REPORT OF: THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (JHOSC):

Development of the All-Age Autism Strategy for Oxfordshire

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Report to:
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INTRODUCTION AND OVERVIEW

1. The Joint Health and Overview Scrutiny Committee considered a report on the development of an All-Age Autism Strategy for Oxfordshire in its public meeting on 16 April 2026.

2. The Committee would like to thank Karen Fuller (Director of Adult Social Care, Oxfordshire County Council); Bhavna Taank (Head of Joint Commissioning [Life Course] – Live Well); Matthew Tait (Executive Delivery Officer, Thames Valley Integrated Care Board); and Dee Nic Sitric (Chief Executive– Autism Champions, and Expert by Experience) for attending the meeting and answering questions from the Committee.

3. The topic of Autism and the services available to support autistic residents for all ages is of significant interest and concern to the JHOSC given that it has a constitutional remit over health and healthcare services as a whole, and this includes the initiatives taken by Oxfordshire's system partners to address some of the challenges that residents with autism can experience, both as a result of the challenges associated with autism as well as in relation to the services/support available.

4. Upon commissioning the report for this item, some of the insights the Committee sought to receive were as follows:

   - The extent to which this is a system-wide strategy, and whether there is clarity on the role of each system partner in delivering its aims and objectives.
   - How has the strategy was developed to ensure inclusion of all key stakeholders and seldom heard voices.
   - How the strategy aims to improve access and support through school, Further Education, and employment.
   - How the strategy will support appropriate, timely support across the lifespan.

- The extent to which community awareness raising and stigma reduction will be supported by the strategy.
- The degree to which people with autism will receive person-centred support (focusing on strengths, independence and quality of life and improved life expectancy).
- The relationship between epilepsy and autism.
- How the strategy identifies and supports care pathways for people with autism at risk of suicide.
- Details of any family and carer support that will be supported by the strategy including– navigation, respite, information, and early help.
- How autism services will become more accessible through helping to removing barriers, improving pathways, and simplifying navigation.
- How partners will track improvements in quality of life, access, employability, education, transitions, and early support.
- How delivery will be sequenced and resourced across Oxfordshire County Council, the NHS, schools, district councils, and community partners.
- Details for wait times for diagnosis and treatment (including support provided whilst families are on waiting lists).
- How the strategy will support other major strategies & programmes at place.
- Details of recruitment and retention for staff involved in providing services for autistic residents.

SUMMARY

5. During the 16 April 2026 meeting, the Director of Adult Social Care described the strategy as having been "on quite a journey" and stressed that, while it remained draft, it represented a significant shift in approach and language. The strategy had been co-produced across multiple organisations and that the drafting process had required repeated pauses, reflection and revision, particularly where language and framing risked reinforcing a deficit narrative.

6. The Chief Executive of Autism Champions and Expert by Experience provided a detailed account of lived experience and, critically, the lived experience of participating in co-production itself. She described co-production as a term that was frequently used but often misunderstood, and explained that meaningful co-production required autistic people and the autistic community to be involved from the beginning and throughout delivery, rather than being consulted at the end.

7. A significant part of the discussion focused on the difficulty of system engagement during the strategy's development. The Chief Executive of Autism Champions and Expert by Experience explained that securing the right stakeholders "in a room" had been extremely difficult and described this as a recurring barrier, despite some successful engagement activity.

8. The Committee heard reflections on education. The Chief Executive of Autism Champions and Expert by Experience described education as feeling separate from health, social care and mental health even though Education, Health and Care Plans were inherently multi-system. The complexity created by differing

statutory responsibilities, including that education provision was the only statutory "surface" within Education, Health and Care Plans, despite the fact that many determinants of outcomes lay in health, social care and system integration.

9. The Director of Children's Services reinforced the need to keep the strategy both accessible and deliverable. Strategies should not raise expectations with commitments that could not realistically be delivered, because failure to deliver would erode trust further. Work would continue to produce a children and young people's version in a concise, accessible format, with young people supported to shape an appropriate version of the strategy and to place it within the local offer.

10. The Committee then moved into detailed scrutiny of governance and accountability. It was queried as to how much authority and "teeth" the Autism Improvement Board would have to hold partners to account if delivery stalled. The Head of Joint Commissioning – Live Well – Housing, Education and Social Care responded that the Autism Improvement Board was co-chaired jointly with lived experience leadership and included representation from partner organisations and lived experience groups. Six implementation groups would sit beneath the Board, corresponding to six key areas within the strategy, and that each group would report up with outcome measures and Key Performance Indicators (KPIs). Where delivery was not occurring, the Board chairs would have the ability to contact relevant organisations, pursue resolution, and escalate. Escalation routes existed through wider system governance, including relevant ICB boards, joint commissioning executive arrangements and place-based partnership structures where system partners were present.

11. The Committee examined financial modelling and asked when financial modelling would be completed, what budgets and partner organisations would be in scope, and how affordability would be assured before final approval. The Head of Joint Commissioning – Live Well – Housing, Education and Social Care explained that much of the intended improvement should be cost-neutral, rooted in changes to practice, communication, training and pathway working rather than new-funded provision. However, implementation planning could surface areas of genuine cost, and that financial modelling would then consider existing budgets within pooled arrangements, local authority and ICB resources and other sector contributions, with the potential to divert existing funding and seek grant funding where appropriate. Officers emphasised that the system had no additional overall money and that affordability would therefore depend on realistic scoping and prioritisation of what could be delivered.

KEY POINTS OF OBSERVATION:

12. This section highlights five key observations and points that the Committee has in relation to the development of the All-Age Autism strategy for Oxfordshire. These five key points of observation have been used to determine the recommendations being made by the Committee which are outlined below:

That the role, authority and escalation mechanisms of the Autism Improvement Board are clearly articulated in the final strategy and/or implementation plan, including how partner organisations are held to account for delivery of agreed actions: The recommendation being made by the JHOSC—that the role, authority and escalation mechanisms of the Autism Improvement Board should be clearly articulated in the final All-Age Autism Strategy and/or its implementation plan—reflects a fundamental principle of effective governance in complex, multi-agency systems. At its core, the recommendation recognises that the success of any system-wide strategy is not determined solely by the clarity of its vision or the ambition of its priorities, but by the robustness of the governance structures that translate those ambitions into coordinated, accountable and deliverable action.

The draft Oxfordshire All-Age Autism Strategy explicitly positions the Autism Improvement Board as the central oversight mechanism responsible for driving implementation across a wide array of partners, including local authority services, NHS organisations, education providers, and the voluntary and community sector. However, while the strategy sets out the existence of this Board and describes its collaborative ethos, it is less explicit about the formal mechanisms through which accountability will be exercised, performance managed, and risks escalated. This gap is precisely what the JHOSC recommendation seeks to address.

From the perspective of public administration and governance theory, this recommendation is well-founded. Accountability is widely recognised in the academic literature as a cornerstone of effective public sector governance, ensuring that organisations entrusted with public resources are "answerable to the public" and subject to mechanisms that require them to justify performance and outcomes[1]. Similarly, research in public administration emphasises that accountability is multifaceted—encompassing vertical accountability (to elected bodies and scrutiny), horizontal accountability (between organisations), and social accountability (to service users and communities)[2]. In the context of an all-age autism strategy, all three forms are relevant: the Autism Improvement Board must coordinate partners (horizontal accountability), report into formal governance structures such as the Health and Wellbeing Board (vertical accountability), and remain responsive to autistic people and their families (social accountability).

The need for clearly defined governance structures is even more acute in integrated health and care systems. The Health and Care Act 2022 established Integrated Care Systems (ICSs) precisely to bring together disparate organisations to plan and deliver services collaboratively.

[1] https://www.europeanproceedings.com/article/10.15405/epsbs.2023.11.77
[2] https://journals.sagepub.com/doi/pdf/10.1177/00208523231211751

However, the parliamentary Health and Social Care Committee has observed that such partnership arrangements create inherent risks of blurred accountability if roles and responsibilities are not clearly articulated[3]. In this context, the JHOSC recommendation aligns closely with national policy expectations: without clear lines of responsibility and oversight, "patients risk falling through the cracks of a system that is already under pressure"[4].

The Oxfordshire strategy reflects many of the characteristics of a mature ICS-aligned approach: it is system-wide, co-produced, and reliant on shared delivery across organisational boundaries. However, the very features that make it ambitious also create risks. The strategy includes commitments relating to diagnostic waiting times, workforce capability, reasonable adjustments, transitions, housing, and employment—areas that span multiple organisations with different statutory duties and funding streams. Without explicit clarity on "who is accountable for what," there is a well-documented risk that responsibility becomes diffused, leading to delays, inconsistent delivery, or failure to act.

The importance of defined escalation mechanisms is particularly significant. In healthcare governance literature, escalation pathways are identified as a critical component of effective oversight, ensuring that risks and under-performance are not only identified but acted upon in a timely way[5]. In practice, this means that governance bodies must not only receive performance information, but also have agreed processes for responding when progress is insufficient—whether through targeted support, intervention, or escalation to higher-level decision-making bodies. The NHS Oversight Framework, for example, is predicated on a "consistent and transparent approach to assessing performance" and taking "quick action" where organisations are not delivering[6]. Translating this principle into the local autism context reinforces the need for a clear escalation framework within the Autism Improvement Board's remit.

Evidence from other local authority areas further illustrates the importance of robust governance arrangements in autism strategies. In Gateshead, for example, delivery of the local autism strategy is explicitly overseen by a multi-agency autism board that reports into the Health and Wellbeing Board, with governance identified as a central component of implementation[7]. Similarly, the London Borough of Bromley has established an All-Age Autism Board which brings together senior leaders, professionals, and people with lived experience to influence

[3] https://publications.parliament.uk/pa/cm5803/cmselect/cmhealth/587/report.html
[4] https://mtg.org.uk/wp-content/uploads/2025/12/Rebuilding-Accountability-in-the-NHS-A-Review-of-ICB-Leadership-Innovation-and-Patient-Outcomes.pdf
[5] https://impact-guru.co.uk/blogs/news/governance-structures-and-accountability-in-autism-services
[6] https://www.england.nhs.uk/long-read/nhs-oversight-framework-2025-26/
[7] https://democracy.gateshead.gov.uk/documents/s43016/Autism%20Strategy-%20Health%20and%20Wellbeing%20Board.pdf

service change, with an emphasis on ensuring that the Board is not merely advisory but has real impact on decision-making[8]. These examples demonstrate that where governance structures are clearly articulated and empowered, they can act as effective vehicles for system-wide improvement; conversely, where governance is ambiguous, strategies risk becoming aspirational rather than operational.

This recommendation being made by the JHOSC also reflects wider principles of good governance identified in healthcare and public sector literature. Effective governance frameworks are characterised by clarity of roles, defined decision-making authority, transparency in reporting, and mechanisms for assurance and review[9]. These principles are directly relevant to the Autism Improvement Board. For example, clarity of roles ensures that no aspect of the strategy is left without a responsible owner; transparency in reporting enables scrutiny bodies, such as the JHOSC, to assess progress; and defined assurance mechanisms ensure that the Health and Wellbeing Board can fulfil its statutory role in overseeing the health and wellbeing strategy for the area[10].

Crucially, the recommendation is not simply a technical request for governance detail; it is a substantive intervention aimed at safeguarding delivery, accountability and public confidence. Autism strategies, by their nature, seek to address entrenched inequalities, fragmented services, and long-standing gaps in provision. These challenges are complex and cross-cutting, and they require sustained, coordinated action over time. Without a governance framework that specifies how partners will be held to account, how progress will be monitored, and how issues will be escalated, there is a significant risk that these systemic challenges will persist despite the presence of a well-articulated strategy.

The emphasis on reporting to the Health and Wellbeing Board and sharing assurance with scrutiny is also particularly significant. Health and Wellbeing Boards are intended to provide strategic oversight and ensure alignment across local priorities, while scrutiny committees play a critical role in holding the system to account on behalf of the public. By recommending that assurance mechanisms are clearly defined, the JHOSC is reinforcing the importance of maintaining democratic oversight within a system that increasingly relies on partnership governance rather than hierarchical control.

Thus, the recommendation being issued by the JHOSC is both proportionate and necessary. It reflects established principles of public sector governance, aligns with national policy expectations for integrated care systems, and responds directly to the risks inherent in delivering a

[8] https://www.local.gov.uk/case-studies/london-borough-bromley-all-age-autism-board
[9] https://academic.oup.com/intqhc/article/35/3/mzad046/7210365
[10] https://www.gov.uk/government/publications/health-and-wellbeing-boards-guidance/health-and-wellbeing-boards-guidance

complex, multi-agency autism strategy. By seeking clarity on accountability, escalation and assurance, the Committee is not merely requesting additional detail; it is strengthening the conditions for the strategy's successful implementation. In doing so, it ensures that the ambition of the All-Age Autism Strategy is matched by a governance framework capable of delivering meaningful, measurable change for autistic people and their families across Oxfordshire.

Recommendation 1: *That the role, authority and escalation mechanisms of the Autism Improvement Board are clearly articulated in the final strategy and/or implementation plan, including: how partner organisations are held to account for delivery of agreed actions; how under performance or delay will be escalated; and how assurance will be reported to the Health and Wellbeing Board and shared with scrutiny.*

That co-production principles are explicitly embedded in delivery, not only strategy development, including a clear role for autistic people (of all ages) and experts by experience (from the entire community) in shaping priorities: The Oxfordshire JHOSC recommendation that co-production principles must be explicitly embedded in delivery, not only in strategy development—goes to the heart of whether the all-age autism strategy becomes a living programme of change or remains a well-intentioned statement of ambition. The draft strategy repeatedly frames itself as a partnership strategy and states that it has been co-produced with autistic people, with experts by experience continuing to shape, guide and influence the work going forward. The accompanying report submitted to the Committee similarly emphasises that co-production has been central to development through consultations, countywide events, and ongoing working groups, and it highlights that the Autism Improvement Board includes autistic people and experts by experience.

Yet the point of scrutiny is not simply to recognise that co-production occurred during drafting; it is to ensure that co-production is not "front-loaded" and then diluted when difficult decisions arise—particularly decisions about prioritisation, sequencing, resource trade-offs, and accountability for implementation. That is why the recommendation appropriately focuses on embedding co-production in the implementation plan, and on specifying exactly how lived experience feedback will influence commissioning, service redesign, and system decisions.

A substantial body of evidence in public service research supports the Committee's concern. Co-production is not merely consultation; it is a model of service planning and delivery in which professionals and citizens share power and responsibility, producing better-fitting services and mobilising knowledge and resources that organisations cannot generate alone. In a widely cited framework, co-production is understood as shifting relationships from one-way service delivery towards

negotiated, reciprocal arrangements in which service users and communities are not passive recipients but active contributors to outcomes. Systematic reviews of co-creation and co-production in public services reinforce that the conditions of co-production (including clarity of roles, resourcing, and genuine influence on decisions) matter as much as the aspiration to collaborate; without these, "co-production" risks becoming a label applied to practices that do not redistribute influence.

The draft strategy itself implicitly highlights why co-production must extend into delivery. It explains that each of the six priority areas will be accompanied by an action plan structured around broad "We will" commitments and that the governance structure includes an Autism Improvement Board and task-and-finish groups. Notably, it also states that the "We will" statements may appear broad, intentionally covering multiple actions, with the action plan providing the granularity. If the detailed action plan is where prioritisation and sequencing decisions will be made, then it is at precisely that point—where commitments are translated into deliverables, timelines, and owner organisations—that autistic people and experts by experience must have a clear, protected role. Otherwise, co-production is confined to the less contentious phase (drafting principles and vision) and excluded from the phase where power is exercised (deciding what happens first, what is funded, what is deprioritised, and what constitutes "progress").

The Committee's emphasis on involving autistic people "of all ages" and experts by experience "from the entire community" is also justified by the strategy's Equality Impact Assessment (EIA) that was also submitted to the JHOSC. The Strategy's EIA explicitly recognises risks that stakeholders may not feel thoroughly included, and it notes barriers to engagement and access (including limited internet access and language barriers), with mitigations such as detailed stakeholder mapping and alternative formats. This matters because co-production that relies only on established organisations or those already "in the room" can inadvertently reproduce inequality—over-representing people with time, confidence, digital access, and existing connections, while under-representing people in rural communities, deprived areas, people from minoritised ethnic communities, and autistic people who are undiagnosed or less connected to services. The EIA's acknowledgment of these risks reinforces the Committee's call for delivery-phase co-production to be explicitly designed to reach beyond the most visible stakeholders, ensuring that the "experts by experience" function is not limited to a narrow subset of the autistic community.

National guidance also supports making co-production a delivery requirement rather than an optional ethos. NHS England defines co-production as an equal partnership with people and communities from the earliest stages of service design through development and evaluation, and it situates co-production as distinct from informing, consulting, or engaging. This is important because it anchors the expectation that co-production should run "from start to finish," not stop

at publication of a strategy[11]. Likewise, NHS England's operational guidance on all-age autism assessment pathways sets out principles for pathway design and specifically includes the expectation that services are "co-designed by clinicians and people who access the services," reinforcing that lived experience involvement is integral to commissioning and evaluation, not a discretionary add-on. When local systems in England are being asked nationally to reduce variation and inequality in autism pathways, Oxfordshire's approach to embedding lived experience influence into delivery becomes a matter of both quality and equity, not simply good practice[12].

This JHOSC recommendation is also supported by practice examples from other areas that have sought to formalise how lived experience influences delivery decisions. A particularly relevant example is the London Borough of Bromley: All-Age Autism Board case study, which describes a governance arrangement that brings together autistic individuals, parent/carer representatives, the voluntary sector, and local authority professionals to influence change, and emphasises creating a board that is not merely "top-down" but structured to grow autistic community voice[13]. Bromley's own local offer page further explains that priorities were chosen through feedback and that an action plan is reviewed through board arrangements, with engagement opportunities open to people without requiring a formal diagnosis—an explicit attempt to widen "experts by experience" participation beyond organisational representation[14]. The Improving support for children with autism and their families using a 100 day challenge framework article also illustrates how structured collaboration with families can shift local systems from repeated discussion of problems to action-oriented change, highlighting the role of parent participation in shaping interventions[15]. These examples do not provide a one-size-fits-all template for Oxfordshire, but they demonstrate a shared lesson: co-production is most resilient when it is built into delivery machinery—boards, action plans, review cycles, and open engagement routes—rather than treated as a completed stage of drafting.

A central feature of the JHOSC recommendation is its insistence on clarity about how lived experience will influence commissioning and service redesign. That emphasis is well-founded because commissioning decisions determine what is funded, what is specified in contracts, what is measured, and what incentives shape provider behaviour. Oxfordshire's all-age autism strategy includes commitments that touch multiple commissioning domains—education, health and care, housing, employment, and criminal justice—each with distinct decision forums and resource constraints. Without explicit routes for lived experience input into commissioning cycles, co-production risks being

[11] [england.nhs.uk]
[12] [thinklocal...nal.org.uk] [england.nhs.uk], [nice.org.uk]
[13] Local Government Association case study.
[14] Bromley Council overview of the BAAB and engagement
[15] BMJ opinion piece

confined to narrative feedback rather than becoming a decision-shaping force. The co-production evidence base in social care is particularly clear that co-production must be more than "a change in words"; it requires organisational culture, structure and practice changes, and it warns that if co-production is not clearly defined and resourced, its meaning is diluted and its transformative potential reduced[16]. The same literature distinguishes between descriptive, compliance-focused approaches to co-production and more transformative models that redistribute power and shape service priorities—directly relevant to the Committee's insistence on co-production in the implementation plan's sequencing and review.

Finally, this recommendation's focus on review and progress monitoring reflects a practical truth about autism strategies: implementation takes place in a changing landscape of demand pressures, workforce constraints and interdependent programmes. The Oxfordshire report notes that the implementation plan is still being developed and will be taken forward through partnership structures, which means the most consequential decisions are still to come. Co-production embedded into delivery creates a disciplined feedback loop: lived experience informs what "good" looks like, influences how actions are prioritised, and then tests whether changes are actually experienced on the ground. This aligns with NIHR guidance on co-production, which stresses the importance of shared power, joint ownership of key decisions, and continuous reflection throughout a programme—not only at the outset[17]. It also aligns with the NHS England framing that co-production is an "equal partnership" from design through evaluation, guarding against tokenism and ensuring decisions remain person-centred[18].

In summary, this JHOSC recommendation targets the precise point at which co-production too often fails: the transition from writing a strategy to delivering it. Oxfordshire's documents already declare a commitment to co-production and recognise inclusion risks, but scrutiny is right to require explicit delivery-phase mechanisms that ensure autistic people of all ages—alongside a genuinely representative range of experts by experience—shape priorities, sequence actions, and review progress, with clear routes for their feedback to influence commissioning and system decisions. The academic literature, national guidance, and practical examples from other areas converge on the same conclusion: co-production produces its greatest value when it is operationalised as shared decision-making over time, rather than treated as a one-off consultation exercise[19].

Recommendation 2: *That co production principles are explicitly embedded in delivery, not only strategy development, including: a clear role for autistic people (of all ages) and experts by experience (from the entire community) in shaping priorities,*

[16] SCIE guide on co-production in social care
[17] NIHR guidance on co-producing a project
[18] [england.nhs.uk]
[19] [local.gov.uk], [livingautism.com]

sequencing actions and reviewing progress within the implementation plan; and clarity on how lived experience feedback will directly influence commissioning, service redesign and system decisions.

That financial modelling for the All-Age Autism Strategy is developed as much as is possible, including: any budgets/funding pots and partner organisations in scope: The recommendation made by the Committee—that financial modelling for the All-Age Autism Strategy should be developed as far as possible, including clarity on budgets, funding sources, partner contributions, and the balance between new investment and reconfiguration—addresses one of the most critical determinants of whether the strategy will achieve its intended outcomes. While the draft strategy document presented to the Committee sets out a clear and ambitious vision, it also explicitly acknowledges that the financial implications of delivery have not yet been fully modelled, and that further work is required to establish affordability and sustainability. This acknowledgement is important, but it also exposes a material risk: without robust financial planning, the strategy may struggle to move from ambition to implementation.

The strategy itself identifies a wide range of system-wide changes, including reducing diagnostic waiting times, strengthening education and transitions, improving workforce capability, and expanding support in housing and employment. These commitments are inherently resource-dependent. They span multiple organisational boundaries and funding streams—local authority, NHS, voluntary sector and community provision—each subject to different budgetary pressures and governance frameworks. In this context, the JHOSC recommendation is not procedural; it is fundamental to ensuring that the strategy is deliverable within the real constraints of the Oxfordshire system.

Public sector and healthcare governance literature strongly supports the Committee's position. Evidence consistently shows that effective strategy implementation depends on alignment between strategic goals, resource allocation, and financial planning. NHS England's commissioning framework emphasises that integrated care systems must align long-term strategies with resource allocation and continuous evaluation of outcomes, ensuring that plans are grounded in affordability and value for money[20]. Similarly, the NHS Oversight Framework highlights the expectation that systems operate within financial constraints and establish clear mechanisms for assessing performance and sustainability, with rapid intervention where delivery is not viable[21]. These national expectations reinforce the principle that strategic ambition must be accompanied by a credible financial model.

[20] https://www.openaccessgovernment.org/nhs-england-launches-strategic-commissioning-framework-for-integrated-care-boards/201060

[21] https://www.england.nhs.uk/long-read/nhs-oversight-framework-2025-26

At a theoretical level, this aligns with broader public administration research, which identifies financial sustainability and accountability as core principles of good governance. Studies of public sector accountability emphasise that organisations must be able to demonstrate how public resources are allocated and used to achieve defined outcomes, and that such transparency underpins trust, effectiveness and long-term system stability[22]. In complex, multi-agency systems such as integrated care partnerships, this becomes even more critical: without a shared financial understanding, organisations may pursue individual priorities that undermine collective delivery.

The Oxfordshire context further underlines the need for clarity. The main report submitted to the Committee explicitly references system pressures, fragmented services and growing demand, all of which create constraints on available resources. In such an environment, strategy delivery cannot rely on implicit assumptions about funding growth or capacity expansion. Instead, it must explicitly address the trade-offs between:

- investing in new services or interventions;
- reconfiguring or redeploying existing resources; and
- prioritising among competing demands.

This is precisely what the JHOSC recommendation seeks to achieve by requiring clarity on the balance between new investment and reconfiguration. Evidence from social care and health reform demonstrates that strategies which fail to articulate this balance risk becoming "aspirational documents" without a realistic pathway to delivery. The Social Care Institute for Excellence, for example, emphasises that transformation in care systems must consider the economics of co-production and service redesign, including how resources are redistributed rather than simply expanded[23].

Examples from other areas illustrate both the necessity and the benefits of financial clarity. In Gateshead, the All-Age Autism Strategy was explicitly supported by a governance framework in which delivery planning, including financial considerations, was overseen by a multi-agency autism board, ensuring that priorities were aligned with available resources and partner contributions[24]. Similarly, in Nottinghamshire, the autism strategy is explicitly embedded within the Integrated Care System's broader commissioning and planning framework, ensuring alignment between strategic priorities and system-level funding and accountability structures[25]. These examples demonstrate that where financial planning is integrated into strategy development, implementation is more coherent and measurable.

[22] https://www.europeanproceedings.com/article/10.15405/epsbs.2023.11.77
[23] https://timebanking.org/wp-content/uploads/2020/05/Coproduction-in-Social-Care-Scie.pdf
[24] https://democracy.gateshead.gov.uk/documents/s43016/Autism%20Strategy-%20Health%20and%20Wellbeing%20Board.pdf
[25] https://www.nottinghamshire.gov.uk/policy-library/112571/all-age-autism-strategy-2022-2025

The JHOSC recommendation also highlights the importance of identifying which partner organisations and funding pots are in scope. This is particularly important in integrated care systems, where funding is distributed across multiple organisations rather than held centrally. NHS England guidance emphasises that Integrated Care Boards and partners must take collective responsibility for delivery of system improvements and financial sustainability, rather than relying on individual organisations acting independently[26]. Without clarity on which organisation is contributing what resource to each priority, there is a risk of duplication, gaps, or misalignment in delivery.

The Equality Impact Assessment (EIA) further strengthens the case for robust financial modelling. The EIA identifies a range of inequalities affecting autistic people, including barriers to access and variations in experience across different groups. Addressing these inequalities—whether through improved diagnostic pathways, culturally appropriate services, or targeted support—will require targeted resource allocation. Without financial modelling, there is a risk that equality objectives remain aspirational rather than embedded in delivery. National guidance similarly emphasises that resource allocation must be explicitly linked to reducing inequalities in outcomes and access[27].

Another key dimension of the recommendation is sustainability. The strategy is intended to operate over a multi-year period, and many of its ambitions—such as improving workforce capability or developing preventative pathways—require sustained investment rather than one-off funding. Healthcare governance literature stresses that short-term, project-based funding can undermine long-term outcomes, particularly in areas requiring cultural and system change[28]. By requiring an assessment of affordability and sustainability, the JHOSC recommendation ensures that the strategy considers not only whether actions can be initiated, but whether they can be maintained over time.

Furthermore, financial modelling creates the conditions for effective performance management and scrutiny. A clear understanding of costs and funding allows the system to assess:

- whether investment is delivering expected outcomes;
- whether resources are being used efficiently; and
- whether adjustments are needed in response to changing demand or performance.

This aligns with the Committee's wider role in ensuring that recommendations are actionable, measurable and capable of scrutiny, rather than simply aspirational. It also supports transparency, enabling

[26] https://www.england.nhs.uk/long-read/guidance-on-good-governance-and-collaboration
[27] https://www.england.nhs.uk/long-read/guidance-on-good-governance-and-collaboration
[28] https://academic.oup.com/intqhc/article/35/3/mzad046/7210365

both the Health and Wellbeing Board and the public to understand how resources are being used to achieve outcomes for autistic people.

In conclusion, the draft Oxfordshire All-Age Autism Strategy sets out a comprehensive vision for improving the lives of autistic people across the county, but its success will depend on the extent to which that vision is underpinned by a realistic, clearly articulated financial framework. The evidence from national policy, academic literature, and practice in other areas all point to the same conclusion: without clear financial planning, accountability and sustainability, even the most well-designed strategies are unlikely to deliver meaningful change. By insisting on clarity around funding, resource allocation and affordability, the Committee is strengthening the foundations for delivery, ensuring that the strategy is not only ambitious but also achievable and sustainable in practice.

Recommendation 3: *That financial modelling for the All-Age Autism Strategy is developed as much as is possible, including: any budgets/funding pots and partner organisations in scope; the balance between new investment and reconfiguration of existing resources; and the affordability and sustainability of priority commitments.*

For a clear outcomes and performance framework to be developed:
The Committee's recommendation that a clear outcomes and performance framework be developed for the All-Age Autism Strategy reflects a critical principle of effective public service reform: that strategies must not only set direction, but must also establish how success will be defined, measured and scrutinised. In the absence of such a framework, there is a significant risk that even well-intentioned and co-produced strategies fail to deliver meaningful change for service users, particularly in complex, multi-agency systems such as autism services.

The reports submitted to the Committee clearly articulate a shared ambition to improve outcomes for autistic people across Oxfordshire, and they emphasise co-production, partnership working and system-wide transformation. The strategy identifies key areas for improvement, including diagnostic pathways, education and transitions, health and care access, and wider determinants such as employment and housing. However, while these priorities are clearly set out, the documentation provides limited detail on how delivery will be measured in practice, beyond broad commitments to monitoring progress and using data and lived experience to inform improvement. This creates a gap between strategic ambition and operational accountability—precisely the gap that the JHOSC recommendation seeks to address.
The need for a comprehensive outcomes framework is well-established in both policy and academic literature. Public administration research consistently emphasises that effective governance requires not only setting objectives but also establishing clear performance indicators and feedback loops, enabling organisations to assess whether interventions are achieving their intended impact. Without such mechanisms,

accountability becomes diffuse, and improvement efforts risk being driven by activity rather than outcomes. As noted in broader governance studies, accountability in the public sector depends on the ability of institutions to provide "regular updates on performance" and demonstrate how actions translate into outcomes for citizens[29].

This principle is particularly important in the context of autism services, where outcomes are often complex, longitudinal and highly individualised. National guidance reinforces the need for outcome-focused approaches. NHS England guidance on co-production and service design stresses that services should be developed and evaluated in partnership with people who use them, ensuring that measurement frameworks reflect real-world experiences and impacts, not just administrative outputs[30]. This aligns directly with the Committee's emphasis on including lived experience and qualitative outcomes, rather than relying solely on access metrics.

The specific components identified in the JHOSC recommendation—diagnostic waiting times, access to support while waiting, reasonable adjustments, transitions, and lived experience—are particularly appropriate given the evidence base on autism services. Diagnostic waiting times are a widely recognised system pressure, with national and local evidence indicating significant delays between referral and diagnosis. The report submitted to the JHOSC highlights long waits as a key issue affecting autistic people and their families. Measuring waiting times is therefore essential, but it is not sufficient in itself. As NHS policy increasingly recognises, the experience of waiting—the availability of support, information and interim interventions—is just as important as the duration of the wait. This justifies the inclusion of "access to support while waiting" as a distinct outcome measure.

Similarly, the Committee's focus on reasonable adjustments across services reflects a growing body of evidence that autistic people often face systemic barriers in accessing healthcare and other services, even where those services are nominally available. NHS England's operational guidance on autism pathways emphasises that services must be designed to be accessible and responsive, including through adjustments to communication, environments and processes[31]. Measuring whether such adjustments are consistently implemented is therefore critical to understanding whether the system is genuinely inclusive, rather than simply compliant at a formal level.

Furthermore, the inclusion of transitions as a key outcome area is also strongly supported by both the strategy and wider evidence. Transitions—from childhood to adulthood, from education to employment, or between services—are consistently identified as points

[29] https://www.europeanproceedings.com/article/10.15405/epsbs.2023.11.77
[30] https://www.england.nhs.uk/always-events/co-production
[31] https://www.england.nhs.uk/long-read/operational-guidance-to-deliver-improved-outcomes-in-all-age-autism-assessment-pathways-guidance-for-integrated-care-boards

of vulnerability for autistic people, often associated with discontinuity of support and poorer outcomes. NICE guidance on autism services highlights the importance of coordinated, multi-agency approaches to transitions and recommends that systems monitor how effectively transitions are managed across organisational boundaries[32]. Including transitions in the outcomes framework therefore ensures that the strategy addresses not only isolated service components, but also the integration between them.

The Committee's emphasis on lived experience and qualitative outcomes is particularly significant. Traditional performance frameworks in health and social care have often relied heavily on quantitative indicators such as activity levels, waiting times and throughput. While these metrics are important, they do not capture the quality or impact of services from the perspective of users. Academic literature on co-production and public service design highlights that user experience is an essential dimension of service quality, and that involving service users in defining and assessing outcomes leads to more responsive and effective services[33]. This aligns closely with the Oxfordshire All-Age Autism strategy's commitment to using lived experience to drive improvement, but the JHOSC recommendation rightly insists that this commitment must be operationalised through the performance framework, rather than remaining an aspirational statement.

Moreover, examples from other areas reinforce the importance of embedding outcomes frameworks within autism strategies. In Nottinghamshire, for instance, the autism strategy is closely linked to the Joint Strategic Needs Assessment and broader system performance monitoring, ensuring that outcomes such as access, inequalities and service experience are tracked and reviewed at system level[34]. Similarly, the Bromley All-Age Autism Board oversees delivery through a structured action plan, with priorities informed by lived experience and reviewed regularly through governance processes[35]. These examples demonstrate that where outcomes are clearly defined and monitored, strategies are more likely to drive sustained and measurable improvement.

In addition, the Equality Impact Assessment (submitted to the JHOSC as Annex 2) further strengthens the case for a comprehensive outcomes framework. It identifies a range of inequalities affecting autistic people, including barriers to access and variation in experience across different groups. Addressing these inequalities requires not only targeted interventions but also the ability to measure differential outcomes across populations, ensuring that improvements are equitably distributed.

[32] https://www.nice.org.uk/guidance/qs51/resources/developing-a-multiagency-local-team-122806333
[33] https://www.seemescotland.org/media/7284/beyond-engagement-and-participation.pdf
[34] https://www.nottinghamshireinsight.org.uk/research-areas/jsna/adults-and-vulnerable-adults/autism-2025
[35] https://www.local.gov.uk/case-studies/london-borough-bromley-all-age-autism-board

Without such measurement, there is a risk that overall performance appears to improve while inequalities persist or even widen.

Crucially, an outcomes framework also underpins effective scrutiny. For the JHOSC to fulfil its statutory role, it must be able to assess whether the strategy is delivering on its objectives and to challenge the system where it is not. This requires clear, agreed indicators and regular reporting, enabling the Committee to move beyond anecdotal evidence and engage in robust, evidence-based scrutiny. The recommendation therefore not only supports delivery but also strengthens democratic accountability.

In conclusion, the Oxfordshire All-Age Autism Strategy sets out a strong vision and a comprehensive set of priorities, but without a detailed framework for measuring progress and impact, there is a risk that these ambitions will not translate into meaningful change. By specifying key areas such as diagnostic waiting times, support while waiting, reasonable adjustments, transitions and lived experience, the Committee is ensuring that the strategy remains focused on the outcomes that matter most to autistic people and their families. Supported by national guidance, academic research, and examples from other areas, this recommendation strengthens the foundations for delivery, accountability and continuous improvement across the Oxfordshire system.

Recommendation 4: *For a clear outcomes and performance framework to be developed. It is recommended that any outcomes and performance frameworks include diagnostic waiting times and access to support while waiting; consistency and effectiveness of reasonable adjustments across services; experiences of transitions; and lived experience and qualitative outcomes, not solely access metrics.*

Developing a children's version of the autism strategy: The recommendation by the Committee—that system partners should work towards developing a children's version of the All-Age Autism Strategy—is rooted in a clear and well-established principle of public policy and service design: that policies must be accessible, meaningful and responsive to the people they affect, including children and young people. In the context of an all-age autism strategy, this is particularly significant, because autistic children and young people are not only recipients of services but also individuals with distinct experiences, needs, rights and perspectives that differ from those of adults.

The draft All-Age Autism Strategy is explicitly framed as a strategy for "everyone", recognising that autistic people are present in all areas of community life and that inclusion is a shared responsibility. However, while the strategy includes commitments relating to education, transitions and young people's pathways, it is primarily written in a general, system-focused format, intended for professionals, commissioners and partner organisations. It does not currently function as a document that autistic children and young people themselves can easily access, understand or use to navigate services or hold the system

to account. The recommendation for a children's version therefore seeks to address a clear gap between the intended beneficiaries of the strategy and its accessibility to them.

This principle is strongly supported by national practice. The UK Government's National strategy for autistic children, young people and adults 2021 to 2026 includes an Easy Read version specifically designed to communicate the strategy in accessible language, explaining what the strategy means, what will happen, and how progress will be monitored[36]. Such documents are not merely simplified summaries; they are a recognition that accessibility is a fundamental requirement of inclusive policy, especially in relation to autism, where communication differences are a central consideration. The same national strategy deliberately extends its scope to children and young people for the first time, reflecting the importance of ensuring that support is available "as early as possible and across their lifetime"[37]. This reinforces the need for local strategies, such as Oxfordshire's, to ensure that children and young people can engage with and benefit from the strategy in their own right.

Across the UK, there are numerous examples of local areas producing child-friendly or easy-read versions of autism strategies, recognising that accessibility is a key component of effective delivery. For instance, North Yorkshire has produced an "easy read version" of its strategy for children and young people with autism, designed to ensure that children and families can understand the services available and how they will be supported[38]. Similarly, Greater Manchester and Norfolk have developed simplified or accessible strategy documents to ensure broader understanding and engagement with planning and delivery priorities. These examples demonstrate that producing accessible or child-focused versions of strategies is not an optional enhancement but an established element of good practice in autism policy[39].

However, the justification for a children's version extends beyond accessibility alone. It is also grounded in the growing recognition that children and young people have a right to participate in decisions that affect their lives, including the design and evaluation of public services. The Local Government Association emphasises that councils have responsibilities under the United Nations Convention on the Rights of the Child (UNCRC) to ensure that children are able to express their views and that those views are taken seriously in policy development[40]. Similarly, UK Government guidance on youth voice in policymaking states that policies affecting young people should incorporate their input

[36] https://assets.publishing.service.gov.uk/media/60d2e20fe90e0743a210e00f/national-strategy-for-autistic-children-young-people-and-adults-easy-read.pdf
[37] https://www.gov.uk/government/publications/national-strategy-for-autistic-children-young-people-and-adults-2021-to-2026
[38] https://cyps.northyorks.gov.uk/sites/default/files/SEND/Autism/Easy_Read_Autism_Strategy.pdf
[39] cyps.north...rks.gov.uk] [autismgm.org.uk]
[40] https://www.local.gov.uk/topics/children-and-young-people/engaging-young-people-policy-development

"throughout the whole policy cycle," from design through to implementation and evaluation[41].

Academic literature reinforces this position. Research on children's participation highlights that including children's voices in policy leads to more accurate, nuanced and effective policy outcomes, as it grounds decision-making in lived experience rather than assumptions[42]. Studies in inclusive education similarly emphasise that learners' voices are often marginalised in policy debates, despite being essential to understanding barriers and improving systems[43]. In the field of autism specifically, participatory research approaches underline the importance of involving autistic individuals—including children—in shaping decisions about services, in order to reduce the disconnect between policy and lived experience[44].

A children's version of the strategy is therefore not simply about simplifying language; it is about creating a platform through which children and young people can engage with, understand and influence the system that affects them. It can serve as a tool for:

- explaining what support they are entitled to receive;
- helping them and their families navigate services;
- enabling schools and professionals to communicate expectations clearly; and
- supporting accountability by making commitments visible and understandable.

The Equality Impact Assessment provides additional justification for this approach. It recognises the importance of inclusion, accessibility and engagement with different groups, highlighting that barriers to communication and engagement must be addressed if the strategy is to be effective for all. In the context of children and young people—particularly those with autism, who may have additional communication needs—this underscores the necessity of producing materials that are not only accessible but designed specifically with their needs in mind. Producing a children's version of the strategy is a practical way of ensuring that equality considerations are translated into tangible action.

Moreover, the recommendation supports one of the strategy's central aims: improving outcomes across the life course, particularly in areas such as education and transitions to adulthood. These are areas where children and young people are the primary stakeholders. A strategy that cannot be understood or engaged with by those stakeholders risks

[41] https://www.gov.uk/government/publications/youth-voice-in-policymaking/getting-ready-to-involve-young-people-in-policy
[42] https://repository.gchumanrights.org/server/api/core/bitstreams/fe94c7ca-e097-46ff-bf30-b48e81cb1b27/content
[43] https://files.eric.ed.gov/fulltext/EJ1317916.pdf
[44] https://warwick.ac.uk/fac/sci/psych/research/autism/creative-approaches-participatory-research-toolkit/fpsyg_12_713982.pdf

limiting its impact. By contrast, a child-friendly version can reinforce continuity across the life course by helping young people understand what support to expect now and in the future.

Additionally, there is also an important cultural dimension. Research on child and youth-friendly governance demonstrates that where children are not included in decision-making, policies risk becoming ineffective or misaligned with real needs, and young people may lose trust in public institutions[45]. Conversely, involving children and making policy accessible to them contributes to more responsive, legitimate and trusted systems. This aligns closely with the co-production principles underpinning the Oxfordshire's All-Age Autism strategy, which emphasise partnership and lived experience as drivers of improvement.

Therefore, this JHOSC recommendation responds directly to the challenges identified in the Oxfordshire documents, aligns with national policy and guidance, and is strongly supported by academic evidence and practice across other local areas. By ensuring that autistic children and young people can access, understand and engage with the strategy, system partners will not only improve inclusivity but also strengthen delivery, accountability and long-term outcomes. In doing so, they will move beyond a strategy that is merely about children and young people, to one that is meaningfully shaped with and for them.

Recommendation 5: *For system partners to work toward the development a children's version of the Autism Strategy.*

Legal Implications

13. Health Scrutiny powers set out in the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide:
  Power to scrutinise health bodies and authorities in the local area
  Power to require members or officers of local health bodies to provide information and to attend health scrutiny meetings to answer questions
  Duty of NHS to consult scrutiny on major service changes and provide feedback n consultations.

14. Under s. 22 (1) Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 'A local authority may make reports and recommendations to a responsible person on any matter it has reviewed or scrutinised'.

15. The Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide that the Committee may require a response from the responsible person to

[45] https://childfriendlygovernance.org

whom it has made the report or recommendation and that person must respond in writing within 28 days of the request.

16. The recommendations outlined in this report were agreed by the following members of the Committee:

Councillor Jane Hanna OBE – (Chair)
District Councillor Dorothy Walker (Deputy Chair)
Councillor Ron Batstone
Councillor Gareth Epps
Councillor Emma Garnett
Councillor Imade Edosomwan
District Councillor Katharine Keats-Rohan
District Councillor Elizabeth Poskitt
District Councillor Val Shaw
City Councillor Louise Upton
Barbara Shaw

Annex 1 – Scrutiny Response Pro Forma

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