local systems

Adults and children; specialist-backed delivery.

£7.79m

Indicative cash envelope

42 months, including contingency and assumed inflation.

Decision requested: support a staged, independently evaluated programme, beginning with a **£350,000 development phase within the overall envelope**. Release the remaining funding only after clinical, workforce, financial and research checks.

A proposal of Matthew Lock ADHD Charity, registered charity 1212972. Not an enacted law, an approved NHS programme or an APPG-endorsed publication. Costs are planning estimates, not supplier quotations. [1-3; M]

02 / Executive overview

The decision in two minutes

Keep the ambition. Strengthen the evidence, delivery and financial case.

The strongest case

Early recognition has value when it leads to the right help. The programme buys an entire care pathway, not just a questionnaire or a diagnosis.

What this version asks government to fund

A six-site demonstration for up to 6,000 people with concerns consistent with ADHD. It combines assisted early enquiry, specialist-backed assessment, support while waiting, indicated treatment and 12 months of treatment follow-up. Participants do not need to be in crisis.

What it does not ask government to assume

It does not assume universal school screening is already proven, that a screen diagnoses ADHD, that a short course authorises every clinician to practise independently, or that projected social savings pay the bill. Existing clinical care continues regardless of research participation.

Decision measure	Base planning case
Programme cost in constant October 2026 prices	£7,543,987 including 15% contingency
Illustrative cash requirement	£7,785,038 including 3% assumed annual inflation
Budgeted clinical activity	2,100 assessments; 1,260 diagnoses; 882 medication starts
Existing campaign waiting-time ambition	Under six months to a diagnostic decision
New proposed treatment standard	Start indicated treatment within eight weeks of decision

These activity numbers are cost assumptions, not quotas or clinical targets. More referrals or complex needs trigger additional commissioning, not refusal of care. The total includes research and programme setup; it is not a per-diagnosis tariff.

Reading route: proposal 3-10 | activity and costs 11-17 | value and evaluation 18-20 | governance and action 21-25 | evidence register 26-28. [1-3; M]

03 / Refining Matthew's Law

What changes from the original proposal

A transparent refinement, not a silent replacement of the charity's campaign.

Original campaign element [1]	Refinement recommended here
Universal digital screening in Year 3 and Year 7	Retain as a research ambition. Begin clinical delivery with people presenting with concerns; evaluate population screening separately.
Accredited GPs and trained nurses	Require demonstrated ADHD specialist competence, supervised practice and explicit scope. Preserve specialist-led child diagnosis and medication initiation.
Digital-first model; up to 40% time saving	Digital-enabled and accessible in person. Budget no efficiency saving until validated in the chosen pathway.
10,000 GPs and 5,000 nurses trained	Begin with 24 training places and procure actual clinical hours. Size a national workforce from measured demand and productivity.
Under-six-month wait ambition	Define referral-to-diagnostic-decision separately from diagnosis-to-treatment; publish both and total time to care.
£724m cost; £3.3-£6.1bn annual savings	Do not rely on these campaign projections. Use a bottom-up pilot budget and independent incremental economic evaluation.
National accountability and early intervention	Retain; add follow-up of non-referred people, equity measures, transparent exceptions and independent scrutiny.

What stays unchanged

Matthew's Law remains a campaign for earlier recognition, more qualified capacity, access before crisis and accountability for the entire journey to care.

The left column records the published campaign, not established outcomes. The right column comprises new recommendations for charity and clinical review. [1-3]

04 / Evidence ladder

What the evidence actually supports

The evidence for treatment is stronger than the evidence for universal screening.

Evidence	What it supports	Boundary
Clinical guideline [4,20]	Qualified assessment and individualised treatment, with monitoring.	Not diagnosis by questionnaire or medication for everyone.
ADHD Taskforce [15]	Earlier support, wider clinical roles and evaluated care models.	A recommendation is not a completed implementation.
AQUA randomised trial [9]	A diagnostic aid can improve decisions after referral in children and young people.	Not a trial of universal screening; not proof of a 40% saving.
Swedish register study [8]	Medication initiation was associated with fewer serious outcomes.	Observational; not a trial of Matthew's Law or NHS waiting-list reduction.
School screening trial [7]	Evidence that identification alone can fail to improve outcomes.	An older, limited intervention does not settle every modern funded pathway.
Existing regional services [11-14]	Trained clinicians can deliver new assessment models.	Activity reports do not establish national cost-effectiveness.

A useful clinical signal, not a screening promise

In the Swedish study of 148,581 newly diagnosed people aged 6-64, medication initiation was associated with adjusted first-event rate ratios of **0.83 for suicidal behaviours, 0.85 for substance misuse and 0.87 for criminality** over two years. These correspond to 17%, 15% and 13% lower relative rates, not percentage-point reductions. [8]

Residual confounding remains possible. Suicidal behaviours are not suicide deaths alone; criminality used convictions in an age-eligible subgroup. No deaths, offences or addictions prevented are credited in the budget. [8; M]

05 / Screening and safeguards

Why screening needs a funded next step

Earlier identification is a means to better care, not an outcome on its own.

The programme distinguishes **clinical enquiry in people with symptoms or concerns** from inviting an apparently unaffected population for screening. These are different activities with different evidential requirements. [6,21]

The evidence that must not be ignored

A follow-up of an English school trial found no generalisable long-term benefit from early screening followed by teacher information and/or identification. Identification alone was associated with worse symptom ratings. It did not test the full funded pathway proposed here. [7]

Why false results matter

Illustration: 1,000 people	5% meet condition	20% meet condition
True positives / false negatives	40 / 10	160 / 40
False positives / true negatives	95 / 855	80 / 720
Positive predictive value	29.6%	66.7%

Mathematical illustration: sensitivity 80%, specificity 90%, assumed true prevalence 5% or 20%. These are not performance claims for any tool, nor pilot yield forecasts. [M]

A positive result requires clinical interpretation; a negative result must not override persistent concerns. A more symptom-enriched group may improve yield, but a severity gate must not replace assessment of clinical need.

The practical rule

No mass invitation without assessment capacity, consent safeguards and follow-up. No automatic exclusion because of a score, a missed form or an apparently low-risk presentation.

06 / Service design

A pathway with no clinical dead end

One route in; different clinical teams; support throughout.

Stage	What happens	Proposed service standard
1. Recognise	Person, family, school or professional raises a concern; urgent safety needs are addressed immediately.	Acknowledge within five working days.
2. Understand	Assisted enquiry, relevant history and impairment, age-appropriate tools and discussion of next steps.	Clinical review within two weeks.
3. Assess	Full diagnostic assessment by a competent team; use specialist routes for complexity and children.	Aim for 12 weeks; under 26 weeks as the access standard.
4. Treat	Shared decision about medication, psychological care, environmental changes or an alternative explanation.	Indicated treatment starts within eight weeks of decision.
5. Follow through	Monitor benefit and harm; optimise treatment; agree continuing responsibility and transition.	12 months of treatment follow-up funded.

Support begins when needed and runs alongside assessment. A provider cannot reset the original referral date by moving someone to another service. Report time from first presentation as well as formal referral.

For someone not referred after enquiry, provide a written explanation, a contact route and a planned review. A person who still has clinically significant concerns can request assessment or a second clinical review without re-entering at the back of a queue.

All timings are proposed commissioning standards, not existing national guarantees. Clinical urgency takes precedence. Record patient-choice and justified clinical deferrals separately, rather than deleting them from the audit. [2,4; M]

07 / Children and young people

Children: early help without premature labels

Keep the school involved, the child heard and specialist responsibilities clear.

The initial clinical programme covers **ages 6-17 with concerns already identified**, not universal Year 3 or Year 7 testing. Schools provide observations and adjustments; parents, carers and young people contribute their perspectives. Children below six retain existing age-appropriate specialist and family-support routes.

A child pathway, not an adult model applied to schools

NICE does not recommend universal ADHD screening in schools and says primary care practitioners should not make the initial diagnosis or start medication in children and young people with suspected ADHD. This proposal therefore funds specialist-led diagnosis and initiation, with coordinated primary-care and school support. [4, 1.2.3 and 1.2.9]

Protection	Programme requirement
Context and differential assessment	Consider development, sleep, learning, anxiety, trauma and other explanations; recognise possible coexisting autism.
Consent and participation	Use age-appropriate information, obtain appropriate consent and involve the child in decisions; separate research from clinical consent.
No diagnosis-dependent school help	Start reasonable classroom and family support according to need; do not wait for the final label.
Transition	Agree continuing clinical responsibility before a young person moves to adult services.
Screening at school transition points	Retain Year 3/Year 7 as a separately evaluated research proposal, not an automatic mandate.

What success looks like

The right explanation and support earlier, better day-to-day functioning and a clinically justified treatment plan. A higher diagnostic rate alone is not success.

Programme requirements are proposed safeguards. Consent arrangements require sponsor and local legal/clinical approval. [4,6,22]

08 / Adults and inclusion

Adults: an earlier route, including complex need

Being employed, articulate or outwardly composed does not settle the need for care.

Offer a consistent enquiry when adults present with possible ADHD. Include access through primary care, mental-health and substance-use services, and youth/adult justice health teams where appropriate. Invitations must be voluntary and must not affect benefits, employment or justice decisions.

Different teams, not different rights to care

A clinician with verified ADHD specialist competence may assess suitable adult presentations in a primary-care setting. More complex cases receive a specialist pathway with a named responsible team. General medical registration or attendance at a course is not sufficient authorisation for independent ADHD practice. [4,11-15]

Situation	Required response
Possible substance-use disorder	Coordinate ADHD and addiction assessment; plan safe prescribing and treatment for both needs.
Self-harm or suicidal thoughts	Immediate clinical safety assessment and appropriate urgent help; do not rely on a low/medium/high label to decide access.
Questionnaire negative but concern persists	Offer human review and access to further assessment when justified.
Possible coexisting autism	Assess or refer appropriately; do not treat an ADHD screen as an autism diagnosis.
Missing childhood records	Use clinical judgement, alternative collateral information and documented reasoning; missing paperwork is not automatic rejection.

Safety is active, not a score

NICE self-harm guidance warns against using global risk categories to predict suicide or determine treatment or discharge in self-harm care. Urgency decisions must remain clinically grounded. [5, section 1.6]

Clinical decisions remain individual. The programme is not a substitute for emergency, addiction or specialist mental-health provision. [4,5,15]

09 / Existing practice

Build on models already in use

The delivery idea is not starting from zero. The national outcome claim still needs testing.

ADHD360: training already includes doctors

The published profile of GP Dr Adriana Nastase records Advanced ADHD Practitioner training in 2024. The Academy also describes a structured programme for experienced nurses. This demonstrates training activity, not universal clinical authorisation or independent proof of improved outcomes. [11,12]

Sussex: newer reported delivery

A September 2026 provider-collaborative update reports **2,440 referrals and 970 assessments in the first five months**, across three pilot areas. This is newer than the 300-assessment figure cited in the earlier charity briefing. It is service-reported activity, not a controlled effectiveness result. [13]

Sheffield: assessment and medication

The University Health Service specification describes a GP with an extended role assessing, and prescribing where required, for approximately **126 less-complex patients over a year**. That number is a planned caseload, not an achieved outcome. Other referrals retain existing routes. [14]

The lesson is to commission suitable clinical settings and capabilities, not to exclude people with lower apparent urgency. National expansion must measure diagnostic quality, treatment access, functioning, cost and whether staff are genuinely additional rather than moved from another waiting list.

No named provider has agreed to participate in this proposal. These examples are not commercial endorsements or a procurement shortlist. [11-15]

10 / Workforce and technology

Buy clinical capacity, not certificates

Training enables delivery only when time, supervision and accountability are funded.

A competence-based starting point

Budget for **24 initial training places**, linked to locally approved roles and supervised practice. Entry criteria, assessment of competence, case review, scope restrictions, revalidation and escalation must be agreed by the host clinical services. Paediatric specialist responsibilities do not move merely because a practitioner completes training.

Clinical work	Base direct-care hours	Full-time-equivalent years*
GP / equivalent medical role	4,441.5	4.04
ADHD specialist role	5,533.5	5.03
Nurse / practitioner role	13,950	12.68
Psychological intervention	3,024	2.75

*Illustration at 1,100 delivered clinical hours per full-time-equivalent year. Totals span the cohort's care, not one year. They exclude research, training and governance hours, which are separately budgeted. [M]

The host must produce a monthly roster and referral forecast before recruitment. Secure surge capacity and a funded response to higher demand. Protected clinical time, supervision and backfill must not be counted twice, or assumed to be free.

Digital support with no assumed productivity dividend

Use validated tools only for their supported purpose and age range. QbTest has NICE support as an optional adjunct for ages 6-17, not a standalone diagnostic test. The AQUA trial reported an assessment-time ratio of 0.85 and a diagnostic-decision hazard ratio of 1.44; that does not mean a 44% reduction in calendar waiting time. **The base budget credits zero time saving.** [9,10]

The hourly rate includes non-delivery time through a productive-hours assumption. The programme must validate actual utilisation and minimum contracted capacity. [16; M]

11 / Activity model

A cohort that can be costed and followed

Clinical conversion rates are planning assumptions, never eligibility caps.

6,000

Completed enquiries

3,600 adults and 2,400 children assumed.

2,100

Clinical assessments

35% of the enquiry cohort assumed.

1,260

ADHD diagnoses

60% of assessments assumed.

Further activity	Planning assumption	Budgeted volume
More complex assessments	20% of assessments need extra specialist time	420
Medication initiation and follow-up	70% of diagnosed people; preference and indication govern	882
Education / family support	All diagnosed people offered a tailored package	1,260
Additional psychological intervention	30% of diagnosed people; may overlap medication	378
No ADHD after assessment	40% receive feedback and an onward care plan	840
No immediate assessment after enquiry	65% receive a planned follow-up contact	3,900
Optional diagnostic aid	25% of child assessments, when appropriate	210

These are expected volumes, not forecasts validated against local demand. People may decline medication, require longer assessment or have another condition. No clinician should be rewarded for reaching a diagnostic or prescribing percentage.

A non-negotiable trigger

If actual clinical need exceeds the budget assumptions, seek additional capacity or pause new research invitations. Do not deny or delay indicated care to preserve the forecast. Existing NHS pathways remain available.

Illustrative cohort for commissioning and evaluation. Clinical eligibility and consent are separate from these arithmetic assumptions. [M]

12 / Cost model: units

Unit costs: enquiry and diagnosis

Transparent staff time, not an unexplained price per test.

Resource	Planning rate	Basis / status
Nurse / qualified practitioner	£75 per delivered hour	NHS salary benchmark plus on-costs and non-delivery time; rounded assumption.
GP / equivalent medical role	£150 per delivered hour	Commissioning assumption, including employment or sessional costs; quote required.
ADHD specialist	£220 per delivered hour	Commissioning assumption; not an official tariff.
Case administration	£35 per hour	Loaded planning assumption.
Psychological intervention	£90 per hour	Qualified-practitioner planning assumption.

The 2026/27 NHS England Band 7 maximum salary is **£56,515**. Adding an assumed 40% employment on-cost and dividing by 1,100 delivered hours gives about **£72/hour**, rounded to £75 for planning. This is not an NHS cost-study estimate; 10% non-pay overhead is added separately. [16; M]

Unit	Micro-cost calculation	Cost
Enquiry	0.5 nurse hour + 0.25 admin hour + £5 tool allowance	£51.25
Adult assessment	3 GP hours + 0.5 specialist hour + 0.5 admin hour + £25 tools	£602.50
Child assessment	3 specialist hours + 1 nurse hour + 0.75 admin hour + £25 tools	£786.25
Complexity supplement	2 additional specialist hours	£440
Optional child diagnostic aid	1 nurse hour + £75 licence / equipment allowance	£150

Time covers preparation, clinical contact, collateral information, decision and documentation; not just a video appointment. Licences, local pay, VAT and complex-case time need validation. [M]

13 / Cost model: units

Unit costs: treatment and continuity

A diagnosis without funded follow-up is not a complete service.

Per medication-start episode	Resource allowance	Cost
Baseline physical / prescribing preparation	0.75 medical hour + 0.5 nurse hour	£150.00
Specialist initiation	0.75 specialist hour	£165.00
Titration contacts	7 contacts x 0.5 nurse hour	£262.50
Titration specialist review	0.5 specialist hour	£110.00
Post-titration monitoring within year one	3 x 0.5 nurse hour + 0.5 specialist hour	£222.50
Case administration	1.5 hours	£52.50
Medication supply	12 months x £50 assumption	£600.00
Total episode	**Clinical time plus drug allowance**	**£1,562.50**

The package is a resource allowance, not a fixed clinical schedule. Individual titration, physical monitoring and review must follow need. Complex investigations, longer treatment adjustment and coexisting care may require the reserve or extra commissioning. [20; M]

Non-medication care is part of the model

All 1,260 diagnosed people have a **£100 education/support allowance**: six group sessions, ten participants, practitioner and administration time, and materials. An additional **£720 per person** funds eight psychological-intervention hours for an assumed 30%, including appropriate individual or family work. These offers can overlap medication.

NICE describes trained initiation, dose optimisation and shared-care monitoring after stabilisation. Responsibility stays with the commissioned service until an explicit transfer is accepted. No forced discharge at a budget anniversary. [20; M]

14 / Cost model: service budget

The direct-care budget

Every person has a funded next step, including those not diagnosed with ADHD.

Resource	Volume	Unit	Total
Assisted early enquiry	6,000	£51.25	£307,500
Adult diagnostic assessment	1,260	£602.50	£759,150
Child diagnostic assessment	840	£786.25	£660,450
Additional specialist complexity time	420	£440.00	£184,800
Four brief waiting-review contacts plus admin	2,100	£92.50	£194,250
Review where no immediate assessment follows	3,900	£27.50	£107,250
Feedback / onward plan after no ADHD diagnosis	840	£83.75	£70,350
Medication initiation, supply and 12-month care	882	£1,562.50	£1,378,125
Education / family support	1,260	£100.00	£126,000
Additional psychological intervention	378	£720.00	£272,160
Optional child diagnostic aid	210	£150.00	£31,500
Direct care subtotal			**£4,091,535**
Non-pay delivery overhead	10% of direct care		£409,154

Overhead covers routine premises, supplies, insurance and delivery infrastructure. It does not repeat employment on-costs already included in hourly rates. Site setup and the shared platform are separate one-off / programme costs.

Care beyond ADHD

A negative ADHD diagnostic decision still needs feedback and an onward plan. A separate £150,000 reserve supports complex investigations and coexisting-need access, but does not replace the full budgets of autism, addiction or mental-health services.

Constant October 2026 prices; totals calculated before rounding. Unit rates and activity are planning assumptions. The budget is gross, before any evidenced comparator cost avoided. [M]

15 / Cost model: programme budget

What makes delivery possible

Setup, supervision, coordination and independent scrutiny are real costs.

Budget line	Total
Site mobilisation	£120,000
Training and accreditation	£279,600
Platform build	£90,000
Platform operation	£105,000
Local coordination	£252,000
Programme management	£157,500
Data management	£122,500
Clinical governance	£70,000
Co-production and access	£30,000
Data safety and regulatory setup	£45,000
Independent evaluation	£450,000
Verification assessments	£135,200
Independent positive-case audit	£52,500
Complex coexisting-need reserve	£150,000
Programme and evaluation subtotal	**£2,059,300**

Training: £279,600. For each of 24 places, allow £3,000 course fees, 60 protected hours at £100, ten supervised cases at 0.75 specialist hour and £1,000 competence assessment: **£11,650 per place**. Initial supervision is additional to routine case-review time, not a second charge for the same work.

Programme staffing over 3.5 years: local coordination 0.2 full-time equivalent per site at £60,000 loaded annually; central management 0.5 at £90,000; data management 0.5 at £70,000; governance 0.1 at £200,000. These are programme roles, not direct clinical sessions.

Verification: 200 assessments x weighted £676; independent audit: 10% of 2,100 cases x £250. Evaluation and governance teams must be independent of commercial interests. All prices require procurement validation. [M]

16 / Cost model: total

The funding request and cash profile

Do not confuse a programme envelope, annual running cost and economic return.

Budget component	October 2026 prices
Direct care	£4,091,535.00
Non-pay delivery overhead	£409,153.50
Programme, setup, evaluation and reserve	£2,059,300.00
Subtotal before contingency	**£6,559,988.50**
15% delivery contingency	£983,998.27
Total in constant prices	**£7,543,986.78**
Illustrative inflation allowance	£241,050.75
Illustrative cash envelope	**£7,785,037.52**

Period	Assumed share of real spend	Cash allowance
Year 1	35%	£2,640,395
Year 2	35%	£2,719,607
Year 3	20%	£1,600,683
Final six months	10%	£824,352

The cash profile assumes 3% annual price growth and 35% / 35% / 20% / 10% real spending. It is not an inflation forecast or a final staffing schedule. The 15% contingency covers operational uncertainty, not planned inflation; replace it with quantified risk allowances as the business case develops.

Release funding in stages

Approve a £350,000 development tranche **within, not on top of**, the envelope. Further release requires an approved protocol, quotations, tax treatment, monthly capacity and a signed continuing-care arrangement.

Planning estimate, not a full Treasury business case. Totals use unrounded inputs. Confirm VAT and clinical-service tax treatment at procurement; no blanket 20% VAT is assumed. [17; M]

17 / Sensitivity and affordability

Stress-test the cost before scaling

Demand, clinician time and delivery volume matter more than optimistic headlines.

Scenario	Real total	Cash total	Real cost / enquiry
Lower throughput	£5.97m	£6.16m	£1,422
Base	£7.54m	£7.79m	£1,257
More assessment demand	£8.87m	£9.15m	£1,478
Higher clinical costs	£8.78m	£9.06m	£1,464
Combined stress	£10.60m	£10.94m	£1,767

Lower throughput: 4,200 enquiries. More assessment demand: 45%, not 35%, proceed. Higher clinical costs: hourly/unit clinical rates +20%, drugs £900 not £600. Combined: higher demand and costs plus complexity 30%, not 20%. Other inputs unchanged. Not probability forecasts. [M]

Costs continue after the pilot

If all 882 medication starters continued after the funded first year, a planning allowance of £840 each for annual medication and routine monitoring would be **£740,880 per year**, or **£814,968 including 10% delivery overhead**, in 2026 prices. Additional clinical needs and future cohorts are extra; continuation and prescribing vary.

What not to infer from unit averages

The programme's real cost averages **£1,257 per completed enquiry** or **£3,592 per assessment** when all programme costs are divided by those counts. Neither is a standalone screen or diagnostic price. The model funds negative-result follow-up, treatment, setup and research too.

A commissioning safeguard

A contingency is not permission to cap clinical need. If the stress case materialises, revise funding and intake with independent oversight. Never transfer an unfunded treatment obligation to general practice or families.

18 / Benefits and economics

How early identification could create value

A benefits case that can survive a sceptical economic review.

Potential benefit	How it would arise	What must be measured
Earlier understanding	Concerns are recognised and explained sooner.	Time to appropriate plan; experience; false reassurance and labelling harms.
Earlier effective care	A funded assessment connects people to indicated treatment.	Time to treatment; functioning; quality of life; adverse effects.
Less avoidable duplication	One coordinated history and a clear pathway.	Actual contacts and clinician time, not assumed percentage savings.
Education, work and family gains	Better functioning and appropriate adjustments.	Attendance, participation and family impact; compare with usual care.
Reduced serious harm	Potential downstream benefit of effective care.	Longer-term linkage; do not promise prevented suicides, addiction or convictions.

The base case credits no speculative cash saving

Cash-releasing savings require evidence that spending really stops elsewhere. Additional wellbeing is valuable but is not cash available to fund the service. Avoided costs, productivity and quality-adjusted life years must not be double-counted. Full economic evaluation needs incremental cost and outcomes against a credible comparator. [17; M]

Illustrative timing benefit: if half of 882 medication starters genuinely began six months earlier than under usual care, that would be **220.5 person-years of earlier access**. It is not 220.5 life-years or quality-adjusted life years gained, and does not prove treatment benefit. [M]

Break-even is a question, not a promise

At the gross real programme cost, £5,987 per 1,260 diagnosed people would need to be offset by valid net benefits to cover the bill. If only half benefited incrementally, the hurdle would be £11,975 each. Diagnosis alone is not proof of benefit.

Formal appraisal discounts real resource flows; it does not discount a cash budget. Green Book 2026 uses 3.5% for ordinary costs/benefits and 1.5% for health/life effects. A recommendation to change rates is not itself a replacement rule. [17]

19 / Evaluation design

Test the extra value of screening

Do not attribute the benefits of more clinicians to a questionnaire.

Two questions need two comparisons

Whole-pathway question: does the programme improve access, functioning and safety compared with existing care? Use a concurrent comparison with pre-intervention measurement and transparent adjustment, or an ethically acceptable randomised rollout. Avoid a simple before-and-after claim.

Identification question: does an enhanced, structured identification offer add value when assessment and treatment capacity are similar? Where feasible, randomise participating practices or invitation timing while ensuring the same downstream clinical route in both groups. Usual clinically indicated care must not be withheld.

Design requirement	Reason
Pre-register protocol and analysis	Prevent changing the outcome after seeing the results.
Count everyone invited / enrolled	Do not report only people who completed or were diagnosed.
Measure false negatives and false positives	Review a sample beyond the screen-positive group; avoid verification bias.
Use blinded independent review	Assess diagnostic quality without provider or campaign pressure.
Include age and equity subgroups	Check who benefits, who is missed and who cannot use the process.

The budget includes **£450,000 independent evaluation**, 200 verification assessments and 210 independent case audits. These are feasibility resources, not a claim of statistical power. An independent statistician must specify the design, sample size, missing-data strategy and comparison-care costs before recruitment.

A fair test can reject the hypothesis

If extra identification adds no benefit beyond faster access to care, fund the effective care improvement and revise or stop the screening component. Publish negative results as well as positive ones.

Comparison services retain their normal funding; additional research assessments are included only to the specified extent. Any larger randomised design needs an approved revised budget. [6,7,17; M]

20 / Evaluation and decision gates

Outcomes that matter to people

Measure improvement, not just activity or a shorter administrative list.

Domain	Proposed measures
Access	Presentation-to-enquiry; referral-to-decision; decision-to-treatment; referral-to-treatment; waiting tails by urgency and group.
Clinical quality	Documented assessment standards; independent review; alternative explanations; appropriateness of treatment decisions.
Benefit	Age-appropriate symptom and functioning measures; quality of life; patient-defined goals; family and school/work experience.
Safety	Adverse events, deterioration, missed cases, re-referrals, complaints and urgent escalations; no risk-label reassurance.
Equity	Offer, uptake, completion, access and outcomes by age, sex, ethnicity, deprivation and disability, with privacy safeguards.
Economics	Resource use, total and incremental cost, continuing obligations and cost-consequence / cost-utility analysis.

Agree thresholds before enrolment

At the development gate, specify clinically meaningful change, acceptable diagnostic disagreement and safety margins, and the power needed to assess them. A six-site pilot is not designed to prove a reduction in suicide deaths. Rare harms need ongoing surveillance and appropriately approved longer-term linkage.

For commissioning, propose a 90% compliance aim with the 26-week assessment and eight-week treatment standards, alongside reporting of every exception. This is a performance trigger, not an allowance to abandon the remaining 10%.

Stop, adapt or expand

Suspend unsafe technology or ungoverned practice immediately. Pause new research invitations where capacity fails; protect enrolled people. Expand only when independent results show acceptable quality, better access and a credible funded care pathway.

Thresholds, the 90% aim and measures are proposed specifications for review, not validated universal standards. [M]

21 / Governance and assurance

Governance that protects trust

Clinical judgement, consent and independence are part of the service, not optional extras.

Owner	Responsibility
Public commissioner / host NHS body	Accountable funding, clinical contracts, safeguarding, complaints, capacity and continuing-care obligations.
Named clinical director	Scope of practice, diagnostic standards, prescribing, supervision, physical monitoring and escalation.
Independent evaluator and safety group	Protocol, data integrity, independent analysis, harms review and publication.
People with ADHD and families	Paid co-design, accessible communications, equity and experience scrutiny.
Matthew Lock ADHD Charity	Campaign leadership, lived-experience partnership and public accountability; no presumption of holding clinical responsibility.
Suppliers and training providers	Evidence, licences, transparent pricing, conflicts declarations and auditable performance.

Data and technology requirements

Complete a data protection impact assessment, establish lawful bases for health-data processing and separate care, research and secondary-use permissions. Minimise access, retention and linkage. Do not make school performance, benefits or justice decisions automatically from an ADHD score. [19]

Use software only within its validated intended purpose and applicable regulatory status. Changes in age range, task or algorithm require reassessment; a generic artificial-intelligence claim is not clinical validation. No autonomous diagnosis or rejection. [18]

Transparent procurement

Run a provider-neutral procurement. Declare the charity's and advisers' relevant interests. Separate campaign support from supplier selection and clinical outcome evaluation. No provider endorsement is implied.

Host organisations must obtain clinical, research, data-protection and procurement advice before launch. This is a governance specification, not legal advice. [18,19,22]

22 / Separate research pathway

A credible route to school screening

Retain Year 3 and Year 7 as an ambition worth testing, not a claim already proven.

The published campaign calls for universal digital screening at school transition points. This refined version keeps that objective visible but does **not** quietly relabel a symptomatic clinical pilot as proof that whole-school screening works. [1]

Research stage	Evidence needed before the next step
1. Review and co-design	Map current evidence, the earlier trial, acceptability, consent, inequality and the likely downstream service demand.
2. Diagnostic validation	Use representative ages and settings, an independent reference assessment, and samples of screen-positive and screen-negative children.
3. Controlled whole-pathway study	Compare invitation to screening plus funded follow-up with usual care; include functioning, harms, resource use and cost-effectiveness.
4. National evidence review	Submit the full pathway evidence to NICE / the UK National Screening Committee as appropriate; demonstrate that benefits outweigh harms.
5. Commissioning decision	Fund assessment and treatment capacity before any national invitation programme begins.

Research must consider relative age within the school year, language, learning differences, multiple informants, changing thresholds and families who do not participate. Repeated testing cannot become a permanent label or an automatic demand for medication.

Budget boundary

The £7.79m envelope is for the clinical demonstration and its specified evaluation. It does **not** include a national school rollout or a definitive universal-screening trial. A separate protocol and costed research bid are required.

This distinction directly responds to the evidence gap and current NICE school-screening position. [4,6,7,21,22]

23 / Policy and implementation

From campaign to a workable legal package

Set duties and accountability without freezing a test or treatment into law.

What Matthew's Law could require

The proposed statutory package should focus on access and public accountability: a duty to publish a funded local ADHD pathway; transparent national access standards; a named responsible service; review and escalation rights; and regular reporting of outcomes and inequalities. Clinical criteria and individual treatment choices remain with qualified professionals.

Set competence and oversight standards through the appropriate clinical and regulatory mechanisms. Do not write a commercial instrument, automatic diagnosis, fixed prescribing proportion or unvalidated prevalence ceiling into legislation.

Phase	Proposed milestone
Months 1-6	Development, co-design, procurement, research approval and workforce readiness; first funding gate.
Months 7-18	Up to 6,000 completed enquiries across six sites; monthly capacity and safety review.
By month 24	Last planned assessments within 26 weeks of late recruitment, subject to individual justified deferrals.
By month 26	Last planned treatment starts within eight weeks; continuing-care responsibility confirmed.
By month 38	Twelve-month treatment follow-up for the final planned starters.
Months 39-42	Final evaluation, accounts and decision on sustained commissioning.

Publish interim access and safety findings at months 12, 18 and 24. Do not wait 42 months to correct an unsafe process. Any individual delay beyond the planned tail requires funded continuity, not abrupt discharge.

A proposed schedule measured from funded project start, not a calendar commitment. England is the first commissioning scope; devolved systems require separate engagement. Parliamentary counsel and government would determine legal powers and the legislative route. [M]

24 / Challenge and response

The questions a sceptical reader will ask

Answer the hardest objections before asking for endorsement.

Challenge	Response in the refined proposal
Is universal early screening proven?	No. The initial service addresses existing concerns. Population screening remains a separately governed research question.
Is this simply more demand?	Earlier recognition can increase referrals. The budget funds assessment and treatment, tests higher demand and prohibits a diagnostic quota.
Why not just train all GPs now?	Training is necessary but insufficient. Buy protected clinical hours, verify competence and retain specialist care for children and complexity.
Does medication evidence prove screening prevents suicide?	No. It supports access to indicated treatment, not a direct causal claim about screening or any individual death.
Is £7.79m guaranteed to pay for itself?	No. It is a gross learning-and-service investment. Independent incremental outcomes and costs determine value for money.
Why is the programme longer than 18 months?	Enrolment ends at month 18, but the last person still needs assessment, treatment and a full year of follow-up.
Could this weaken existing NHS services?	Contracts must demonstrate additional or protected capacity and backfill. Monitor displacement, not just pilot throughput.
Why not cheaper digital-only assessment?	A low price does not demonstrate accurate diagnosis or safe follow-up. Technology must add value without becoming a clinical shortcut.

The defensible claim

Matthew's Law offers a testable route to earlier recognition and care. Its strength is a funded pathway, transparent assumptions and a willingness to change when evidence shows a better approach.

25 / Decision requested

The request to the APPG

Turn shared concern into a funded, testable and accountable next step.

01	02	03
Convene	**Develop**	**Evaluate**
Bring commissioners, clinical leaders, researchers and lived experience together.	Support the £350,000 first-stage business case within the envelope.	Secure independent oversight and publish outcomes, including negative findings.

Seek a government response on four points

Access: will ministers support separate assessment and treatment standards, protected access for lower-priority people and a clear route to reassessment?

Capacity: which existing trained-clinician and specialist-backed services could host a demonstration, with funded treatment and continuity rather than screening alone?

Evidence: will government commission an independent evaluation of the whole pathway and the incremental value of structured identification, alongside a distinct school-screening evidence programme?

Funding: will government and research funders examine the indicative £7.79m cash envelope, its assumptions and stress cases, and require quotations and a signed continuing-care plan before release?

Why this matters to Matthew's family

Matthew's life and our family's devastating loss drive this campaign. We want people's needs to be recognised and treated before they become a crisis. No policy can promise to prevent every tragedy. That makes careful, earlier care more urgent, not less.

Richard and Christine Lock
Founders, Matthew Lock ADHD Charity
Registered charity 1212972
info@matthewlockadhdcharity.com

This version refines the published campaign for discussion. It requires charity approval and independent clinical, economic and legal review before submission as a formal funding or legislative proposal. [1-3; M]

26 / Evidence register

Sources: campaign and clinical evidence

Numbered references distinguish source evidence from the proposed model.

[1] Matthew Lock ADHD Charity. Published Matthew's Law proposal.

Core objectives: Year 3/Year 7 screening, accredited clinicians, workforce ambition, £724m and £3.3-£6.1bn projections. Source of original campaign, not proof of effectiveness.

Open source

[2] Matthew Lock ADHD Charity. Care before crisis. 11 October 2026.

Supplied 16-page APPG briefing, especially pages 8-13: screening, clinical models, safe scale-up, two waits and accountability.

[3] Matthew Lock ADHD Charity. Prevalence is not settled. 12 October 2026.

Supplied 20-page briefing, especially pages 2 and 16-17: uncertainty, comparable measures and no diagnostic quotas.

[4] NICE. NG87: ADHD - diagnosis and management.

Recommendations 1.2.1-1.2.10, 1.3.1-1.3.4, 1.5 and 1.7-1.8. Current clinical requirements and screening/primary-care boundaries.

Open source

[5] NICE. NG225: Self-harm - assessment, management and preventing recurrence.

Section 1.6. Risk scores and global categories must not determine treatment/discharge or predict suicide in self-harm care.

Open source

[6] UK National Screening Committee. Criteria for a population screening programme.

Criteria 4-15: test, intervention, complete pathway, harms and resources. Screening requires evidence of net benefit.

Open source

[7] Sayal K et al. Impact of early school-based screening and intervention programs for ADHD. 2010.

Archives of Pediatrics and Adolescent Medicine 164(5):462-469. School trial follow-up: no long-term generalisable benefit; limited intervention, not a modern full pathway.

Open source

27 / Evidence register

Sources: treatment and existing practice

Numbered references distinguish source evidence from the proposed model.

[8] Zhang L et al. ADHD drug treatment and serious outcomes. BMJ 2025;390:e083658.

DOI 10.1136/bmj-2024-083658. Swedish target-trial emulation; Methods and Results (first events), limitations. Observational, not a screening trial.

Open source

[9] Hollis C et al. QbTest and diagnostic decision-making. 2018.

Journal of Child Psychology and Psychiatry. DOI 10.1111/jcpp.12921. Randomised study, decision hazard ratio 1.44, consultation-time ratio 0.85; no calendar-wait percentage inferred.

Open source

[10] NICE. HTG729: Digital technologies for assessing ADHD. 2024.

Resource impact summary: QbTest as an option for ages 6-17 alongside standard assessment; other uses may be research-only.

Open source

[11] ADHD360. Dr Adriana Nastase: professional profile.

Provider-reported GP training example, 2024. Not independent accreditation or outcome evidence.

Open source

[12] ADHD360 Academy. Advanced ADHD Practitioners Course.

Provider description of training, intended participants and curriculum. Prices in this proposal are not quotations from this provider.

Open source

[13] Sussex Primary Care Provider Collaborative. Transforming adult ADHD care webinar, September 2026.

Reports 2,440 referrals and 970 assessments in the first five months. Reported service activity, not controlled evaluation.

Open source

[14] NHS Sheffield. Primary Care ADHD Screening Interface and Diagnostic Pilot with UHS. September 2025.

GP extended-role assessment and medication for approximately 126 less-complex patients planned; other referrals retain routes.

Open source

[15] NHS England. Independent ADHD Taskforce: Part 2. November 2025.

Sections on early support, waiting lists, expanded clinical capacity and general practice; proposals need evaluation.

Open source

28 / Evidence register

Sources: costs and governance

Numbered references distinguish source evidence from the proposed model.

[16] NHS Employers. Pay scales for 2026/27.

England annual pay bands: Band 7 maximum £56,515. On-cost, productive hours and the rounded £75 rate are this model's assumptions.

Open source

[17] HM Treasury. The Green Book (2026).

Options, appraisal, uncertainty, optimism bias, distribution and discounting. A full business case is still required.

Open source

[18] MHRA. Crafting an intended purpose for software as a medical device.

Evidence must match clinical purpose, population and setting; avoid unsupported expansion of a tool's role.

Open source

[19] Information Commissioner's Office. Rules on special category data.

Health data, lawful processing and data protection impact assessment. Host legal/data protection review is required.

Open source

[20] NICE. NG87: Rationale and impact.

Medication - care arrangements; prescribing and dose titration. Trained initiation and explicit shared-care transfer after stabilisation.

Open source

[21] UK National Screening Committee. Principles of screening.

Distinguishes national screening programmes from routine clinical investigations of concerns or symptoms.

Open source

[22] Health Research Authority. Research involving children.

Consent and assent; requirements vary with study type and jurisdiction. Consult the current sponsor/HRA process.

Open source

[M] Model and evaluation assumptions

All volumes, unquoted unit prices, hour allowances, timings, conversion rates, scenario choices and modelled benefits in this proposal are new planning assumptions. The accompanying workbook contains formulas and sensitivity controls. They require independent validation, not acceptance on the strength of presentation.

Evidence checked 12 October 2026. No claim is made that a particular pathway would certainly have prevented Matthew's death. The costed clinical pilot is not evidence of a proven universal-screening programme. Brand artwork and approved layout are retained from the supplied reports.