CYP Call for Evidence: Evidence-Based Interventions to Improve Quality and Performance in Child Health

COMPLETE

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Q1

Organisation

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Q2

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Q4

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Q5

Title of intervention

Paediatric Autism Communication Therapy (PACT)

Q6

What is the care delivery setting of the intervention?Select all that apply

Care delivered at home

Hospital care (including elective, inpatient, outpatients)

Specific mental health setting (including community and acute) - We are particularly interested in interventions that support both mental and physical health.

Education settings (Health delivery only e.g. mental health support teams, immunisations delivered in schools, school nursing)

Community setting (including health visiting, early support (e.g. early support hubs) and detection (e.g. hearing services))

Integrated Care (e.g. integrated care hubs)

Virtual/digital delivery (e.g. remote monitoring, telehealth)

Q7

What is the clinical need the intervention addresses?Select all that apply

Long term condition (e.g. asthma, epilepsy, diabetes)

Therapies (e.g. speech and language, occupational therapy, physio, audiology)

Complex care needs (i.e. Children with chronic, severe and often multiple physical, mental or developmental conditions) - Please note that submissions should not relate to palliative and end of life care as a Modern Service Framework is under development for these areas

Mental health

Neurodiversity (including ADHD and Autism)

Early years

Q8

What is the target population of the intervention?Select all that apply

Infants and young children (0-5)

Children (5-12)

Specific population group (e.g. Core20PLUS5 groups)

If specific population, specify here::
Autistic Neurodivergence - 2-10 years

Q9

What is the scale of implementation of the intervention?

ICS-wide

Regional

Provide more detail on scale of implementation (including details of when the intervention was implemented).:
PACT is trained in 26 countries worldwide and in UK implemented in a number of regions including greater Manchester, Midlands, and London and South West

Q10

Description of interventionDescription of intervention, including: Describe the aim of the model, including specific details of intended outcomes. A high-level overview of the intervention. This should include: Details of the problem/gap addressed including clinical need addressed and population. Key components of the intervention. A theory of change or logic model if available. How the intervention aligns with the ambitions of the 10-Year Health Plan. How co-production has shaped the intervention. Details of the delivery model are to be included in the next question. 500 words max

Aim
The Paediatric Autism Communication Therapy (PACT) aims to improve autistic children's social communication by enhancing parental responsiveness and synchrony during everyday interactions. Through parent-mediated, video-feedback-based coaching, PACT supports long-term developmental, emotional, and relational outcomes while empowering families and promoting personalised, early intervention.

Problem/gap
Autistic development is usually enduring and can have significant impacts, with lifetime costs (including health, education, social care, family out-of-pocket expenses and productivity losses) estimated to be between £1-1.5 million in the UK and $1·4 -2.4 million in the USA (doi:10.1001/jamapediatrics.2014.210). Effective early intervention support that benefits its long-term course would therefore have great potential benefits for individuals, families, and society.

Key components of the intervention
PACT is a parent-mediated intervention for young autistic children. Key components include specialist-led sessions using video-feedback to help parents recognise and respond to their child's communication cues. Therapy focuses on enhancing parental synchrony, shared attention, and social communication within everyday interactions. PACT is manualised, time-limited, and delivered by trained clinicians with regular supervision to ensure fidelity. Intervention is embedded in the home environment, promoting generalisation and sustainability. PACT adopts a family-centred, strengths-based approach, supporting personalised care, early intervention, and improved developmental and mental health outcomes.

Logic model

The therapist works alongside the caregiver using video feedback techniques in a manualized sequence, to increase their understanding of their autistic neurodivergent childs sensitivities, behaviours and communication; increasing parental sensitivity and synchronous response and consistent use of communication strategies at home. Short-term outcomes are improved child social communication, reduced distress, and improved parent confidence and relatedness with their child. Longer term, the infant generalizes these changes into to social communication and wider aspects of development outside the family. Embedded change in the family interactions facilitates the long-term impact, including better functioning in education, improved developmental and mental health trajectories, reduced inequalities from delayed intervention, and improved value for money through reduced long-term system demand.

Relevance to 10-Year Health Plan

- Its approach is pre-emptive - using developmental science to work in the early years of autistic developmental trajectories in order to optimise outcomes. By reducing later crisis presentations and specialist service demand, PACT supports cost-effective, preventative care and long-term system sustainability.
- Its ethos is family focused and home-based, shifting care to the community and empowering families to care confidently for their neurodivergent child. Early, parent-mediated intervention helps reduce inequalities associated with delayed diagnosis, deprivation, and reduced access to specialist services.
- PACT improves social communication, emotional regulation, and family functioning, supporting better developmental and mental health outcomes for autistic children.
- Use of video-feedback and flexible delivery models including digital online, it aligns with digital innovation and hybrid care approaches

Co-production

Co-production has been central to the development and effectiveness of Paediatric Autism Communication Therapy (PACT). Close collaboration with parents and clinicians shaped the focus on everyday interactions, parental synchrony, and video-feedback as an acceptable, practical tool. Embedding lived experience improved engagement, cultural relevance, and adherence. Ongoing parent feedback has informed delivery models and materials, supporting flexible, family-centred care and aligning with NHS commitments to personalised care and equitable access.

Q11

Delivery model of the interventionDescribe the delivery model of the intervention, including: Where is it delivered? What is the population footprint of delivery? Describe the delivery model including key partnerships, funding model, and workforce required for delivery. Describe the core processes and pathways involved to enable delivery. Details of barriers and enablers are to be included in section 4 of the form. 500 words max

PACT delivery model centres on a family/caregiver-led, clinician-coached approach that promotes naturalistic, developmentally appropriate interaction to improve social communication in young children with autism. PACT is suitable for children aged 2-11 years with a range of language difficulties, from children who use sentences to those who use few or no words. Services are typically delivered in three interlinked components: assessment, parent-mediated intervention sessions, and generalization support. Delivery is accessible in the home, centre/ clinic, school or online and flexibly accommodates available time frames and family needs.

A multidisciplinary evaluation establishes the child's baseline communication, sensory profile, cognitive level, and family priorities. Observational measures and standardised tools identify target behaviours (e.g., shared attention, reciprocal interaction, engagement, communication initiation and function through nonverbal (gestural) and vocal and verbal use and guide individualised goals.

The core of the model trains caregivers to become the child's primary communication coaches. Therapists use video-feedback and live coaching to teach parents responsive interaction strategies—following the child's lead, imitating play, recognising and responding to child cues and signals of intent, using simplified language, creating child communication opportunities, reciprocal non-verbal and verbal interaction, expanding and elaborating on the child's language for children who become verbal. Sessions are structured but play-based, typically weekly or fortnightly for 3–12 months depending on need. Fidelity is emphasized: therapists regularly review recorded parent–child interactions to reinforce strategy use, set incremental targets, and problem-solve barriers.

Core processes involve incremental adult adjustment to child characteristics, developmental skills and needs, following structured PACT manualised stages. At each PACT session, therapist-guided video feedback highlights imperceptible developments of interaction, social and communication skills to set new individual goals. Parents/caregivers undertake 30 minutes of daily practise focused on their written goals between PACT sessions. Therapist role and intensity: Clinicians (speech–language therapists, clinical psychologists, or specialist therapists) provide modelling, scaffolded support, and individualised strategies to expand and extend the child's social communication skills. Intensity is flexible—short, frequent sessions support skill acquisition, while booster sessions maintain gains. A skills mix of qualified and non-specialist training can increase reach and reduce cost.

Generalization and community integration: The model promotes transfer across settings by coaching other caregivers (teachers, grandparents), embedding strategies in daily routines, and coordinating with educational providers. Progress is monitored with periodic re-assessment and outcome measures assessing both child communicative initiations and parent/caregiver adaptation, support and responsiveness.

Outcomes-focused and culturally adaptable, this delivery model prioritizes caregiver empowerment, naturalistic interaction, and scalable training pathways to improve communication outcomes and family quality of life.

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Q12

Q12

Describe how the intervention addresses health inequalities.Include details of: Which groups benefit most. Specific inequalities the intervention aims to reduce and specific steps taken to reduce barriers to access, including for Core20PLUS5 groups. How the intervention improves equity and evidence of reduced inequalities. The impact of the intervention on vulnerable groups (e.g. children with disabilities, complex needs, safeguarding concerns, children experiencing deprivation). 500 words max

PACT reduces health inequalities by addressing unequal access to early identification, intervention, and support for autistic children and their families. Children from socio-economically disadvantaged backgrounds, minority ethnic communities, and families with lower health literacy are more likely to experience delayed diagnosis and reduced access to specialist services. Timely, evidence-based communication interventions help mitigate these disparities by supporting early development of functional communication, social interaction, and emotional regulation. PACT particularly targets Core20PLUS5 groups by its focus on autism disability and child mental health, and its suitability and accessibility for lower SES groups. Clinical trials have included the full range of demographic status and demonstrated effectiveness across all SES groups. They have also importantly shown good engagement and results with autistic parents, removing this barrier to access for parental disability.

Family-centred and parent-mediated approaches are particularly effective in addressing inequalities, as they empower carers with practical skills and improve outcomes regardless of socio-economic status. Culturally sensitive practice and flexible service models further reduce barriers to engagement. Overall, paediatric autism communication therapy supports the NHS commitment to reducing health inequalities by promoting earlier access, improving long-term outcomes, and enabling more equitable life chances for autistic children.
Within an NHS context, equitable delivery of autism communication therapy supports wider system goals, including early intervention, prevention, and inclusion. Improving communication skills enhances engagement with education, reduces behavioural distress, and supports mental health, thereby lowering the risk of school exclusion, crisis presentations, and later reliance on acute or specialist services. Integrating therapy across health, education, and community settings—such as schools, children's centres, and virtual platforms—improves accessibility for underserved populations.

PACT delivers interventions directly within the child's existing home and educational environments, ensuring ease of access and maximising family engagement and benefit. Through the use of video, PACT can be delivered both face-to-face and online, enabling access for autistic children across a wide range of settings, including those in remote, inaccessible, and underserved communities. Parents and teachers submit recordings of their everyday interactions, which are reviewed by therapists who provide tailored video feedback remotely.
This approach ensures that PACT is convenient and accessible regardless of geographical location, culture, or socio-economic background. Delivering the intervention within familiar environments, such as the home or school, reduces the need for travel and minimises disruption to daily routines. Online delivery further removes barriers associated with attending unfamiliar settings or meeting unfamiliar professionals, increasing acceptability for vulnerable and hard-to-reach families.

Accessibility is strengthened by the intervention's adaptability to diverse cultural, linguistic, and socio-economic contexts. PACT is available in 5 languages and can be translated live or online. Remote components, including video-based feedback and virtual sessions, reduce logistical challenges while maintaining consistent therapeutic support. Children with complex needs who are unable to engage in traditional therapy interventions, such as those with co-existing anxiety, demand avoidance, emotional behavioural, and learning needs, can equally access PACT, which involves caregivers and educators embedding the intervention within existing relationships and routines, supporting meaningful and sustained engagement.

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Q13

What type of evidence is available to demonstrate the impact of this intervention?Select all that apply

Peer-reviewed research

Independent evaluation

Local service evaluation

Routine service data/audit (not part of a formal evaluation)

Case study/descriptive account

Q14

Improving safetyDescribe how this intervention has improved safety and quality of care to minimise risks and avoid causing harm, and summarise the evidence available to show this improvement. You may wish to include: Impact on consistency or standardisation of care. Improvements in safer decision-making and earlier intervention. Strengthening of safeguarding, escalation and monitoring processes. Reduction in avoidable harm. How impact was measured, including specific metrics, data sources, evaluations or reviews undertaken. Strength of the evidence. When the evidence is from. 500 words maxInclude links to publications where possible.

PACT employs video-feedback, guiding therapists to coach parents on recognizing and responding to their child's cues. This fosters increased parental responsiveness and improved social synchrony, creating a safer environment where interaction mismatches (a common source of emotional distress or behavioural escalation) are minimized .

The intervention is delivered through a manualised, time-limited protocol by trained clinicians, ensuring consistency and fidelity to evidence-based practice. Such structure mitigates clinical variability and ensures quality control across diverse settings .
PACT's co-production model ensures that treatment is embedded within families' everyday routines and cultural contexts, improving uptake and reducing the risk of disengagement. Parents report increased competence and confidence in navigating communication challenges, promoting an emotionally safe and stable home environment .

Early intervention supports school readiness, reduces crisis episodes, and lowers the probability of acute service use. PACT's emphasis on integrating communication strategies into daily life diminishes risks of safety incidents related to poor emotional regulation or behavioural outbursts.
PACT improves safety and quality of care by reducing risks associated with poorly attuned interactions, delayed intervention, and fragmented support for autistic children and their families. The intervention is manualised, parent-mediated, and delivered by trained clinicians, ensuring consistency, fidelity, and clinical governance across settings.

A core safety mechanism is PACT's focus on parental synchrony and responsiveness, supported through structured video-feedback. This reduces interactional mismatch, child distress, and escalation, which are recognised contributors to behavioural risk and family stress. In the original randomised controlled trial, improvements in parent–child interaction mediated later reductions in autism symptom severity, demonstrating a clear and theoretically coherent mechanism of action (Pickles et al., 2015, doi:10.1111/jcpp.12291).

Qualitative studies reinforce that parents feel empowered, validated, and supported, leading to improved family functioning and reduced risk of emotional strain. Parental feedback highlights how the home-based nature of PACT reduces anxiety and increases safety in the domestic environment .

PACT is one of only two social communication interventions recommended by NICE for young autistic children, basing its guidance on PACT's robust evidence base. Adoption within UK autism care pathways reflects strong confidence in its quality and safety impact .
PACT enhances safety and quality of care by strengthening parent responsiveness, embedding evidence-based practices in familial contexts, and reducing clinical variability. Large-scale RCTs—including long-term follow-up and generalised delivery—demonstrate sustained reductions in autism severity and improvements in social communication. Qualitative and policy-level endorsement further underscore its capacity to minimize risks of crisis, promote emotional well-being, and deliver equitable, high-quality outcomes.

Q15

Improving effectiveness, performance and efficiencyDescribe how this intervention has improved effectiveness, performance or efficiency, and summarise the evidence available to show this improvement. You may wish to include: Impact on performance and efficiency, such as waiting times, patient flow, reduction in avoidable admissions, activity shift from hospital to community. Impact on clinical outcomes and wider child outcomes (e.g. development, education, wellbeing, participation etc.). Cost-effectiveness, including whether the intervention demonstrated cash-releasing or time-releasing benefits, and any quantified efficiencies or savings (including any economic evaluation). How impact was measured, including specific metrics, data sources, evaluations or reviews undertaken. Strength of the evidence. When the evidence is from. 500 words maxInclude links to publications where possible.

PACT has internationally leading effectiveness evidence grounded in randomized trials and long-term follow-up, demonstrating meaningful improvements across autism symptoms, social communication, and parental involvement. The only NICE (2013/21) consider recommendation for autism is for this model of care, citing PACT evidence.

The MRC Preschool Autism Communication Trial (PACT RCT), published in two Lancet papers, is one of the largest (N=152) and most rigorous RCTs conducted in autism, and the only one that has achieved a longer-term follow-up analysis of effects while preserving the RCT design (masked assessments at followup with preserved intention to treat analysis). The trial found that PACT intervention showed significant gains in parent–child synchrony and child communication initiations, mediating improved autism-related functioning in the child generalised outside the family environment. The long-term follow-up study (median 5.75 years post-intervention) confirmed sustained improvements in autism-related functioning (log-odds effect size on ADOS CSS = 0.55, p=0.004, and improved child initiations with parents (Cohen's d = 0.33, p=0.004) (Pickles et al., 2016; doi:10.1016/S0140-6736(16)31229-6). Further significant effects in this study were found on parent-ratings of child language development (while not on lab measures of language), adaptive functioning, and family wellbeing. Teacher ratings of school adaptive behaviour showed that the adaptive gains were also recognisable in the school environment six years out from the end of therapy. All these results underscore the durable developmental benefits for child and family of early PACT intervention and are unique to date in autism intervention science.

Mediation analysis in this trial showed a clear causal chain of effect; increased parental synchronous response to increased child social initiations and engagement with parent, to the child developmental gains in autistic functioning, supporting the intervention's mechanism of action (Pickles et al., 2015; doi:10.1111/jcpp.12291). At followup, the increased child social engagement during therapy mediated 73% of the long-term improvement in autistic functioning and school adaptation, confirming that intervention's active ingredients sustained their developmental impact through time (Carruthers et al., 2024; doi:10.1111/jcpp.13798).
Health economic studies show a statistically significant £46,000 saving per family by middle childhood after pre-school intervention (Tinelli et al 2023, https://doi.org/10.1192/j.eurpsy.2023.2449). As a result of this and other studies, PACT intervention was nominated by the London School of economics (Knapp et al 2024, https://www.lse.ac.uk/cpec/assets/documents/Autismeconomics.pdf), based on effectiveness and cost effectiveness analysis, as the top current economic case for UK autism implementation.

NHS implementation studies are described in our MSF Pathways submission.

The PACT-G trial (2022) extended PACT to home and school settings, using a parallel, single-blind RCT design over 12 months. It demonstrated broad improvements in dyadic social interactions, and reflected the mediation pathway, while showing less effect on autistic outcomes. This supports the

scalability of PACT into school settings, albeit with reduced effect (Green et al., 2022; doi:10.1016/S2215-0366(22)00029-3).

Together, these studies—including mechanistic, long-term, and generalisation trials and health economic studies, make PACT arguably the best evidenced autism intervention world-wide. Effect sizes observe moderate clinical impact (ES ~0.3–0.6), and sustained outcomes confirm intervention value over time. The intervention's co-produced design, manualisation, and strong theoretical underpinnings have translated into measurable improvements in autistic functioning, social communication, and parental competence, providing a compelling evidence base for commissioning and integration into NHS autism services.

Q16

Improving experienceDescribe how this intervention has improved patient experience, and summarise the evidence available to show this improvement. You may wish to include: Details of which part of experience improved (e.g. person-centred, compassion, dignity, respect, involvement, responsive to individual need). Improvements in navigation of care or care coordination. How CYP are involved in decisions and feel listened to. How impact was measured, including specific metrics, data sources, evaluations or reviews undertaken. Strength of the evidence. When the evidence is from. 500 words maxInclude links to publications where possible.

Research in PACT has done extensive family service user and community consultation to evaluate how the intervention improves experience.

The Autism Family Engagement Questionnaire, AFEQ), a parent-nominated, ecologically valid tool, co-produced with families during the PACT trial, reflects outcomes that parents value most—impact on themselves, their child, and the wider family—including emotional wellbeing, relationships, and daily routines. Developed through focus groups with 31 parents and a national parent consultation, the resulting 48-item questionnaire responded directly to family priorities. It was responsive to change, showing significant treatment effects at therapy endpoint and even greater effects at long-term follow-up. Parent-prioritized domains such as family quality of life and parental wellbeing exhibited large effect sizes at endpoint, which further increased by follow-up, indicating both immediate and sustained enhancements in engagement and satisfaction (doi:10.1007/s10803-017-3350-7). The structured inclusion of AFEQ in PACT reflects meaningful family co-production, aligning therapy goals with lived priorities. Measured improvements in AFEQ scores underscore enhanced family engagement, emotional outcomes, and overall satisfaction—core markers of quality and person-centred care in autism intervention.

Several high quality rich qualitative studies report profound shifts in engagement and emotional connection during PACT therapy. In the UK Preschool Autism Communication Trial context, Leadbitter et al. (2020) doi:10.1177/1362361320936394 interviewed 18 parents of autistic children, revealing that most initially doubted video-feedback but later valued it deeply. They described growing attunement to their child, stronger relationships, and more meaningful interactions. Parents noted that PACT brought about "poignant realisations" about their child and themselves, helped them respond more sensitively, and expanded family quality of life—despite practical challenges like time burden and venue access. Further qualitative insight emerged from Engberg Conrad et al. (2024 doi:10.3390/children11070838), who conducted semi-structured interviews with 13 parents. The study identified three core themes: the "struggle of fitting PACT into everyday life," which families overcame through adaptation; "relational connection," wherein families experienced enhanced sensitivity, attachment, and mutual enjoyment; and "cascading relational effects," indicating broader family wellbeing linked to improved caregiver interactions. A recent 2026 focus group study by Bouaziz et al. doi:10.1186/s13034-026-01072-x further elaborated these experiences via interpretative phenomenological analysis. Five key themes emerged: 1) video-feedback heightened parental recognition of emergent child skills; 2) parents moved from feeling "incompetent" to "supported and empowered"; 3) embedding strategies into daily life reinforced relationship improvements; 4) parent–child play, while not universal, was recognized as central when feasible; and 5) systemic impacts on siblings and partners influenced engagement, highlighting the need for broader family considerations. Collectively, these qualitative insights confirm that PACT not only achieves clinical goals in symptom reduction but also transforms the care experience, making it more person-centred, equitable, and sustainable.

"PACT has helped me feel confident in my own parenting. Everything I'm doing is how I wanted to be treated as a kid. I wanted to feel heard. PACT has helped me come to terms with how I communicate. If only my parents had had this when I was young. Then I wouldn't have felt like a burden because I couldn't get my words out".

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Q17

WorkforceYou may wish to consider: What additional workforce training, capacity and skills would be required? What clinical governance is required? Is a professional registration required? What are the workforce risks and constraints? Is a culture shift required to deliver this? What is the impact on workforce experience (e.g. workload, satisfaction)? 500 words max

PACT professionals often comprise Speech and Language Therapists (SLTS), Speech and Language Therapy Assistants (SLTAs), Psychologists early years, mainstream and special needs teachers, therapists, family support workers, social workers, specialist nurses, and health visitors and may also include other health or educational professionals whose existing role involves working with neurodivergent children aged 2 years plus. PACT training is delivered by the non-profit IMPACT CIC training organisation - https://www.pacttraining.co.uk/ - to a skill mix of qualified, experienced professionals and non-specialist to reduce cost and increase accessibility.

After participating in the PACT training, professionals (from localities) work towards certification under supervision with the IMPACT CIC supervisors. Professionals are required to submit videos of the initial children and families they are working with to show evidence of meeting acceptable fidelity to the programme protocol. Professionals share their clinical videos through recognised secure platforms, meeting NHS governance, data protection and confidentiality guidelines. IMPACT maintains annual cybersecurity certification. Further group 'community of practise' and fidelity sessions provide quality maintenance in accordance with the protocol

provide quality maintenance in accordance with the protocol.

Professional registration is not required, although most health care professionals will have professional registration, teams and service delivery involve a skill mix with local clinical support and supervision to non-specialists

The primary risks relate to workforce transformation and the cultural shift required for implementation. Workforce roles, schedules, and commitments are already under significant pressure due to rising service demands and long waiting lists. As a result, there may be a perception that introducing a new intervention will further increase workload and exacerbate delays, potentially deterring services and professionals from engaging with the transition to evidence-based practice.

To mitigate these risks, a programme of conference workshops and webinars is planned, presenting evidence of improved efficiency and effectiveness. Contributions from established services with sustained, successful implementation—sharing their transformation processes and outcomes—can strengthen professional confidence and support engagement.
Successful implementation also requires sufficient preparation time for services to build cohesive teams, develop shared understanding and commitment, and maintain staff morale during the transition. In addition, services must address confidentiality and data protection considerations, ensuring full compliance with organisational clinical governance frameworks.
Sustaining transformative care presents an ongoing workforce risk and constraint, with staff morale and turnover playing a significant role in the continuity of a new care pathway. These risks are mitigated by training a group of professionals within each service to provide internal peer support and ongoing development, alongside maintaining a stable core workforce through the training of new recruits.

IMPACT provides continued professional support, including 3–4 Communities of Practice group sessions, supervision, and shared learning. In addition, regular annual fidelity sessions are delivered to maintain and strengthen PACT skills as practitioners gain experience and confidence. This structured support network fosters a sense of professional belonging, enhances motivation, and helps sustain high-quality delivery of PACT.

Q18

Capital and financialYou may wish to consider: What new equipment or capital is required to deliver this intervention? What are the estates requirements? Are capital investments one-off or ongoing? Are there financial or commissioning risks? Is funding sustainable? 500 words max

What new equipment or capital is required to deliver this intervention?
Cameras, phones or laptops are required to record parent child interactions and carry out video feedback discussions which is a core part of the PACT programme. Increasingly, teams have the technology in place already (i.e. laptops and work phones) so often do not require additional technology to deliver the interventions. For remote delivery, online videoconference facilities are required. Many services already host online meetings and have access to video conference facilities.

What are the estates requirements?
PACT sessions may be carried out in the children and families' homes, via telehealth, or in a clinic to suit the family and service. If carried out in clinic or online, a private room is required so that the session may be carried out in confidence.

Are capital investments one-off or ongoing?
PACT training consists of two levels:
PACT Level 1: a ½ day e-learning programme contains approximately 90 minutes of video interactive tasks, a video demonstration of PACT and an introduction to the method, techniques and research behind PACT.
PACT Level 2: 2 or 4 days of online live training with a hybrid of trainer presentations, demonstration videos small group role-play and post-course supervised practice, complete with an ePACT practitioner manual and forms available for professional use.
Post-training group and individual supervision to fidelity is provided to gain PACT certification. IMPACT trains on PACT in UK and internationally. The total fee for Level 1 and 2 is £1,570. IMPACT membership is £65 for individual professional or £50 per professional for NHS groups.
Details are here: https://www.pacttraining.co.uk/.

Are there financial or commissioning risks?
Other than staff attrition, no.

Is funding sustainable?
Once the pathway is embedded, the therapy is self-sustaining so required little ongoing funding other than the licence fees and certification costs outlined above.

Q19

DigitalYou may wish to consider: What digital systems or platforms are required? Are digital tools required for clinical pathways? What digital skills training is required? Are improvements in data quality/reporting required? Are there data risks? 500 words max

What digital systems or platforms are required?
Secure Microsoft 365 for business SharePoint, OneDrive and Teams to store clinical documentation and videos from the programme, implement training and meetings.
Following registration with IMPACT, professionals complete the Hogrefe PACT Level 1 e-learning programme before progressing to Level 2 training. Level 2 consists of either a two-day course or four half-day live online sessions delivered by IMPACT associate trainers.

After training, professionals begin applying PACT in practice by working with two practice case families to develop their skills. This is followed by participation in an associate trainer-led group supervision session, along with two individual supervision sessions focused on fidelity. Successful

participation in an associate trainer-led group supervision session, along with two individual supervision sessions focused on fidelity. Successful completion of these components enables professionals to demonstrate fidelity and achieve PACT certification.

Are digital tools required for clinical pathways?
Microsoft 365 for business Teams or similar video sharing platform for supervision sessions or telehealth sessions if practitioners wish to deliver PACT sessions online.

What digital skills training is required?
Functional knowledge of Microsoft Teams or a similar platform. Most NHS professionals already have this knowledge, If not, IMPACT CIC supervisors will support during supervision sessions.

Are improvements in data quality/reporting required?
Yes as standard practice for NHS.

Are there data risks?
IMPACT professionals guide services on data protection and video security as follows:
A Data Protection Impact Assessment (DPIA) is completed jointly by the service manager, organisation IT department and and IMPACT lead to manage risks.

Organisations are supported in having the right legal basis for processing the data – through video consent and consent to share the videos for professional training purposes to mitigate risk.

A secure online platform e.g. Microsofft 365 SharePoint, is identified to provide digital security of parents sending in video clips to the service to comply with service digital security expectations.

A secure method of storing video clips during therapy e.g. on Microsofft 365 SharePoint is identified to comply with digital security expectations. Safe practice and transfer of data on Work laptops is implemented by professionals only transferred confidential data when the profesisonals returns to the organisation clinic/ workbase to ensure the wrong people do not have access to the video clip or work laptop.

Q20

OtherDescribe any other risks, barriers and enablers to the implementation of this intervention, or any unintended consequences of the intervention.300 words max

Paediatric Autism Communication Therapy (PACT) is a high-value, evidence-based early intervention that aligns strongly with NHS priorities for effective, scalable, and sustainable autism care. Barriers to new therapy implementation at this time can occur in training and initial support costs. The IMPACT training CIC is an enabler in this through its efficient and cost-effective training

From a commissioning perspective, PACT offers strong value for money: it is manualised, deliverable by trained non-specialist practitioners with supervision, and lower intensity than therapist-led models, supporting scalability across community and CAMHS pathways. Its focus on empowering parents enhances generalisation, reduces reliance on specialist services over time, and aligns with NHS Long Term Plan objectives for early intervention, prevention, and family-centred care. Overall, PACT represents a robust, cost-effective intervention with durable clinical impact, suitable for integration within NHS autism assessment and early support pathways.