A pilot-first route to a UK-wide ambition

Matthew's Law

Earlier identification.
Timely, effective care.
A national ambition, tested locally.

A revised national proposal that keeps the long-term ambition visible while using a smaller, costed programme to test delivery, benefits and affordability.

14 November 2026 | UK ambition; England pilot | Review edition for discussion

The proposition

Recognise possible ADHD earlier, fund appropriate assessment and care, and build evidence for fair access across the UK. Begin with the England demonstration; scale only when the evidence and delivery capacity justify it.

£7.79m
Pilot cash envelope
Six sites, up to 6,000 people and 42 months. Development funding is included.

£2.11bn
England reference
Three annual cohorts; costed components only. Not a complete UK budget.

£0.85-3.4bn
UK value scenarios
Illustrative gross annual societal value at 5-20% of a £17bn burden; not a forecast.

Decision requested: support the staged pilot and an independently reviewed national business case. Keep the original national savings ambition in view, with corrected costs and clear evidence limits.

Prepared for Matthew Lock ADHD Charity, registered charity 1212972. Test-review edition, 14 November 2026. Figures are planning estimates and scenarios, not quotations or validated returns. National delivery and four-nation costs remain to be agreed. Not enacted law, an approved NHS programme or an APPG endorsement. [P; N; 1; M]

02 / Executive overview

The decision in two minutes

A manageable first step with a clear national purpose.

Keep both parts of the campaign visible

The pilot is the next decision. The UK-wide system is the longer-term ambition. The pilot should test whether an improved pathway is safe, effective, fair and deliverable before larger commitments.

Decision	Pilot now	National ambition
Geography	Six local systems in England	All four UK nations, through their own health and education arrangements
Purpose	Test an end-to-end pathway and collect comparative evidence	Make earlier identification and timely care available at sustainable scale
Coverage	Up to 6,000 people with concerns consistent with ADHD	Population and cohort choices require a four-nation plan
Cost status	£7.79m indicative cash envelope over 42 months	£2.11bn cash reference for England costed components; further national costs remain
Benefits status	Outcomes and costs to be measured; no credited cash savings	Potential societal value; original savings claims require reappraisal

What has changed in this edition

The original £724m national headline was an incomplete, mainly England-based estimate. This review separates screening schedules, adds the clinical pathway and identifies delivery allowances. It also separates economic burden, potential benefit and savings that can actually release public money.

Reading route: ambition and scope 3-5 | pilot 6-8 | national pathway 9-12 | costs 13-17 | benefits and evidence 18-20 | delivery and decisions 21-23 | sources 24. [P; N]

03 / Purpose and history

Why Matthew's Law

The national ambition remains; the route to proving it is staged.

Matthew's Law is Matthew Lock ADHD Charity's campaign for earlier recognition of possible ADHD and timely access to appropriate assessment, treatment and continuing support. It honours Matthew and the family's experience of the consequences of delayed recognition and inadequate care.

The original national ask

The original proposal sought a UK-wide reform, with school-based digital screening, more diagnostic capacity in primary care, workforce accreditation, shared care, better data and cross-government accountability. It aimed to reduce long waits and prevent avoidable difficulties in education, work, health and family life.

Why begin with a smaller pilot?

The scale of the original ask made an immediate national commitment difficult. The October pilot reframed the next step as a six-site England demonstration. This gives commissioners a manageable way to test the whole pathway, understand demand and workforce needs, and identify which costs and benefits hold up in practice.

A staged route, not a reduced ambition

National reach remains the goal. A pilot provides evidence to improve the design, stop ineffective elements and justify expansion where benefits, safety and affordability are demonstrated.

What this national review does

It preserves the original reform themes and the possible scale of national value, but revises unsupported certainty. It records the old financial headlines, corrects the cost scope and sets out what a credible four-nation business case still needs.

This edition reconciles the supplied original 19-page national proposal with the 28-page pilot dated 12 October 2026. It does not alter the original pilot document. [N; P]

04 / The case for change

Measure the problem accurately

Long waits and fragmented support matter; the data must be used with care.

People and families can encounter long waits, repeated histories, difficult transitions between services and uncertainty about what help is available before assessment. The national proposal seeks a coordinated response to these problems, with current support and a properly funded clinical pathway.

Problem to address	What the programme should establish
Delayed access	Measure referral-to-decision and decision-to-treatment times, including the full distribution of waits.
Fragmented pathways	Record repeated contacts, handover failures and whether a named service owns each next step.
Unequal access	Compare participation, completion and outcomes by age, sex, ethnicity, deprivation, disability and location.
Unmet support needs	Record the practical help offered before and after assessment, including where ADHD is not diagnosed.
Workforce constraints	Measure clinician time, supervision, administrative work and additional specialist capacity.

Do not turn incomplete datasets into false precision

The original proposal combined different waiting-list sources and used modelled workforce and capacity figures. Those numbers are not treated here as a complete, current UK census. A refreshed baseline needs consistent definitions, reporting periods and checks for people appearing in more than one dataset.

Backlog reduction needs additional care capacity

Finding more people with possible needs can initially increase demand. A credible plan must fund the assessment and care that follow, while protecting access for people already waiting.

Context and data concerns: original national proposal pp.5-10; pilot evidence and activity framework; NHS England ADHD Taskforce. [N; P; 1]

05 / Geographic scope

A UK ambition needs a UK plan

The original cost denominators were largely England-based.

Matthew's Law has a UK-wide ambition, but the original cost model used approximately eight million pupils, 20,000 schools and England service structures. Those assumptions cannot simply be labelled a priced UK rollout.

Level	What can be stated now	What is still required
England pilot	Six sites; up to 6,000 people; 42-month programme	Named delivery partners and approved local pathways
England-derived national model	Illustrative scale using inherited school and clinical activity assumptions	Current cohort counts, workforce capacity, procurement and demand validation
UK-wide expansion	Long-term policy ambition across four nations	Separate country cohorts, service models, unit costs, governance and cash profiles

Four-nation participation from the outset

The national business-case group should involve people with lived experience, clinical and school representatives, commissioners and the relevant bodies in England, Scotland, Wales and Northern Ireland. Each country should agree how the pathway fits its own services and accountability arrangements.

Do not scale by population alone

Population ratios are insufficient where cohort ages, referral thresholds, staffing, travel, school organisation and existing services differ. Shared infrastructure may reduce duplication, while rural delivery or language support may add cost. These effects require explicit country models.

How to read the costs in this document

A national ambition is not the same as a complete national budget. The revised figures identify their scope and assumptions; remaining UK-wide costs are a commissioning task, not an implied zero.

Scope reconciliation: original national proposal pp.2-4 and 13-16; pilot title, geography and delivery scope. [N; P]

06 / The first funded step

What the pilot would deliver

A six-site England demonstration of the whole pathway.

6,000
People supported
Planned enquiry cohort; not a promised number of diagnoses.

6 sites
Local systems
Adults and children across diverse delivery settings.

42 months
Programme duration
Development, delivery, follow-up and evaluation.

Stage	Proposed activity
Recognise and understand concerns	Accessible enquiry and information, with consent and practical support while waiting.
Make an appropriate clinical decision	Specialist-backed assessment by appropriately qualified clinicians, including differential diagnosis and comorbidity.
Provide indicated care	Treatment, education and family support where indicated; an onward plan where ADHD is not diagnosed.
Follow up and learn	Monitor response, adverse effects, experience, equity, costs and functioning; independent evaluation.

Illustrative clinical activity

The pilot budgets for 2,100 assessments, 1,260 ADHD diagnoses and 882 medication starts. These are conversion assumptions for costing. They are not eligibility limits, clinical targets or quotas; need and informed preference determine care.

Support is part of the pathway

The pilot includes contact and onward planning for people who do not proceed immediately to assessment or do not receive an ADHD diagnosis. Earlier identification only has value when it connects people to useful help.

Pilot proposal pp.1-2 and 11-17. The supplied October pilot remains the authoritative detailed description. [P]

07 / Pilot costs

What the pilot costs include

The pilot exposed costs missing from the original national headline.

Pilot financial measure	Planning figure
Base programme cost before contingency	£6,559,989
Contingency at 15%	£983,998
Constant October 2026 programme cost	£7,543,987
Illustrative cash requirement, including 3% annual inflation assumption	£7,785,038
Development phase, already included in the envelope	£350,000

A whole-pathway budget

The pilot includes clinical assessment and complexity, medication initiation and follow-up, support packages, practical contact and administration. It also allows for workforce preparation, digital and data work, leadership, evaluation and delivery risk.

This matters because the original national model concentrated on screening licences, training and IT. A licence does not pay for a clinician's assessment, treatment, consent administration, a support worker or independent evaluation.

Development funding is not an additional £350,000

The initial development phase sits inside the £7.79m indicative cash envelope. The remainder should be released only after the clinical, workforce, financial and research checks described in the pilot.

Limits of the figure

The pilot amounts are planning estimates from the 12 October 2026 proposal, not supplier quotations or an approved NHS allocation. Actual need above the assumptions requires additional capacity or a change to recruitment, not withholding indicated care.

Pilot base, contingency and cash profile: pp.12-17. Figures rounded to the nearest pound. [P]

08 / Pilot benefits

What the pilot can demonstrate

Test the pathway and the evidence needed for expansion.

Potential benefit	Pilot measure
Earlier understanding and an appropriate plan	Time to assessment or an agreed support plan; participant experience.
Timely access to indicated care	Time from clinical decision to treatment; functioning and quality of life.
Less avoidable duplication	Repeated histories, contacts, staff time and handover failures.
Better participation in everyday life	School attendance, study and work participation, and family impact.
Fairer access	Participation and outcomes across different groups and locations.
Safe, sustainable delivery	Adverse effects, false reassurance, clinician workload, supervision and full cost.

The comparison matters

An improvement after joining a programme does not by itself show that the programme caused it. The evaluation should use a credible usual-care comparator, consistent outcome measures and a pre-specified analysis plan. Recruitment and consent should be separate from ordinary clinical entitlement.

The pilot does not promise national savings

The October pilot credits no speculative cash saving in its base case. It can estimate pathway costs and outcomes and improve national assumptions; it is not large or long enough to prove all future effects on employment, crime or severe harm.

A decision gate before scaling

Expansion should depend on evidence of useful outcomes, acceptable harms, sufficient workforce and care capacity, equity, affordability and a viable implementation plan. A weak result should lead to redesign or stopping the relevant element.

Pilot benefits, economics, evaluation and governance sections, pp.18-25. [P]

09 / The national service model

One coordinated route to help

Retain the reform themes while protecting clinical standards.

Original reform theme	Revised national direction
School-based digital screening	Accessible early identification and support, with any population screening requiring a separate evidence and policy decision.
More diagnostic capacity in primary care	Build competent, supervised clinical capacity with specialist links; work to agreed scope and standards.
Shared care and monitoring	Fund responsibility for initiation, stabilisation, monitoring and escalation; agree handovers.
Training and accreditation	Use role-based competencies, assessed practice and continuing supervision, not attendance alone.
National data and accountability	A common minimum dataset and outcome definitions, adapted to each nation.
Ring-fenced funding and governance	Fund the full pathway, stage investment and publish independent evaluation.

The route should remain understandable

A person or family should know who receives their enquiry, who decides the next step, what help is available now and how to contact the responsible service if circumstances change. Digital tools should support that relationship rather than become a barrier to access.

A questionnaire is a starting point

An enquiry or screening result identifies possible needs. It does not establish an ADHD diagnosis, determine medication or remove the need to consider other explanations. The assessment and support pathway must remain available.

Reform themes from the original national proposal pp.2-4 and 11-12; clinical safeguards from the pilot and NICE NG87. [N; P; 2]

10 / Schools and families

Early identification with safeguards

Provide practical help while testing any proposed screening approach.

Schools can recognise concerns, record examples across settings and help families prepare a conversation with the appropriate service. Support for current needs should be available while assessment is being considered or awaited.

A staged and proportionate route

- Explain the purpose, likely next steps and limits of any questionnaire or digital aid in accessible language.
- Include the child's or young person's own perspective and obtain the appropriate consent or assent.
- Bring together parent, school and individual information; consider difficulties, strengths, context and other needs.
- Make an agreed referral or support plan, with a named contact and a review point.
- Provide non-digital routes, language support and reasonable access arrangements.

Current policy position

NICE does not recommend universal ADHD screening in nursery, primary or secondary schools. A future population programme would need evidence about the complete pathway, benefits and harms, acceptable tools and sufficient capacity. This proposal does not claim that universal screening is already endorsed.

Do not assume five tests for every pupil

The original costing added five separate products for every pupil. A national design should first define the clinical question and minimum evidence needed, then evaluate and procure appropriate tools. Bundling all five is not an established standard pathway.

School proposals and tool list: original pp.11-14. Current screening safeguards: NICE NG87 recommendation 1.2.3; UK National Screening Committee criteria. [N; 2; 3]

Capacity, competence and follow-up

Primary care participation needs funded training and specialist support.

The campaign seeks more accessible assessment and care. The safe route is a workforce model that defines competence, supervision, protected clinical time, escalation and accountability for each role.

Clinical assessment remains essential

NICE describes diagnosis by a specialist psychiatrist, paediatrician or another appropriately qualified healthcare professional with ADHD training and expertise. Rating scales or observation alone are insufficient. Training must support competence in the full assessment, not just the use of a digital test.

Workforce element	What the business case should fund
Learning and competency assessment	Role-specific curriculum, supervised practice and evidence of capability.
Backfill and clinical time	Time away from existing work, appointments, documentation and coordination.
Specialist consultation	Complexity review, differential diagnosis, comorbidity and escalation.
Treatment pathway	Initiation and titration, monitoring, patient education and planned follow-up.
Continuing assurance	Audit, supervision, quality improvement and workforce retention.

A short course is not a complete workforce plan

The original 2-5-day training proposal is an input assumption. It does not establish that every attendee can independently diagnose ADHD or initiate treatment. Local credentialing, supervision and clinical standards remain necessary.

Original workforce proposal pp.5-7 and 11-12; refined pilot safeguards; NICE NG87 recommendations 1.3.1-1.3.2 and treatment/shared-care guidance. [N; P; 2]

12 / Digital and data design

Useful tools, accountable decisions

Digital infrastructure should reduce work and improve access.

Procure by clinical purpose

A national programme should specify what information a tool adds, which population it is intended for, how results are interpreted and how it fits existing systems. Tool choice should be open to evaluation and procurement; this proposal is not a recommendation to buy every named product in the original document.

NICE supports QbTest as an option alongside standard clinical assessment for ages 6-17. That recommendation does not validate every digital product, population, setting or combination proposed in the original national paper.

Requirement	Practical test
Accessible service	Can someone complete the route without a smartphone, private computer or high digital confidence?
Secure information flow	Are access, consent, retention, sharing and responsibilities clearly defined?
Interoperability	Can information reach the responsible clinical team without duplicate entry or unsafe workarounds?
Clinical safety	Are error handling, escalation, product changes and human oversight covered?
Useful data	Are time, outcomes, experience, equity, staff work and full resource use recorded consistently?

Evaluate the effect on the whole pathway

Faster completion of one test is not the same as a shorter end-to-end wait or better health. Measure both the process effect and outcomes, including unintended consequences.

Digital proposals: original pp.11-14. QbTest: NICE HTG729. The AQUA trial measured assessment process effects; it did not prove a 40% reduction in all waiting times. [N; 4; 5]

13 / Original national cost

What the original £724m covered

The total added correctly, but did not price the whole pathway.

Original component	£m	Original assumption
School digital-tool allowance	640	8m England pupils at £80 for one screening round
School staff training	15	20,000 schools at £750
IT infrastructure	20	One-off national rollout allowance
GP and nurse training	15	15,000 people at £1,000
Digital diagnostic tools	10	Rounded three-year licence allowance
Maintenance	24	£8m per year for three years
Total	724	Original three-year headline

Two material scope problems

England was labelled as the UK. The pupil, school and service assumptions were mainly England-based. The other three nations require their own quantities, delivery models and financial plan.

One screening round was described as annual. The £640m was counted once. If the same 8m pupils were screened annually for three years, the original listed components alone would total £2.004bn, before omitted clinical care and delivery costs.

The revised reference uses an explicit alternative

It assumes one initial 8m round, then 1m new-cohort episodes in each of years 2 and 3: 10m episodes at the inherited £80 allowance, or £800m. This is an illustrative budget profile, not a recommendation to screen everyone or administer five tools.

Original national proposal pp.13-16. All pupil, school, training and price figures above are inherited planning assumptions, not current population counts, market quotations or an approved service design. [N; M]

14 / Revised cost reconciliation

From £724m to a fuller reference

England costed components, with care and delivery allowances made visible.

Component	Original £m	Revised £m
School digital-tool allowance	640.000	800.000
School staff training	15.000	15.000
Clinician competence package	15.000	174.750
Digital infrastructure build	20.000	20.000
Digital maintenance	24.000	24.000
Separate diagnostic licence line	10.000	Included below
Full clinical pathway and first-year care	Not included	584.505
10% non-pay clinical overhead	Not included	58.451
Earlier-cohort continuing care	Not included	116.424
Costed subtotal	724.000	1,793.130
15% planning contingency	Not included	268.969
Constant-price reference	724.000	2,062.099
Illustrative inflation allowance	Not included	44.467
Cash reference	724.000	2,106.566

Rounded headline: £2.11bn cash (£2.06bn before inflation). This uses three annual assessment cohorts, pilot clinical units and inherited national licence and infrastructure allowances. Figures may differ by £0.001m because of display rounding.

Training uses 15,000 inherited places at £11,650 each: £3,000 course, £6,000 protected time, £1,650 supervised cases and £1,000 competence assessment. These pilot inputs are assumptions to validate at national scale. [P; M]

A costed subtotal, not an all-in national budget

School delivery time, national mobilisation, programme staffing, evaluation, additional demand, tax and the other UK nations still require explicit budgets. Contingency does not make these missing costs disappear.

Derived review model [M], based on original pp.13-16 and pilot pp.11-17. October 2026 clinical assumptions are used; inherited national prices have not been independently repriced. No UK implementation total is claimed.

15 / Clinical-care costing

Price the care that follows

A scenario of 100,000 assessments a year for three annual cohorts.

Activity	Volume	Unit £	Total £m
Selected clinical enquiries	857,143*	51.25	43.929
Adult assessments	180,000	602.50	108.450
Child assessments	120,000	786.25	94.350
Complexity supplements	60,000	440.00	26.400
Waiting-review packages	300,000	92.50	27.750
No immediate assessment: review	557,143*	27.50	15.321
No ADHD: feedback and plan	120,000	83.75	10.050
Medication start and year-one care	126,000	1,562.50	196.875
Education and family support	180,000	100.00	18.000
Psychological intervention	54,000	720.00	38.880
Optional child diagnostic aid	30,000	150.00	4.500
Direct clinical care			584.505
10% non-pay clinical overhead			58.451

The model uses the pilot's 60/40 adult-child split, 20% complexity, 60% diagnosis, medication for 70% of diagnoses and psychology for 30%. These are costing assumptions, never clinical quotas. Optional aids are budgeted for 25% of child assessments.

Do not apply clinical conversion to all school pupils

The 35% enquiry-to-assessment assumption applies to a selected clinical-enquiry pathway. It does not mean 35% of a universally screened school population would need assessment. The 300,000-assessment allowance has not been shown to meet demand from 10m school screening episodes. Higher referral or treatment need would increase costs.

* Modelled expected enquiry volumes are rounded for display; calculations use the unrounded values. Actual contracts must use whole people and clinical need. The care total already includes an optional diagnostic-aid allowance, replacing the old separate licence line to avoid duplication. [P; M]

16 / Missing delivery costs

What still needs a national budget

The £2.11bn figure is a reference for the components priced so far.

Unresolved work package	Concrete costing basis
School delivery and administration	Invitations, consent, staff support, non-response, safeguarding, translation and access.
Local mobilisation	Pilot starting allowance: £20,000 per site; national host numbers and requirements need validation.
Programme workforce	Pilot loaded annual rates: coordination £60,000; management £90,000; data £70,000; senior clinical governance £200,000 per full-time post. Quantities and duration remain open.
National assurance and evaluation	Data integration, clinical safety, quality assurance, regulatory work, public involvement, accessibility and independent evaluation.
Additional clinical need	Demand above 100,000 assessments a year; different case mix; coexisting conditions and exceptional needs.
Four-nation scope and taxation	Country-specific pathways, populations, commissioning, governance, contracts and VAT/tax treatment.

School staff time has a material cost

Across 10m screening episodes, each extra 10 minutes costs £58.3m at £35 an hour, or £125m at £75 an hour, before contingency and inflation. These are sensitivity calculations, not a claim that 10 minutes is sufficient.

A definitive whole-school screening trial is also a separate research and funding question. The clinical pilot does not settle the evidence or budget for a population screening programme.

Unit benchmarks come from the pilot; no national quantities or quotations are implied. The original £20m digital-build allowance also requires revalidation. [P; N; M]

A programme creates future obligations

Three-cohort modelling is not a promise that costs stop after year three.

Model year	Before contingency £m	With contingency £m	Illustrative cash £m
1	955.569	1,098.904	1,098.904
2	399.377	459.283	473.061
3	438.185	503.912	534.600
Total	1,793.130	2,062.099	2,106.566

This profile puts the first screening round, school training and IT build in year one; spreads clinician training, first-year care and maintenance; and adds continuing care for earlier cohorts. It assumes 3% annual cash inflation and 15% contingency. Inflation is not an appraisal discount rate.

Earlier cohorts remain in care

Each annual cohort produces an illustrative 42,000 medication starts. Two extra years for the first cohort and one for the second give 126,000 continuing-care patient-years at £924 each, including 10% overhead: **£116.424m**, included in the reference.

If all 126,000 starters then continued for another year, routine medication and monitoring alone would add **£116.424m a year** before inflation, new cohorts and additional needs. This is not the full operating cost of the system.

Before commissioning

Reprofile recruitment, assessment and the late-cohort follow-up tail on an actual calendar. Revalidate rates, quantify risk and confirm which costs are additional to existing services. [M]

UK costing framework: country-specific screening and school time + training + each clinical activity + overhead + continuing-care patient-years + mobilisation + digital operation + governance/evaluation/access/research + risk, then cash-profile inflation. Sum country models without duplicating shared costs. Current Treasury guidance applies to any later economic appraisal. [M; 6]

Where national value could arise

Better outcomes can create value across several systems.

Benefit channel	Mechanism to test	Evidence needed
People and families	Earlier understanding, useful support and indicated treatment	Functioning, quality of life, experience and adverse effects
Health and care	More effective care and fewer avoidable contacts or crises	Actual service use, unit costs and clinical outcomes
Education	Support that improves attendance and participation	Attendance, exclusions, attainment and additional support use
Work and participation	Improved ability to remain in or return to education and employment	Employment, hours, productivity and effects on carers
Justice and community	Potential reduction in avoidable harm and service involvement	Long-term linked outcomes with a credible comparison
Public finances	Some avoided expenditure or increased receipts	Evidence that the money is genuinely released or generated

Do not count the same benefit twice

A person entering employment can create earnings, tax and benefit effects. Those are related perspectives on the same change, not automatically separate benefits to add together. The economic appraisal must define its perspective, identify overlap and separate transfers from net resource gains.

Value is wider than cash saving

Wellbeing, educational participation and family functioning matter even if they do not reduce a departmental budget. Equally, a social value estimate is not cash available to finance the programme.

Benefit mechanisms retained from the original pp.12-16 and refined by the pilot pp.18-20; NHS ADHD Taskforce economic context. [N; P; 1]

Keep the scale of the opportunity visible

An illustrative sensitivity, not a savings forecast.

The NHS England ADHD Taskforce discusses an estimated annual UK economic burden of about £17bn. It is a broad economy-wide estimate, not an NHS healthcare budget and not an amount that this programme can assume it will recover.

£0.85bn
5% illustration
Annual gross societal value if 5% of a £17bn burden were avoided.

£1.70bn
10% illustration
Annual gross societal value if 10% were avoided.

£3.40bn
20% illustration
Annual gross societal value if 20% were avoided.

These percentages are scenarios

The 5%, 10% and 20% reductions are not estimated programme effects. They show why the ambition matters, but do not establish deliverability, timing, net benefit, cash savings or return on investment. Costs and any overlap would have to be deducted.

What happens to the original £3.3-6.1bn claim?

It remains recorded as the original campaign projection. The old table treated a share of the £17bn cross-economy burden as healthcare savings and then added education, justice and productivity. That risks double counting. It also mixed in a lifetime NEET estimate in the discussion. The combined total is therefore not retained as a validated annual saving.

A refreshed appraisal should estimate incremental outcomes against usual care, value distinct benefit streams, subtract full costs and apply current appraisal guidance to an explicit time profile. Until then, the old payback claim is not a reliable conclusion.

Original savings and payback claims: pp.15-17. £17bn context: NHS England ADHD Taskforce Part 1; underlying cost literature discussed in Daley et al. 2019. [N; 1; 7]

20 / Evaluation

What evidence would justify scaling?

Build the evaluation before recruiting the first participant.

Question	Required approach
Does the pathway improve outcomes?	Pre-specified outcomes and a credible comparison with usual care; report uncertainty.
Is it safe and acceptable?	Record harms, false reassurance, inappropriate labelling, treatment adverse effects and participant experience.
Does it improve access fairly?	Recruit and analyse across relevant groups; investigate non-participation and loss to follow-up.
Can services deliver it?	Measure capacity, clinician time, supervision, administration and bottlenecks.
What does it really cost?	Resource use and unit costs across the full pathway, including support and additional demand.
Is national expansion justified?	Independent review of effect, uncertainty, transferability, workforce and affordability.

Distinguish short-term evidence from long-term potential

A demonstration can establish feasibility and estimate pathway effects. Employment, education, serious harm and justice outcomes may require larger samples, longer follow-up and carefully governed linkage. Absence of a measurable effect in a small sample is not proof of absence; an early positive signal is not proof of a national return.

Publish positive and negative findings

The purpose of evaluation is to improve decisions. The programme should publish its protocol, analysis plan, costs, limitations and results, with appropriate privacy protections and independence from tool suppliers.

Evaluation principles draw on the supplied pilot and screening appraisal criteria. Formal methods and approvals must be agreed during development. [P; 3]

21 / Delivery and governance

A staged route to national delivery

Decisions follow evidence, capacity and funding.

Stage	Decision and output
Develop the England pilot	Use the included £350,000 development phase to finalise partners, workforce, pathways, research design, costs and approvals.
Deliver and evaluate	Implement the six-site programme within agreed gates; publish activity, experience, outcomes and resource use.
Build the four-nation case	Agree target cohorts and country service models; procure appropriately; update costs and benefit estimates.
Commission expansion	Expand only where evidence, care capacity and affordability support it; retain stop and redesign options.
Review at scale	Continue quality, safety, equity and financial monitoring; adjust to evidence and changes in demand.

Shared leadership, clear responsibility

For the England pilot, health, education and local delivery partners should agree ownership of the whole pathway. A future UK programme requires the relevant national administrations and services, rather than treating England institutions as UK-wide bodies.

Clinical governance, data stewardship, safeguarding, economic evaluation, procurement and lived-experience involvement need named leads. Each delivery site should have an accountable service owner, escalation route and transparent financial reporting.

A timetable is a proposal, not a guarantee

The original years 1-3 national rollout is replaced by evidence-led stages. National coverage should not be promised on dates that have not been tested against workforce, care capacity, procurement and approvals.

Original implementation roadmap pp.18-19; pilot staged funding and governance. [N; P]

The policy package to develop

Retain clear duties and ambitions without presenting draft law as enacted.

Policy theme	Proposed direction for discussion
Earlier identification and support	Make accessible, appropriate routes to recognition and support available; evaluate any proposed population screening separately.
Competent clinical capacity	Develop accredited or locally assured roles, supervision and specialist pathways consistent with clinical standards.
Timely care	Set measurable access ambitions and fund treatment and follow-up, not simply diagnosis.
Data and transparency	Use consistent definitions, publish activity and outcomes, and protect personal information.
Funding and oversight	Provide staged investment, independent evaluation and accountable cross-sector governance.

How the original draft clauses are treated

The original national document contained illustrative legislative clauses on school screening, GP accreditation, reporting and ring-fenced funding. They are retained here as policy themes, rather than copied as settled legal duties. Any legislative route requires legal drafting, consideration of devolved responsibilities and evidence on the intervention.

The campaign name is not a statement of legal status

Matthew's Law is a charity proposal. It is not an enacted law, an approved NHS service, or an APPG endorsement. The immediate request is support for a staged demonstration and development of the national case.

Access ambitions remain visible

The pilot retains a campaign ambition of a diagnostic decision within six months and proposes indicated treatment within eight weeks of the decision. These are proposed standards to test and resource, not current universal guarantees.

Original illustrative clauses pp.3-4; pilot decision measures and access ambitions pp.1-2. [N; P]

What must be settled before commitment

A credible ambition includes clear limits and a route to resolve them.

Material risk	Required response
Identification exceeds care capacity	Commission assessment and treatment capacity before increasing recruitment.
False reassurance, labelling or unequal access	Evaluate harms, consent, accessibility and outcomes across groups.
Costs exceed assumed activity	Use transparent activity triggers, contingency and explicit re-approval of scope.
Digital tools fail to add useful information	Test added value and workflow impact; keep non-digital options.
Savings are overstated or double counted	Independent economic appraisal; separate societal value from budget impact.
UK scope is assumed from England data	Commission country-specific cohort, pathway, workforce and budget models.

Next decisions

- Agree the pilot sponsors, sites and development governance.
- Confirm the clinical model, workforce responsibilities, research approvals and comparator.
- Replace inherited prices and assumptions with current activity evidence and supplier or commissioner estimates.
- Commission a four-nation model with full recurring costs, a cash profile and independently reviewed benefits.
- Publish the findings and make an explicit expand, redesign or stop decision.

Review status: AI-assisted reconciliation and source checking prepared for charity review, 14 November 2026. Clinical, financial, procurement and legal sign-off are not claimed. The costs and benefits are decision-support scenarios, not commitments. [P; N]

How to check this review

Source documents, primary guidance and the principal revisions.

[P] Supplied pilot proposal. Matthew Lock ADHD Charity, Matthew's Law: earlier identification, timely care, 12 October 2026, 28 pages. Pilot design, activity, costs, gates and evaluation.

[N] Supplied original national proposal. Transforming ADHD diagnosis in the UK: a systemic reform proposal, 19 pages, supplied 14 November 2026. The source describes figures as current to December 2025; PDF created February 2026.

[M] This review's derived cost model. 14 November 2026. Reconciles the supplied original with pilot unit costs and explicit activity assumptions. The model is reproduced in this document on pp.13-17; figures are planning scenarios pending independent financial and clinical review.

[1] NHS England ADHD Taskforce, Part 1. Economic burden and national service context.
england.nhs.uk/long-read/report-of-the-independent-adhd-taskforce-part-1/

[2] NICE NG87, recommendations. School screening; qualified assessment; rating-scale limits; treatment pathways.
nice.org.uk/guidance/ng87/chapter/Recommendations

[3] UK National Screening Committee. Criteria for appraising screening programmes.
gov.uk: Evidence review criteria - national screening programmes

[4] NICE HTG729. Digital technologies to help diagnose ADHD; QbTest recommendation.
nice.org.uk/guidance/htg729/chapter/1-Recommendations

[5] Hollis et al., AQUA randomised trial. Assessment-process effects of QbTest.
pmc.ncbi.nlm.nih.gov/articles/PMC6124643/

[6] HM Treasury, Green Book discount-rate review response, 28 October 2026. Apply current appraisal guidance to a full future cost-benefit model.
gov.uk: Green Book discount-rate review 2026 - HM Treasury response

[7] Daley et al. (2019). Economic burden of adult ADHD: cost literature underlying the economic context, not a trial of this programme.
pubmed.ncbi.nlm.nih.gov/31288209/

Principal revisions

UK ambition distinguished from England costing; original £724m reconciled; screening schedules and omitted care costs made explicit; original £3.3-6.1bn savings and payback claim qualified; full-pathway, clinical and evidence safeguards carried forward from the pilot.

Source review date: 14 November 2026. This document supersedes the original national financial presentation for the test campaign page. It does not supersede an approved clinical guideline or change the supplied October pilot.