NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

OXFORDSHIRE COUNTY COUNCIL

healthwatch Oxfordshire

To: Members of the Oxfordshire Health & Wellbeing Board

Notice of a Meeting of the Oxfordshire Health & Wellbeing Board

Thursday, 9 July 2026 at 1.00 pm
Room 2&3 - County Hall, New Road, Oxford OX1 1ND

If you wish to view proceedings online, please click on this Live Stream Link.

Martin Reeves OBE
Chief Executive

July 2026

Contact Officer: ***Democratic Services***
Email: committees.democraticservices@oxfordshire.gov.uk

Membership
Chair – Cllr Tim Bearder (Leader, Oxfordshire County Council)

Board Members:

Ansaf Azhar	Director of Public Health & Communities, Oxfordshire County Council
Michelle Brennan	GP Representative
Councillor Rachel Crouch	West Oxfordshire District Council
Councillor Lisa Smith	Cherwell District Council
Councillor Georgina Heritage	South Oxfordshire District Council
Karen Fuller	Director of Adult Social Care, Oxfordshire County Council
Councillor Sean Gaul	Cabinet Member for Children and Young People, Oxfordshire County Council
Caroline Green	Chief Executive, Oxford City Council
Councillor Kate Gregory	Cabinet Member for Public Health and Inequalities, Oxfordshire County Council
Lisa Lyons	Director of Children's Services, Oxfordshire County Council
Grant MacDonald	Interim Chief Executive, Oxford Health NHS Foundation Trust
Councillor Bethia Thomas	Vale of White Horse District Council
David Radbourne	Regional Director Strategy and Transformation, NHS England
Barbara Shaw	Chair, Healthwatch Oxfordshire

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Matthew Tait	Chief Delivery Officer, Thames Valley ICB

Notes:• Date of next meeting: 24 September 2026

If you have any special requirements (such as a large print version of these papers or special access facilities) please contact the officer named on the front page, but please give as much notice as possible before the meeting.

AGENDA

1. Welcome by Chair

2. Apologies for Absence and Temporary Appointments

3. Declarations of Interest - see guidance note below

4. Petitions and Public Address

Members of the public who wish to speak on an item on the agenda at this meeting, or present a petition, can attend the meeting in person or 'virtually' through an online connection.

Requests to present a petition must be submitted no later than 9am ten working days before the meeting.

Requests to speak must be submitted no later than 9am three working days before the meeting (ie, Monday 9th July 2026 9AM).

Requests should be submitted to omid.nouri@oxfordshire.gov.uk AND committeesdemocraticservices@oxfordshire.gov.uk

If you are speaking 'virtually', you may submit a written statement of your presentation to ensure that if the technology fails, then your views can still be taken into account. A written copy of your statement can be provided no later than 9am on the day of the meeting. Written submissions should be no longer than 1 A4 sheet."

5. Note of Decisions of Last Meeting (Pages 7 - 26)

To **APPROVE** the Note of Decisions of the meeting held on 14 May 2026 and to receive information arising from them.

6. All-Age Autism Strategy (Pages 27 - 190)

The Health and Wellbeing Board is **RECOMMENDED** to:

1. **ENDORSE** the Oxfordshire All-Age Autism Strategy 2026-2031, approve its publication and implementation, and agree the contents and principles set out in the strategy. (**Annex 1**)

2. **NOTE** that LGR may affect delivery of the Oxfordshire All-Age Autism Strategy 2026-2031 by changing system-wide governance, leadership and funding arrangements. While this may cause delays, it also provides an opportunity to strengthen partnership working and improve service alignment.

7. **Marmot Update** (Pages 191 - 214)

The Health and Wellbeing Board is **RECOMMENDED** to:

1. **NOTE** the progress made in embedding the Marmot approach, using the 8 Marmot principles as a framework for understanding inequalities, and strengthening system-wide action on health inequalities in Oxfordshire.

2. **NOTE** the next phase of delivery, focused on converting insight and deep-dive recommendations into agreed actions, clear ownership and measurable outcomes.

3. **AGREE** that Marmot related equity measures should be embedded within the refreshed Health and Wellbeing Strategy outcomes framework to strengthen oversight and accountability.

8. Neighbourhood Health Plan Update (verbal)

The Health and Wellbeing Board is **RECOMMENDED** to **NOTE** the Neighbourhood Health Plan Update.

9. **Prevention of Homelessness Directors Group Update** (Pages 215 - 224)

The Health and Wellbeing Board is **RECOMMENDED** to **NOTE** the report and update.

10. **Report from Healthwatch Oxfordshire** (Pages 225 - 230)

To receive and **NOTE** the Healthwatch Oxfordshire Report on patient views and experiences of Oxfordshire health and care services.

11. Reports from Partnership Boards

To receive updates from Partnership Boards:

- Place-Based Partnership (Verbal Update)
- Health Improvement Board (Verbal Update)
- Children’s Trust Board (Verbal Update)

12. **Forward Work Plan** (Pages 231 - 232)

The Board is asked to **NOTE** the forward work programme.

Councillors declaring interests

General duty

You must declare any disclosable pecuniary interests when the meeting reaches the item on the agenda headed ‘Declarations of Interest’ or as soon as it becomes apparent to you.

What is a disclosable pecuniary interest?

Disclosable pecuniary interests relate to your employment; sponsorship (i.e. payment for expenses incurred by you in carrying out your duties as a councillor or towards your election expenses); contracts; land in the Council’s area; licenses for land in the Council’s area; corporate tenancies; and securities. These declarations must be recorded in each councillor’s Register of Interests which is publicly available on the Council’s website.

Disclosable pecuniary interests that must be declared are not only those of the member her or himself but also those member’s spouse, civil partner or person they are living with as husband or wife or as if they were civil partners.

Declaring an interest

Where any matter disclosed in your Register of Interests is being considered at a meeting, you must declare that you have an interest. You should also disclose the nature as well as the existence of the interest. If you have a disclosable pecuniary interest, after having declared it at the meeting you must not participate in discussion or voting on the item and must withdraw from the meeting whilst the matter is discussed.

Members’ Code of Conduct and public perception

Even if you do not have a disclosable pecuniary interest in a matter, the Members’ Code of Conduct says that a member ‘must serve only the public interest and must never improperly confer an advantage or disadvantage on any person including yourself’ and that ‘you must not place yourself in situations where your honesty and integrity may be questioned’.

Members Code – Other registrable interests

Where a matter arises at a meeting which directly relates to the financial interest or wellbeing of one of your other registerable interests then you must declare an interest. You must not participate in discussion or voting on the item and you must withdraw from the meeting whilst the matter is discussed.

Wellbeing can be described as a condition of contentedness, healthiness and happiness; anything that could be said to affect a person’s quality of life, either positively or negatively, is likely to affect their wellbeing.
Other registrable interests include:

a) Any unpaid directorships
b) Any body of which you are a member or are in a position of general control or management and to which you are nominated or appointed by your authority.

c) Any body (i) exercising functions of a public nature (ii) directed to charitable purposes or (iii) one of whose principal purposes includes the influence of public opinion or policy (including any political party or trade union) of which you are a member or in a position of general control or management.

Members Code – Non-registrable interests
Where a matter arises at a meeting which directly relates to your financial interest or wellbeing (and does not fall under disclosable pecuniary interests), or the financial interest or wellbeing of a relative or close associate, you must declare the interest.

Where a matter arises at a meeting which affects your own financial interest or wellbeing, a financial interest or wellbeing of a relative or close associate or a financial interest or wellbeing of a body included under other registrable interests, then you must declare the interest.

In order to determine whether you can remain in the meeting after disclosing your interest the following test should be applied:
Where a matter affects the financial interest or well-being:

a) to a greater extent than it affects the financial interests of the majority of inhabitants of the ward affected by the decision and;
b) a reasonable member of the public knowing all the facts would believe that it would affect your view of the wider public interest.

You may speak on the matter only if members of the public are also allowed to speak at the meeting. Otherwise you must not take part in any discussion or vote on the matter and must not remain in the room unless you have been granted a dispensation.

Agenda Item 5

NHS Oxfordshire Clinical Commissioning Group · Oxfordshire County Council · healthwatch Oxfordshire

OXFORDSHIRE HEALTH & WELLBEING BOARD

OUTCOMES of the meeting held on Thursday, 14 May 2026 commencing at 1.00 pm and finishing at 4.01 pm

Present:

Board Members:

Councillor Neil Fawcett (In the Chair)
Councillor Sean Gaul
Michelle Brennan
Karen Fuller
Caroline Green
Lisa Lyons
Kate Holburn (as substitute)
Chris Wright (as substitute)
District Councillor Rob Pattenden
District Councillor Helen Pighills
Barbara Shaw t

Other Members in Attendance:

District Councillor Rachel Crouch (online)
District Councillor Georgina heritage (online)

Officers:

Kate Austin (Public Health Principal, OCC)
Professor Erics Charters (University of Oxford)
Craig Miles-Clarke (Senior Research Officer, OCC)
Annette Perrington (Deputy Director, Education & Inclusion)
Isabel Rockingham (Head of Joint Commissioning, Age Well)
Tom Addey (Public Health Registrar, OCC)
Veronica Barry (Executive Director, Healthwatch Oxfordshire)

These notes indicate the outcomes of this meeting and those responsible for taking the agreed action. For background documentation please refer to the agenda and supporting papers available on the Council's web site (www.oxfordshire.gov.uk.)

If you have a query please contact Democratic Services (Email: omid.nouri@oxfordshire.gov.uk AND *committees.democraticservices@oxfordshire.gov.uk)*

ACTION

187 Welcome by Chair

(Agenda No. 1)

Cllr Neil Fawcett, the acting leader of the Council and Chair of the board explained the following:

- Given the departure of Professor Sir Jonathan Montgomery as Chair of Oxford University Hospitals NHS Foundation Trust (OUH), the Health and Wellbeing Board (HWB) did not currently have a vice-chair. Once a new Chair of OUH was recruited, they would become the new vice-chair of the HWB.

- The All-Age Autism Strategy had been postponed until the July HWB meeting, and this was to allow the strategy to be discussed at the Oxfordshire Joint Health Overview Scrutiny Committee (JHOSC) prior to its formal sign off by the HWB.

- There was a likelihood that the HWB would revert to having four public meetings per year as opposed to five, so as to allow for a fifth meeting to potentially constitute a workshop to be organised to examine/discuss key developments in the health and wellbeing landscape.

The Board RESOLVED to:

1. **NOTE** the Chair’s introduction.

2. **AGREE** to revert to four public meetings per year.

188 Apologies for Absence and Temporary Appointments

(Agenda No. 2)

Apologies were received from Cllr Kate Gregory.

Apologies were received from Ansaf Azhar, with Kate Holburn substituting.

Apologies were received from Matthew Tait, with Chris Wright substituting.

189 Declarations of Interest - see guidance note below

(Agenda No. 3)

None were made.

190 Petitions and Public Address

(Agenda No. 4)

The Board received a public address from Cllr Jane Hanna, the previous Chair of the JHOSC, who spoke in a personal capacity but reflected on scrutiny activity over the previous year. She welcomed the evident progress in system collaboration, emphasising that partnership working remained both the most difficult and the most critical aspect of delivering improved outcomes for residents.

She expressed strong support for the community-based, grassroots approach set out in the papers, particularly the focus on building resilience and working with local ecosystems. However, she raised concerns regarding rural inequalities, noting that some rural districts had experienced decline and faced challenges around transport, access to care, and population growth.

She urged the Board to consider how an Oxfordshire-wide ambition could better reflect rural needs and to explore ways of strengthening connections between local communities, parish councils, and grassroots organisations.

In addition, she highlighted the tension between locally driven, community-based approaches and nationally imposed targets, such as those relating to end-of-life care, and asked how the system could reconcile these while maintaining a focus on residents’ needs.

The Board RESVOLED to:

1. **NOTE** the comments by Cllr Jane Hanna.

191 Note of Decisions/Minutes of Last Meeting

(Agenda No. 5)

The minutes of the previous meeting on 12th March 2026 were considered. No amendments were raised.

The Board **AGREED** them as an accurate record.

192 Community Research- Community Health Development Officer & Well Together Programme Evaluation

(Agenda No. 6)

Kate Holburn (Deputy Director of Public Health) and Professor Erica Charters (University of Oxford) presented a report on the independent evaluation of the Community Health Development Officer (CHDO) programme and the Well Together (WT) programme.

Both initiatives formed a central component of Oxfordshire's approach to tackling health inequalities through a Marmot-aligned, community-based model. It was explained that the CHDO programme had emerged from earlier community insight profile work, with officers embedded within priority communities to work alongside local assets and respond to locally identified needs. The Well Together programme had complemented this by providing targeted funding to grassroots organisations to deliver community-led activities addressing those needs.

It was emphasised that the evaluation had been independently undertaken by Professor Erica Charters of the University of Oxford, and that this external academic perspective had been intentionally commissioned to provide an objective and robust assessment of impact. The evaluation had taken place over a 24-month period and had focused not on long-term population health outcomes—which it was acknowledged would not yet be measurable—but on implementation, engagement, and the extent to which the programmes had achieved their intended objectives.

The findings of the evaluation were presented; and it was explained that a mixed-methods approach had been adopted, combining statistical analysis, household surveys, interviews, focus groups, and extensive fieldwork within communities. The research had included engagement with approximately 1,600 households, with detailed responses obtained from 225 households, as well as qualitative work with community organisations and programme participants.

In presenting the findings, Professor Charters reported that both programmes had been effective in achieving their objectives. They had supported over 150 community organisations and facilitated more than 200 community health and wellbeing activities. These activities had reached a substantial number of residents, with evidence suggesting that at least 40,000 individuals had engaged directly with programme-supported initiatives.

A central theme of the evaluation was the importance of the individuals delivering the programmes. It was emphasised that Community Health Development Officers and Community Capacity Builders had been a critical strength, demonstrating strong communication skills, sustained presence within communities, and the ability to build trusted relationships. This relational approach had enabled effective engagement with both residents and local organisations.

The evaluation also identified that community health should not be viewed in isolation, but as part of a wider ecosystem of health and care. Community-based activities were described as both entry points into formal healthcare and as support mechanisms for individuals leaving clinical services.

During discussion, the Chair reflected on the tangible benefits of the programmes within his own local area, citing specific examples of funded initiatives and the high level of community engagement observed. Other members of the Board welcomed the evaluation and its findings, particularly the emphasis on trust-building and community-led approaches.

District Cllr Georgina Heritage raised a question regarding the methodology of the household survey, specifically seeking clarification on response rates. Professor Charters confirmed that while 1,600 households had been visited, detailed responses had been obtained from 225 households through in-person engagement, noting that this approach had generated rich qualitative data, particularly from individuals who might not otherwise engage through traditional consultation methods.

The Chair and other members emphasised the importance of viewing the programmes as part of a broader system response to entrenched inequalities, noting that deprivation was shaped by long-term structural factors and that the role of such programmes was to contribute to incremental change and improved outcomes for residents.

Members also reflected on the wider implications for system working, noting that the findings reinforced the importance of co-production, community engagement, and integration with other elements of the health and care system, including neighbourhood models and voluntary sector partnerships.

The Board RESOLVED to:

1. **SUPPORT** the promotion and sharing of the findings from the evaluation of the Oxfordshire County Council-funded Community Health Development Officer (CHDO) programme and the Thames Valley ICB-funded Well Together programme, with partners and

colleagues across the system.

193 Oxfordshire Joint Strategic Needs Assessment 2026
(Agenda No. 7)

Craig Miles-Clarke (Senior Research Officer, Oxfordshire County Council) presented a report on the Oxfordshire Joint Strategic Needs Assessment (JSNA) for 2026.

Since the previous iteration of the JSNA, additional support and resources had been developed to improve usability. These included training sessions delivered across multiple teams within the County Council, as well as the production of three public-facing videos available via the Oxfordshire Data Hub. These resources were intended to support users in navigating the increasingly digital format of the JSNA, particularly the interactive Power BI dashboards that had been introduced.

The Senior Research Officer summarised the findings of a recent user feedback survey conducted following the 2025 JSNA, and reported that the majority of users felt confident navigating the JSNA and expressed a preference for the blended format, which combined interactive dashboards with traditional narrative reports. Users had indicated that data was generally easy to find, although there had been mixed feedback regarding the effectiveness of training provision, with some respondents suggesting that further improvements were required.

Turning to the proposals for the 2026 update, it was confirmed that the blended format would be retained, with continued use of interactive dashboards alongside downloadable narrative reports for each thematic chapter. It was explained that content development would be guided by the JSNA steering group, which would review existing indicators and consider new areas for inclusion based on public health need, strategic alignment, and capacity. The 2025 JSNA had included approximately 435 indicators, and future development would involve prioritisation to ensure the assessment remained focused and usable.

The Senior Research Officer drew attention to three proposed areas of focus for the 2026 JSNA. These included an updated and expanded section on inclusion health groups, further development of data and research relating to homes and health, and an update to the gambling harms section, which had last been refreshed in 2024. The importance of the JSNA in supporting Oxfordshire’s status as a Marmot Place was also emphasised, particularly in improving understanding of health inequalities across the county.

Chris Wright (Associate Director of Oxfordshire Place, Thames Valley ICB) expressed appreciation for the work undertaken in developing the JSNA, and noted that he had been involved in the previous year's process and considered it to have been well executed. They highlighted the value of the JSNA and wider data resources hosted by the County Council, particularly from an NHS and healthcare planning perspective, and emphasised their usefulness for both professionals and the wider public.

Michelle Brennan echoed these comments, noting that she had made frequent use of the JSNA dashboards in her work on neighbourhood initiatives. She described the tools as highly useful and welcomed the continued development of the digital format.

The Board RESOLVED to:

1. **NOTE** and Provide feedback on the proposed design of the 2026 Joint Strategic Needs Assessment (JSNA).

2. **ADVISE** on the content of the 2026 JSNA, approach, and to highlight any additional topics and themes of research and intelligence interest that they would like to see included.

3. Via relevant officers in their organisations, **CONTRIBUTE** information and intelligence to the JSNA to further its development and participate in making information more accessible to everyone.

194 Health & Wellbeing Strategy Update- Start Well

(Agenda No. 8)

Lisa Lyons (Director of Children's Services, Oxfordshire County Council) and Annette Perrington (Deputy Director of Education and Inclusion) presented the Start Well Update report.

The item was introduced by Councillor Sean Gaul (Chair of the Children's Trust Board), who emphasised that this was a significant and ambitious programme of work focused on improving early years outcomes and reducing inequalities in child development across Oxfordshire.

Councillor Gaul reflected on the persistent inequality in outcomes for young children, noting that children eligible for free school meals were currently achieving a 'good level of development' at a significantly lower rate than the wider population. He explained that previous national targets would have improved outcomes overall but would not have sufficiently narrowed this gap. As a result, local partners had set a more ambitious target to reduce the inequality gap from approximately 30% to 20%. He described this as a major system commitment which, if achieved, would have a substantial positive impact on children's life chances.

Cllr Gaul explained that a detailed and robust delivery plan was being developed, bringing together system partners through the Children's Trust Board. He proposed that the Board delegate responsibility for overseeing delivery and monitoring progress to the Children's Trust Board, which would act as a coordinating body to ensure that all partners had the necessary support to contribute to achieving the target. He stressed that this work represented a transformative opportunity for Oxfordshire and required sustained commitment across organisations.

Lisa Lyons (Director for Children's Services, Oxfordshire County Council) provided an overview of the report. She explained that the Start Well work encompassed a wide range of programmes and reforms, including the Family First reforms, Special Educational Needs and Disabilities (SEND) reforms, anti-poverty strategies, and changes to national education policy. She highlighted that the plan also incorporated the Best Start in Life programme, Family Hub and Youth Hub rollouts, and work on emotional health and wellbeing.

The Deputy Director for Education and Inclusion noted that there was now a stronger alignment of national and local focus on early years than had previously been the case, and that Oxfordshire's status as a Marmot Place had supported a deeper understanding of the drivers of inequality in early childhood development.

The Executive Director of Healthwatch Oxfordshire asked how the Family Hubs model would ensure accessibility for families in rural areas. She highlighted concerns regarding geographic barriers and the ability of rural residents to access centralised services. In response, the Deputy Director for Education and Inclusion explained that the model would include a combination of district hubs, satellite provision, and pop-up services delivered within local communities. She outlined that existing community assets, including voluntary, community and faith sector organisations, would be utilised to extend reach into rural areas.

Discussions ensued regarding the measurement of impact for specific initiatives within the plan, including programmes such as the LIFT initiative (supporting low-income families) and oral health interventions such as supervised tooth brushing. The question was raised as to how the system would ensure that these interventions resulted in measurable improvements rather than simply identifying need.

Lisa Lyons responded by explaining that a combination of short-term and longer-term metrics would be used. For example, uptake and participation in programmes could be tracked immediately, while longer-term outcomes, such as improvements in oral health or reductions in inequality, would require longitudinal measurement.

The Deputy Director for Education and Inclusion added that the programme would aim to replicate the universal elements of earlier initiatives such as Sure Start, where services had been made widely available to all families, thereby raising the baseline level of wellbeing across the population.

The Board RESOLVED to:

1. **NOTE** the progress of the delivery of priorities 1 and 2 under the thematic domain of Start Well within the Health and Wellbeing Strategy along with key challenges.

2. **NOTE** the Best Start in Life plan, attached as an appendix to this report, and:

   a. **DELEGATE** responsibility for regular monitoring of progress on outcomes relevant to the Best Start in Life Plan to the Children's Trust Board;

   b. **NOTE** that those outcomes will include the inequality of Good Level of Development (GLD) outcomes for children eligible for free school meals; and

   c. **NOTE** that the Children's Trust Board will report to the Health and Wellbeing Board on this matter as part of these annual Start Well updates and as required for escalation.

195 Oxfordshire Better Care Fund Plan (2026-27)

(Agenda No. 9)

Karen Fuller (Corporate Director for Adult Social Care, Oxfordshire County Council) and Isabel Rockingham (Head of Joint Commissioning – Age Well) presented the Oxfordshire Better Care Fund (BCF) Plan for 2026–2027.

It was emphasised that the BCF remained a central mechanism for delivering integrated health and social care across Oxfordshire. She described the plan as a genuinely co-produced document developed jointly by the County Council, the Thames Valley ICB, and wider system partners. The purpose of the plan was to align investment across organisations in order to improve outcomes, support independence, and deliver more seamless care for residents.

The key strategic focus for the coming year was the continued shift from acute hospital-based care towards more preventative, community-based provision. This aligned with the broader ambition of the “Oxfordshire Way” and the emerging neighbourhood model of care, both of which aimed to support people to remain independent and well in their own communities for longer. The Head of Joint Commissioning – Age Well provided a detailed overview of the plan. She explained that 2026–2027 was being treated as a transition year ahead of anticipated national reform of the Better Care Fund in 2027–2028. As a result, there were no major structural changes to funding in the current year, and the focus had instead been on stabilising performance, strengthening alignment with neighbourhood working, and preparing the system for future reform. The Head of Joint Commissioning – Age Well outlined the four key priority areas within the plan. She reported that admission avoidance remained a central priority, with Oxfordshire having achieved a 3% reduction in non-elective hospital admissions for people aged over 65 in the previous year, equivalent to approximately 800 fewer admissions. This had been supported by services such as the Single Point of Access and enhanced clinical triage systems through 111 and 999 services. She noted that continued investment in these services would seek to build on this success. She then addressed the area of hospital discharge and system flow, noting that while Oxfordshire had maintained strong performance in enabling timely discharge, there had been an increase in delays due to the rising complexity of patients and workforce challenges. In response, the plan included additional investment in staffing capacity, intermediate care provision, and digital tools to improve discharge processes and reduce administrative delays. Finally, it was emphasised that the BCF remained a system-owned plan, with shared governance and jointly funded roles across organisations. It was also explained that a system-wide finance schedule had been developed to improve transparency and support longer-term planning, particularly in anticipation of national changes to funding arrangements. Karen Fuller also addressed the issue of rural service delivery, explaining that new models of home care provision had been introduced, including locality-based arrangements where providers operated within specific geographic areas. She reported that this had improved the availability of home care and increased overall capacity by approximately 25%, demonstrating a	

successful response to the challenges of delivering services in rural communities.

Michelle Brennan emphasised the importance of a more preventative approach across the system. She reflected that historically, services had focused disproportionately on the most complex and frail individuals, whereas greater long-term impact could be achieved by supporting people earlier in their health journey. She highlighted the need to focus on individuals who were currently well, or at risk of developing long-term conditions, to prevent progression to frailty and reduce overall system demand.

The Board RESOLVED to:

1. **NOTE** and **APPROVE** the direction of travel set out in this report for the Oxfordshire Better Care Fund Plan for 2026/27 and the decision-making process set out at paragraph 14 of the report.

2. **APPROVE** the Oxfordshire Better Care Fund Plan for 2026/27 and decision on the assurance statements set out at paragraph 19 (of the main report for this item) for submission by 19th May 2026.

196 Oxfordshire Combating Drugs Partnership Annual Report

(Agenda No. 10)

Tom Addey (Public Health Registrar), Oxfordshire County Council) and Sam Read (Public Health Programme Manager, Oxfordshire County Council) presented the Oxfordshire Combating Drugs Partnership Annual Report.

The Public Health Registrar provided the context for the work of the Combating Drugs Partnership. The partnership brought together a wide range of organisations across the system, including public health, NHS partners, the police, and voluntary sector organisations, to address drug and alcohol-related harm across Oxfordshire.

The key findings of the needs assessment which underpinned the report were highlighted. Oxfordshire generally performed better than national averages on measures such as drug-related deaths, hospital admissions, and engagement with treatment services, these headline figures masked significant inequalities within the county. Patterns of harm varied between districts, with some areas experiencing disproportionately higher levels of alcohol-related hospital admissions. Specific areas of concern, including

the impact of parental substance use on children and young people, declining engagement with treatment services among younger cohorts, and emerging threats such as synthetic opioids and increasing ketamine use were also highlighted.
Increased access to drug and alcohol treatment services, and support for those leaving prison were highlighted as particular achievements over the last year.

Reference was made to the partnership’s task and finish groups, which focused on specific priorities such as reducing drug-related deaths, improving outcomes for children and young people, and strengthening links between substance use and mental health services. While progress had been made in strengthening referral pathways and partnership working, engagement with children and young people remained a significant challenge.

In response to the report, the Board engaged with a number of key issues, including exploring the difficulties of engaging children and young people with services. Officers provided recognised the multiple barriers which existed, and reiterated the crucial role of ensuring services which were delivered relationally, informally and non-judgementally. To support this, the service was already delivering outreach in locations such as schools, cafés, and youth clubs, and had increased activities such as walking sessions to engage young people in less formal settings. They emphasised that the service was also developing a digital front door to enable young people to access support more easily and was undertaking a co-production exercise with young people to better understand their needs and preferences.

The Board RESOLVED to:

1. **NOTE** the activities and outcomes of the Oxfordshire Combatting Drugs Partnership, reflected in the Annual Progress Report in Annex 1.

197 Health & Wellbeing Strategy Indicator Review (Verbal Update)

(Agenda No. 11)

Kate Holburn (Deputy Director of Public Health, Oxfordshire County Council) provided a verbal update on the proposed review of the Health and Wellbeing Strategy indicators. The item focused on the need to refresh and rationalise the current framework of indicators used to monitor progress against the Health and Wellbeing Strategy, which had been launched in 2024.

Feedback had been gathered from partners across the system regarding the effectiveness and usability of the existing indicator set. There was a growing concern that several indicators had become outdated, were difficult to source reliable data for, or no longer adequately reflected the work currently being undertaken across the system. The existing list of indicators was extensive and, in some cases, lacked clarity or focus, making it difficult for partners to use the framework effectively in performance reporting and strategic oversight.

Kate Holburn set out that, in response to this feedback, she intended to lead a structured review of the indicator framework in collaboration with the Public Health Intelligence team and the Council’s Performance and Insight team. She explained that the primary objective of the review would be to develop a more streamlined and coherent set of indicators, which would be both meaningful and practical for partners to use.

She emphasised that the revised framework would be significantly more concise, with a clearer hierarchy. Under the proposed approach, each strategic priority within the Health and Wellbeing Strategy would be supported by a small number of overarching outcome indicators. These would then be supplemented, where necessary, by more detailed process and supporting indicators within individual reports, enabling a more proportionate and focused approach to performance monitoring.

A key element of the proposed review was the intention to align the indicator set more closely with Marmot principles and outcomes.

The review would take place over the coming months, with a comprehensive written report to be brought back to the Health and Wellbeing Board. This was likely to be in September, in order to allow sufficient time for detailed analysis and engagement with partners.

The Board RESOLVED to:

1. **NOTE** and **SUPPORT** the plans to review the Health and Wellbeing Strategy indicators.

2. **AGREE** that a revised framework would be brought back for formal consideration at a future Board meeting.

198 Marmot Place Update (Verbal)

(Agenda No. 12)

Kate Holburn (Deputy Director of Public Health, Oxfordshire County Council**)**, presented the Marmot Update.

Kate Holburn reminded the Board that Oxfordshire had formally adopted the Marmot Place approach as a framework for tackling the wider determinants of health, with a particular focus on reducing entrenched inequalities across the county. She emphasised that this approach required a whole-system response, extending beyond health and social care services to include housing, transport, employment, and community development. It was explained that a key strand of the work had been direct engagement with communities, particularly in areas experiencing higher levels of deprivation or disadvantage. This had included engagement with over 700 residents across a range of urban and rural communities. This engagement had provided valuable insight into lived experience, highlighting issues such as access to services, cost of living pressures, transport barriers, housing quality, and social isolation. One of the most important findings was the clear variation in experience across different parts of the county, with rural communities often facing distinct challenges compared to urban areas. While deprivation in Oxfordshire was often described as relatively low compared to national averages, this masked significant pockets of inequality, which required targeted and locally informed responses. Work was also ongoing to align Marmot principles with the Health and Wellbeing Strategy, the Better Care Fund, and emerging neighbourhood models of care. This included efforts to ensure that all major programmes considered their impact on health inequalities and incorporated a stronger focus on prevention. Chris Wright (Associate Director for Oxfordshire Place, Thames Valley ICB) asked how Marmot principles were being translated into operational delivery within NHS services. Kate Holburn responded by explaining that this remained a key area of focus, and that work was ongoing with NHS partners to develop practical approaches to embedding Marmot principles. She highlighted that Integrated Neighbourhood Teams were seen as a critical mechanism for achieving this, by enabling a more proactive and preventative model of care that was closely aligned with community needs. The Executive Director of Healthwatch Oxfordshire queried how community voice and lived experience were being incorporated into the Marmot programme. She emphasised that engagement should not be limited to one-off exercises and that there was a need to ensure ongoing involvement of communities in shaping services and priorities.	

Kate Holburn responded that strengthening community engagement was a central objective of the Marmot work. She explained that the intention was to move towards more sustained and meaningful participation, including building relationships with community organisations and supporting community-led research.

Cllr Sean Gaul reflected on the connection between the Marmot work and the Start Well programme. He noted that many of the inequalities identified through the Marmot analysis were evident from early childhood and emphasised the importance of early intervention in reducing long-term disparities. He expressed support for the alignment between these programmes and stressed the need to maintain a strong focus on children and young people within the Marmot framework.

In concluding the discussion, the Chair reflected on the importance of the Marmot approach as a unifying framework for addressing health inequalities across the system. He noted that the update demonstrated both the complexity of the challenges faced and the progress that had been made in building a shared understanding of those challenges.

The Board RESOLVED to:

1. **NOTE** the Marmot Place Update.

199 Neighbourhood Health Plan Update (Verbal)

(Agenda No. 13)

Michelle Brennan (Oxfordshire GPs representative) presented the Neighbourhood Health Plan update.

It was explained that the Neighbourhood Health Plan formed a central component of the system’s ambition to shift towards a more preventative, integrated, and locally responsive model of care. The concept of neighbourhood health was intended to bring together services across primary care, community services, adult social care, mental health, and the voluntary sector, organised around defined local populations and tailored to the specific needs of those communities.

Michelle Brennan emphasised that this was not a wholly new initiative, but rather an evolution of existing partnership working, seeking to build on established relationships and structures. She noted that significant work had already taken place to define neighbourhood footprints and to begin aligning services within those footprints.

The next phase of work would focus on strengthening Integrated Neighbourhood Teams, improving data sharing, and ensuring that services were coordinated more effectively at a local level. There was also a strong emphasis on prevention, with neighbourhood models expected to play a key role in identifying individuals at risk of poor health outcomes and intervening earlier. Chris Wright (Associate Director of Oxfordshire Place, Thames Valley ICB) enquired about the operationalisation of Integrated Neighbourhood Teams. He asked how the system intended to overcome existing organisational and professional boundaries, particularly in relation to workforce arrangements and accountability structures, which could present barriers to truly integrated working. Michelle Brennan responded by acknowledging that these challenges were well recognised. She explained that progress would depend on establishing shared objectives, strengthening relationships between organisations, and creating opportunities for joint working at a local level. She noted that while formal structural changes might take time, there was already progress being made through co-location of teams, joint meetings, and collaborative service planning. Karen Fuller noted that adult social care services were already operating at a locality level and were well positioned to contribute to neighbourhood working. She emphasised that social care had longstanding experience of working in a place-based way and that this expertise should be built upon as part of the development of Integrated Neighbourhood Teams. She also highlighted the importance of aligning eligibility criteria and access pathways to support more seamless services for residents. Cllr Sean Gaul then reflected on the importance of ensuring that children and young people were fully integrated within neighbourhood models. He noted that services for children were often planned and delivered separately from adult services, and he emphasised the need to take a more whole-family approach, particularly in the context of early intervention and prevention. The Board RESOLVED to: 1. **NOTE** the Neighbourhood Health Plan update.	

200 Report from Healthwatch Oxfordshire

(Agenda No. 14)

Veronica Barry (Executive Director of Healthwatch Oxfordshire) presented the Healthwatch Oxfordshire update.

It was emphasised that Healthwatch's work complemented the wider system's approach to community engagement, particularly within the context of the Marmot Place programme and neighbourhood working, but also provided a distinct and independent perspective grounded in lived experience.

The Executive Director of Healthwatch Oxfordshire highlighted key areas of work undertaken over the previous period and explained that Healthwatch had continued to engage with a wide range of communities across Oxfordshire, including groups who were traditionally underrepresented in consultation exercises. This had included targeted work with minority ethnic communities, individuals experiencing socioeconomic disadvantage, and those with limited access to services due to geographic or social barriers.

The Executive Director of Healthwatch Oxfordshire also placed particular emphasis on the development of a community research approach, explaining that Healthwatch had been working with local groups to support them in undertaking their own research into issues affecting their communities.

It was explained that early findings from this work reinforced many of the themes identified through other system initiatives, including the importance of trust, accessibility, and the wider determinants of health. Residents often spoke about health in terms of their broader life circumstances, including housing, employment, and social connection, rather than purely in terms of clinical services.

District Cllr Rob Pattenden asked how insights from rural communities were being captured, given the challenges associated with engaging residents in more isolated areas.

The Executive Director of Healthwatch Oxfordshire responded that Healthwatch was actively seeking to engage with rural communities through a range of approaches, including outreach activity, partnership working with local organisations, and attendance at community events. She acknowledged that this required additional effort but emphasised the importance of ensuring that rural voices were represented within the evidence base.

The Chair reflected on the critical role of Healthwatch in ensuring that the system remained accountable to residents. He noted that the report demonstrated the value of independent community insight and highlighted the importance of ensuring that this intelligence was effectively integrated into decision-making processes.

The Health Scrutiny Officer explained that the Board's Independent Patient Voice working group was continuing its work to explore a future local patient voice function in light of government's intention to proceed with its originals plans to abolish the Healthwatch function.

The Board RESOLVED to:

1. **NOTE** the Healthwatch Oxfordshire update.

201 Reports from Partnership Boards

(Agenda No. 15)

Children's Trust Board:

Cllr Sean Gaul (Chair of the Children's Trust Board) represented the Children's Trust Board update.

Cllr Sean Gaul reiterated the Board's ongoing focus on improving early years outcomes and reducing inequalities in child development, noting that this work was closely aligned with the 'Start Well' priorities considered earlier in the meeting. He emphasised that partners across education, health, and social care were increasingly working in a coordinated way through the Children's Trust Board to deliver the Best Start in Life programme, and that there was a strong collective commitment to achieving the more ambitious local targets that had been set.

Cllr Sean Gaul explained that recent discussions within the Children's Trust Board had focused on improving system-wide accountability and ensuring that delivery plans were clearly owned across organisations. He highlighted that progress was being monitored through a structured framework, with particular attention being given to narrowing inequalities in early years development outcomes.

Oxfordshire Place-Based Partnership:

Michelle Brennan provided an update on the Oxfordshire Place-Based Partnership. She explained that the Partnership continued to act as the primary forum for coordinating NHS and system planning at place level, bringing together the Integrated Care

Board, local authority, and provider organisations. She highlighted that the Partnership had been focusing on delivering integrated care models, improving system flow, and responding to operational pressures, while maintaining alignment with longer-term transformation priorities such as neighbourhood working and prevention.

Michelle Brennan noted that a key area of recent work had been the development of commissioning intentions at system level and their alignment with local needs. She emphasised that the Partnership was increasingly using population health data and community insight to inform planning decisions, and that there was a continued emphasis on improving access to services and addressing health inequalities. She also reflected on the importance of ensuring that system-wide decision-making remained responsive to the needs of local communities.

The Board RESOLVED to:

1. **NOTE** the updates from the Children's Trust Board and the Place-Based Partnership, recognising that the Health Improvement Board had not yet convened and could therefore not provide an update.

202 Forward Work Plan

(Agenda No. 16)

The Board RESOLVED to:

1. **NOTE** the forward work plan.

2. **AGREE** to **DELEGATE** to the Health Scrutiny Officer and Deputy Director of Public Health to make minor amendments to the work plan offline if need be.

.... in the Chair

Date of signing ....

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HEALTH AND WELLBEING BOARD

DATE: 09 JULY 2026

ALL-AGE AUTISM STRATEGY AGREEMENT

Report by Karen Fuller, Director of Adult Social Care

1. RECOMMENDATION

The Board is **RECOMMENDED** to:

1.1 Endorse the Oxfordshire All-Age Autism Strategy 2026-2031, approve its publication and implementation, and agree the contents and principles set out in the strategy. (**Annex 1**)

1.2 Note that LGR may affect delivery of the Oxfordshire All-Age Autism Strategy 2026-2031 by changing system-wide governance, leadership and funding arrangements. While this may cause delays, it also provides an opportunity to strengthen partnership working and improve service alignment.

2. Executive Summary

2.1 The Oxfordshire All-Age Autism Strategy 2026-2031 has been developed and shaped through wide consultation and co-design with autistic individuals, families, professionals and experts by experience. It was developed in response to national policy and statutory requirements. Local evidence and needs assessments for autistic people across the county also informed the content of the strategy.

2.2 The strategy responds to a range of long-standing issues affecting autistic people and their families, including long waits for diagnosis, fragmented and overstretched voluntary and community sector support, limited awareness of available provision among the public and professionals, barriers to education, employment and community life, and inconsistent understanding of autism across sectors. Needs analysis undertaken in 2024 and 2025 confirmed continued health inequalities, poor coordination between services, and difficulties for families and autistic adults in navigating available support.

2.3 To create meaningful change, the strategy commits to reducing diagnostic waits, expanding employment pathways, strengthening education and SEND practice, preventing unnecessary hospital admissions, and improving housing and transitions. It also emphasises the importance of reasonable adjustments that respond to each person's individual needs, helping autistic people to access services, take part in their communities, and get on with everyday life with greater independence, dignity and confidence. The strategy will be delivered through existing and developing partnerships across Oxfordshire County Council, the NHS, education providers, voluntary groups, and organisations representing autistic people and families.

2.4 Oversight is provided by a countywide Autism Improvement Board, co-chaired by the Head of Joint Commissioning – Live Well and an Expert-by-Experience. The Board brings together autistic people, families, health, education, social care, voluntary and community sector partners to oversee delivery, monitor progress and risks, and provide shared accountability for the six thematic subgroups responsible for taking forward the strategy's priority areas.

2.5 The strategy recognises that progress will require long-term commitment, cultural change, sustained partnership working and shared responsibility across all sectors supporting autistic people in Oxfordshire. It has been co-designed over several months, with the voices of autistic people central to its development, and shaped by input from more than 200 professionals, autistic individuals, experts by experience, family members and sector leaders.

2.6 The Health Overview and Scrutiny Committee considered the Strategy on 16 April 2026 and made recommendations to strengthen the final document and delivery arrangements. Officers have prepared a formal written response setting out how each recommendation has been addressed, including amendments to the strategy and actions to be taken forward through implementation. This provides assurance that scrutiny feedback has informed the final strategy and is attached at **Annex 2**.

3. Background

Policy and Evidence.

3.1 The Oxfordshire All-Age Autism Strategy 2026-2031 has been developed in response to current national policy expectations and statutory requirements, alongside local needs and clear evidence of poorer outcomes for autistic people. The National Strategy (National strategy for autistic children, young people and adults: 2021 to 2026 - GOV.UK) sets out expectations for all local areas to improve support, reduce inequalities, and ensure more consistent pathways across health, education and social care.

3.2 Earlier transformation work and pooled-budget arrangements have helped build an initial base for joint commissioning and closer working between social care and health. However, autistic people and families across Oxfordshire consistently highlight systemic issues such as:

- Long waits, unclear pathways and inconsistent communication around diagnosis
- Limited community understanding and persistent stigma or misconceptions
- Overstretched or fragmented education, health and social care systems
- Barriers to employment and risk of exclusion from the workforce
- Poor accessibility in healthcare and inconsistent use of reasonable adjustments

- Poorly managed transitions, such as moving into adulthood or between services

3.3 Local evidence shows clear gaps in support, including long waits for diagnosis, fragmented services, poor access to support and limited autism awareness in the community. The SCIE needs assessment, undertaken between July 2024 and January 2025, confirmed these issues and identified the following key themes for autistic people and families in Oxfordshire (**Annex 3**):

- Autistic people experience health inequalities and poorer access to timely, coordinated support.
- Diagnosis pathways remain a key pressure, with long waits and inconsistent communication across age groups.
- Services are fragmented, making it difficult for autistic people and families to understand pathways and navigate support.
- Awareness and understanding of autism vary across services, highlighting the need for more consistent reasonable adjustments.
- Barriers remain in education, employment, housing, health and community participation.
- Transitions between services and life stages can increase risk and lead to poorer experiences.
- SCIE recommended embedding autism priorities across commissioning, care, housing, education and co-production, aligned with wider local plans.

Approach to strategy development and implementation

3.4 The strategy is grounded in neuro-affirmative, rights-based and strength-focused principles. It commits to:

- Co-design at all stages
- Trauma-aware practice
- Removing environmental barriers rather than expecting autistic people to change
- Using respectful, neuro-affirming language
- Moving away from functioning labels and deficit-based models. This approach recognises autism as a lifelong identity and emphasises autonomy, safety, belonging and dignity.

3.5 The strategy has been developed and will be delivered in partnership with Oxfordshire County Council, local NHS partners, education, children’s services, the voluntary and community sector, and groups representing autistic people, carers and families. Existing partnerships will be strengthened and new partnerships formed to support delivery and improve outcomes for autistic people across Oxfordshire.

3.6 Co-design has been central throughout the development of the strategy. Engagement activities have included:

- Targeted engagement and wide public consultation, including surveys, events and the needs assessment, led to the first draft of the strategy being reviewed and further developed.
- A countywide event was held on 4 December 2025 to review the first draft. More than 100 participants provided detailed feedback on priorities, lived experience and barriers to support.
- Ongoing involvement through fortnightly working groups, including autistic adults, families, carers, professionals from children's and adult services, and provider organisations. Review sessions with working group members focused on specific areas to further refine the strategy, including positive reinforcement of the language, structure and accessibility of the strategy.

Strategic intentions.

3.7 The Oxfordshire strategy identifies six priority areas for improvement across all ages:

- Community awareness
- Housing and employment
- Health and social care
- CYP/Education-centred support
- Diagnosis
- Criminal justice systems

3.8 The strategy's key intention is to work with partners to influence and drive system-wide change, rather than create all services directly. It aims to make support for autistic people and their families clearer, more accessible and better coordinated across Oxfordshire. Through partnership working, it will support reductions in diagnostic delays, improve pathways, increase community awareness, strengthen reasonable adjustments, improve access to health and care, and promote better outcomes in employment, housing and life transitions. It will also ensure autistic people and families have a stronger voice in shaping services through ongoing co-design and representation.

3.9 Feedback from autistic people and families through engagement and consultation highlighted the need for clearer support pathways, better communication, stronger community inclusion, and practical guidance for organisations and staff.

Implementation and assurance for delivery.

3.10 Overall governance for delivery of the Oxfordshire All-Age Autism Strategy 2026-2031 is provided through a countywide Autism Improvement Board, co-chaired by the Head of Joint Commissioning (Live Well) and an Expert by Experience, with representation from autistic people, families, health, education, social care, voluntary and community sector partners. This approach emphasises:

- Clear oversight of the strategy implementation and monitoring of progress
- Monitoring progress of wait times and service quality

- Evidence-informed priorities and shared leadership between key partners
- Stronger joint working across health, education, social care and community sectors
- Workforce training and confidence building
- Use of lived experience and data to drive continuous improvement

3.11 The governance approach is based on co-design, shared ownership and partnership delivery. Implementation must be managed within existing resources and the agreed financial envelope.

3.12 The strategy acknowledges that meaningful change requires long-term commitment, cultural transformation, and collective responsibility across all partners.

3.13 The Autism Improvement Board will oversee delivery, monitor progress and risks against a co-designed annual delivery plan (**Annex 4**) and support shared accountability across the system. This is complemented by thematic task-and-finish groups leading specific priority areas, ensuring that implementation remains co-designed, evidence-informed and aligned with wider partnership and integrated care arrangements.

3.14 Significant risks, delivery barriers or decisions that cannot be resolved by the Autism Improvement Board will be escalated through the Senior Responsible Officer, the Director of Adult Social Care, to the Joint Commissioning Executive and the Thames Valley Learning Disability and Autism Programme Oversight Board. These governance arrangements are being finalised and will be confirmed before the strategy is launched. Regular project management meetings and the Autism Strategy Working Group will support coordination. (**Annex 5**)

3.15 Updates may also be provided to the Joint Health Overview and Scrutiny Committee and the Place Based Partnership, as required during delivery of the strategy, through the Senior Responsible Officer.

4. Key Issues [Corporate Policies and Priorities]

4.1 The Oxfordshire All-Age Autism Strategy 2026-2031 will help Oxfordshire County Council achieve the priorities set out in the council's Strategic Plan:

- Tackling inequalities in Oxfordshire
- Prioritise the health and wellbeing of residents
- Support carers and the social care system

4.2 Oxfordshire County Council has a general responsibility when exercising its functions under the Care Act 2014 in respect of an individual, to promote that individual's 'well-being', as defined by Section 1 of the Act.

4.3 In doing so, the local authority must have regard to several general principles set out in Section 1(3) of the Act, including the importance of beginning with the assumption that the individual is best placed to judge their own well-being. By encouraging engagement in its consultation and the development of the All-Age

Autism Strategy 2026-2031, Oxfordshire County Council is seeking to ensure that people who use services can contribute to decision-making in a meaningful way.

4.4 The Act further requires that the authority meets the assessed eligible needs of those with care and support needs in its area, in the way that best promotes that individual's well-being and prevents or reduces the need for care and support. It is anticipated that the development of this strategy will ensure that the Council meets those statutory responsibilities in an effective and person-centred way.

5. Financial Implications

5.1 There are no financial implications that the Health and Wellbeing Board is asked to note in relation to this report, noting the effect LGR may have on the funding arrangements across the system.

Completed by:
Stephen Rowles, Strategic Finance Business Partner,
Stephen.rowles@oxfordshire.gov.uk

6. Legal Implications

6.1 The Oxfordshire All-Age Autism Strategy 2026 sets out the council's response to the National Strategy for Autistic Children, Young People and Adults: 2021–2026, issued pursuant to the Autism Act 2009 and supporting statutory Guidance.

6.2 Oxfordshire's Strategy details how the council will exercise its responsibilities under relevant legislation, (such as the Care Act 2014, Children and Families Act 2014 and wider equality duties), with its partners, to provide a clear, lawful and coordinated framework to meet the needs of autistic children, young people and adults, in its area.

Completed by: Janice White, Principal Solicitor, ASC, SEND and Education

7. Staff Implications

7.1 There are no Council staff implications arising from the implementation of the All-Age Autism Strategy 2026-2031.

8. Equality & Inclusion Implications

8.1 An Equality Impact Assessment has been completed for the Oxfordshire All-Age Autism Strategy 2026-2031 (**Annex 6**) and approved by the Deputy Director of Joint Commissioning HESC. Regular reviews will be carried out to ensure that the plan continues to promote inclusivity and that equality is considered across all areas of life for autistic people.

9. Sustainability Implications

9.1 The All-Age Autism Strategy 2026-2031 is not expected to have any direct negative impact on Oxfordshire County Council's climate or ecological commitments. By improving access to local, coordinated and person-centred support, the strategy may contribute to wider social sustainability by helping autistic people and families access services more effectively, reduce avoidable crisis responses and support greater inclusion in community life.

10. Risk Management

10.1 Autistic people are at high risk of poor health and life outcomes, including delays and inconsistencies in diagnosis, fragmented education and support systems, barriers to employment, overrepresentation among the homeless, difficulties in accessing health and social care, ongoing stigma, inconsistent use of neuro-affirming language, and inadequate support during life transitions. The All-Age Autism Strategy 2026-2031 aims to mitigate these risks through:

10.1.1 Thematic task-and-finish groups will be established for the All-Age Autism Strategy 2026-2031. Experts by experience, organisations, service providers and other professionals will continue to be involved in delivering the plan. The groups will contribute to identifying and managing risks associated with implementation to support successful delivery.

10.1.2 The All-Age Autism Strategy 2026-2031 will be a standing agenda item for the Autism Improvement Board. A risk register will be managed and covered as part of updates provided to the Board, with escalations made as appropriate.

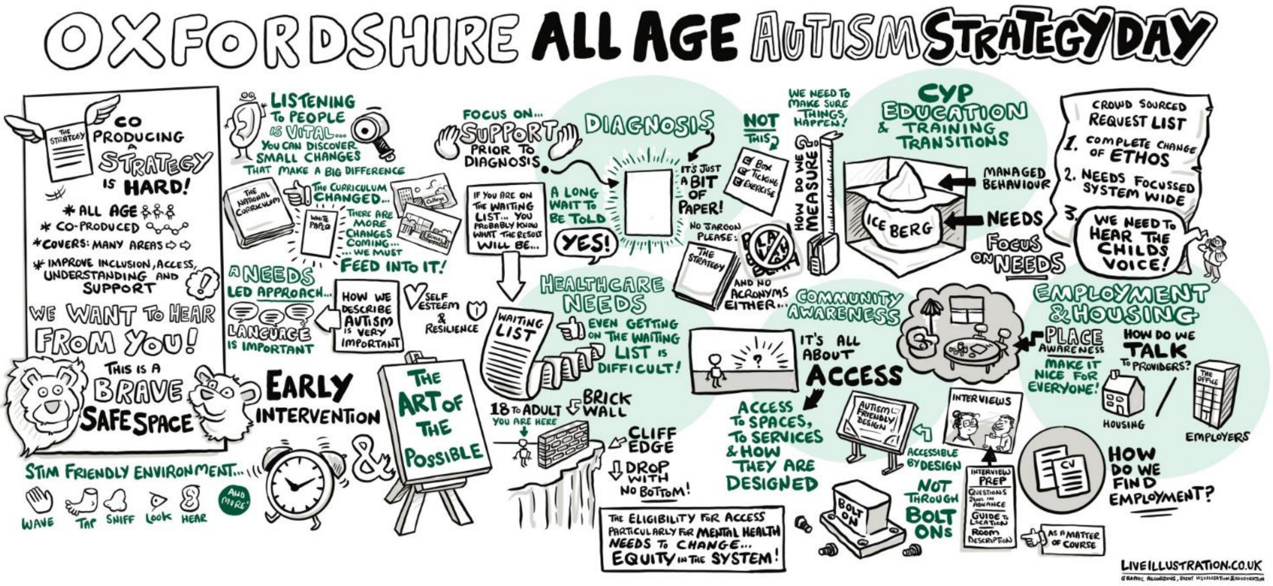
10.2 The strategy highlights several opportunities for positive change. Co-design with autistic individuals, families, and partners ensures that lived experience drives meaningful action, while a strengths-based, neuro-affirmative approach promotes belonging and empowerment. Prioritising inclusive education and employment practices, holistic and person-centred support, and improved autism-informed training for professionals can help address unmet needs and foster genuinely inclusive communities. Furthermore, increased community awareness, early identification and intervention, and strong governance—such as the establishment of an Autism Improvement Board—are expected to deliver continuous improvement, transparency, and better outcomes for autistic people across Oxfordshire.

11. Consultations/Communication

11.1 A Data Protection Impact Assessment was carried out prior to the engagement stage of the Oxfordshire All-Age Autism Strategy 2026-2031. **Annex 7**

11.2 The council's Engagement and Consultation Team has been actively involved in developing the Oxfordshire All-Age Autism Strategy 2026-2031. Consultation phases were carefully planned to support wider public engagement and co-design before the proposed publication of the final strategy.

11.3 A formal consultation on the strategy was completed through the Let's Talk Oxfordshire platform, alongside meetings with key stakeholders. More than 100 online survey responses were received. Seven in-person sessions were held across four sites and at a range of times, attended by autistic people and people who represent or work with autistic people. A further event was held in Oxford on 4 December, which attendees felt set new standards for inclusive events. This included a quiet space, sensory equipment and a comprehensive pre-attendance pack with images showing what to expect.



Karen Fuller
Director of Adult Social Care

Annex:	*Annex 1 – Strategy Document* *Annex 2 – HOSC outcome response* *Annex 3 – SCIE report from engagement in 2024/25* *Annex 4 – Year 1 delivery plan* *Annex 5 – Governance chart* *Annex 6 – EQIA* *Annex 7 - DPIA*
Background papers:	NIL
Other Documents:	NIL

Contact Officer: Derek Gravett-Smith
Strategic Commissioner – Live Well
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JUNE 2026

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Oxfordshire All Age Autism Strategy 2026

Introduction

Welcome to Oxfordshire's All-Age Autism Strategy.

This is a partnership strategy, jointly developed and owned by organisations, services and communities across Oxfordshire. It has been co-produced with autistic people and shaped through collaboration between:

- Oxfordshire County Council
- Thames Valley Integrated Care Board (TV ICB)
- Oxford Health NHS Foundation Trust
- Oxford University Hospitals NHS Foundation Trust (OUH)
- Oxfordshire Parent Carers Forum
- Autism Champions
- Response
- Experts by Experience

Every partner has played a role in developing this strategy. Autistic people, parent carers and other experts by experience will continue to contribute through co-production shaping, guiding and influencing this work.

Who this strategy is for

This strategy is for everyone.

Autistic people are part of every community in Oxfordshire in families, education settings, workplaces, neighbourhoods, public services and community groups. Creating an inclusive county is a shared responsibility, and this strategy provides direction for all of us.

It is for everyone involved in supporting, working with or designing services, environments or opportunities for autistic people.

It is also for wider communities because inclusion does not sit only within services. It sits in workplaces, leisure settings, places of worship, arts and cultural venues, public spaces, transport, friendship groups and everyday interactions.

This strategy invites the whole of Oxfordshire to help build a county where autistic people feel a strong sense of belonging and are supported to live the lives they choose.

Our shared vision for Oxfordshire

Our vision is a county where autistic people of all ages:

1. Are respected, understood and valued
2. Can access the right support without unnecessary barriers
3. Experience genuine belonging in their education settings, workplaces and communities
4. Feel safe, listened to, believed and empowered
5. Are supported to thrive, grow and live with autonomy
6. Have their strengths recognised and their contributions celebrated
7. Shape the decisions, services and environments that affect their lives

Achieving this vision requires sustained commitment and meaningful change across all services and communities. We will focus on early understanding, inclusive education, meaningful employment opportunities, and supportive networks for families. Our commitment is to create communities and services that recognise neurodivergence as a natural and valuable part of human diversity, and to ensure autistic people can flourish and reach their full potential.

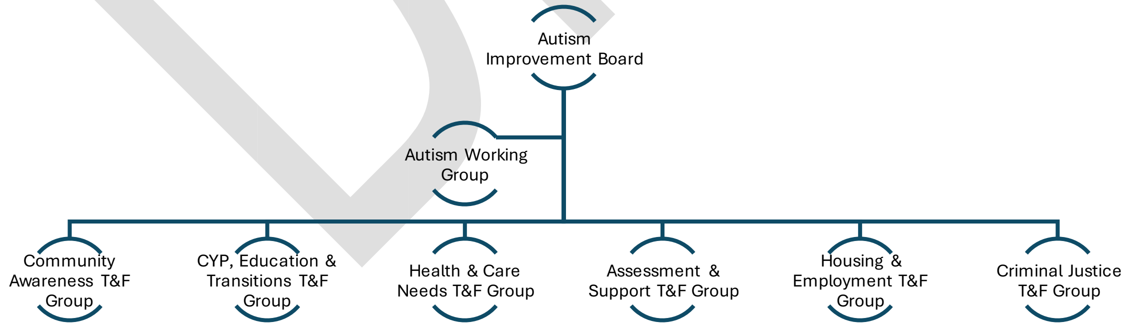
This strategy identifies six priority areas and the actions we will take to strengthen support, increase inclusion and improve outcomes for autistic people.

How will this be delivered?

This strategy will focus on six priority areas, each area will have ‘We Will’ statements, these are the pledges we make to the community. The ‘We Will’ statements may seem vague or broad; however, they are intentionally written this way to cover different and multiple actions.

To accompany this strategy document, an action plan has been created, each area is a heading and each ‘We Will’ statement is a subheading.

Below is the governance structure for the strategy and action plan:



The Autism Improvement Board - made up of experts by experience, professional representatives, service providers and system partners. This meeting is hosted by Oxfordshire County Council commissioners and co-chaired with an elected expert by experience.

Each area will have a task and finish group, that will include experts by experience and professionals. Each task and finish group will be responsible for delivering elements of the action plan and reporting progress to various channels.

Our Six Priority Areas

1. **Community awareness:** Promoting understanding and acceptance of autism throughout Oxfordshire, reducing stigma and building inclusive, welcoming environments for all.
2. **Supporting autistic children and young people in education, and positive transition to adulthood:** Ensuring autistic people can access the right learning pathways and are supported with the opportunities, adjustments and environments needed to thrive in education.
3. **Health and care needs:** Providing responsive, person-centred health and social care that reflects the unique strengths, experiences and needs of autistic people across their lives.
4. **Autism Assessment and Support:** Providing accessible pathways for diagnosis/confirmation. Ensuring clear, concise and concrete information is available to support autistic people and their families.
5. **Housing and employment:** Providing information for employers to ensure autistic people can access opportunities, adjustments and are supported in environments to thrive in employment. Increasing knowledge and support for autistic people to have sustainable housing, to maintain tenancies, exit homelessness and have a safe home environment.
6. **Criminal Justice system:** Autistic people will be supported through the criminal justice system, by providing early identification for support.

The following principles provide the foundation for this strategy and will be embedded throughout each area. They reflect our shared commitment to co-production, strengths-based approaches, sharing consistent and reliable information, and upholding the rights and dignity of autistic people of all ages.

- **Co-production:** Working in partnership with autistic people at every stage of planning, delivery and review.
- **Strength-based approaches:** Building on individual abilities and interests rather than focusing on perceived deficits.
- **Autism informed training:** Working with autistic people to create training/learning materials that are relevant to the autistic experience to create meaning change within the workforce.
- **Consistent information:** Providing consistent, reliable and concrete information, that is relevant to the whole system, in a centralised place for professionals, autistic people and their families to access easily when needed.
- **Rights and dignity:** Upholding the human rights of autistic people and challenging stigma, discrimination and harmful practices.
- **Shared learning and best practices:** Working together across the whole system, inclusive of Health, Social Care, Education, Criminal Justice and Voluntary Sector. Sharing experiences and best practices to enhance the lives of those who encounter services.

By embedding these principles, and working across Oxfordshire as a committed collective, we aim to create a culture that not only supports autistic people to thrive but also celebrates neurodivergence as an asset to our communities.

Being Autistic

Autism is described as a neurodevelopmental identity and a distinct way of experiencing and processing the world. It looks different for every autistic person, with each individual having their own unique sensory experiences, communication styles, patterns of thinking, movement and interests. Autism is an integral part of who a person is throughout their life and should be recognised, respected and supported as such.

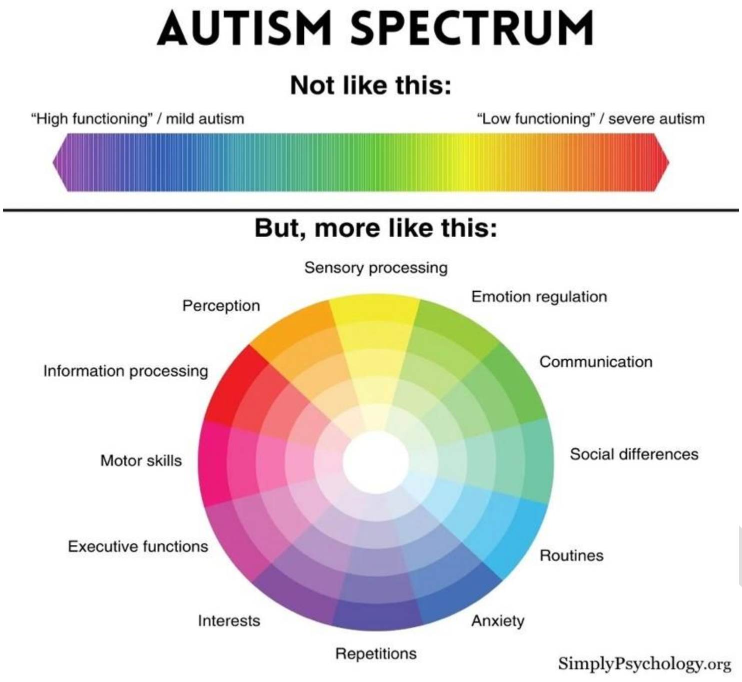
Understanding the autistic experience *(this can be referred to as the autism spectrum)*

Autism is often described as a spectrum, but it is sometimes misunderstood as a straight line from “mild” to “severe”. This is inaccurate and can lead to unhelpful assumptions about ability or support needs.

The autism wheel (see below) offers a more accurate and respectful way of understanding autistic experience. It illustrates that autistic people have varied strengths, support needs and intensities of experience across multiple areas, such as:

- sensory processing
- communication
- perception
- motor skills
- executive functioning
- emotion regulation
- routines
- interests
- anxiety
- information processing

This approach reflects that autistic people are not “more” or “less” autistic — they have individual profiles that can change over time and across different environments.



How we talk about Autism

It is important to recognise that the phrase *"we are all on the spectrum"* is unhelpful. While everyone has sensory preferences or communication differences, autism is a distinct neurotype, a specific way the brain processes information and experiences the world. Saying that everyone is "a bit autistic" can unintentionally minimise autistic people's lived experiences, mask real support needs, and blur the unique identity and culture of the autistic community. Autistic people have a recognisable pattern of strengths, challenges and neurological differences that should be understood in their own right, not diluted or generalised.

Functioning labels

Terms such as *high-functioning* or *low-functioning* are outdated and potentially harmful. They oversimplify complex experiences, mask support needs, and make assumptions based on outward behaviour. Instead, this strategy uses strengths-based and needs-based language, recognising that context and environment heavily influence how much support a person requires.

Terminology and neuro-affirming language

Language shapes how autistic people are understood. This strategy uses neuro-affirming language, recognising autism as an important part of identity. Many autistic people prefer identity first language, such as *"autistic person"*, rather than *"person with autism"*, because autism is not separate from who they are. However, language is personal and no single approach is right for everyone.

Examples of neuro-affirming language include:

- **Autistic person** rather than *person with autism*
- **Support needs** instead of *high- or low-functioning*
- **Communication style** instead of *communication deficit*

- **Intense interests / deep focus** rather than *obsessions*
- **Distress behaviour / unmet need** instead of *challenging behaviour*

Some older diagnostic terms, such as Asperger's syndrome, are no longer used in the UK. People who previously received this diagnosis are autistic, and their identity and preferred terminology remain valid and must be respected.

A Neuro-Affirmative Approach

This strategy is grounded in neuro-affirmative practice, recognising autistic ways of being as valid and meaningful. Being neuro-affirmative means:

- respecting autistic communication and sensory experiences
- adapting environments rather than expecting autistic people to mask or change
- valuing autistic strengths, passions and perspectives
- recognising that distress often arises from unmet needs or inaccessible systems — not autism itself

It also involves promoting autonomy and agency. Autistic people must be listened to, believed and involved in decisions about their lives. When autistic people identify barriers, we must act to remove or reduce them. By embracing neurodiversity and adopting neuro-affirming practice, we create environments where autistic people can feel safe, understood and supported to flourish.

Co-occurring experiences

Autistic people may also experience other health-related or neurodevelopmental needs alongside autism. These are not caused by autism but can influence wellbeing. They may include:

- **ADHD and other forms of neurodivergence**: Differences in attention, focus, energy levels or processing that may overlap with or mask autistic traits.
- **Anxiety, depression and autistic burnout**: Emotional or physical exhaustion caused by long-term stress, masking, or unmet support needs.
- **Epilepsy**: Seizure conditions that occur more frequently in autistic people and may require ongoing medical support.
- **Gastrointestinal conditions**: Issues such as chronic constipation, irritable bowel syndrome, reflux or abdominal pain, which are widely reported within the autistic community.
- **Learning difficulties (e.g., dyslexia, dyscalculia)**: Specific differences in reading, writing or number processing.
- **Learning disabilities**: Differences in intellectual ability and adaptive functioning which may require additional support in daily life.
- **Hypermobility and Ehlers–Danlos syndromes (EDS)**: Conditions affecting joints, flexibility, pain, fatigue and mobility.
- **Hormonal and endocrine-related experiences**: Differences or difficulties related to menstruation, pregnancy, menopause or other hormonal changes that may affect sensory, emotional or physical wellbeing.
- **ARFID, RSD, PDA profiles**:
  - **ARFID (Avoidant/Restrictive Food Intake Disorder):** A pattern of eating linked to sensory, interoceptive or anxiety-related differences, where certain foods or textures feel overwhelming or unsafe.
  - **RSD (Rejection Sensitive Dysphoria):** Intense emotional or physical responses to real or perceived rejection, criticism or disappointment.

  - **PDA (Pathological Demand Avoidance / Persistent Drive for Autonomy):** A profile within the autism spectrum characterised by high anxiety around everyday demands and a strong need for autonomy and control.
- **Sleep regulation differences**: Differences in sleep patterns or the ability to fall asleep or stay asleep, often linked to sensory or neurological factors.

Recognising these co-occurring experiences is essential for designing services and supports that are holistic, responsive and person-centred.

Oxfordshire's Autistic Community

Oxfordshire is home to a vibrant and diverse autistic community. In 2021, the county's population was 725,314, with around one in five residents identifying as disabled. National prevalence estimates suggest that up to 5% of the population may be autistic, which would equate to approximately 37,500 autistic people living in Oxfordshire.
This figure is based on national prevalence research rather than local diagnostic rates, and estimates vary depending on the methods used.

The 2023 Joint Strategic Needs Assessment (JSNA) recorded around 2,600 autistic pupils in Oxfordshire schools — a 9% increase from previous years. This rise reflects improved identification and awareness, as well as growing recognition of autistic strengths and needs within education settings.

It is important to note that school-based identification suggests higher prevalence within the local pupil population, and prevalence across the wider community is likely to be significantly higher than the 5% national estimate.

This strategy also recognises the wider context of neurodiversity, which describes the many natural variations in how people think, learn, communicate and experience the world. National estimates suggest that around 1 in 10 people in the UK are neurodivergent (Embracing Complexity Coalition, 2019). Autism is one part of this wider neurodivergent community.

Autistic individuals, carers and families in Oxfordshire shared the following strengths when asked what they value most about themselves and their community. These are captured in the image below:

On the following pages, you will find the six themes, shaped by the feedback received from autistic people and families, along with the "We will" commitments that show how we will respond.

1. Community awareness of Autism

Autistic people and their families describe a lack of visibility, understanding and acceptance within their local communities. This is often because public awareness campaigns and professional training can feel tokenistic or disconnected from real experience.

Public campaigns play an important role in reducing stigma. Although awareness of autism is now very high, understanding remains limited. Research shows that while 99.5% of people have heard of autism, misconceptions persist: more than one-third of UK residents still mistakenly believe autism is a learning disability, and 30% are unsure whether autism can be cured (Autism Alliance, 2024). These gaps in understanding reinforce negative stereotypes and highlight the need for targeted, accessible information shaped by autistic expertise.

Building genuine community awareness involves valuing diverse communication styles, recognising sensory needs, and respecting identity and language choices. It also means recognising and accepting autistic behaviours — such as stimming/movement, communication differences or seeking space, as valid human expressions, not behaviours to be managed or corrected. This shift in mindset is essential for creating environments where autistic people feel safe to be themselves.

Active allyship is also crucial. Allyship means individuals and organisations choosing to stand alongside autistic people: listening to autistic-led expertise, challenging misinformation and stereotypes, advocating for accessibility, and modelling inclusive behaviour. It is not a one-off action but an ongoing commitment to learning, reflection and meaningful change. True allyship helps create communities where autistic people feel genuinely seen, heard, respected and supported.

A truly autism-aware community makes inclusion visible in everyday life — from the way events are planned and public spaces designed, to how schools, services and community groups respond with empathy, flexibility and curiosity. This theme sets a clear expectation for cultural change, rooted in partnership, authenticity and accountability.

Personal experiences

"Empathy and understanding comes from people knowing each other in meaningful ways, NOT by segregation."

We will:

Create a co-produced charter for local businesses, organisations and individuals to sign up to which:

Builds understanding through authentic resources by:

- Providing autism-informed resources that are trauma aware evidence-based and co-produced with autistic people.
- Ensuring regular, high-quality and practical guidance is easily accessible.
- Promoting approaches that are trauma-informed, curiosity-led and authentic.

Centre autistic voices and increase visibility by:

- Amplifying autistic voices by letting people tell their own stories.
- Co-produce campaigns, events and communications with autistic people so a wide range of experiences are represented.

Strengthen connection and share learning by:

- Establishing a central website for resources
- Identifying and promoting best practice examples and guides of inclusion.

Commit to accountability and impact by:

- Organisations signed up to the charter are accountable for supporting meaningful change and will have an appointed autism champion.
- Measuring the impact of the charter using learning, data and feedback from autistic people and families via the Oxfordshire autism website.
- Using the learning and data from the charter to influence policy and practice.

2. Supporting autistic children and young people, including through education and transition to adulthood

Every autistic child and young person should be supported to thrive and become the most they can be, including through education and to be set up for later in life. Families, and professionals describe systems that feel fragmented, overstretched, and not yet equipped to recognise or respond to the full range of autistic experience. While many settings want to be inclusive, they often lack the resources, training and flexibility needed to make this happen consistently.

This is not only about supporting autistic people but about creating environments that meet every child and young person where they are, leading with curiosity and accepting differences. When systems and services respond early, communicate openly, and value individual difference, barriers are reduced, wellbeing improves, and young people are better equipped for the future. A diagnosis should never be a gateway to support; help should be needs-led and proactive.

There is a need for stronger accountability across the system, ensuring that every part works together with clear responsibilities, consistent standards and a shared commitment to improving outcomes. Families have emphasised the importance of early identification, high-quality and consistent autism-informed practice, and well-co-ordinated transitions into adulthood.

In practice, this means ensuring that:

- **Signs of support needs are recognised early**, without waiting for escalating difficulties or a diagnosis.
- **Families, children and young people are involved from the start**, with open communication and shared decision making.
- **All staff receive regular, practical autism informed training**, developed with autistic people and their families, where possible, focusing on communication differences, sensory needs and reasonable adjustments.
- **Education settings, health teams and social care are jointly responsible** for meeting statutory duties and delivering agreed actions, with transparent monitoring
- **Young people are prepared for life, not only exams,** including emotional wellbeing, independence, relationships and meaningful employment.
- **Transitions into adulthood are planned early**, with clear pathways into further education, employment, independent living and community life.

Delivering this requires sustained investment, honest communication, and genuine coproduction. It also requires celebrating good practice, building shared understanding, and recognising that small, practical adjustments can make a significant difference.

Personal experiences
“I was made to feel "naughty" despite not being so”

“Loved school and learning. In gifted and talented programs. Completed year 6 curriculum a year early because I was so advanced. Felt so happy to be successful”

We will:

Build inclusion into every education setting by:
- Making inclusion a shared responsibility
- Ensuring education settings are accountable for reasonable adjustments and inclusive practice, supported by the whole system to ensure a wide range of resources and knowledge are available.
- Providing timely, needs led support — including early identification and flexible interventions.

Equip staff with knowledge and confidence by:
- Investing in high quality, autism informed training that is co-produced with autistic people and families ensuring that leads to meaningful changes in practice
- Learn from best practice locally and nationally, including our local area partnership SEND improvement work to strengthen consistent practice.

Transitions: support at every stage by:
- Strengthening planning and communication at every transition point.
- Developing coordinated pathways into further education, employment, training and community opportunities.

- Provide varied opportunities for young people to participate in planning for their future and to advocate for themselves, setting up every young person to thrive for life and to be as independent as possible

Improving services and support for children with SEND and their families by:

- Working together across the SEND local area partnership to progress our improvement journey and SEND reform
- Exploring early help and multidisciplinary approaches that build shared understanding between children and young people, their families and other professionals
- Learning from best practice and evidence to shape future SEND and Inclusion strategy and services.

Innovate, evaluate and be accountable by:

- Exploring evidence-based tools and technologies that support learning and communication alongside relational practice
- Monitoring progress through listening to lived experience, outcomes and other feedback.
- Expecting partners to demonstrate how their work contributes to inclusion, wellbeing and successful preparation for adult life.

3. Health and Care needs (community and inpatient support)

Autistic people, like anyone else, may need to access physical or mental health support at different points in their lives. However, autistic people are much more likely to experience mental health difficulties, often because of navigating environments and systems that are not yet designed with neurodivergent people in mind. These challenges are not caused by autism itself but by external factors such as sensory stress, communication barriers, stigma, trauma, and prolonged unmet need.

Research shows that a significant proportion of autistic people have a diagnosed mental health condition, yet many experience difficulties accessing services (One in three autistic adults unable to access healthcare for potentially life threatening conditions - BSMS Young Ambassadors content gallery).

Too often, support is offered only when someone reaches crisis. Autistic people are at higher risk of suicide than non-autistic people, up to 66% of autistic adults had thought about suicide during their lifetime, and up to 35% had planned or attempted suicide. This is due to several factors, including mental health distress/problems, social isolation, unemployment, the need to mask their true self/identity, difficulty in describing how they feel (Alexithymia), repetitive thoughts and lack of support. (Suicide and Autism, a National Crisis. Autistic people and suicidality)

Autistic people and their families report that they are not taken seriously when raising concerns about their physical or mental health, with symptoms dismissed, misinterpreted, or attributed solely to being autistic. Along with many health services not being accessible, due to sensory environments causing overwhelm, unpredictable waiting areas, and appointment systems reliant on rapid communication or telephone use. These barriers can prevent people from seeking help early, lead to unmet health needs and contribute to poorer outcomes.

To improve outcomes, service remits must be reviewed to address the challenges autistic people face by recognising sensory and communication needs, adapting environments and processes, prioritising early help, and ensuring staff have the confidence and tools to provide autism-informed care.

Tools such as care plans, health passports and hospital passports are designed to support communication, highlight reasonable adjustments and keep autistic people safe. Making personalised plans visible, understood and routinely applied is essential for safe and person-centred healthcare.

Co-ordination across health, education and social care, smoother transitions between child and adult services, and clear accountability for delivering reasonable adjustments are required to improve experiences and outcomes for autistic people. To embed these changes, genuine co-production with autistic people and their families is needed, to shape services, feedback on what works, and develop solutions.

Personal experiences

“Worried about physical health”

“Worried about perimenopause & menopause”

“Pregnancy is the first time I felt "other". Anxiety and depression, I am still on antidepressants years later. I wanted to ‘get it right’.”

We will:

Train for change

- Enhance the understanding and confidence of health and social care staff by delivering high-quality, autism-informed training.

Accessible adjustments

- Ensure reasonable adjustments are not only identified but consistently implemented, reviewed and personalised.
- Design for inclusion when planning new services/pathways e.g. lighting, IT infrastructure.

Commission with accountability

- Embed autism competence within commissioning practice by requiring all providers to demonstrate autism-informed approaches and a clear understanding of the autistic population.
- Set clear expectations around service access and inclusion for autistic people within contracts, and monitor delivery to ensure practice is inclusive, safe and meets agreed standards.

Increase awareness and meaningful use of health passports

- Promote, support and monitor the meaningful use of health passports across all health and care settings, that are written by or with the person and their care givers.

Support before crisis

- Strengthen collaboration across organisations to develop and maintain preventative pathways.

Recognising transitions

- Improve understanding of the impact of different life changes, such as, puberty, ageing and menopause for autistic people.

4. Autism Assessment and Support

A diagnosis or confirmation can be deeply meaningful to some people, offering understanding, validation, identity, and a way to access the right support. For some, it brings relief; it can help make sense of experiences they have carried for years.

Autistic people and their families across Oxfordshire describe long waits, unclear pathways and inconsistent support when seeking an autism assessment. This experience can be confusing and distressing, especially when people are left without information, guidance or communication while they wait.

The assessment pathway must be transparent and supportive from the very beginning, ensuring consistent and concrete information is shared with all. As well as learning from feedback to continually improve services, quality monitoring will take place additional to the organisations that provide autism assessments being regulated and registered with CQC and/or OFSTED.

Personal experiences

Collective experiences:

“Support and empowerment for teaching staff to highlight early signs as parents may not be aware of autism”

“Clear and consistent information and communication is needed to make the assessment process easier for autistic people and their families”

These lived experiences will help ensure our actions are grounded in what matters most to autistic people.

We know that achieving real improvement will require sustainable funding, clear responsibilities and strong collaborative working across health, education, social care, the voluntary sector and wider services. The system must shift towards early understanding and proactive support at every stage.

Everyone seeking assessment, undergoing diagnosis or accessing post-diagnostic support should experience:

- empathy and respect
- timely, accessible information
- consistent communication
- practical support that meets their needs
- pathways that are clear, coordinated and person-centred

This applies equally to adults, children, young people and families.

We will:

Improve pathways for assessment and support by:

- Effectively using resources to increase support whilst waiting for an assessment and post-diagnostic support
- Developing an accessible, co-produced assessment and support pathway that reflects the lived experiences of autistic people and families.
- Ensuring emotional support, advice and reasonable adjustments are available, with transparent processes to access.
- Collecting and using regular feedback from autistic people, families and advocates to understand service quality, accessibility and timeliness.

Embed a needs-led approach by:

- Working across education, health and social care so decisions are holistic and needs-led, not based on diagnostic labels.

Provide clear communication by:

- Providing clear, consistent, concrete information at every stage — from referral through assessment to post-diagnostic support.

Strengthen training and workforce development by:

- Enhance the diagnostic workforce

5. Employment and Housing

Employment is an important part of life for many autistic people. It can offer independence, purpose, routine, and the opportunity to use strengths and talents. However, autistic people often face barriers long before they reach the workplace. These may begin in childhood and include misunderstanding in school, limited access to appropriate careers advice, sensory challenges in education and work settings, or recruitment practices that prioritise social performance over ability.

Many autistic people say they want to work but struggle to find employers who understand their needs or who recognise the value they bring. This is not due to a lack of willingness or capability, but because systems, workplaces and recruitment processes are often not designed with neurodiversity in mind.

Employment: what the research tells us

The Buckland Review of Autism Employment (2024) gathered views from autistic people, employers, organisations and specialist support groups to understand how autistic people are recruited, supported and progressed at work. It identified significant barriers and made recommendations aimed at increasing autistic employment.

The findings show a clear inequality:

- Only **3 in 10** autistic adults are in employment
- Compared with **5 in 10** disabled adults overall
- And **8 in 10** non-disabled adults

It is also important to note that many people go through life unaware they are autistic. Employers therefore need practices that are inclusive and accessible regardless of diagnostic status.

Supporting autistic people into employment

Supporting autistic people into meaningful and sustainable work requires personalised support, inclusive workplaces and greater understanding. Approaches that can help include:

- **Job coaching and mentorship**: personalised support to navigate workplace expectations, build confidence and develop skills.
- **Workplace accommodations**: adjustments such as flexible hours, sensory-friendly spaces, predictable routines and clear written communication.
- **Specialist training programmes**: including supported internships, skill development and volunteer opportunities.
- **Inclusive recruitment**: accessible interviews, work trials, advance questions, and initiatives such as Autism @ Work.
- **Supportive organisations**: access to autism charities, employment support services and vocational rehabilitation.
- **Workplace awareness**: training for managers and colleagues to reduce stigma and foster supportive, inclusive cultures.

The Get Oxfordshire Working Plan mgConvert2PDF.aspx highlights how support would be best utilised across systems and tackle inequalities in the workforce. Connect to Work Connect To Work | Enterprise Oxfordshire is a programme set up to support those with a disability into work and to sustain those positions.

Self-employment

There are initiatives and information widely available relating to autistic people and employment. There is significantly less information focusing on autistic people that choose self-employment. For some autistic people, self-employment is a much more suitable and sustainable option, for the following reasons:

- Autistic people often have unique and specialist skills
- Self-employment can lead to greater confidence and self-esteem
- Self-employment can mean that some of the common challenges in working for and alongside others can be avoided.

Housing

Housing can look different for everyone; it will vary based on a person's needs and preferences. In In Oxfordshire the District Councils provide social housing, those who are eligible can access additional support with the process of obtaining and maintaining a tenancy. Supported Living is an option for autistic people that require support (and are Care Act eligible) but want to have their own home in the community, since June 2023, Oxfordshire County Council have had The Live Well Supported Services Framework, which currently has 58 Support Providers on, ensuring a range of expertise.

The Housing Needs Assessment was published in September 2024, which is a report of research undertaken by the Housing Learning & Improvement Network (LIN) for Oxfordshire County Council to provide a Specialist and Supported Housing Needs Assessment. The council has commissioned the Housing LIN to undertake an assessment of the future need, over the next 10-20 years, for specialist and supported housing and accommodation.

Autistic people and homelessness

Emerging research shows that autistic people are more likely to experience homelessness. Studies suggest that autistic people are disproportionately represented in homeless populations, yet many remain undiagnosed and unsupported.

Homelessness can make it significantly harder to access an autism assessment. Without regular contact with services or the ability to provide developmental history, many autistic people cannot obtain a diagnosis — which may then prevent them from accessing the support needed to leave homelessness.

A London study of 106 homeless adults found that 12.3% met diagnostic criteria for autism yet only one person in the entire group had a previous diagnosis. This highlights the need for earlier identification, accessible assessments, and joined-up support between housing, health and social care.

Personal experiences

“Being able to move out and live alone meant I could set my own routine without expectations from others. But lack of affordable housing meant renting in a house share where it became difficult managing conflicts with housemates.”

“No support. I don't "apply" as needing support because it looks like I'm fully independent. Burnout led to mental health crises, suicide attempts, breakdown of relationships, forced to move home with parents because I couldn't live alone. Completely lost all of my independence.”

We will:

Strengthen employment support for autistic people

- Access to job coaching and personalised guidance
- Mapping out clear pathways into work; including supported internships, volunteering and skill development
- Access to apprenticeship opportunities.

Review and improve recruitment and employment processes across all partner organisations with experts by experience

- Review policies, procedures and workplace environments to remove barriers for autistic jobseekers and employees.
- Create/share toolkits and evidence-based approaches to improve accessibility, recruitment, onboarding and workplace culture.
- Educate employers about workplace accommodations/adjustments, offering practical guidance and training for employers, managers and colleagues to build confidence, reduce stigma and support autistic staff effectively.

Strengthen collaboration between employment, education, community organisations and support services

- Ensuring autistic people receive consistent support during key transitions into adulthood and throughout their working lives.

Work with housing providers and related services

- Ensure policies, communication, and support pathways are accessible, flexible and responsive to the needs of autistic people.
- Ensure information on housing options are easy to access and transparent in eligibility criteria.

Develop approaches that identify and support autistic people at risk of homelessness earlier

- Ensuring autistic people can access assessments, support/advocacy and accommodation without unnecessary barriers.

6. Criminal Justice System

What do we mean by Criminal Justice System? When we talk about the Criminal Justice System, we mean the system of law enforcement. The below bullet points include some examples of people you may meet, places you may need to attend and things you may need to do, (this list is not exhaustive):

- Police officers, solicitors, barristers, jury members, clerks, police administrators, appropriate adults, advocates, emergency call handlers, hospital staff, prison officers, Mental health workers, Approved Mental Health Practitioners (AMHP), social workers, forensic teams etc.
- Police stations, custody suites, court buildings, Section 136 place of safety, secure hospitals, prisons.
- Police interviews, police stop & searches, trials in court and capacity assessments.

This section may not apply to all, however, there is evidence to indicate that autistic people may be over-represented as people who come into contact with the criminal and youth justice systems, as victims, witnesses or defendants. We know from the APPGA inquiry that they often have poor experiences of these systems, there are many reasons for this, including poor understanding of autism among professionals as well as challenges with getting adjustments they need to engage in processes.

Further findings from the APPGA inquiry have highlighted that autistic people often find prison environments overwhelming because they can be noisy, brightly lit and cause sensory distress. The inquiry found that prison staff do not always understand people's needs or miss those who may be undiagnosed. Additionally, autistic people in the criminal justice system often struggle to access support or the health and social care services they may need, including support they may require on leaving custody, making transitions back into the community more challenging.

Adjustments must be made to processes and recognised early on, to support autistic people to process the situation and engage with the system. Adjustments should not be dependent on proof of a diagnosis, based on the principle 'innocent until proven guilty' autistic people should not have to prove themselves autistic to access basic adaptations that will enable their participation, ease overwhelm and anxiety and prepare them for a safe transition back in to the community.

If other areas in this strategy are implemented correctly around the systemic changes, autistic people encountering the criminal justice system could be significantly reduced. By providing early identification, diagnosis or confirmation, appropriate and active support in all areas, there would likely be a reduction in offending rates as people's needs would be met.

We will:

Understand the experience of the Criminal Justice System for autistic people by:

- Identifying the autistic population that are currently involved with the Criminal Justice System locally.
- Understanding what existing provisions and support services there are within Oxfordshire and out of county
- Work systemwide to ensure that local priorities, strategies and commissioning intensions are aligned to meet the needs of potential and actual young offenders with autism.

Provide resources and support for the Criminal Justice System by:

- Introducing autism champions within services
- Upskilling staff knowledge of autism
- Ensuring a neurodivergent specialist is embedded within the teams or available to teams working with those on county lines and directly with autistic people.
- Improving autistic people's access to adjustments and support and help make environments like prisons and probation services easier to cope within.
- Driving better access to health and social care services for those in contact with the criminal and youth justice systems, including the support they may need as they leave custody.

Conclusion

This strategy sets out a shared commitment for the next five years, to making Oxfordshire a place where autistic people of all ages are respected, understood and supported to thrive. Its success will depend on sustained partnership, meaningful co-production, and collective accountability across services, communities and organisations. Through the six priority areas, the accompanying action plan, and the leadership of autistic people and experts by experience, we will work together to remove barriers, strengthen inclusion and create lasting change that improves lives now and in the future.

Autism Strategy Glossary

(Including additional relevant terms from the Oxfordshire SEND Local Offer glossary)

Core Terms

Access to Work

A government scheme offering financial and practical support to help disabled people, including autistic adults, start or stay in work. It can fund job coaching, assistive technology, communication support at interviews, or help with travel where public transport is difficult.

Advocacy

Advocacy can be a formal service provided by a specialist service provider (the council does commission advocacy services, please check the website for the current provider details). Advocacy can also be informal support that is provided by a friend or family member helping to get a person's point of view across and their preferences taken into consideration when making decisions.

Alternative Provision (AP)

Education arranged for children and young people who cannot attend mainstream school full-time. This may be due to anxiety, exclusion, medical needs or other reasons. Many autistic children experience AP at some point, making inclusion and early support essential.

Attention Deficit Hyperactivity Disorder (ADHD)

A neurodevelopmental condition that can co-occur with autism. It affects focus, impulse control and activity levels. Some autistic people may identify as AuDHD, which is when you have autism and ADHD.

Autism Spectrum Condition (ASC) / Autism Spectrum Disorder (ASD)

Clinical diagnostic terms used in health services to describe autism. Although widely used in clinical pathways, many autistic people find “disorder” language unhelpful. This strategy uses **identity-first, neuro-affirming language**, recognising autism as part of a person’s identity.

Child and Adolescent Mental Health Services (CAMHS)

NHS services that assess and support children and young people with mental health needs. CAMHS plays a major role in supporting autistic young people, including through neurodevelopmental assessments.

Dynamic Support Register (DSR)

A health and social care register identifying autistic people and people with learning disabilities at risk of admission to a mental health hospital. The aim is early planning and support to prevent crises and reduce avoidable hospital stays.

Education, Health and Care Plan (EHCP)

A legally binding plan for children and young people aged 0–25 who need more support than is normally available in their setting. It sets out the individual's needs and the provision required to meet them across education, health and social care.

Education, Health and Care Needs Assessment (EHCNA)

An assessment carried out by the Local Authority to determine whether a child or young person needs an EHCP. It gathers information from professionals, the family and the child or young person themselves.

Education Other Than at School (EOTAS)

Education provided somewhere other than a school when attending a setting is not appropriate. This can be significant for autistic children whose needs cannot be met in school environments.

Graduated Approach

The cycle of "assess, plan, do, review" used by education settings to identify needs and provide support. It is a cornerstone of early support for autistic pupils in mainstream schools.

Joint Strategic Needs Assessment (JSNA)

A local assessment of current and future health and wellbeing needs in Oxfordshire. Data on autistic children, young people and adults inform planning and priority setting for this strategy.

Neurodevelopmental

Refers to the way a person's brain develops and functions, influencing how they think, learn, communicate, move and experience the world. Neurodevelopmental differences, such as autism, ADHD or developmental coordination disorder, begin in childhood and continue throughout life. These differences are part of a person's neurology and are not the result of parenting, environment or behaviour.

Neurodevelopmental Diagnostic Clinic (NDC)

A specialist NHS clinic (often within CAMHS) that assesses for autism, ADHD and other neurodevelopmental conditions.

Ordinarily Available Toolkit (OAT)

Guidance setting out the support mainstream schools should typically provide for children and young people with SEND, including autistic pupils, *without* the need for an EHCP. It describes inclusive practice expected of all settings.

Reasonable Adjustments

Legal duties requiring organisations—including schools, health services and employers—to remove barriers that prevent disabled people, including autistic individuals, from accessing services. Examples include flexible appointments, sensory-friendly environments and clear written information.

SEND Transformation Programme

Oxfordshire’s improvement programme following the Ofsted/CQC inspection, aimed at strengthening early identification, improving coordination, and ensuring consistent, inclusive, needs-led support for children and young people with SEND, including autistic children.

Strategic Improvement and Assurance Board (SIAB)

Oxfordshire’s SEND board responsible for overseeing improvement and holding the Local Area Partnership to account. It monitors delivery of action plans, including those linked to this Autism Strategy.

Autism Improvement Board

A dedicated board within Oxfordshire’s Local Area Partnership that oversees the delivery of the All-Age Autism Strategy. It brings together autistic people, families, the Local Area Partnership, education, health, social care and community partners to monitor progress, drive system-wide improvement, and ensure accountability for actions that support autistic children, young people and adults.

Thematic Terms

Community Awareness

Actions to build public understanding, reduce stigma and promote acceptance of autistic people across community spaces, workplaces and services.

Education

Support, inclusion and reasonable adjustments for autistic children and young people in early years settings, schools, colleges and higher education.

Employment

Programmes and support that help autistic people access, secure and sustain meaningful work, including job coaching, supported internships and workplace adjustments.

Health and Care Needs

Physical and mental health support for autistic people across primary care, community services, acute hospitals and mental health settings.

Housing

Support to access safe, appropriate housing options, including supported living, social housing and independent accommodation.

Inequalities

Differences in access, outcomes or experiences faced by autistic people due to systemic, social or environmental barriers.

SEND (Special Educational Needs and Disabilities)

Support for children and young people with additional needs as outlined in the Children and Families Act 2014 and SEND Code of Practice.

Transitions

Key life stages such as moving between schools, entering adulthood, starting work or accessing adult services. Effective transitions planning is essential for autistic people

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Process & Engagement Terms

Action Plan

A detailed plan setting out actions, timelines, responsibilities and measures used to deliver the Autism Strategy.

Co-production

Working *with* autistic people, families and carers as equal partners throughout design, decisionmaking and delivery. This strategy has been co-produced.

Consultation

Gathering views and feedback from autistic people, families, practitioners, communities and partners to shape decisions.

Experts by Experience

Autistic people and carers who share their lived experience to shape strategy, services and decision-making.

Monitoring and Evaluation

How we track progress, measure outcomes and assess the impact of the strategy over time.

Local Area Partnership (LAP)

The partnership responsible for SEND in Oxfordshire, made up of:

• **Oxfordshire County Council** • **NHS Thames Valley Integrated Care Board (TV ICB)** which includes **Oxford Health NHS Foundation Trust** and **Oxford University Hospitals NHS Foundation Trust (OUH)** • **Oxfordshire Parent Carers Forum (OxPCF)**, representing parent carer voices • **Education leaders, schools and settings** • **SEND Youth Forum representatives**

The LAP jointly plans, delivers and monitors services for autistic children, young people and adults.

Further Reading and Resources

This strategy is supported by a broad range of evidence, research and lived-experience-led insight.
The resources below offer additional information on autism, neurodiversity, co-production, inclusive practice, and the design of supportive services.

Understanding Autism and Neurodiversity

- **National Autistic Society – What is Autism?** https://www.autism.org.uk/advice-and-guidance/what-is-autism
- **Autistic UK – Neurodiversity and Language Guidance** https://autisticuk.org
- **National Development Team for Inclusion (NDTi) – Autism and Neurodiversity Resources** https://www.ndti.org.uk
- **The Spectrum Wheel – Accessible Explanation (Simply Psychology)** https://www.simplypsychology.org/autism-spectrum.html
- **Devon County Council – Autism Wheel Tool** https://www.devon.gov.uk
- **The Art of Autism – ‘Understanding the Spectrum’ Comic** https://the-art-of-autism.com/understanding-the-spectrum-a-comic-strip-explanation/

Neuro-affirming Practice

- **The Neurodiversity Podcast** https://www.neurodiversitypodcast.com
- **Neurodivergent Insights – Neurodiversity Education** https://www.neurodivergentinsights.com
- **AASPIRE Healthcare Toolkit (Autistic Adults)** https://autismandhealth.org
- **British Psychological Society – Autism Position Statements & Guidance** https://www.bps.org.uk

Policy, Reviews and National Guidance

- **The Buckland Review of Autism Employment (2024)** https://www.gov.uk/government/publications/buckland-review-of-autism-employment
- **National Autism Strategy for England (2021–2026)** https://www.gov.uk/government/publications/national-strategy-for-autistic-children-young-peopleand-adults-2021-to-2026
- **NHS Long Term Plan – Autism and Learning Disability** https://www.longtermplan.nhs.uk
- **SEND and Alternative Provision Improvement Plan (DfE)** https://www.gov.uk/government/publications/send-and-ap-improvement-plan

Education and Inclusion

- **Ambitious about Autism – Education Resources** https://www.ambitiousaboutautism.org.uk
- **Autism Education Trust (AET) – Inclusive Practice Frameworks** https://www.autismeducationtrust.org.uk
- **Council for Disabled Children – Participation & Inclusion** https://councilfordisabledchildren.org.uk

Employment

- **Autism @ Work – Inclusive Employment Frameworks** https://disabilityin.org/autism-at-work-roundtable

- **Job Accommodation Network – Workplace Adjustments Guidance** https://askjan.org
- **BASE (British Association for Supported Employment)** https://www.base-uk.org

Health and Wellbeing

- **NICE Guidelines on Autism (Children, Young People and Adults)** https://www.nice.org.uk/guidance/conditions-and-diseases/mental-health-and-behaviouralconditions/autism
- **Autistica – Autism Research and Health Insights** https://www.autistica.org.uk
- **Mind – Neurodiversity and Mental Health** https://www.mind.org.uk

Local Support in Oxfordshire

- **Oxfordshire Parent Carers Forum (OxPCF)** https://oxpcf.org.uk
- **Autism Champions** https://www.autismchampions.co.uk
- **Response – Mental Health and Autism Services** https://www.response.org.uk
- **Oxfordshire SEND Local Offer** https://www.oxfordshire.gov.uk/residents/children-education-and-families/special-educationalneeds-and-disability-local-offer
- **SENDIASS Oxfordshire – Information, Advice and Support Service** https://sendiass-oxfordshire.org.uk
- **AFSO** https://www.afso.org.uk
- **Oxfordshire SEND Improvement** https://www.oxfordshire.gov.uk/children-and-families/oxfordshire-send-local-offer/sendstrategy/send-improvement

- **OxFSN**
- **Carers Oxfordshire**
- **Oxfordshire MIND**
- **Oxfordshire Youth**

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

Where a joint health overview and scrutiny committee makes a report or recommendation to a responsible person (a relevant NHS body or a relevant health service provider[this can include the County Council]), 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 whom it has made the report or recommendation and that person must respond in writing within 28 days of the request.

This template provides a structure which respondents are encouraged to use. However, respondents are welcome to depart from the suggested structure provided the same information is included in a response. The usual way to publish a response is to include it in the agenda of a meeting of the body to which the report or recommendations were addressed.

Issue: All-Age Autism Strategy

Lead Cabinet Member(s) or Responsible Person:

- Karen Fuller (Director of Adult Social Care, Oxfordshire County Council).
- Ian Bottomley (Deputy Director, Integrated Commissioning).
- Bhavna Taank (Head of Joint Commissioning [Life Course] – Live Well)
- Dan Leveson (Director for Places and Communities- Thames Valley ICB).

It is requested that a response is provided to each of the recommendations outlined below:

Deadline for response: Thursday 2nd July 2026.

Response to report:

This is a draft response and could be subject to changes as required ahead of the deadline to respond of the 2nd of July

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

Response to recommendations:

Recommendation	Accepted, rejected or partially accepted	Proposed action (including if different to that recommended) and indicative timescale.
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.	Accepted	The role, authority and escalation mechanisms of the Autism Improvement Board (please be aware that the name of this board may change but the function will stay the same) will be clearly set out through the Board's TOR. The TOR are being co-designed with the Board as part of the year 1 project plan. The current working documents describe the Board's main forum for strategic oversight of autism improvement. The Board is co-chaired by the Head of Joint Commissioning (Live Well) and an expert by experience. There are thematic task and finish groups supporting development and delivery of the strategy which report into the board. The year 1 project plan will review and refine the Board's TOR and: • Define escalation routes from the sub-groups into the Board and/or within partner organisations • Establish reporting templates into the Board • Establish formal progress updates to the Board. Health and Wellbeing board will be asked in July to hold system wide responsibility for development and delivery of the Strategy with the Director of Adult Services, OCC as the SRO. Reports on progress will be received by the Board and any issues with performance or delay escalated to the DASS on behalf of the Health

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

		and Wellbeing Board. Board updates will be shared with nominated senior officers in partner organisations.
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, 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.	Accepted	Co-Design will be embedded in the development of the strategy and in its implementation, delivery, review and improvement. Whilst there have been pockets of Co-production due to the statutory nature of the strategy and elements of delivery this is a co-designed process. The strategy has set out within it that Autistic people, parent carers and experts by experience will continue to shape, guide and influence the work. The year 1 project plan will translate this into delivery through membership of experts by experience in the workstream, task and finish groups and co-design of the priorities, design and implementation approach for each workstream. The Autism Improvement Board is designed to ensure representation of people with lived experience of autism at system level, and TOR for task and finish groups emphasise that lived experience should inform priority-setting, sequencing of actions, performance review and continuous improvement. This provides a route for lived experience feedback to influence commissioning, service redesign and wider system decisions rather than being limited to strategy development alone.
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;	Partly Accepted	Financial modelling of the costs and impact of the Strategy is only partly developed at this stage. The assumption of system partners is set out in the Strategy that there are no direct new financial commitments attached to adoption of the Strategy itself and that costs of delivery should be met from within the existing pooled budget between the council and the ICB. The development of the Strategy has identified that some priority areas may create resource implications over time, for example

and the affordability and sustainability of priority commitments.		around digital information infrastructure, training, and strengthened specialist support for autistic individuals. These areas will need further development within the implementation plan and, if they require new investment will need to be funded from savings identified elsewhere. The year 1 project plan takes a pragmatic approach by focusing first on governance, baselines, pathway mapping, data, and targeted improvement work, which should allow the system to clarify which actions can be delivered through reconfiguration of existing resources and where future business cases should be developed to identify resource requirements and where these might be found. The final implementation plan will make explicit which budgets and contracts are in scope, where existing resources might be aligned to the aims of the Strategy, and where there are affordability and sustainability issues that need to be resolved as part of the implementation.
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.	Accepted	An outcome and performance framework will be co-designed within the year 1 project plan. A draft document includes commitments to: • Confirm baseline indicators and data sources • Develop a year 1 milestones implementation dashboard • Agree a reporting cycle • Create a baseline reporting templates for sub-groups The draft document provides a framework for further development through co-design that goes beyond simple activity reporting. In line with concerns raised by HOSC and reflecting evidence set out in the Strategy and SCIE report, the framework will include:

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

		• Diagnostic waiting times • Use of support while waiting • Assessment of consistency and effectiveness of reasonable adjustments across services • Experience of transition between children's and adult pathways and across services • Lived experience and qualitative outcomes alongside quantitative access measures. The draft implementation document also emphasises the use of feedback and data together to shape year two priorities, which support a more meaningful and improvement-focused framework.
5. For system partners to work toward the development a children's version of the Autism Strategy.	Accepted	Work is already moving in this direction. The Strategy is described throughout as all-age and jointly owned across adults' and children's services, with children's partners involved in development and delivery. The latest draft year 1 implementation plan goes further by including a specific action to create a children-friendly version of the Autism Strategy, led through children's colleagues, alongside production of a more accessible all-age version. This means the recommendation for system partners to work toward a children's version is consistent with current implementation planning and can be reflected as an active commitment within the final document rather than a future aspiration only.

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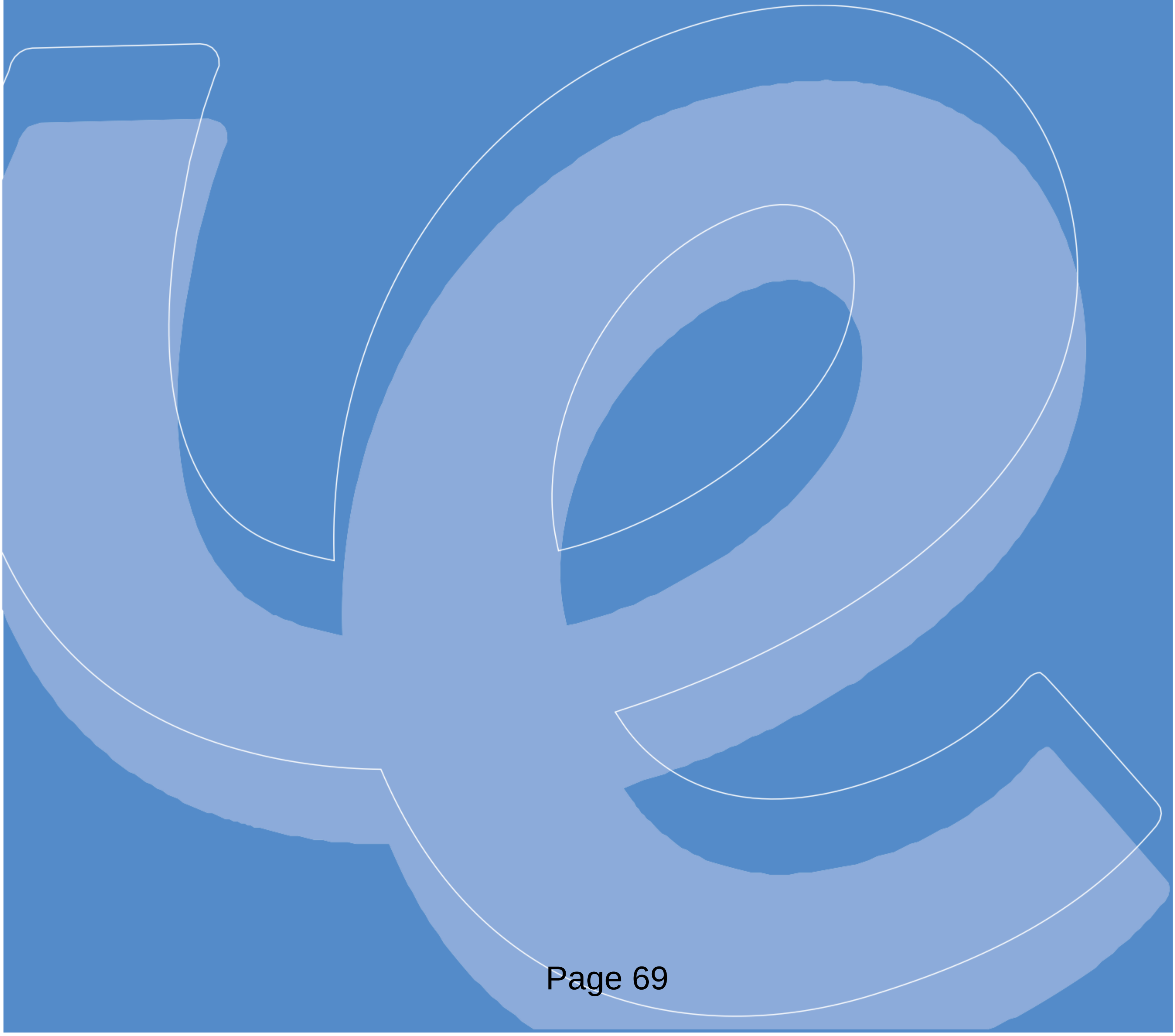
Supporting the development of an All Age Autism Strategy for Oxfordshire

An evidence piece from SCIE for Oxfordshire County Council



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About SCIE

The Social Care Institute for Excellence improves the lives of people of all ages by co-producing, sharing, and supporting the use of the best available knowledge and evidence about what works in practice. We are a leading improvement support agency and an independent charity working with organisations that support adults, families and children across the UK. We also work closely with related services such as health care and housing.

We improve the quality of care and support services for adults and children by:

- identifying and sharing knowledge about what works and what's new
- supporting people who plan, commission, deliver and use services to put that knowledge into practice
- informing, influencing and inspiring the direction of future practice and policy.

Written by Claire Webster

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Introduction - why develop an all age autism strategy?

The Government states in their ministerial foreword for their National Autism Strategy that “The introduction of the Autism Act 2009 was ground-breaking because it was the first disability-specific piece of legislation in England. Over the decade since its inception, it has resulted in improvements in support for autistic adults across the country, and greater awareness of autism in society. However, we know that more still needs to be done to improve autistic people’s lives.” The Government therefore proposed **The national strategy for autistic children, young people and adults: 2021 to 2026 - GOV.UK**

Oxfordshire County Council is developing its own autism strategy in line with the National Autism Strategy, to improve the lives of autistic people living in the county across all aspects of their lives. This reports sets out the evidence base to underpin any new strategy which should be developed with key local partners especially autistic people, their families, parents, and carers. The new strategy needs to align with the existing statutory guidance on implementing the Autism Act for local authorities and NHS organisations to support implementation of the Adult Autism Strategy (2015). This sets out local authorities’ and NHS organisations’ duties to support autistic adults and remains in force, which means that local systems should continue to deliver on existing requirements, including having active Autism Partnership Boards in local areas. **The national strategy for autistic children, young people and adults: 2021 to 2026 - GOV.UK**

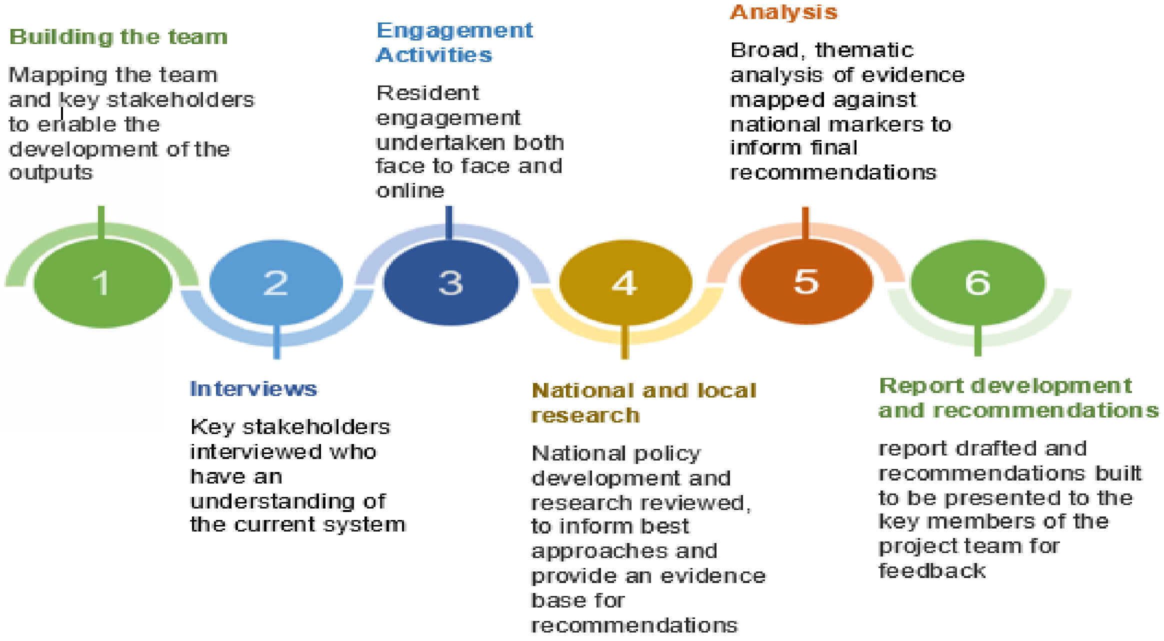
This paper sets out evidence against the key areas outlined in the national strategy alongside information gathered from residents and stakeholders. The strategy needs to be shaped by the clear and consistent messages we heard from Oxfordshire residents which were:

- for both young people and older adults to be heard,
- for autistic people to feel that they are being heard and for them to experience a system that communicates better with each other and better with them.

This strategy should forge a clear pathway between children’s and adults’ services and across health, social care, education and housing.

We would suggest that the final strategy also references and links to other strategies in Oxfordshire County Council including (but not limited to) the Oxfordshire Way Strategic Vision, the All Age Care’s Strategy, SEND strategy, Learning Disability Strategy and Oxford Health’s Autism Strategy.

Methodology



Building the team

Mapping the team and key stakeholders to enable the development of the outputs

Interviews

Key stakeholders interviewed who have an understanding of the current system

Engagement Activities

Resident engagement undertaken both face to face and online

National and local research

National policy development and research reviewed, to inform best approaches and provide an evidence base for recommendations

Analysis

Broad, thematic analysis of evidence mapped against national markers to inform final recommendations

Report development and recommendations

report drafted and recommendations built to be presented to the key members of the project team for feedback

How to use this report

This paper sets out evidence against the key areas outlined in the national strategy alongside information gathered from residents and stakeholders.

For each area we have tried to set out the following (where available):

- Data and evidence from the national context
- Data and evidence from the local context
- Views from autistic residents of Oxfordshire and their families, and stakeholders.

We have also based on the information and knowledge in some areas made:

- Recommendations for the development of the relevant section of the strategy
- Identified additional areas to consider that are not covered by national strategy headings.

*data used throughout this report was the most up to date available at time this report was written and research undertaken, some areas of research and data may be a few years old but still relevant.

*We also acknowledge that some language in this report is not necessarily what the autistic community would use, for example, recent national discussion has centred on the person first language and no longer referring to the ‘spectrum’ but referring to autistic people, generally. Some research refers to ‘Autism Spectrum Disorder’. We would always recommend checking language, with the communities you engage with, before using.

Creating an autism strategy

In SCIE's work and research nationally, and work with residents in Oxfordshire, a number of themes were consistently mentioned when discussing the creation of a strategy, and these are set out in the word cloud. A key test for the council and its partners would be to evaluate evidence against these, in both in the development of the strategy and how they are implemented, as part of the strategy.

Communication and engagement

A consistent theme in our engagement with young people, parents and adults was the need to communicate clearly and consistently. Any document created with and for communities, should be accessible and useable for communities. We would therefore recommend the adoption of:

Gloriously Ordinary Language - "We think too much of the language people use in and about social care reveals and shapes attitudes and ways of working that prevent people from living gloriously ordinary lives. We believe that the language of social care should be ordinary. Everyday words about everyday life. And we think our language should be glorious. Wonderful words about flourishing lives." **Gloriously Ordinary Language — Gloriously Ordinary Lives**

Oxfordshire County Council have already started this programme and so would recommend using the learning from this programme to shape the strategy.

SCIE recommends using language that is identified by your local autistic community and working with them to design topic headings and language, to use. It should be noted that while there are general headings that are indicated in the national strategy, there is no statutory requirement to use these headings, so you are able to coproduce a strategy in a language that works for the autistic community in Oxfordshire.

In the interest of good communication, accessibility and transparency, we have (throughout the project) recommended a dedicated web page be created to connect the strategy to, and to link other strategies to. During our research for this report, one area's strategy web page was cited as a good example:

LSC Integrated Care Board: Learning disabilities and autism

This would facilitate clear and timely communication and enable all those with an interest to know what is happening and how they can engage with the development of the strategy.

Co-production

Throughout this project, residents and stakeholders raised concerns about the involvement of autistic people in the development of the final strategy. It was acknowledged that the initial stages would involve a level of engagement only due to timescales but assurances give about further opportunities to get involved, in the development of the strategy and the action plan that arises from the strategy.

Evaluation

Within the principles of co-production, communication and transparency, we would recommend the development of an evaluation framework, with autistic people and their families.

A consideration for a framework to utilise for this evaluation would be Think Local Act Personal's (TLAP)'s **'Making it real' Statements** (**Making-It-Real.pdf**). These are a set of co-produced statements that describe what good care and support looks like. They are aligned to the Care Act, and built into the CQC Single Assessment Framework. The statements are written from two different perspectives:

The 'I statements' describe what good looks like from the perspective of someone who draws upon care and support.

The 'We statements' describe what people who work in care and support should do to make the 'I statements' real.

All of the statements were co-produced by people who draw upon care and support and people who work in it, so they are rooted in real life experience

They can be used to help evaluate the implementation of various aspects of the strategy.

We would also recommend an ongoing feedback loop for the strategy, for residents, when it is live.

What is autism?

National context: wording from national research

"Autism is a lifelong developmental disability that affects how people perceive, communicate and interact with others, although it is important to recognise that there are differing opinions on this and not all autistic people see themselves as disabled. With an estimated 700,000 autistic adults and children in the UK – approximately 1% of the population – most people probably know someone who is autistic. In addition, there are an estimated 3 million family members and carers of autistic people in the UK (**National Autistic Society**).

Autistic people see, hear and feel the world differently to other people. Autism varies widely and is often referred to as a spectrum condition, because of the range of ways it can impact on people and the different level of support they may need across their lives. While autism is not a learning disability, **around 4 in 10 autistic people have a learning disability (Autistica)**.

Some autistic people will need very little or no support in their everyday lives while others may need high levels of care, such as 24-hour support in residential care. People may need help with a range of things, from forming friendships, coping at school, managing at work, or being able to get out and about in the community. In this strategy, we also talk about neurodiversity, which refers to the different ways the brain can work and interpret information. It is estimated that around 1 in 10 people across the UK are neurodivergent, meaning that the brain functions, learns and processes information differently (**Embracing Complexity Coalition, 2019**)."

Views of residents

Autistic people, carers and their families, in Oxfordshire also said the following, when asked about their strengths:

Autism in Oxfordshire

Local context

According to local GP registers, the current Oxfordshire population is 827,848

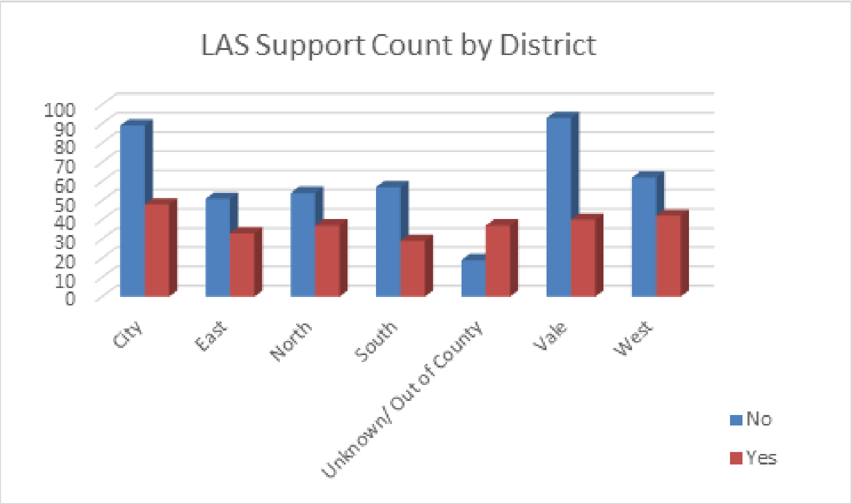
ONS Census Data 2021 shows the population of people with a disability was 165,482 in Oxfordshire, approximately 1 in 5 residents.

Adults (aged 16+) National Autism Prevalence 2020 Autism prevalence, UK, 2020 - Office for National Statistics (ons.gov.uk):

NHS Digital has indicated that up to 5% of the overall population will be impacted by Autism, as a diagnosed individual, carer or family member. Based on the ONS mid-year population data estimates, this would equate to 41,392people in Oxfordshire.

A revised estimate is that 1.7% of population autistic which is likely to be an underestimate, 2.9% prevalence rate in CYP (improving recognition and identification), 90% of autistic adults aged 50 or over undiagnosed - Petersen I, Buckman JEJ, Charlton R, Cooper C, Corbett A, et al. Autism in England: assessing underdiagnosis in a population-based cohort study of prospectively collected primary care data. Lancet Reg Health Eur [Internet]. 2023;29(100626):100626. Available from: **https://linkinghub.elsevier.com/retrieve/pii/S2666776223000455**

Data provided by the Council's performance team in December 2023 showed that the number of people with an autism diagnosis with a record on Liquid Logic Adults LAS is 691, of which 266 receive support provided by Oxfordshire County Council.



Autistic children and young people in Oxfordshire

The Joint Strategic Needs Assessment (JSNA) for 2023 showed there were 2,600 pupils in Oxfordshire registered with their primary/main type of need as “Autism Spectrum Disorder” This is 2.6% of all pupils. Of these, 995 were in state-funded primary schools, 1,151 were in state-funded secondary schools and 454 were in special schools. This is a 9% increase in the number of registrations in previous years, with 2,600 in 2022/23 compared with 2,385 in 2021/22.

*Autism Spectrum Disorder is a clinical term used in the medical manuals such as the DSM-5. While acknowledged this will be used in data collection and recording in the health system, the language recommended currently in communications, is to use person first - autistic people.

Ethnicity in Oxfordshire

According to the Office for National Statistics (ONS) Census 2021 survey, 13% of the total resident population of Oxfordshire was from an ethnic minority background, compared with 18% across England. According to the January 2021 Schools Census, 29% of pupils in state primary schools (in years 1 to 6) and 27% of pupils (years 7-11) in state secondary schools in Oxfordshire were from ethnic minority backgrounds.

Across Oxfordshire’s districts, Oxford has the highest proportion of ethnic minority pupils and pupils whose first language isn't English. All districts aside from West

Oxfordshire have a higher proportion of ethnic minority pupils and pupils whose first language isn't English in Primary year groups (years 1-6) than in Secondary year groups (years 7-11).

National research on impact of Autism in communities would suggest, from a statistical viewpoint, that these groups are also likely be impacted. Conversations have also mentioned traveler community engagement needs.

Recommendations

It would be recommended to review co-production opportunities with wider ethnic communities.

Recommendation from Simon Tarrant to engage with Clitherow Trust **Margaret Clitherow Trust**.

It would also be recommended to work closely with public health and housing in the development of this strategy to review how to address the additional inequalities that are often faced by other ethnic groups in communities.

Diagnosing autism

There is both a national and local issue in relation to the time it can take to be assessed for autism across all age groups.

National context

The National Institute for Health and Care Excellence (NICE) has said people referred for an autism assessment should be seen within three months. The median waiting time ranged between 218 and 306 days (roughly seven to 10 months) in the months from April to December 2023.

The National Institute of Health and Care Excellence has set a target time of 13 weeks for those with suspected autism to be assessed.

Local context

BBC Local press (20/12/24) wrote "The Oxfordshire Adult Autism Diagnostic and Support Service (OAADSS) stopped taking on new patients at the end of November due to the size of its current waiting list.

In documents seen by the BBC, the OAADSS has told patients that those referred after July of this year will not be assessed until 2041 at the earliest.

Buckinghamshire, Oxfordshire, Berkshire West Integrated Care Board (BOB ICB), who oversee adult autism diagnoses in the county, said it was working to 'find a solution' to the delays."

Referral data for adults (Kingswood/Oxfordshire Adult Autism Diagnostic Support Service): Number of referrals in the last 12 months - 1026

Data from March 2024 covering the previous 3 months, states:

Number of people currently on the waiting list for a diagnosis	1308
Awaiting assessment	169
Awaiting screening	147
Awaiting return of screening forms	
Current wait time for seeking a diagnosis - pre-screening	10 years 6 months
Current wait time for seeking a diagnosis - post screening	8 years, 9 months
Number of people assessed in the last 12 months	176
% of the people referred to the service, that were formally diagnosed in the last 12 months	87%
% of the people referred to the service, that were signposted due to not meeting screening criteria in the last 12 months	25%

% of people in the last 12 months that have 'dropped out' of having a diagnosis, either in favour of Right To Choose or private assessment?	Less than 1.2%[1]
% of people that didn't return the screening forms /disengaged / moved out of area/diagnosis sought elsewhere	17%

Children's service data

"The request for Neuro Developmental Assessments continues to be high, the service is commissioned to provide 50 assessments per month and currently receiving 150 referrals per month. However we have implemented a living well programme for all families so they can learn about the conditions and adapt the way they respond to their child if they believe they have a neurodiversity. Initially this wasn't taken up a lot by families, but we have since been offering webinars jointly with the Parent Carer Forum (PCF) which have been more popular." **Oxfordshire Child and Adolescent Mental Health Service HOSC report.pdf**

Resident and stakeholder feedback

"I mean so many times I've been diagnosed with depression, anxiety post Natal depression, blah, blah, blah. All of these things with the root cause in the anxiety caused by social situations, which is the root causes of autism"

"I'm worried about with this project, it says it's about autism, but I think it should be about neuro neurodiverse children, because a lot of young people don't get that full diagnosis they present with autism, but they're eight. They've got ADHD. My young person has got autism, ADHD, and processing disorder".

"often a problem really to get the diagnosis in the 1st place, which and there are huge waiting lists which we will be aware of both for children and for adults. I was quite lucky. I think I waited for my assessment for 10 months, but someone told me that it's now like closer to five years or something like that. It's like crazy."

This is a key area of concern for residents especially for parents as significant delays have a cumulative impact on their child and their subsequent challenges in being able to secure a EHCP plan. Some who had experienced input from professionals (teachers / SENCOs) especially in primary schools stated that had they been better trained and supported in terms of autism, then the experiences for their child and themselves may have been less antagonist.

Some also asked about the disparity with other local authorities such as West Berkshire who were identified as having a much better approach and resources.

Gaps

Notwithstanding the issue of lack of diagnostic provision in Oxfordshire, the local statistics available at the time of this report relate to the adult diagnostic waiting list

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[1] This figure may be higher; however, patients do not always inform the provider when they choose an alternate provision or move out of county

and therefore could be a much bigger picture when reviewing waiting times (if they exist) for autism diagnosis in children.

People we spoke to while had some stories around issues waiting for diagnosis, or mis diagnosis until later life, discussed the need to speak to someone when querying a diagnosis, to seek advice, guidance and usually support.

The majority of people we spoke to alluded to not necessarily seeing the diagnosis as providing any further help with their issues, but was part of their identify and understanding themselves, but they felt that if services were able to identify how to support them without diagnosis, this would have provided benefits to their overall wellbeing and experience.

Recommendations

Specifically address the issue of diagnostic waiting times in the strategy, with key achievable actions these could include, but not limited to:

- Providing training to education staff on how to provide support/adjustments before and after a person receives a diagnosis.
- Create a system that will support without diagnosis, and are needs lead rather than diagnosis lead.
- Providing training and information to GP services about available support and signposting when a person seeks further support.
- Providing training and information to children's and adults mental health teams on supporting a person in the absence of diagnosis.
- Setting up or signposting to peer support groups for families and individual to meet with others awaiting or confirmed diagnosis.
- Provide a directory of services available to support people without diagnosis
- Provide support to people who are waiting for a diagnosis, such as information and advice, peer support and existing community groups.
- **Westminster commission on autism also proposed acceptance of self-identification.** support-surrounding-diagnosis.pdf

Improving understanding and acceptance of autism within society

National context

Public campaigns play a key role in raising awareness and reducing the stigma surrounding autism. While professional knowledge of autism has improved, public understanding remains limited. Despite 99.5% of people being aware of autism, misconceptions are widespread: over one-third of UK residents still mistakenly believe autism is a learning disability, and 30% are unsure whether it can be cured **(Autism Alliance, 2024)**. These gaps in understanding perpetuate negative stereotypes, highlighting the need for targeted education to foster a more accurate and empathetic perspective on autism.

There are a number of potential actions that could be considered. The actions below have been listed from work underway at national, regional or local level.

National level:

- At a national level this has led to a range of actions focusing on staff training across a range of sectors some of which are listed below Encouraging more autism-friendly programmes in the cultural and heritage sectors
- Providing funding (£600,000) for autism training and professional development in schools and colleges
- Carrying out a new anti-bullying programme in schools, to improve the wellbeing of children and young people in schools, including those who are autistic
- Engaging with potential providers of training as part of our commitment to recruit and train Designated Mental Health leads in schools
- Continuing to trial and develop the Oliver McGowan Mandatory training on learning disability and autism for all health and adult social care staff
- Reviewing the call for evidence on neurodiversity, and developing a toolkit to educate frontline staff about neurodiversity, and the additional support they might need
- Providing training for healthcare, social care, and education professionals can lead to earlier identification of autism and better immediate responses to the needs of autistic individuals (N8 Research Partnership, 2024; Autism Alliance, 2024).
- Autism training for transport staff, businesses, and community services to make public spaces more accessible. See initiatives including:
    - Nexus (2023): Trained over 100 staff (Metro, ferry, and bus stations) in autism awareness. The programme included communication techniques, recognising hidden disabilities, and creating sensory guides to make services autism-friendly.

  - NAS Pilot with DfT (2022a): Collaborated with the Department for Transport to develop a programme reducing barriers for autistic passengers, aiming to decrease social isolation.

Regional actions

Some regional information (particularly in West Berkshire) provided as part of this project included:

- Training and development – support co-ordinated training offers to reduce the burden on systems to develop individual packages locally. This will include training on autism awareness and reasonable adjustments for staff both in inpatient units and in the community.
- Provision of central communication and campaign resource to pro-actively promote and deliver autism campaigns, share good practice, and support engagement with the autistic community.
- Support staff to participate in autism related training and development. This will include Oliver McGowan mandatory training and any other core or advanced training once available. Ensure locally procured training is co-produced and co-delivered by autistic people.
- Improve the level of information available to autistic people and their families through better guidance and signposting, and greater support for self-help, self-management, and parent/carer groups locally.
- Develop an autism service directory/ booklet that gives information about autism and lists local services for autistic people
- Set up an autism web page
- Work with the local autism diagnostic service to ensure everyone who receives a diagnosis has more information about existing groups/services post diagnosis
- Raise awareness of the Autism Alert Card
- Identify a single identifiable contact point where autistic adults (whether or not in receipt of a statutory service) can get information, signposting and autism-friendly entry points for a wide range of local services
- Raising awareness of initiatives undertaken elsewhere and encouraging them locally: Find good practice about slower lanes / quieter hours, changing lighting, turning down volume of music etc. and present to Newbury Bid at a themed Autism Partnership Board
- Encourage organisations to make autism friendly adjustments to the physical environment and practice, provide autism friendly specific sessions/days where possible
- Develop a range of information stands/roll up banners and coordinate where they will be displayed

- Support autism training that enables delegates to understand autistic behaviours and how to deal effectively with them
- Hold an annual event to celebrate national autism day (2nd April each year)
- Ensure local residents, professionals, and employers have access to autism awareness training to learn more about autism.
- Work in partnership with the West Berkshire libraries service to develop and promote a list of books about autism.

Improving autistic children and young people's access to education, and supporting positive transitions into adulthood

National context

For the purposes of an all age autism strategy in Oxfordshire, depending on the particular circumstances of the individual, different legislation may be in operation. Therefore, it is SCIE's recommendation that the All Age Autism Strategy will need to recognise overarching legislation including but not limited to: The National Health Service Act, 1946, Health and Social Care Act, 2012. The Mental Health Act, 1983, The Mental Capacity Act, 2005, The Care Act, 2014, The Human Rights Act, 1998, The Children Act, 1989 and 2004, The Education Act, 1988, The Data Protection Act, 2018, and General Data Protection Regulation (GDPR). However, for individuals where different legislation, regulations and statutory guidance are relevant these will need to be taken into account as well.

There is a legal duty on local authorities under section 19 of the Education Act 1996 to make arrangements for the provision of suitable education (in school or out) for children of compulsory school age who, for whatever reason, may not receive suitable education unless such arrangements are made for them.

Supporting autistic children and young people in education requires targeted interventions to address the challenges they face. Key priorities include:

- Improving the Special Educational Needs and Disabilities (SEND) system to better meet the needs of autistic students
- Implementing anti-bullying campaigns
- providing teacher training to foster inclusive learning environments
- Additionally, supporting transitions to adulthood—such as access to higher education and employment opportunities.

Evidence highlights significant gaps in support. Delays in diagnosis and inadequate school interventions negatively affect the emotional and physical health of autistic children and their caregivers. Training is needed to clarify thresholds for education, health, and care needs assessments while promoting evidence-based approaches (Martin-Denham, 2022). Funding constraints further compound these issues: only 2% of school leaders in England report having sufficient funding for Educational, Health, and Care Plans (EHCPs), and 94% face challenges in supporting disabled students (King et al., 2018).

Bullying is another critical concern. In the UK, research from NAS (2022b) indicates that 34% of autistic children report experiencing bullying at school. International evidence suggests even broader challenges: pooled prevalence rates show 47% of autistic individuals experience bullying, 16% face child abuse, 40% endure sexual victimisation, 13% experience cyberbullying, and 84% report multiple forms of victimisation (Trundle et al., 2023).

Promoting acceptance within school pupils: **Learning About Neurodiversity at School (LEANS) | Salvesen Mindroom Research Centre** this point also links to promoting acceptance.

Despite only 32% of pupils with EHCPs having autism, almost half (45%) of appeals were related to autistic children and young people – suggesting that autistic children may find accessing support particularly challenging. **New statistics on Education, Health and Care Plans (EHCP) for children with special educational needs | Children's Commissioner for England**

Special Educational Needs and Disabilities (SEND) has been a recent, (and continuous) topic area for discussion and national focus:

Ofsted says special educational needs 'biggest issue' for schools - BBC News

from 2018-2023, there has been an 81% increase in EHCPs

• There are many professionals and agencies involved and often they are not joined up around cohorts of need –

these are defined in the Code of Practice as:

(1) Communication & interaction;

(2) Cognition & learning;

(3) Social, emotional & mental health, and;

(4) Sensory &/or physical needs.

There are often conflicting demands on different parts of the system resulting in different prioritisation of delivering services for children with SEND. Examples include:

- Current behaviors/practice direct demand to specialist support – impacting spend allocations.
- Lack of focus on effective early intervention
- Ineffective and weak joint commissioning
- Parents and professionals not having confidence in the local offer
- Not having a consistent and strategic ownership and oversight of area system
- Workforce vacancies.

In December 2024, the Department for Education (DfE) announced £740m of funding to increase the number of places available for Send pupils in mainstream schools.

Human rights approach to preparing for adulthood

NHS guidance states the need to “think about how to best involve the young person so that they are involved in these significant decisions about their lives” (NHSE guidance for meeting the needs of autistic adults in mental health services).

This is supported by a variety of legislation (The Human Rights Act Mental Health Act 1983, The Mental Capacity Act 2005 and the Care Act 2014).

“Each autistic person should be at the centre of their own transition and be supported to participate from the outset”.

Human rights for young autistic people and young people with a learning disability aged 14 – 25 (guide) | Local Government Association

Notwithstanding requirements under various legislation, there are recommended requirements also, under the United Nations Convention on the Right of The Child, as well as the Convention of the Rights of Persons with Disabilities (both signed up for by the UK).

The relevant conventions state:

The following rights are of equal importance to every child. Every child has the right to:

- Relax and play (Article 31)
- Freedom of expression (Article 13)
- Be safe from violence (Article 19)
- An education (Article 28)
- Protection of identity (Article 8)
- Sufficient standard of living (Article 27)
- Know their rights (Article 42)
- Health and health services (Article 24).

UN Convention on Rights of a Child (UNCRC) - UNICEF UK

And

“The purpose of the present Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.

Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.”

Convention on the Rights of Persons with Disabilities | OHCHR

Autism and parent blame

The report ‘Autism and Parental Blame: Blamed Instead of Helped’, is intended for professionals, policymakers, researchers, and anyone who is interested in improving the lives of autistic children, young people, and their families.

It presents key findings from all three phases of the project and sets out eight areas that we believe are worthy of further consideration. These are:

- Autism is widely misunderstood by professionals
- Accusations of blame result in trauma, long term damage and increased risk of suicide
- Autistic parents may be at higher risk of parental blame as they face additional discrimination when seeking help for their child
- Parents of autistic children have a high level of mistrust in services and professionals.
- Parents of autistic children may be at higher risk of child protection proceedings as parents were frequently accused of neglect or harm
- Parental knowledge is not recognised or valued,
- Parental blame is more likely before a child is diagnosed as autistic
- Current support offered to parents is often unhelpful and sometimes reported as doing more harm than good.

Autism and parental blame research | WMADASS

To be linked to SEND strategy, policies and improvement | Oxfordshire County Council)

Autism and ethnicity in education

National context

A study undertaken in 2020 found:

- Chinese and Black pupils were 38% and 26% more likely to be recorded with an Autism Spectrum Disorder (ASD) in the English educational system than White pupils.
- Pupils from a Roma/Irish Traveler background were almost 60% less likely to be recorded with ASD compared with White pupils.
- Pupils whose first language was not English were less likely to have an ASD diagnosis in the English education system.

They also noted that racial/ethnic differences in ASD were mediated through socioeconomic disadvantage. The greatest effect was found among Black pupils (with 12.41% of the increased prevalence of ASD among Black pupils being explained by social disadvantage).

Association of Race/Ethnicity and Social Disadvantage With Autism Prevalence in 7 Million School Children in England | Population Health | JAMA Pediatrics | JAMA Network

Autism and socio-economic disadvantage in education

When comparing socioeconomic disadvantages in the school population, we found that pupils with ASD (35.23%), pupils with ASD and a learning difficulty (37.93%), and pupils with other types of SEND (44.61%) all had higher proportions of socioeconomic disadvantage than pupils with no SEND (24.47%).

Our findings show that pupils facing social disadvantage were more likely to have ASD (aPR, 1.61 [95% CI, 1.59-1.63]).

Comments from Simon Tarrant: “There will be an additional impact on parents capacity for holding down a job plus SEND caring responsibilities, exacerbated if child not in school or frequently excluded - something to be considered in action planning.”

Association of Race/Ethnicity and Social Disadvantage With Autism Prevalence in 7 Million School Children in England | Population Health | JAMA Pediatrics | JAMA Network

The conversations with residents identified this as a theme. Residents that we were able to speak to, commented that they were confident in navigating and negotiating education systems. They also noted in most cases they had the resources, knowledge and confidence to do so, but they were worried for those families who did not have resources or confidence to advocate and not take “No” for an answer.

Resident and stakeholder feedback

- Poor communication in SEND services
- Trauma in education
- Mainstream education not suitable.

“Mainstream schools rough for neurodiverse people”

“Cliff edge at 18, mental health services said couldn’t support because he had autism.”

“We have a neurodiverse child with complex needs. We have been trying to access support for years and have been constantly ignored by services. We should have a Child in Need Assessment in place again this has been ignored despite assessment stating we need support.”

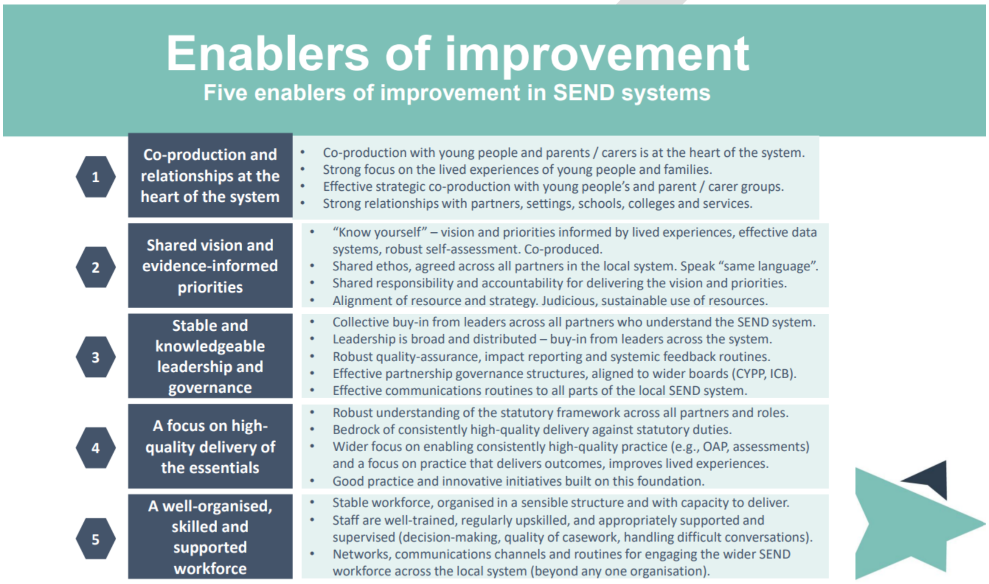
Gaps

- Support in mainstream education
- A clear and transparent pathway between children’s and adults services
- Training for all mainstream schools on support autistic young people.
- A whole family approach to support pre and post diagnosis
- Communication and transparency with families about SEND, EHCP, children’s social care pathways (which are often diagnostic rather than needs driven).

Recommendations

National research recommendations include, developing a continuum of local high-quality provision and enable all services to be inclusive and deliver excellent outcomes for children with SEND, including building on existing good practice.

- Enable children and young people with SEND to access opportunities that are important to them and for them.
- To provide timely and equitable access to high quality services before, during and beyond statutory school age including education, health and social care.
- To ensure that there is seamless and effective transition at all points for young people with SEND to access opportunities that are important to them and for them.



Enablers of improvement

Five enablers of improvement in SEND systems

1	Co-production and relationships at the heart of the system	• Co-production with young people and parents / carers is at the heart of the system. • Strong focus on the lived experiences of young people and families. • Effective strategic co-production with young people's and parent / carer groups. • Strong relationships with partners, settings, schools, colleges and services.
2	Shared vision and evidence-informed priorities	• "Know yourself" – vision and priorities informed by lived experiences, effective data systems, robust self-assessment. Co-produced. • Shared ethos, agreed across all partners in the local system. Speak "same language". • Shared responsibility and accountability for delivering the vision and priorities. • Alignment of resource and strategy. Judicious, sustainable use of resources.
3	Stable and knowledgeable leadership and governance	• Collective buy-in from leaders across all partners who understand the SEND system. • Leadership is broad and distributed – buy-in from leaders across the system. • Robust quality-assurance, impact reporting and systemic feedback routines. • Effective partnership governance structures, aligned to wider boards (CYPP, ICB). • Effective communications routines to all parts of the local SEND system.
4	A focus on high-quality delivery of the essentials	• Robust understanding of the statutory framework across all partners and roles. • Bedrock of consistently high-quality delivery against statutory duties. • Wider focus on enabling consistently high-quality practice (e.g., OAP, assessments) and a focus on practice that delivers outcomes, improves lived experiences. • Good practice and innovative initiatives built on this foundation.
5	A well-organised, skilled and supported workforce	• Stable workforce, organised in a sensible structure and with capacity to deliver. • Staff are well-trained, regularly upskilled, and appropriately supported and supervised (decision-making, quality of casework, handling difficult conversations). • Networks, communications channels and routines for engaging the wider SEND workforce across the local system (beyond any one organisation).

Improving the SEND system for children, young people and their families

Supporting more autistic people into employment

The Buckland Review of Autism Employment: report and recommendations, Published 28 February 2024 The review sought views from autistic people, employers, employer organisations, and specialist support groups. It explored how employers recruit, retain and develop autistic people, identifying barriers to this happening and developing effective ways to overcome those barriers, with the aim of significantly improving the autism employment rate over the next 5 years.

It states that despite their wish to work, only around 3 in 10 working age autistic people are in employment, compared with around 5 in 10 for all disabled people and 8 in 10 for non-disabled people.

Resident and stakeholder feedback

“Some simple (Needed) mentoring help, with CV writing, interviews.
You know, help with raising awareness to employers, there are fantastic people out there. The actual interview process, I don't know how many interviews I've kind of, you know, messed up because I'm too direct and don't play the game.”

Gaps

Local autism employment data

Information on how to access support for the autistic people, to apply for and maintain, employment.

Recommendations

Recommendations

1. Use of an Employment toolkit such as **Supporting neurodivergent people at work :: Workforce Transformation**.
2. Link to **Oxfordshire Employment | Oxfordshire County Council**.
3. Review Oxfordshire County Council’s recruitment process to ensure it is accessible for neurodivergent people.
4. Set up a task group for autistic/neurodivergent employees to review recruitment and retention needs.

Tackling health and care inequalities for autistic people

*Link to Oxfordshire Health Autism Strategy

National context

Tackling inequalities for adults with learning disabilities – SCIE guidance

Autistic adults are more likely than non-autistic adults to report poorer adult life outcomes (**37**), lower quality of life (**38**), symptoms of mental ill health and to be diagnosed with a mental health condition (**39** – **41**).

Many autistic people have at least one co-occurring condition, including mental and physical health conditions, other neurodevelopmental conditions, learning difficulties or a learning disability (**20**,**39**,**42**). For instance, an estimated 12-30% of autistic people have a co-occurring learning disability (**42**,**43**) and approximately a third report a diagnosed mental health condition (**44**,**45**).

Lever and Guerts estimate this higher at 78%: Lever AG, Geurts HM. Psychiatric co-occurring symptoms and disorders in young, middle-aged, and older adults with autism spectrum disorder. J Autism Dev Disord [Internet]. 2016;46(6):1916–30. Available from: **http://dx.doi.org/10.1007/s10803-016-2722-8**

Additionally, other neurodevelopmental conditions often co-occur with autism, for example, attention deficit/hyperactivity disorder (ADHD) has been found to have a lifetime prevalence of 40.2% in autistic people (**46**). NHS England » Meeting the needs of autistic adults in mental health services

The **NHS Long Term Plan** (2019) includes objectives for improving access to autism diagnosis and post-diagnostic support, as well as improving autistic people's mental and physical health.

Autistic traits, alongside many wider determinants of health, place autistic people at a higher likelihood than non-autistic people of needing mental health services during their lifetime, with approximately a third of autistic people reporting a diagnosed mental health condition. This increased need is often compounded by autistic people facing more barriers to good mental health care than non-autistic people; barriers such as inaccessible services, treatment which is less effective for autistic people than non-autistic people, and services with insufficient capacity to meet demand.

It is noted that also staff may also lack the knowledge and skills to change approaches to supporting autistic people, and people suspected to be autistic. A systematic review and thematic meta-synthesis. Clin Psychol Rev [Internet]. 2022;93(102131):102131. Available from: **https://linkinghub.elsevier.com/retrieve/pii/S0272735822000162**

Autism or learning disabilities aren't a mental health problem, but research suggests that autistic people, and people with learning disabilities are more likely to experience mental illness.

Autistic people also often face significant healthcare disparities – for example, more than 5 in 10 autistic adults have had depression, and autistic adults (without an intellectual disability) are more than 9 times more likely to consider suicide than the general population."

The latest National LeDeR report which reported on Autistic people for the first time, detailed suicide, misadventure* or accidental death** as the highest cause of death for this cohort of people, accounted for in 11 cases. Master LeDeR 2023 (2022 report) (kcl.ac.uk)

Autistica's **Happier, Healthier, Longer Lives** briefings have identified that autistic people have poorer physical health outcomes and a lower life expectancy than the general population. The available evidence indicates that autistic people die on average 16 years earlier than the general population (Premature Mortality in Autism Spectrum Disorder, The British Journal of Psychiatry, 2016) (Latest research indicates this gap is 6-7 years, this is because previous research has combined autism with LD: **Premature death of autistic people in the UK investigated for the first time | UCL News - UCL – University College London**).There are many possible reasons for this gap, including poor professional understanding of autism among health and care staff, which can result in autistic people having signs of illness or their needs overlooked. Without the right understanding, autistic people can miss out on adjustments needed for them to engage in medical appointments, which often leads to distressing experiences, avoiding seeking medical attention or losing out on support.

Mental Health 360 | Access | The King's Fund - also references poor access and poor outcomes.

We note that as well as healthcare, there continues to be poor access to social care for autistic people:

- SDS report 2022 Report highlights barriers to social care support for Autistic people - Self Directed Support Scotland
- Autism: Improving access to social care support (Sheffield Autism Society) 2017 Autism: Improving access to social care for adults
- Barriers to healthcare and their relationship to well-being and social support for autistic adults during COVID-19, Featherstone et al 2022 (Barriers to healthcare and their relationship to well-being and social support for autistic adults during COVID-19 – PMC)
- Healthwatch 2018Six ways we can improve services for people with autism | Healthwatch.

Autism and drugs and alcohol

Research shows that 45% of autistic adults would not seek help if they were experiencing problematic drinking. Reasons for this include concerns about challenging, unfamiliar environments and being judged and misunderstood by a therapist. Drug and alcohol service providers have reported that they have received no specific training or support focusing on autism and they thought that treatment outcomes of autistic clients were likely to be worse than non-autistic clients.

There is a potential gap in local data on autistic people drawing on support for drug and alcohol addiction.

Autism, human growth and development

“Menopause was a nightmare”

“Some autistic people report that menopause played a role in discovering that they are autistic, as their autistic traits became more apparent during menopause or perimenopause.

Menopause can affect autistic people in a number of ways and their autistic characteristics may become more apparent including:

- Intensified sensory sensitivities
- Difficulty with emotional regulation
- Difficulty with executive function, for example planning, and focusing
- Increased difficulty with social interaction and communication
- Some autistic people with ADHD found their ADHD traits became more prominent. “ **NAS_MenopauseGuide.pdf**

Another area to consider for autistic people is the experience of puberty. While research is available on Menopause, there is limited research on puberty and autism. Due to the physiological changes experienced, it would be beneficial to explore the impact of the physical and emotional changes on autistic people, to provide the most appropriate support at certain stages of their life.

Local context

Oxfordshire CAMHS data:

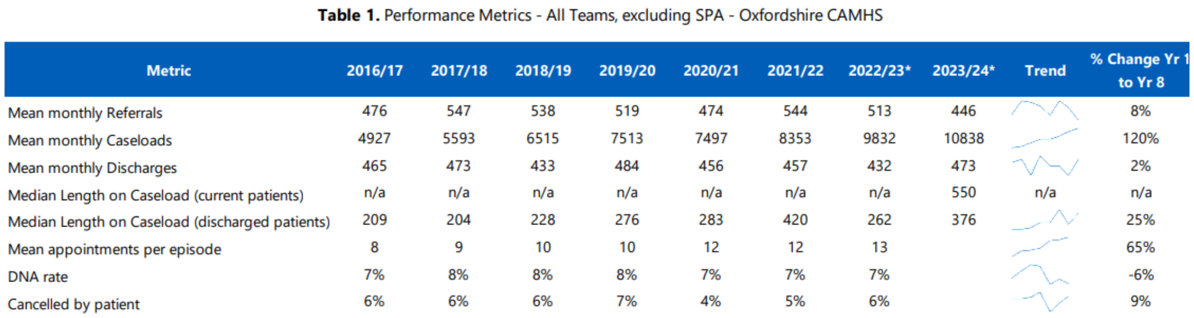


Table 1. Performance Metrics - All Teams, excluding SPA - Oxfordshire CAMHS

Metric	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23*	2023/24*	Trend	% Change Yr 1 to Yr 8
Mean monthly Referrals	476	547	538	519	474	544	513	446		8%
Mean monthly Caseloads	4927	5593	6515	7513	7497	8353	9832	10838		120%
Mean monthly Discharges	465	473	433	484	456	457	432	473		2%
Median Length on Caseload (current patients)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	550	n/a	n/a
Median Length on Caseload (discharged patients)	209	204	228	276	283	420	262	376		25%
Mean appointments per episode	8	9	10	10	12	12	13			65%
DNA rate	7%	8%	8%	8%	7%	7%	7%			-6%
Cancelled by patient	6%	6%	6%	7%	4%	5%	6%			9%

Resident and stakeholder feedback

“Online GP form took me 1.5 hours to complete because it asked me if there was anything else I would like to add, and then the GP didn’t even refer to it”

“Needed help with a mental health collapse for my teenage autistic child. A year and a half wait for first appointment. Initial online appointment by someone who tried to tell me .. wasn't depressed, and this was normal for autistic people and to do some activity days. Ill-informed and failing. Offered completely inappropriate CBT type thing or social prescriber neither of which my child could access (because depressed) also because not autism friendly. The social prescriber however has been supportive and managed to get us (with a fight) an appointment with a psychiatrist 6 months after my initial complaint and in the meantime my child's mental health has got worse. Mine has been affected as well."

"My child has ADHD and CAMHS refused to see them, they said he did not meet their threshold for an assessment."

Gaps

A new commissioning strategy that looks at the needs of the Oxfordshire Autistic population.

Link to and collaboration with Oxford health and public health to develop and evaluate actions to address health inequalities for autistic people in Oxfordshire.

Recommendations

National recommendations:

improve health and social care staff understanding of autism

Social prescribing has shown positive effects on mental health, subjective well-being, self-esteem, and social isolation in general population groups (Boyce et al., 2018; Foster et al., 2020; Kimberlee, 2016).

Build the strategy with commissioning teams, to embed recommendations around housing, care, education and co-production into commissioning strategies and approaches to commissioning support for Autistic people in Oxfordshire, using guidance such as the following:

- **https://www.skillsforcare.org.uk/resources/documents/Developing-your-workforce/Care-topics/Autism/Commissioning-autism-services**
- **NHS England » National framework and operational guidance for autism assessment services**

School-based identification programme - based on a pilot in Bradford This involves health and education staff working together in schools to assess children suspected to be autistic. Early findings from the pilot are positive, with children being identified and getting support earlier. **The national strategy for autistic children, young people and adults: 2021 to 2026 - GOV.UK**

Building the right support in the community and supporting people in inpatient care

This section sets out some areas where there is limited local data, but these are areas which need consideration.

National context

"The numbers of people diagnosed as autistic in mental health inpatient settings is increasing; data collected by NHS England tells us that there was an increase of 7.3% in the numbers of autistic inpatients (both with and without a learning disability) in mental health hospitals between March 2017 and August 2023 and an increase of 51.3% in the numbers of autistic inpatients without a learning disability in the same timeframe. More work is needed to ensure all mental health services are accessible to autistic adults and have capacity to meet their mental health needs, which can range from mild to severe."

Mental ill health is a significant aspect of increased mortality for autistic adults. Autistic adults are up to nine times more likely than non-autistic adults to experience suicidal ideation (**47**,**48**). Overall, autistic adults are up to seven times more likely to die by suicide than non-autistic adults (**21**,**49**). The relative risk may be greater for autistic people with co-occurring ADHD (**50**) and for autistic women, who have been found to be 13 times more likely than non-autistic women to die by suicide (**21**). Prevalence of non-suicidal self-injury in autistic people is also high, with a recent meta-analysis suggesting this may be around 42% (**51**).

Autism in a mental health inpatient setting: Alexis' story: **Rarely an hour goes by that I don't think about what happened in hospital.**

"People in hospital report widespread frustration, feel that hospital environments are not conducive to getting/staying well, and face multiple barriers to leaving hospital. Without someone to fight for them, people struggle to overcome the inertia built into our current systems and processes."

"Hospital staff from different professional backgrounds do not have a shared sense of how many people really need to be in hospital or how many people could be cared for in different settings – suggesting that different definitions, world views and professional judgements might be at play."

Why are we stuck in hospital? - University of Birmingham

The research proposed actions that local authorities should take including:

- Agree as a local system that delayed discharges are a potential harm event,
- Use the existing tools and frameworks (including the 12-point discharge plan, the clinically ready for discharge definition, the joint guiding principles, and Care (Education) and Treatment Reviews (C(E)TR) and the C(E)TR toolkit discharge standards)

- Identify and engage at the earliest opportunity with all relevant partners, including (where appropriate) the Care Quality Commission, and the Ministry of Justice where there are restrictions relating to a person's care and discharge.

Throughout a person's inpatient stay:

- ensure that the clinical care and treatment plans are based on a holistic assessment of need, and have a plan for discharge from the point of admission
- have a continued focus on the person's mental, physical and emotional wellbeing
- ensure that discharge planning properly considers any support needed through the transition from hospital to life in their local community.

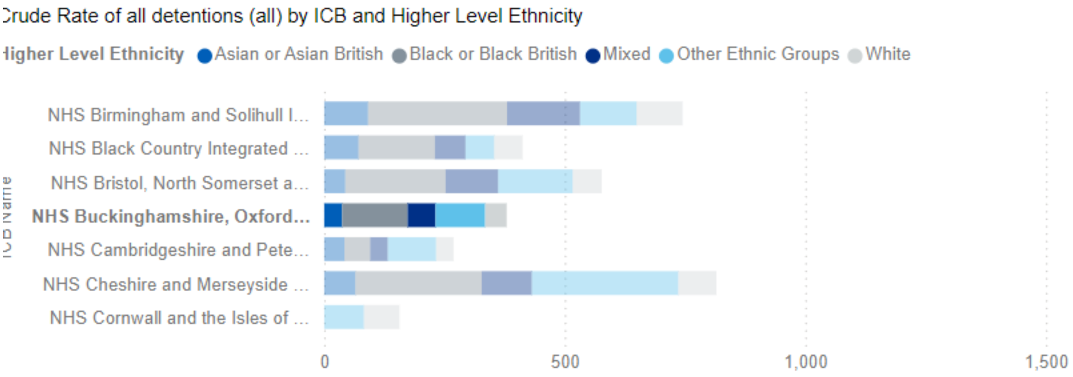
NHS England » Five key elements for discharge – supporting people with a learning disability and autistic people to leave hospital

- The Dynamic Support Register (ensuring autistic people at risk of inpatient admission are identified and receiving the correct multi-agency support and interventions **NHS England » Dynamic support registers and Care (Education) and Treatment Review code of practice**
- Ensuring CeTR is in place and providing the correct support functions, once admitted into hospital ensuing the Commissioner Oversight Visits are of good quality and happening: **NHS England » Monitoring the quality of care and safety for people with a learning disability and/or people who are autistic in inpatient care**

Racial disparities in Mental Health

Local data and information:

At the end of November 2024, similar to most ICB areas, the majority of people detained under The Mental Health Act are recorded as Black or Black British, in the Buckinghamshire, Oxfordshire ICB footprint (likely to need to include Berkshire also).



In November 2024, there were 30 inpatients recorded with an autism diagnosis and a further 15 autistic people also with a learning disability diagnosis, in the NHS Buckinghamshire, Oxfordshire and Berkshire West ICB area (NHS England's Learning disability services monthly statistics from the Assuring Transformation (AT) dataset reports).

Autism and housing options

National context

The autistic experience of homelessness: Implications from a narrative enquiry - Beth Stone, Ailsa Cameron, Sandra Dowling, 2023

"Emerging research suggests autistic people are disproportionately represented in homeless populations (**Churchard et al., 2019**; **Kargas et al., 2019**; **Pritchard, 2010**). Less is known about how autistic people experience homelessness and what prevents them from exiting homelessness

After becoming homeless, a clinical diagnosis is more difficult to obtain due to the lack of regular service access and requirement of additional information, such as developmental history (Nishio et al., 2015). In a recent screening study of 106 adult people in London, 12.3% of the sample met Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) autism criteria, but only one had a pre-existing diagnosis (Churchard et al., 2019). In consideration of service eligibility, the lack of clinical diagnosis could constitute a significant barrier to exiting homelessness for autistic people."

Local data on homelessness

There was a 39% increase in households assessed as owed a homelessness duty (prevention or relief) in Oxfordshire in 2023. It had risen from from1906 in 2022 to 2655 in 2023.

Resident and stakeholder feedback

"Quite a big problem in Oxfordshire is housing"

Gaps

Considering and meeting the sensory needs of autistic people in housing | Local Government Association

Local homelessness data on autism.

Recommendations

Review homelessness data for disability type and break down to include autism, or neurodiversity (likely to be undiagnosed).

Consider or review current screening mechanisms to identify additional support needs associated with autism, particularly if undiagnosed.

Additional support for identified autistic people to transition to accommodation due to potential challenges of change in environment and routine and sensory needs.

Improving support within the criminal and youth justice systems

Autistic people, like anyone else, can sometimes come into contact with the criminal justice system

Average age range for early concerns for both autistic adults and parent/carers is 13-15 years

Many autistic respondents had not had their autism diagnosis until adulthood, whereas most relatives of parent/carers were diagnosed at primary school age

75% of autistic adults and 86% of parent/carers reported that they had been visited at least once by the police

In most cases both autistic adults and parent/carers received no reasonable adjustments from all sections of the criminal justice system.

When they were put in place, adjustments that were common when being interviewed by police were use of an appropriate adult and clear language when questioning. In court the most common adjustments were assessment by a psychologist or psychiatrist and being told in advance what to expect.

Higher rates of female autism in prisons: **Short report: Prison-reported rates of autism in female prisons in England - Katy-Louise Payne, Emma Gooding, 2025** higher rates of autism in prisons **Characterization of autism spectrum disorder inside prison - PMC**:

We do not have access to local data on autism presentation in the Oxfordshire Criminal and Youth Justice Systems.

Additional areas for consideration

Keeping autistic people safe from abuse

There are currently limited resources available on how to approach safeguarding of children and adults, who are autistic. Safeguarding requirements will follow statutory requirements in Safeguarding, generally – however there are questions around known inequalities for autistic people, that may increase their risk of harm and abuse, and have been subject of some serious cases such as that of Winterbourne View and Cawston Park.

LeDeR data has also only recently started to include autistic people.

We would recommend working with Oxfordshire Safeguarding Adults Board and The Oxfordshire Safeguarding Children's Partnership to review information and guidance on the specific needs of autistic people, in Safeguarding process and procedures, as part of the strategy development.

This should include, (not limited to):

1. Supporting autistic parents through child protection proceedings
2. Tailoring safeguarding awareness for children, for autistic children, where they may communicate in different ways
3. Supporting autistic adults to understand indicators of abuse and support available, and various ways to raise a concern.
4. Supporting professionals to recognise that changes in behaviour, rather than verbal disclosure could indicate potential abuse and trauma.

Autism and intimate lives

"Intimate relationships are an important, yet ordinary, part of many people's lives. However, autistic people experience greater challenges around sex and intimate relationships and more loneliness and isolation. As diagnostic rates for autism in the United Kingdom increase, international research shows that support around sexuality and gender diversity is imperative to promote autistic people's well-being. Health and social care policies should guide social care systems to address inequalities that autistic people face. However, our recent policy analysis shows that national health and social care policies in England tend to overlook support for intimate relationships" **A Critical Analysis of How Local Autism Strategies Represent Autistic Adults' Intimate Lives | Autism in Adulthood**

Supported Loving have tailored, accessible resources to inform, and promote healthy and informed relationships. **Choice Support | Supported Loving**

While there is no local information or indeed feedback in relation to this area, it was clear from conversations with residents that 'ordinary lives', relationships and self-awareness was an important part of their experience as young people and adults.

We would recommend linking with public health to ensure that any agenda relating to sexual health, and healthy relationships takes into account the needs of autistic people.

Autism and aging

Some residents that we spoke to, discussed their experience of being diagnosed in later life.

One resident said that she had gone through life diagnosed with everything else including post-natal depression and anxiety and found Menopause a ‘nightmare’, before she eventually considered being screened for autism. The resident went onto explain how it has helped in the workplace, to be able to identify when she needs additional support in her workplace to reduce ‘burnout’.

Another resident discussed her experience as an adult carer for her parents, one of whom has cancer and is end of life. She stated that she would like to see support for autistic carers and specific support to prepare for and after the death of a person in their family.

Looking to the future

1. Incorporating **Mental Health Act** reforms that relate to autistic people.
2. Link to findings of Social Care Commission review due 2028 (initial findings to be shared 2026).
3. Review implications of '**Get Britain Working**' white paper – only 30% of autistic people nationally, are in work. Including review of the impact on Promoting Independent Payments,

.

Final summary

While there are a number of areas to consider, as included in this document, there are a few areas which we feel outweigh some, due to the consistency in feedback from residents and stakeholders that we spoke to, and the detail within that feedback.

These areas are:

1. Special Education Needs and Disabilities (SEND) support, pathways, information and services
2. Moving between childrens and adults services (often referred to as ‘transitions’) and preparing for adulthood, support, pathways, information and services.
3. Mainstream education support for autistic people.

We would suggest these as the top three areas to review and determine short and long-term actions against based on current work taking place across children and SEND and would highly recommend identifying real opportunities for co-producing this part of the strategy based on feedback from residents

In addition to these, and the overview contained in this report of recommendations, we would highlight again, the importance of intersectionality and not considering the needs of autistic people in isolation of multifaceted areas of identity and need that lead to multiple inequalities faced by individuals drawing on health and social care support, and reasonable adjustments and better knowledge and skills in health and social care services including (but not limited to):

- Perinatal and postnatal services
- Children’s and adults social care workforce
- Drug and alcohol services
- Housing services.

Good communication with Oxfordshire residents has been a key message given to us, by residents and would therefore advise that co-production and involvement become an integral party to the development of this strategy and accompanying evaluation framework.

References

Youth Justice Report

Oxfordshire Joint Health Scrutiny Committee (HOSC) Annual Report 2022/23

The Oxfordshire Way in Adult Social Care

Making-It-Real.pdf

Autism and addiction | Autistica

PowerPoint Presentation 16.9

Preparation for adulthood arrangements in local areas: a thematic review - GOV.UK

BOB ICB LEDER 2023

Autism-Strategy-Final-draft-290622.pdf

Autism and the Law — Autism Alliance UK

Appendices

Literature review: Key messages to support the building of an All-age Autism Strategy

To support the work, a short literature view was undertaken to consider the research question , “What factors contribute to good lives for autistic people?”

This document has been organised based on the six key areas outlined in the **National Autism Strategy (2021–2026)** to enhance the lives of autistic individuals across the country.

Area 1: Raising Awareness and Understanding of Autism

Public campaigns play a key role in raising awareness and reducing the stigma surrounding autism. While professional knowledge of autism has improved, public understanding remains limited. Despite 99.5% of people being aware of autism, misconceptions are widespread: over one-third of UK residents still mistakenly believe autism is a learning disability, and 30% are unsure whether it can be cured (Autism Alliance, 2024). These gaps in understanding perpetuate negative stereotypes, highlighting the need for targeted education to foster a more accurate and empathetic perspective on autism.

Evidence:

Short-term outcomes:

- **Improved Public Knowledge**: Campaigns and education initiatives can help dispel stereotypes and increase understanding of autism to promote more inclusive attitudes in communities, schools, and workplaces (Autism Alliance, 2024).
- **Professional Training:** Providing training for healthcare, social care, and education professionals can lead to earlier identification of autism and better immediate responses to the needs of autistic individuals (N8 Research Partnership, 2024; Autism Alliance, 2024).
- **Autism training** for transport staff, businesses, and community services to make public spaces more accessible. See initiatives including:
    - *Nexus (2023)*: Trained over 100 staff (Metro, ferry, and bus stations) in autism awareness. The programme included communication techniques, recognising hidden disabilities, and creating sensory guides to make services autism-friendly.
    - *NAS Pilot with DfT (2022a)*: Collaborated with the Department for Transport to develop a programme reducing barriers for autistic passengers, aiming to decrease social isolation.

Long-term outcomes:

- **Enhanced Data Collection:** Improved mechanisms for gathering data to better understand the needs and experiences of autistic individuals (Heyl et al., 2023).
- **Creation of Autism-Friendly Spaces:** Development of environments that accommodate sensory and accessibility needs, promoting greater inclusion in public spaces (Rees and Tissot, 2023; Milton et al., 2016).
- **Expanded Professional Understanding:** Increased awareness among professionals in public services, enabling earlier recognition and identification of autism in children and adults (Crane et al., 2018; Rogers et al., 2016).

Area 2: Support for Autistic Children and Young People in Education

Supporting autistic children and young people in education requires targeted interventions to address the challenges they face. Key priorities include improving the Special Educational Needs and Disabilities (SEND) system to better meet the needs of autistic students, implementing anti-bullying campaigns, and providing teacher training to foster inclusive learning environments. Additionally, supporting transitions to adulthood—such as access to higher education and employment opportunities—remains essential for long-term success.

Evidence highlights significant gaps in support. Delays in diagnosis and inadequate school interventions negatively affect the emotional and physical health of autistic children and their caregivers. Training is needed to clarify thresholds for education, health, and care needs assessments while promoting evidence-based approaches (Martin-Denham, 2022). Funding constraints further compound these issues: only 2% of school leaders in England report having sufficient funding for Educational, Health, and Care Plans (EHCPs), and 94% face challenges in supporting disabled students (King et al., 2018).

Bullying is another critical concern. In the UK, research from NAS (2022b) indicates that 34% of autistic children report experiencing bullying at school. International evidence suggests even broader challenges: pooled prevalence rates show 47% of autistic individuals experience bullying, 16% face child abuse, 40% endure sexual victimisation, 13% experience cyberbullying, and 84% report multiple forms of victimisation (Trundle et al., 2023).

Short-term outcomes:

- Ensure Autistic Children and Young People feel supported in schools
- **Clear and easy access to support** for families and young people where the autistic young person is experiencing difficulties accessing school based learning, including through non-attendance (Rees and Tissot, 2023)

Area 3: Improving Employment Opportunities

Employment opportunities for autistic individuals remain significantly limited, with systemic barriers and societal biases contributing to high unemployment rates. In the UK, only 29% of autistic people aged 16–64 are in employment, with just 16% in full-time work (ONS, 2021; Autism.org, 2024). This contrasts starkly with the willingness and capability of many autistic individuals to work. Globally, the unemployment rate for autistic people is estimated at 80% (Ki-moon, 2015).

Challenges in accessing employment are multifaceted. Hiring processes, such as job applications and interviews, often fail to accommodate neurodiverse candidates, leading to exclusion (Davies et al., 2023). Moreover, social networks—frequently critical for job opportunities—tend to be smaller for autistic individuals, reducing their access to suitable roles (Markel and Elia, 2016; Orsmond et al., 2013). Autistic people also face barriers in securing work experience and tailoring their skills to job requirements, further reducing their employability (Baldwin et al., 2014; Vincent, 2020).

Many autistic individuals report that employers focus on their diagnosis rather than their abilities, reflecting a pervasive culture of ableism in employment systems (Martin, 2020). This issue is compounded by misconceptions, as behavioural and social challenges are more likely to lead to job loss than the inability to perform assigned tasks. These systemic issues underline the need for targeted interventions to promote inclusivity and address biases in employment practices.

Efforts to improve employment opportunities must address these barriers through initiatives such as autism-inclusive hiring practices, tailored support for job retention, and education campaigns to challenge ableism and shift societal perceptions of autism in the workplace.

Short-term outcomes:

- **Support autistic residents** who want to work to have better access to employment opportunities (Mavranezouli et al., 2014), prepare individuals for employment by developing or improving their employability skills using a customised approach (specialist employment services) (Lynas, 2014).
- **Support employers** to understand the needs of autistic people in the workplace and provide practical examples of how reasonable adjustments can be applied prior to application, at interview and after recruitment. (Romualdez et al., 2021)

Preventing instances where employers don't see their ability, but rather their autism.

- **Training** for job centre staff to better assist autistic job seekers (UK Government, 2021)
- **Tackling challenges in retirement planning** and adjustment for autistic adults and awareness of avenues for improved support during and after the retirement transition (Davies et al., 2024)

Long-term outcomes:

- Recognising and leveraging the strengths of autistic individuals enriches society and contributes to economic productivity (Autism Alliance, 2024; Mavranezouli, 2014)
- Accessible support and advice around welfare benefits system
- Working with employers to create autism-friendly workplaces (Remington and Pellicano, 2019).
- Enhanced support through the Access to Work scheme or work internship programs (Romualdez et al., 2020)

Area 4: Equal Access to Health and Social Care Services

Autistic individuals face significant barriers when accessing health and social care, contributing to stark disparities. Although autism is not a degenerative condition or illness, its characteristics—including differences in communication, social interaction, and sensory processing—can be disabling in many contexts (Barber, 2017; World Health Organisation, 2018). These factors, combined with systemic issues, result in a higher prevalence of preventable physical and mental health concerns, as well as increased mortality and shorter life expectancy compared to the general population (Hirvikoski et al., 2016; Hudson et al., 2019; Kinnear et al., 2019; Woolfenden et al., 2012).

Autistic individuals are significantly more likely to have co-occurring conditions. For instance, 70% have a mental health condition, and 40% live with two or more (UK Parliament, 2020). Anxiety, depression, and a lower quality of life are more common in this population, with suicide being a leading cause of early mortality (Autistica, 2024). Research shows that up to 66% of autistic adults have considered suicide, and 35% have attempted it. While autistic individuals make up 1% of the UK population, they account for as much as 15% of those hospitalised after a suicide attempt (Autistica, 2024).

Research highlights stigma, communication challenges, and anxiety as common experiences for autistic people in health and social care settings (Grant et al., 2024). These barriers often lead to unmet needs and significant health inequalities. Autism Health Passports (AHPs) offer a potential solution by providing standardised information about care needs, yet a recent study found that only 4% of autistic participants were familiar with them, and 73% had never encountered one. Barriers to using AHPs include fears of discrimination, staff unfamiliarity, and negative responses from professionals (Grant et al., 2024).

Despite the urgent need for tailored support, adjustments in health and social care remain inadequate. Services must adopt meaningful changes, including improved sensory environments, clinician training, and more accessible services. Bridging gaps in diagnosis, particularly for females, and creating policies that reflect the lifelong needs of autistic individuals are essential to reducing inequalities and improving outcomes.

Focus:

- Reducing diagnosis waiting times with significant funding.
- Improving adult diagnostic pathways and post-diagnostic support.
- Expanding community mental health services to prevent crises.

Short-term outcomes:

- Ensuring that need/support is evaluated on an individual basis, rather than being prescribed homogenously (Spain et al., 2021)
- Assessing the suitability of residential care for older autistic adults (Davies et al., 2024)

Long-term outcomes:

- Actively challenge mainstream services where autism diagnosis (or lack of diagnosis) is perceived as a barrier to access to prevent discriminatory practice (Wilson et al., 2023; Radev, 2023)

Area 5: Community-Based Support

Community-based support is vital in addressing the unique needs of autistic individuals by promoting social inclusion, improving well-being, and reducing health inequalities. In the UK, an autism diagnosis alone does not grant access to mental health or learning disabilities (LD) services (Barber, 2017; Department of Health, 2014). The UK Government's Autism Strategy (Department of Health, 2014) emphasises the need for community-based, low-level services for autistic adults. These services aim to reduce inpatient admissions, promote social inclusion, and support individuals who are ineligible for or not engaged with other services, ultimately improving outcomes for this group.

Social prescribing, a key component of this support model, links individuals to community-based activities such as art groups, exercise clubs, and outdoor events, through referrals from GPs or link workers (Chatterjee et al., 2018; Kimberlee, 2015). This holistic approach offers an alternative to traditional healthcare by focusing on long-term well-being and addressing the social determinants of health. It is increasingly prioritised and funded within primary care networks in the UK (NHS, 2019; Polley et al., 2017). Social prescribing has shown positive effects on mental health, subjective well-being, self-esteem, and social isolation in general population groups (Boyce et al., 2018; Foster et al., 2020; Kimberlee, 2016).

Autistic individuals, who often face significant disadvantages such as lower educational attainment, high rates of unemployment, housing disparities, and social isolation (Brugha et al., 2011; National Autistic Society, 2016; Orsmond et al., 2013), could greatly benefit from these initiatives. By addressing social factors like financial difficulties, skill development for employment, and opportunities for social participation, social prescribing can reduce stress, enhance emotional well-being, and improve relationships (Jani et al., 2020; Parkinson et al., 2015; South et al., 2008).

Autistic people experience greater challenges around sex and intimate relationships and more loneliness and isolation (Jay et al, 2024). Intimate relationships are a common part of life for many adults but are less accessible to autistic people, who face stigma and significant barriers in this area (Botha et al., 2022). These challenges stem largely from navigating a neuro-normative, heteronormative society with dating norms that exclude or even harm autistic individuals. Harmful stereotypes, including the infantilisation of disabled people, frame relationships as inappropriate or risky for autistic individuals, further marginalising them and limiting their access to support (Botha et al., 2022; Huysamen et al., 2023; Jay et al, 2024). This lack of support contributes to greater loneliness, social isolation, and mental health issues for autistic people, who are at higher risk of suicide compared to non-autistic individuals. Positive relationships can reduce loneliness, improve mental health, and enhance well-being (Cassidy and Rodgers, 2017; Hedley et al, 2019). Despite many autistic people wanting and valuing support around sex and relationships, it is rarely provided (Bates and Matthews, 2024)

Gaps in current health and social care provision often leave autistic individuals without adequate support. There is also an increasing call for greater funding to help local authorities support autistic individuals in integrating into their communities. Increased investment is needed to provide services that focus on daily living skills, such as cooking, budgeting, and personal care, which can enhance independence and quality of life. Expanding services that promote social inclusion, like community groups, work placements, and volunteering opportunities, is equally crucial. These services would help autistic individuals build relationships, gain confidence, and actively participate in their communities.

Integrating social prescribing into community-based support systems, combined with increased funding and expanded services, can address these gaps in support. By providing tailored, accessible, and holistic care, this approach would not only improve health outcomes for autistic individuals but also empower them to lead fulfilling lives within their communities.

Short-term outcomes:

- Importance of understanding cultural views of autism and the need to raise awareness, reduce stigma and provide support to encourage families not to delay seeking help for their children (Fox et al., 2017)

Long-term outcomes:

- Integrating social prescribing into community-based support systems
- Increasing funding for local authorities to help autistic people integrate into their communities.
- Expanding services for daily living skills and social inclusion.

Area 6: Addressing the Needs of Autistic People in the Justice System

Autistic individuals face significant challenges within the criminal justice system (CJS), often due to misidentification or lack of recognition of their condition. The condition affects various stages of their journey through the CJS, from police questioning to court proceedings and long-term legal outcomes. However, prevalence estimates within the CJS remain unclear (Robinson et al., 2012), and autism is frequently overlooked or misunderstood (Woodhouse et al., 2024). Research indicates that the lack of autism-specific screening tools and insufficient awareness among police, courts, and prison staff exacerbate these issues, leaving many autistic individuals disadvantaged and vulnerable (Chaplin and McCarthy, 2014).

For example, police officers report dissatisfaction in handling interactions with autistic individuals, with many feeling inadequately trained to manage such situations. Crane et al. (2024) surveyed 394 police officers, and 52% reported feeling unknowledgeable about autism, with 29% feeling poorly equipped to manage autistic individuals effectively. The Criminal Justice Joint Inspection (2014; 2015) identified that insufficient support and awareness within the police, courts, and prisons contribute to a lack of appropriate accommodation for autistic people, affecting their experiences and treatment.

Furthermore, autistic individuals may face heightened distress when navigating environments like police stations or prisons, where their communication and social interaction challenges are not adequately addressed. Adaptations such as noise-cancelling headphones or designated retreat spaces could help mitigate some of these difficulties, improving their overall wellbeing (Vinter, 2020).

The lack of specialised, autism-sensitive assessment tools and policy reforms in this area suggests that improvements in training, screening, and institutional adaptations are necessary to reduce the risk of distress and miscarriages of justice for autistic individuals within the CJS.

Evidence:

Short-term outcomes:

- Training frontline justice staff to improve understanding of autism.

Long-term outcomes:

- Ensuring better treatment and accommodations within the system.
- Improved data collection on autistic individuals in contact with the justice system

Key legislation, strategies and guidance

- NHS Long Term Plan (2019)
- The National Strategy for Autistic Children, Young People and Adults: 2021 to 2026
- Department of Health in 2010 (Fulfilling and Rewarding Lives; the strategy for
- adults with autism in England)
- National Institute Of Health & Care Excellence (NICE) Guidelines
- Special Educational Needs and Disability and Childrens and Families Act 2014
- The Autism Act (2009)
- Strategy for Adults with Autism 2010
- Learning Disability Mortality Review (LeDeR/ learning from lives and deaths)
- Think Autism 2014 and Statutory Guidance 2015
- Care Act 2014
- Equality Act 2010
- The Health and Care Act 2022
- Core Capabilities Framework for Supporting Autistic People 2019. The Department of Health and Social Care

References

Autistica (2024) Understanding suicide in autism. Retrieved from: **https://www.autistica.org.uk/our-research/research-projects/understanding-suicide-in-autism#:~:text=Autistic%20people%20are%20much%20more,alarming%2035%25%20have%20attempted%20suicide**

Bates, C., & Matthews, R. (2024). No “cookie cutter rules”: best practice for social care staff in supporting autistic adults with relationships and sexuality. *Advances in Autism*, *10*(2), 69-81.

Botha, M., Dibb, B., & Frost, D. M. (2022). " Autism is me": an investigation of how autistic individuals make sense of autism and stigma. *Disability & Society*, *37*(3), 427-453.

Brice, S., Rodgers, J., Ingham, B., Mason, D., Wilson, C., Freeston, M., Le Couteur, A. and Parr, J.R., (2021). The importance and availability of adjustments to improve access for autistic adults who need mental and physical healthcare: findings from UK surveys. *BMJ open*, *11*(3), p.e043336.

Chaplin, E., & McCarthy, J. (2014). Autism spectrum disorder and offending–a UK perspective. *Autism Spectrum Quarterly*, (Summer), 14-16.

Crane, L., Batty, R., Adeyinka, H., Goddard, L., Henry, L. A., & Hill, E. L. (2018). Autism diagnosis in the United Kingdom: Perspectives of autistic adults, parents and professionals. *Journal of autism and developmental disorders*, *48*, 3761-3772.

Criminal Justice Inspectorates (2014). A joint inspection of the treatment of offenders with learning disabilities, within the criminal justice system: phase one – from arrest to sentence. In: PROBATION, H. M. S. I. O. (ed.). Manchester: Her Majesty’s Inspectorate of Probation; 2014.

Criminal Justice Inspectorates (2015). A joint inspection of the treatment of ofenders with learning disabilities, within the criminal justice system: phase two – in custody and the community. In: PROBATION, H. M. S. I. O. (ed.). Man- chester: Her Majesty’s Inspectorate of Probation; 2015.

Davies, J., Heasman, B., Livesey, A., Walker, A., Pellicano, E., & Remington, A. (2023). Access to employment: A comparison of autistic, neurodivergent and neurotypical adults’ experiences of hiring processes in the United Kingdom. *Autism*, *27*(6), 1746-1763.

Davies, J., Matthews, R., Romualdez, A. M., Pellicano, E., & Remington, A. (2024). “Retirement Is One Hell of a Change”: Autistic People's Experiences of Retiring. *Autism in Adulthood*.

Fox, F., Aabe, N., Turner, K., Redwood, S., & Rai, D. (2017). “It was like walking without knowing where I was going”: A Qualitative Study of Autism in a UK Somali Migrant Community. *Journal of Autism and Developmental Disorders*, *47*, 305-315.

Grant, A., Turner, S., Shaw, S. C., Williams, K., Morgan, H., Ellis, R., & Brown, A. (2024). “I am afraid of being treated badly if I show it”: A cross-sectional study of healthcare accessibility and Autism Health Passports among UK Autistic adults. *Plos one*, *19*(5), e0303873.

Hedley, D., Uljarević, M., Bury, S. M., & Dissanayake, C. (2019). Predictors of mental health and well-being in employed adults with autism spectrum disorder at 12-month follow-up. *Autism Research*, *12*(3), 482-494.

Heyl, J., Hardy, F., Tucker, K., Hopper, A., Marcha, M. J., Liew, A., ... & Gray, W. K. (2023). Data quality and autism: issues and potential impacts. *International Journal of Medical Informatics*, *170*, 104938.

Huysamen, M., Kourti, M., & Hatton, C. (2023). A critical overview of how English health and social care publications represent autistic adults' intimate lives. *Critical Social Policy*, *43*(4), 626-653.

Jay, B., Huysamen, M., & Hatton, C. (2024). A Critical Analysis of How Local Autism Strategies Represent Autistic Adults' Intimate Lives. *Autism in Adulthood*.

Lynas, L. (2014). Project ABLE (Autism: Building Links to Employment): A specialist employment service for young people and adults with an autism spectrum condition. *Journal of Vocational Rehabilitation*, *41*(1), 13-21.

Mansour, H., Gillions, A., Brown, J., Pattenden, A., Hartley, S., Patel, S., James, S., Styles, M., Mandy, W., Stott, J. and O'Nions, E., 2024. 'It's designed for someone who is not me': A reflexive thematic analysis of the unmet healthcare support needs in UK autistic adults aged 65 years and over. *Autism*, p.13623613241291081.

Martin, N. (2021). Perspectives on UK university employment from autistic researchers and lecturers. *Disability & Society*, *36*(9), 1510-1531.

Mavranezouli, I., Megnin-Viggars, O., Cheema, N., Howlin, P., Baron-Cohen, S., & Pilling, S. (2014). The cost-effectiveness of supported employment for adults with autism in the United Kingdom. *Autism*, *18*(8), 975-984.

Milton, D, Martin, N and Melham, P (2016). Beyond reasonable adjustment: autistic-friendly spaces and Universal Design. in: Milton, D and Martin, N (ed.) Autism and Intellectual Disabilities in Adults Vol. 1 Hove Pavilion. pp. 81-85

N8 Research Partnership (2024) A country that works for all children and young people: An evidence-based plan for addressing the autism assessment and support crisis. **www.doi.org/10.48785/100/195**

NAS (2022a) **https://www.autism.org.uk/what-we-do/news/driving-change-for-autistic-people**

NAS (2022b) **https://www.autismtoolbox.co.uk/wp-content/uploads/2022/09/B_is_for_bullied-National-Autistic-society.pdf**

Nexus (2023) **https://www.nexus.org.uk/news/item/making-public-transport-more-autism-friendly-0**

Radev, S. (2023). A systematic review of autistic adults experiences of healthcare in the UK, and An empirical study of autistic mothers experiences of statutory services when acting on behalf of their autistic children. Diss, Cardiff University.

Rees, E., & Tissot, C. (2023). Can child-friendly tools support young, autistic children to better communicate about their well-being to help inform school provision?. *Early Child Development and Care*, *193*(13-14), 1367-1384.

Remington, A., & Pellicano, E. (2019). ‘Sometimes you just need someone to take a chance on you’: An internship programme for autistic graduates at Deutsche Bank, UK. *Journal of Management & Organization*, *25*(4), 516-534.

Robinson, L., Spencer, M. D., Thomson, L. D., Stanfield, A. C., Owens, D. G., Hall, J., & Johnstone, E. C. (2012). Evaluation of a screening instrument for autism spectrum disorders in prisoners. *PLoS One*, *7*(5), e36078.

Rogers, C. L., Goddard, L., Hill, E. L., Henry, L. A., & Crane, L. (2016). Experiences of diagnosing autism spectrum disorder: A survey of professionals in the United Kingdom. Autism, 20(7), 820-831.

Romualdez, A. M., Heasman, B., Walker, Z., Davies, J., & Remington, A. (2021). “People might understand me better”: Diagnostic disclosure experiences of autistic individuals in the workplace. *Autism in Adulthood*, *3*(2), 157-167.

Romualdez, A. M., Yirrell, K., & Remington, A. (2020). Exploring participants’ views on a supported work internship program for autistic and learning disabled young people. *International Journal of Disability Management*, *15*, e3.

Spain, D., Mason, D., Capp, S. J., Stoppelbein, L., White, S. W., & Happé, F. (2021). “This may be a really good opportunity to make the world a more autism friendly place”: Professionals’ perspectives on the effects of COVID-19 on autistic individuals. *Research in Autism Spectrum Disorders*, *83*, 101747.

Trundle, G., Jones, K. A., Ropar, D., & Egan, V. (2023). Prevalence of Victimisation in Autistic Individuals: A Systematic Review and Meta-Analysis. *Trauma, violence & abuse*, *24*(4), 2282–2296. **https://doi.org/10.1177/15248380221093689**

UK Government (2021) **https://www.gov.uk/government/news/new-government-support-package-to-help-more-disabled-people-into-work#:~:text=Johnson%20Conservative%20government-,New%20package%20of%20support%20to%20help%20thousands%20of%20disabled%20people,jobcentre%20services%20for%20disabled%20people**.

Vinter, L. P. (2020). Working with autistic individuals in prison-based interventions to address sexual offending. Nottingham Trent University (United Kingdom).

Wilson, R. B., Thompson, A. R., Rowse, G., & Freeth, M. (2023). The experience of seeking, receiving, and reflecting upon a diagnosis of autism in the UK: A meta-synthesis of qualitative studies conducted with autistic individuals. *Research in Autism Spectrum Disorders*, *103*, 102135.

Resident conversations

Transcript

December 18, 2024, 12:36PM

DV 0:52

Not not not at this point. Really. I it's good to to know that you said there might be later conversations because when I so when I heard about this about the strategy and that there will be appointments I thought oh, that's amazing. That's really great that that you seek like feedback from all different.

DV 1:10

Groups like yeah, parents.

Autistic grown grown-ups or adults? And then I thought 15 minutes. I don't think that there is anything in the world which I managed to explain in 15 minutes.

DV 1:25

Because I'm not sure, it might not be all autistic persons, but the ones I know usually quite detail oriented.

DV 1:34

And I also I should probably mention I'm not only autistic, but I also have ADHD, which can make me quite an entertaining storyteller, but it can also mean I start at some point and end somewhere completely different. And then I don't remember what the start was so that that that would have been actually my question like, is this like because we only have 15 minutes, do you have specific questions which you are asking me or is it like free text?

DV 2:52

Yes, and and I also had a look at it yesterday. So I didn't receive it right in the beginning. So when I received the consent form and the the first question referred to the briefing Pack, I thought I haven't received any. And then I sent an e-mail asking and then I received it three times. So Derek sent it. Ruby send it, you send it. So I thought, OK, now I really have it. And and and I was quite glad about that because that's that's another thing which might not be much of a problem for other people. I wouldn't be.

DV 4:01

Not in the school or education system, because I'm an adult who was diagnosed only three years ago.

DV 4:11

So both, yes. So my ADHD diagnosis back in Germany in 2014 and autism in 2021 here in Oxfordshire.

DV 4:22

I have experienced quite quite a few barriers, but not not referring to to schools or education system. I do. I do think though what I hear from from friends.

DV 4:35

That it's often a problem really to get the diagnosis in the 1st place, which and there are huge waiting lists which we will be aware of both for children and for adults. I was quite lucky. I think I waited for my assessment for 10 months, but someone told me that it's now like closer to five years or something like that. It's like crazy.

DV 4:56

And it might be difficult depending on where you go to and in schools. Apparently to receive the proper support. Although I think technically it shouldn't be based on the diagnosis, it should be possible to get support without a proper diagnosis, but sometimes it seems to be a barrier.

Don't have the official diagnosis, but this is not like my personal experience now because I just yeah.

DV 5:35

Yeah.

So I think what is quite a big problem in Oxfordshire is housing. So I I lived in chat accommodation for quite a long time, which is not ideal for someone with my conditions because also I am I am working full time which I have to to pay my rent etcetera, because living in Oxford is expensive.

In a career which is not the perfect one for someone with my condition, so I'm working in an administrative role which for someone with ADHD can be challenging.

DV 6:11

And probably I would have chosen a different career if I had been diagnosed like in childhood. I mean, I'm I'm doing the best I can and I'm I think I'm doing quite well because I you also learn. I have been like in this path now for, for, in, in, in this profession for about 20 years or now for, for, for over almost 25 years. But so yes. So the need to work full time because housing is very expensive.

The problem to find appropriate housing. So I had to share because nothing else was.

Was affordable and I do think so in in theory or not in theory. There there is something like supported accommodation for people.

Who are autistic? However, I think this would usually be for people who might not be able to work full time, etcetera.

Whose support needs are deemed higher?

I tried at some point. Actually this applies to when when you want to access any service I.

I was off sick for a longer time this year, which was, yeah.

Basically a burnout.

Dealing. Yeah, I mean, stress and anxiety would be something which very commonly happens in in autistic people.

Especially the ones maybe which which might deem and I don't like the term very much. High functioning. I really don't like these terms because for one it also implies that there was.

Something which is called low functioning, but also because just because I appear like I I I do manage. I I I I work, I pay my rent, but this doesn't mean that life is easy. It's not nothing. Nothing feels easy. And so yes. So I I find it quite difficult.

DV 8:08

To to access services I did when I was.

Unwell. I did talking therapy, but again, this is usually not.

For new divergent people and there are not necessarily experts for working with new divergent people, I still found it helpful, but it would be good if there was something like me because it's very much focused then on like depression and anxiety and.

DV 8:38

And you, you, you then have to complete this questionnaire every every week where you are asked, like how much your conditions or no where it's more or less measured. If you're getting better, but it's not. I mean, I'm not. I'm not. I'll as such.

DV 8:52

I'm differently wired, and yes, depending on how wested I am or how stressed I am, I might feel better or worse, but it's not something it. It would be good to have like more like a long term support, which which also can help people with, I don't know, like yeah, excess housing or for me it can be a difficulty already to make an appointment with the GP because.

DV 9:19

You.

In the past, I was encouraged to complete an equan site form and I was told this takes like 10 minutes for me because they ask is there anything else you need to mention or you want to mention? It took 1 1/2 hours to complete this form and I put like everything in and then I'm going to the appointment very nervous already and the GP asked me what can I do for you today and they said I've wrote it all in there.

DV 9:42

And they even made notes on my phone and showed it to her. And then you're told, OK, so we will do like another appointment then, but you will only be able to book that appointment two weeks before. So please call then and these things to remember these things because I can do these things for my job. I need to be very organised in my job. But in my personal life, things like, I don't know, keeping my household in order.

DV 10:08

Organise these doctor's appointment, then constantly feeling misunderstood or not being taken seriously. So maybe I know from a previous role that there is something in Oxfordshire for people with mental health issues like floating support.

DV 10:24

Which used to be offered by connection support and Elmore if there was something like that in place for autistic people or for new divergent people, that would be amazing.

Just really to and and I know this would probably be very expensive.

Yes, some kind of network or some something where where people also can contact them if they need in a specific situation for a specific discussion with an authority with the GP, whatever. If they need kind of an advocate and there might be something in place like that which I'm just not aware of.

But yes, so.

Because that's the other thing. Very often you are depending on on searching for, for, for office yourself proactively, which not everyone might have the possibility to do. Because I mean, many of us are like very good in researching information and once you find like your special interest.

You, you, uh, you will be really good at that. And we'll spend a lot of time on that, but you don't always necessarily have the energy to do so because I spent a lot of energy on functioning at work as well as I possibly can.

Yeah, I hope I didn't jump too, too, too, too, too, too much back and forth now. But it gave gave you, like, kind kind of an idea. So I know that when I applied for the talking therapy and had like the the assessments.

DV 11:52

With Oxfordshire talking therapy that I also had phone calls and at some point autism at Kingwood was mentioned, which I know of a supported housing and I do think they also offer some other kind of support and they got in touch with them at that point. But.

To to inquire with them if they might actually be the better place for me or the the well, not the better place. But if if the support they offer might be more suitable for me.

And they were told Pexen. I think that they don't take any any referrals right now because they would just be, you know, swarmed with, with referral, with referral. And again, I think and I can fully understand that I I know from from a previous role which I had as referred coordinator in a mental health charity, I wouldn't be in the top priority of list because I am yeah. So.

I I am in a situation that I can.

Well, I.

I can live independently. I can manage my finances more or less. I can. Yeah, I can work full time. Although I probably shouldn't. So if I really would be focusing on what would be good for my well-being and what would enable me to also have have energy for, for a social life, I probably would work maybe three days per week. Because when, when, when I go out on a Friday, when I'm meeting friends on a Friday, I struggle to be.

DV 13:25

To go to work. But yes, so there there are always people, of course, who really have higher support needs and I think they need to be prioritised. So if there it might be maybe there that there would even be kind of a peer system or something like that which which which could be set up. It doesn't need to be like as an expensive experts but but if there was something like a hub like where where where people really can go. So I know for example for ADHD.

DV 13:55

There, there, there is like a support group in Oxfordshire, Idhd, Oxfordshire, which I used to visit, but I'm not aware of something like that for autistic people.

I mean, maybe also because we might not be the most social or or because it it costs so much energy for many, but I still think that that many of us would also find a type. And I mean one can still create it in a way then that it that it is at least stressful as as possible.

So it's usually less stressful for me to to speak to other new divergent people because they they understanding and also the the the tolerance for maybe not staring into someone's eyes.

Is is is higher.

DV 14:45

But housing is, so I managed in the end because I I really I I got very angry in, in, in, in the end. And I thought yeah, it doesn't I I would spend all of my spare time in my room would not dare.

Down into the kitchen because I just didn't manage to have any conversations, I got the most twist. I got the most sensitive. I got to to to the smells and and sounds in the house. So yeah, in the end, I was lucky enough to to find like, like a little apartment. Like a tiny apartment. And like a family home. But I have my own kitchen. I have my own bathroom, still noisy. But I have noise cancelling headphones but it.

Like it costs an arm and a leg so it's so I I wouldn't be able. So if I was somebody who wasn't able to work full time.

DV 15:35

I I wouldn't be able to afford that because it's almost like 1000 lbs per month, which is, which is for Oxford. Actually not that bad for self-contained, but yeah, but just just a lot of money so.

Yeah, some some advice around these things, because that's the other thing. Maybe they would. Technically, I don't know if I would have had any prior if I could have gotten in any priority group, if I had applied for the housing register, maybe.

But I don't really know and I didn't I I wasn't in the place to spend like time going into these things and going through the process because that again is like quite difficult. I think that they're they're quite a few obstacles to apply for these things and to advocate for yourself. So yeah, sorry, I think I I almost exceeded our 50 minutes already.

DV 17:13

Thank you. Thank you very much. Lovely to to, to meet you too. And yes, I I'd love to to to be kept in the loop on like any further development. And if you would like any further input, please please get in touch because I I think it's an amazing opportunity.

DV 17:31

To to to to ask the people who are affected, and I thought that probably there will be quite a lot of parents because obviously I I think the the the easier of the earlier diagnosis takes place.

DV 17:44

Or support needs amid the easier it might be later in life. So I mean that that, that that is obviously very important to focus on, but I've had there were also quite a lot of people like me because when I grew up I I was born in 78, not many people my age will have been diagnosed in early childhood until they they were like really disruptive or like really you know, so they I think there was quite a huge group out there.

Transcript

December 18, 2024, 1:52PM

LM 0:29

Either the parent or the carer, in order to enable and be the voice for the child.

By understanding loads of different things, which is amazing. So we know that it's all evidence based and we're where where it's on our plan and we're moving forward with that, which is amazing. So we're training and those families and parents and carers as NT as one to ones teachers and senkos that we are attempting to get trained up and understand it's been very successful. And So what happens is the parent or the OR the carer and that other people.

LM 1:01

They become the advocates, and then they're like, I don't need you anymore.

Speech and language therapist. Thanks very much. I can do this on my own, which is fantastic. So that's really good. So that's perfect. I also do something called Maya. Join you where we packed is. So I mean, it costs, I think it's around 5 to 10 grand per person to train. So it's very expensive. And so we've we've just my amazing managers done that really well to do that and so.

LM 1:31

That couldn't be the only thing that we did because it's too much. So we've create, there's a lady has created another package called mayor join you.

You can just Google. May I join you? YouTube is a 40 minute thing that the.

LM 1:48

This is also in Welsh, which is really helpful, so it just gives you strategies and there's a lovely print that does the strategies in the middle and then as in like the they bubble out on the outside and I use that quite a lot in my hold on one SEC, if I can just get it up, that'd be really helpful for you to get snapshot. And so we use that quite a lot and we empower families in order to again using similar.

LM 2:21

To sort of aid those families, which is great. So that's kind of the thing that we want to do and what it does is we use because mostly professionals know how to do most things, which is great. And so we're just enhancing them with a mayor, drawing you principles and being more reflective. And so we're asking, you know, what is he saying by doing this, what what is his action?

LM 3:06

So and a lot of these are packed principles as well.

And which is great. And so it was just like, how can we get families on this? So then I'm going to share one other thing.

So that was that. And then we do a reflections log.

Which I'll just give you sort of some of the reflective bits of it, because obviously I need to be really careful.

With what I'm doing as well, but the strategies are all in line, so that's easy, but this isn't, but it's kind of a reflection of like using those strategies which were just there. How? How do I watch and learn? How do I what? How did my play help them to achieve that? How you know that kind of it, you know, self leading questions that you know which.

LM 3:55

Most early years professionals are doing anyway.

LM 3:58

As somebody who is early years trained at Mvq Level 3 done a degree, but in exercise science I have underpinned a lot of my.

Understanding from somebody called Kathy Stevenson, she is AOT. Sorry, I'm going really fast just to try and get all this stuff in. Yeah, I don't. I've got 4 minutes left and basically there is a book called Ready Steady Connect by a lady called Jesse Aaron's Insbourg. And it's amazing because it basically says that the foundation of any learning is sensory regulation.

LM 4:32

And unless that happens in our 1970s legislated school buildings.

LM 4:40

It's 50 years out of date, folks.

LM 4:43

We there's a lot that needs to be changed. I spoke to a lecturer yesterday here at Brooks University. Just so happened to create a networking connection and he happens to also have a child who is on the autistic spectrum is accessing things, but he can see that that's not the access that others have had. The same access that his child who is now in secondary has.

Which is difficult. I'm come from background of working in children's centres where I was a room lead and I was very, very fortunate to have children centre workers around me. If somebody needed support I could say, hey, can you just come in at the end of the session, I'm going to introduce you to this parent. You can then support them. We'll do the childcare. You can help them through life. And so it that is now missing. That is now no longer available as a parent. I was really able to access that when my child was, you know, 10 years ago.

LM 5:36

But it very quickly with my other two children, came along. There was no children, centres to access.

So they were the ones that were catching it quickly. They were the ones that we were doing ehcps with and EHCN as so then there's that.

LM 5:51

As a as a professional going into schools absolute nightmare, I find it really difficult because a nobody knows anything about sensory processing in any way. Nobody knows about the fact that schools hoard like.

LM 6:06

And they got so much stuff, they don't know what to do with the stuff. And actually the stuff is not the thing. It is us as the people who are the ones that are using whatever that child touches to create a learning development opportunity. And that's not happening at all. So that's really tricky. And so they and they feel alone, one to ones haven't got a clue. They haven't got any support to their sencos, they're useless. I'm really sorry. As somebody who was one to one, I have no one to talk to. Ever.

LM 6:35

You know, I'm running around 17,000 steps a day after a child. I'm exhausted, you know? And I don't have the support. The fact that I might actually be near a typical as well. I mean, so neurodiverse as well, because I have such great skills that you guys need, because I that's the only thing I could do. I couldn't go on to university. Couldn't do all these things. But I've got an NVQ Level 3 in childcare because I'm great with kids, but nobody is saying these really basic things to these people.

And it's really unfair.

LM 7:05

I've never been able to progress from my career because that's the only thing I was good at.

And I, you know, haven't been able to lead, haven't been able to do these things. I mean, that's my own professional frustration. But also, I am neurodiverse. I'm not diagnosed. I've probably got ADHD, which you're finding with the fact that I'm talking so fast and I keep missing opportunities to do things. But I know that I know all these things. So I'm living like I am and knowing and accepting that there will be a marvellous mistakes that come along the road because that's the only way I'm learning. But it's not fair. We've got a culture here.

LM 7:37

That is really damning.

And we're not celebrating anybody. Like, there's so much to celebrate. Yeah, so.

LM 8:33

So the only thing that the NHS delivers is if you are on a communication pathway as as in a social comms pathway social communication pathway, do you get access to and depending on your age will depend on whether you get packed and then it will be the school that might be delivered. May I join you, the sensory processing, Sally, the lady called Kathy Stevenson from the NHS.

LM 9:00

Sadly, she was not commissioned to do her thing.

Even though Jessica and her book ready, so to connect, says the fundamental thing that we need in order to do anything is regulation. And if we can't, we can't even learn. We can't even engage none of it. And so if we. Yeah. And so the fundamental thing and as a parent, I asked my husband to go on the pilot that she commissioned, that she was commissioned because I know what I know from my work. But as a couple.

LM 9:33

We didn't know. I was saying all this stuff and my husband's like, yeah, you know.

How do you cook eggs? You know? But he's like, oh, this is the thing. It's transformed our lives. Our children are accessing school. But in a Independent School because we chose that because we did. We couldn't access things as a couple when we were younger. So our children couldn't either. So yeah, there's a lot. Yeah, to access. Sorry.

Claire Webster (SCIE) 10:04

This is absolutely brilliant and I will e-mail you to arrange another catch up so we can talk about this more and if there is anything you want to send me in advance of that. So all of that stuff that you've been talking about, just send it to me. That'd be brilliant. And I'll make sure it's all included. So that's great. Thank you so much, Liz, for your time.

Transcript

December 18, 2024, 2:08PM

DR 0:14

The kind of the leverage and the bridge to kind of get across irrespective of my.

For diversity.

DR 0:22

Kind of in terms of kind of any barriers and kind of the the more juicy bits of kind of what we're looking at today. For me, it's the writing aspect now. I appreciate there are many different things in Neuro. Diversity covers a whole spectrum of things, but that's kind of where I struggle a bit. I mean thankfully we've got Co pilot now, which is especially with the roles I do, I'm sure you'll speak to a variety of people and but what I do writing is quite essential. And and Oxford, you have been very good at providing that tool.

DR 0:49

Kind of impasse instances, though. There have been things where it's like, maybe it's just the unfortunate reality of working in children's and in education there's this kind of innate presumption that you work in children's and you can just write and it's. And I'm. I don't. And I'm not calling people out because this is not the place to do that, but it's there is a special it's getting better. I want to say that I want to put that in there, but there used to be a presumption that.

DR 1:15

You know, we're senior people with degrees, and I think it happens because it's a professional local authority where there are people with degrees like.

DR 1:21

Innate presumption that you can just write and that being semi bad at maths is understandable.

Not saying that is the case, but I'm saying there you can. From my perspective, there is a can be a culture of that. I think that's Day's getting better as time goes on, especially in reverse groups. But that's kind of where there's been a main barrier in terms of my work. But I've been working on tools of that. But to say that it hasn't been a challenge in the in the past we'll be lying.

Yeah, absolutely. It's good to know that they're using technology to make some of those bits of work that you find most difficult, easier, which is.

DR 1:55

Of course. Oh, it's it's definitely. It's definitely improving. It's just about how we go about it, because I think it's thing is, I don't know, you don't always know whether it's an individual case by case. Someone's being a bit ignorant, put it politely or whether it's actually a system thing. And I don't have the expertise or knowledge to evidence that correctly and appropriately so. But I mean from my understanding is it it wouldn't surprise me if it was, you know, very educated people and children's and maybe some in adults that are just so used to being around people.

DR 2:24

That are highly educated.

DR 2:26

And not saying I'm not intelligent because everyone's intelligent in their own way. That's why we've got these jobs and what not. But I think occasionally there is kind of this blind laugh of why can't this minutes just be good and, you know, it's like you can't. This is a bit of a dig, but it's not a dig at the same time, it's actually useful.

DR 2:43

You have if you want to have neurodiversity and you want to provide an environment where people prosper, you, you have to accept there's going to be a variety of results.

Arjuna, there's a there's a variety of ways of achieving results. That is what I'm trying to say. I've proven not explained it very well. But yeah, that's kind of more past. But yeah, that's kind of.

DR 3:21

So yeah, so in terms of oxfordoverall, I've been around. So in terms of I've, I mean, I've been diagnosed since I was born practically, so they not practically essentially so into I used to be on the old statement system as well as being on the well. I think I was on the HCP system for a year or two. I mean this was I finished secondary school in 2018, so that would have been that that period. Then in terms of kind of my experiences, it's been pretty good. I mean, I was very lucky. I was at the Warriner school, we had a senco called Rachel Cosgrove.

DR 3:49

And some sencos are literally lifesavers, because without their support, you know.

DR 4:17

I say that that was a hardship, but just be one look is he can be hardships, but it's yeah, it's how is that it's it's a normal teenage thing that you are going to find school a bit stressful basically and whether that's due to the neurodiversity not too sure but I think that definitely didn't help but that's kind of that'll be where my thoughts are with that question.

DR 4:47

Yeah, I mean, I definitely try and do my best with it. I mean, I'm very lucky. I am quite a sociable person. It's definitely a skill that I've developed. I've been very lucky with some of the relationships I've made at work. I mean, I didn't. I have either reasonably good network of people who I meet and whatnot. I'm part of APA Private PA network outside of work, so I don't struggle on that front compared to a lot of neurodiverse people. I think kind of the things that I would struggle with is just kind of as you know, always knowing other people how people view things like the, the writing and kind of there are bits of perspective things. And I'm just like, well.

DR 5:17

No, The thing is, you've got to give yourself that because no one is perfect, so you can't. It's just not realistic to be everyone's cup of tea. But I think that's I think that's a gradual young person's think because I'm 23. I'm imagining you're going to be interviewing the people of a variety of ages. So you're going to get interesting. Well, not interesting. You're going to get a variety of different responses about that question, but that'll be where my thought process is on that.

DR 5:50

So during before Occi sadly got kicked out of a classic car apprenticeship, which was not a good time and I used the the neat set well, the things called the E service or the NEAT service and they were OCC and I think every council has one. It's a not employment education training and they were fantastic and they and I was going for a really tough period then I don't because it wasn't clinical depression, but it definitely was this is not the right thing going on.

DR 6:15

And people were concerned about me. But I mean, I'm very thankful. I've managed to sort my life out, but I'm not from an Uber privileged background, but I was very lucky to have that support, and I don't think people always have that support. So, and I'm aware of that so.

DR 6:35

I think it was. I think the, I mean I was about 17 at the time. Yeah, 1617 and especially as a young bloke it's very difficult. You've got this is going down a long path. I can't go on forever and ever in terms of when you're a young bloke you want to especially during that period of time you want to be in college or training or you want to be doing something in your life and there's this kind of not pressure but there's this kind of idea in the back of your mind you want to move out you want to get your first car you want to you know.

DR 7:11

It's and it's it and it's very difficult if you're if you're employed and it's very difficult for people that get that all their full a stars at GCSE. But you know, if you've got no opportunity, no opportunities, you know you're not getting interviews for employment, you know, and X the list goes on and on and on it you, you'd be surprised by how much people struggle. It's, yeah. When when people are struggling with employment, it's not a joke. It's.

DR 7:43

The difference between you and someone like is luck. Like I look. Yeah. So that that's kind of I think that's kind of how it manifests itself and how it that's how it affected me and that's kind of how I think it affects most people. But I know depression comes in a variety of forms. So yeah.

DR 8:04

So in terms of in terms of sensory things, I kinda I well, I have a chair that I like. I was a big gaming chair that I like. I changed that over 'cause. I found it too too much.

DR 8:13

I I mean, I don't know whether it's just because I like it or I sometimes when I'm in meetings, I just turn my camera off and I'll start typing away in one minutes. But admittedly, that's more of a practical thing because it lets the higher priority people go on camera and be on the screen. And also it means that I don't have to worry about what people are looking at me. I can type all on pace. Don't think that's really a sensory thing. I think that's just me being courteous and just common sense in terms of a sensory thing.

DR 8:35

I don't really. I mean, I get chill blains a lot, so I try and keep myself warm and especially this time of year, it's not been too bad actually. But yeah, not the funnest. As you can imagine. Yeah, I don't. Yeah. I mean, for me, it's more about the Co pilot and recordings in AI. That's kind of where I'm where I'm at. And I occasionally I use earplugs occasionally, but it's mostly because I don't want to burst my eardrums, which I think is a semi reasonable.

important or you know that kind of thing so.

DR 9:41

OK, OK.

Yeah. So in so in terms of in terms of the one, the kind of thing we'll not think as you mentioned about the kind of supporting people and what you know the thing about cost really, really and I'm not going to go down too much. The rabbit hole is, I'll tell you a story. I have two people I work with who are definitely paid more than me. That is, you don't even need to look at their salaries, but you know a Co pilot licence is two £300 a year. I think I roughly worked out how.

Claire Webster (SCIE) 9:58

Yeah, yeah.

DR 10:14

Hours that need to use to cover the cost in terms of efficiencies and at the moment we're not producing any more copilot licences and I'm just thinking how many things are going that's not really that important. It's important, but it's like, imagine how many things like that are going on in regards to things that people need for sensory and so and so forth, just for the sake of cost and imagine how much savings that they need basically needs to be. I don't know what the word is, but there needs to be a kind of a thought process around if we do give this person what they need.

Yes, it will cost us £200. Let's say let's think about how much better there'll be, how much more efficient it'll be over a course of a year. And I know that's easier said than done and we're not here to change Council viewpoints because, believe it or not, they're bigger than me. But that's kind of that's one thing I think about because I mean, I on my stepmum, she's a Sen consultant, so, so I so she gives me a lot of insight to things. So that's kind of where my a lot of my education needs come from. So.

Of course.

Absolutely.

Transcript

December 18, 2024, 3:47PM

ON 0:20

But I suppose I'll start with him first, so.

I think some of the barriers have been within.

Education. Getting access to educational, health and care plan was a challenge.

We came from overseas here from Australia back about 10 years ago and at that time we'd gotten wealth of reports on his disabilities, including, you know, everything and but they wouldn't recognise them, which was a bit ridiculous because we're, you know, we even have cams in Australia. So it didn't make sense. Yeah.

ON 1:00

Yeah, it it was. Yeah. So it wasn't a third world country. It was a, you know.

On par with here, really. But anyway, so we had a challenge there. We ended up having to involve the MP and all the challenges to get that educational, healthcare and plan.

ON 1:17

In place, then accessing special education need education was challenging because he was that he had a breakdown and was quite poorly. And I'm getting that access was difficult.

I think then once we got into an SEM school, it went really well. So there was a period, I mean other than the lack of mental health support, which is been a concern all the way along. He coped quite well. He was underpinned by the adoption support team, which gave us some of that mental health that we couldn't get him anywhere else.

But I know he's got peers that weren't so fortunate, and then when he came to.

18 at that time he was had a consultant with CAMS, a consultant with the.

Adoption support team. He had a consultant with the Tavistock because he was being seen by them as well. All three of those and but at 18 it all the Cliff edge happened because he didn't meet the threshold initially for adult mental health. They all challenged it. They were really good progressive team and they challenged it and eventually got got some got some support but.

ON 2:34

What their excuse? Eventually you got to not support him was the fact they said he had autism and we don't support autism, which so and there is nothing else within.

The county he was referred to the reasonable adjustment team for autism, but at that time they only did the a report which allowed profession to give a communication plan for other professionals to work with them, which was useless because then adult mental health team weren't involved, with no professionals involved.

ON 3:06

Social care. He was lucky. He had initially had a really poor social worker that didn't understand the concept of masking, and he, you know, he's a quite an intelligent young man and he just to get her out of the room. He'll just said he did it. You could do everything. When he can't do anything.

ON 3:25

Fortunately, we had to challenge that, got it redone, and we've got a great social worker now. She does understand she was able to drill through that and understand that when he said he could cook.

He meant he could look on Google when we drilled down. Oh, I could look on Google. Maybe I could do it from that.

ON 3:44

Yeah, but I've never done it and he still doesn't 23 because he doesn't like hot things or. Yeah, so there's barriers still, but yes, we got over that. But mental health is still an ongoing problem. And I recently raised a complaint to the CQC about it and it's now being dealt with by the NHS. That's a separate thing.

ON 4:08

As a as a professional working with those young people moving into adulthood team.

I think the biggest gap for us is the mental health support, the lack of.

Support for young people who don't have a learning disability but present with autism in the county, from meeting friends to, you know, get get meeting up with like minded people through to respite.

ON 4:42

Out, out, out, outreach services, they're just not channelled or or very rarely suited for that cohort of people.

ON 4:52

Commissioning. Don't and brokerage don't seem to have a specialised support team for that.

And they do get missed out on the thing I'm worried about with this project, it says it's about autism, but I think it should be about neuro neurodiverse children, because a lot of young people don't get that full diagnosis they present with autism, but they're eight. They've got ADHD. My my young person has got autism, ADHD, central, autistic processing disorder.

ON 5:21

Also associated with autism, but you know or on that strength, but.

ON 5:28

I think that some people aren't so fortunate if they just got ADHD this this this might miss and a lot of the people we worked with that came out of leaving care could be within the moving into adult team had diagnosis for ADHD but not autism and yet they presented with very similar traits.

ON 5:51

Yeah. So I think that's that's so I think this project should be wider.

Yeah, I think that's the basic things I've tried to think of.

Wanted to say.

ON 6:25

I'm saying, yeah, specialised housing, there's going to be able to live on its own. So specialised housing, he's very intelligent, got up to Level 3 in advanced Level 3 at college with a lot of with one to one support, which was, you know, that was great that we got that. But he's now at home and has nothing to do. So yeah, some some help more help on that. I think we've got the Oxygen employment service great and.

ON 6:53

But I still think there's that missing link for those young people that are stuck in their room and can't engage with those services.

There needs to be more hands on approach, somebody that's willing to, you know, meet them online. Do you know other other methods of communication?

ON 7:11

Yeah, much more in the way of reasonable adjustments.

It's all in the reasonable adjustment team for autism report, but people don't read it or use it. So.

ON 7:26

So when you get referred to the reasonable adjustment T for autism in Oxfordshire, they can do a communication plan. It's brilliant. It tells them what they really do get to know the person they get to write, how to communicate with them, what works best, what doesn't, very informative but sadly not used, no.

ON 7:49

Yeah, I think that's really important. It's such a it's such a shame because it's such a, you know, it took weeks of.

Hard work from the person to write it and do it and to because they managed. They got the skills to do to communicate with that with him. You know, it's brilliant.

ON 8:22

And other parents get those reports and share them with us in in the moving into adulthood team.

Yeah, OK. All right. No, that's worth noting. OK, because I think there is, there's always something about that even when you have got these really good pockets of resource, how are they making sure that that information is shared with all the other relevant organisations?

It would be. It would be really good from day one. The educational health and care plan was always the concept that it would include education, health and care, social care.

ON 9:13

Throughout my whole time of using it, it was all focused on education.

ON 9:18

It was very difficult to get anything added to that.

And.

They and education really are quite strong ownerships of that report and.

And don't necessarily work well with social care and health to keep to maintain that report, there needs to be a report out or something that captures that young person that's updated on a regular basis and follows them through health, education and social care. As a parent, the worst nightmare is having to repeat yourself over and over again every year. And.

ON 9:57

And more frequently, and also the fact that you know, it's quite emotional having to go through all those negatives that you live every day.

And put it down on paper again. It's quite soul destroying and I think that would be good. Yeah. And we and we do get traumatised as parents I think from the process.

ON 10:18

I think one of the biggest things that my young person needs to lead a good life and the people I was born is that ability to access social care, social skilling or social groups.

ON 10:32

Some more focus on finding some meaningful activities.

Work and or work experience that's that can be adjusted to their needs.

ON 10:44

And yeah, I think those are the biggest things. And also I'm social care, recognising that the Sen Act covers 18 to 25 and yeah, we have a children's provision that provides a local OfferUp to 18 and then we have adults provid a low cost from 818 onwards.

ON 11:06

But the adults offer is very much focused on older adults, not younger people. So we have this little missing cohort of 18 to 25 year olds that they totally miss out.

ON 11:22

Yeah. And it and I think it's more about our systems are wrong. You know we need to, we need to embrace the fact that if we're looking at a local offer, it should be from 18 to 25 for that you know or 16, sorry 25. Yeah across the pitch. And one more thing. Last thing is that we've.

ON 11:43

It the global authorities really addressing everything through online services. But I worked with a lot of young people and their families.

ON 11:53

Who were not it literate and I had three sets of parents that couldn't do anything online. Two of them couldn't read or write, and we are discriminating against them by not having accessible system. So I used the only way I could do it was literally to visit them for everything and to do it manually because our systems don't allow it to do it otherwise they couldn't even make GP appointments. So I had to help them with that because the GP said no, they have to do it online. And I said but.

Claire Webster (SCIE) 12:28

And it's interesting because I just had a conversation with somebody, even when they can get online, the process of going through that form isn't straightforward for people. I've heard people spending hours just thinking about what to complete on it because it just doesn't. It's not reasonably adjusted to think about that. So.

ON 12:50

For mine and I found it so not strength based, it was all about the negatives. There was nothing about, you know, all the in the things you might enjoy with your own person or, you know, to celebrate. It was all it was, always. It drove you always in the way of saying what was wrong. And that's not how, as a social worker, we would do those.

ON 13:12

Those those assessments, we would, we would take a lot more focus on the strengths first and then look at the things that they can't do.

Claire Webster (SCIE) 13:28

Yeah, I'm saying that's definitely something to report in in terms of a strategy and approach. If people are going to be sported to do, say, their own assessments.

Or contributing to their assessments is actually how well that reflects how you would have a conversation with people about it so.

ON 13:44

And also to reflect the local authorities ethos, which is about strength based and the what they call the Oxfordshire Way, which is about finding.

ON 13:55

Solutions within the their local area and not not locally. Oh yeah, and the language we need to keep the language better. Things like not using community like notice I said local area, not using community, you know not using all those buzzwords. We want to talk about them as individuals. Yeah.

Transcript

December 18, 2024, 5:05PM

Yeah. OK.

Sure, it has been absolutely awful experience. My daughter has very light autism. I'd say she's mainstream. She will remain mainstream. She does have combined ADHD. So those things work.

WS 1:18

In contrast to each other, which has made it complex, she's 8 1/2, but just the parental experience.

Has been horrendous because I think.

Actually, they're blind side of us.

And I think the main thing that was difficult is.

There's no guidance.

WS 1:43

There's, it just feels like you are just thrown into the abyss and you're told.

Oh, look at this website and and navigate it. Navigate this **** show that you found yourself in.

That's fine going to do every single page of an ****** website to and just summarise and distil and work out what you're supposed to be doing. But we were.

WS 2:15

She had really bad sleep, so we were utterly broken, human beings told to just.

Squeeze.

Pulling through websites into our day jobs and our free time that wasn't free.

And you know, it's actually I'm getting upset. I'm actually getting trauma therapy. I've just started to get trauma therapy because the whole thing. And I had a whole issues postpartum. So that was just, you know, an explosion decimated things. But.

WS 2:55

Just the that experience was really, really, really unnecessarily awful and there's.

Central Guidance, central signposting. There's so much out there, but again, you you your brain is pulverised.

WS 3:16

Anyway, as a as a working parent of a with a young child, your brain is pulverised. Aden Sen issues and it's just, you know, you neurologically toast. You're absolute toast.

WS 3:29

And you know, it's sort of your responsibility to have the wherewithal to make it happen. And I think, you know, I would pass myself as one of the lucky ones. Like, I am intelligent, educated.

You know, determined so out of lots of people, I would be the one who would be trawling the websites and I couldn't and I literally didn't have the emotional energy to.

I've been upset here. I didn't have the emotional energy.

To just.

Do any more work and and use my brain any further and and you know. You know what it's like when you're like, if your brain is mashed and someone says solve this really big problem. Well, how on Earth are you meant to do that?

WS 4:21

And it's all these different agents, all these websites and you know I have I if you told me now who I spoke to about what and when and what I did, I say I haven't a bloody clue.

WS 4:34

Not a clue. I couldn't recount any of it. Sorry. So you are bad to ask a question there.

WS 5:30

That's OK. Yeah, I would. I would also say actually one of the things that makes it quite difficult is.

The the the spectrum is so broad you have other Sen issues that overlap and the information is like, you know, if your child's autistic do this, but it's like well, my autistic child has farly different to every other autistic child I know with all that. But I mean it's and it's in a different even just different levels of severity it's and there's no real help for it didn't seem like.

.

WS 6:02

There was help for daughter of at my level at her level, which is.

Reasonably, you know mainstream.

We went to send gymnastics and all the parents there said they'd have to take their children out of mainstream school and into special school because they got zero help from their school. So this was the everybody but me had had an awful experience with their primary school.

And we just were very lucky. We had an incredible primary school.

WS 7:10

So I think that the general experience is that schools haven't clear what's what they're doing.

WS 7:17

Just adds to the pain, frankly.

WS 7:30

Yes.

Well, they just, they sort of, they're just they put lots of interventions in place, there's loads of send kids there because they are attracted to the school. So you don't feel like your child's weird. They have lots of interventions in place and they're doing the eacp and yeah, you feel like.

As much as they can do to be with the funding they have that they have, you know it's a safe hands situation which is great, but obviously they can do a lot more funding as could everybody. And obviously I think you'll have heard this about 11 billion times a day. Cans is on its knees.

WS 8:12

I can say what you're doing is you're having parents, sort of.

You know, back borrowing and stealing to go private and then that's not a sort of that does not dovetail back into the GP system.

WS 8:26

And again, it says more. It's more like, you know, you have to go looking under every single rock of the Internet to find out what the Hell's going on.

WS 8:41

It's been awful. It's underfunded.

Yeah, I think so. I think I think it. Yes. For me the key message is those that the information is so confusing, it's it's almost inhumane.

WS 10:34

Well, we're doing a teacher. We're we're all trying to teach her integral life skills. We're getting the trying to get an ehcp with her. Secondary schooling would be very closely monitored as to where we send her.

WS 10:51

Regards what we think between handle and yeah, it will all be focused on just getting her safely into adulthood and beyond.

WS 11:23

I mean, I think it's it's no understatement to say that it can destroy marriages.

WS 11:30

The the experience in its entirety, and it could that just be really could be avoided.

it and it's also like, you know what support genuinely could be offered. You know, there's a lot of, oh, go and find time to go and meet other parents in the same or a similar ish phone. It's like that's not helpful.

WS 13:08

Really, in advancement, yeah.

So yeah.

Yes. And it's just, it's just not ultimately not going to change what's going on at home, so.

Transcript

December 18, 2024, 5:56PM

R 0:34

I would say the main thing for me is that I'm so I was diagnosed in January this year, so I'm 60.

R 0:43

So 1259. So I was 59 3/4.

R 0:47

So to me the main thing is that it's it's it's we're invisible people. Older people are invisible and.

I had no idea. I only know I only got diagnosed because one of my sons and my adult sons, who's also counts as late diagnosed.

Has got had a diagnosis last year, so one of the things is it's it's we're invisible. Everything is a gut geared around younger people, but there are lots of older people like me who struggle through life with mental health issues and particularly, I mean so many times I've been diagnosed with depression, anxiety post Natal depression, blah, blah, blah. All of these things with the root cause in the anxiety caused by social situations, which is the root causes of autism. So that's the first thing in terms of the visibility.

R 1:31

And it's quite difficult because lots of people, obviously of my age and older have no idea because it wasn't a thing, so.

R 1:38

But that is a barrier that I feel like I have to explain every time. I'm very lucky that I'm a teacher, so I work in a school where they're very supportive and one of my fellow faculty members is there, you know, key stage four and five senko. So I'm very lucky.

But it's it's a funny situation to be in that you're trying to like you're invisible. You have needs that are invisible. And there are things which are not necessarily huge things to.

Address. They're just and you know, things like little tiny adjustments that I've got small adjustments in my routine. What I do that make my life manageable and mean that I'm still almost full time as a teacher.

Rather than a few years ago thinking that I would just, you know, Chuck it all in, because I couldn't cope.

So I think that's that's the first thing.

Other than that, generally it said, I think a lot of education is needed to people I've I spend a lot of my time, I mean.

Both in the in the sense that what I know about autism is mainly from stuff I've taught myself, so it's become one of my special interests.

Partly because of me and my friends, and partly because I'm a teacher and I want to know, I'm desperate to know more, so I can help my students. So I'm firing on all cylinders. You know, young, you know, teenagers. I teach teenagers so teenagers and older people. I'm interested. I'm just interested in the whole thing. So it's very difficult for. I've spent a lot of time trying to explain to people.

R 3:07

You know what it is. So one of my friends when I was diagnosed, you know, he's known me since I was a teenager.

You know well, that can't be true because you know, because you've had all these traumatic things happen to you in your life, and that's why you're depressed and.

It's very, very hard to actually convince her that there's something else going on.

R 3:25

So yeah, so there's two things is we're invisible. Older people are invisible. Things are no one twigs that if there's all these youngsters being diagnosed with autism, then their parents are, you know, their parents doesn't come out of thin air genetic.

R 3:40

That's something. And the other thing is just, yeah, awareness, really.

R 4:21

No, no, I mean it's it's almost I think anybody who's who's older and has diagnosed as basically self diagnosed first.

R 4:30

Because no one's going to say to you. Oh, do you think you might be autistic? You know, several of my friends afterwards said, oh, I thought you might be, but why didn't say anything?

R 4:39

But.

No, and I and I did it through. So, Dylan, my son, last year I had he he's was I paid for it as a private diagnosis and then mine. I got through right to choose. So I went to London ultimately and have face to face the face to face session because it's just I want and it was quite good it was pretty good. It was pretty quick. So I was very lucky to get that get that slot in there.

R 5:06

I've lost the thread of what we're going to say now.

No, I mean you, you wouldn't. Nobody would know what you would particularly with older, you know particularly with older people. The other thing I have done is I have tapped into the Oxford into the adult Autism Service, which is available through the NHS in Oxford, which is I have been, I've done there.

Post diagnosis course, which sort of already knew it, but I went anyway. I went to see what was available, so I think in terms of, I mean, I'm fine. Obviously I've managed to get through my whole life, you know, and I'm still working. And you know, I'm still here despite everything. But for other people like my son, who's much, he's much more badly affected, sort of mental health side of things than I am. I just think in terms of the for me, the small adjustments have meant that I can carry on working.

R 5:49

So there must be lots and lots of people who want to be employed or who, you know, that employment support.

For adults, it doesn't seem to be. I mean, I say I've I've because I'm on it like as as research. One of the things that that's just as an autistic person. I'm just like that because I'm on it. I've burrowed away and found anything that I can find out. But there are lots of things I was completely hopeless, you know, doesn't have a clue without me helping him. There must be other, you know, it's an area that if you want more people working, if we're all supposed to be, you know, more people in the workplace then.

Claire Webster (SCIE) 5:56

Yeah.

Yeah.

Yeah, absolutely.

R 6:22

Some simple things to sort of mentoring help with CB writing interviews.

You know, help with raising awareness of employers, that they're fantastic people out there. But for them, the actual interview process, I don't know how many interviews I've kind of, you know, messed up because I'm too direct and and don't play the game, can't play games.

R 6:42

So those those kinds of things, that awareness would be good.

Claire Webster (SCIE) 6:58

Is thinking about the female experience of autism, and there's been a lot of discussion which I think is really important about, for example, menopause and how menopause effects autistic women even more differently than the rest of the population. And we're not talking about it enough. And I wondered.

R 7:28

I had the menopause from hell. I mean, it may be almost suicidal. I used to drive to work and think I have to crash the car and die.

R 7:36

Because it was so bad at that time, it was before the the recent awareness as well. So I was sort of under almost, you know, threatened with disciplinary action for having time off.

Because I was a previous employer, previous school.

And but because I'm very persistent, I kind of tried every kind of hrti think until I found something that worked, but it was it was really, really bad. And and friends who just like had a few nights where, you know, oh few flutters and off you go. I had no idea it was it was very, very bad. Now I don't know whether that's me or.

R 8:09

Whether that's I wouldn't know whether that's, you know, unfortunately, I'm still over the age where most women my age, we didn't talk about it.

R 9:13

Basically, you know, The thing is well, the sleep, the sleep, the disturbed sleep and menopause. If you already have poor sleep. So my sleep is very odd, you know.

I've got Bing me. I've got, like, 10 years of data from sleep cycle.

R 9:29

You won't be surprised to know Mrs Data collection, so I know that my cycle of my sleep, I don't sleep like a good night. I'd go through this. I cycle through the different parts of the rhythm of sleep. And there are other nights where sleep cycle tells me that I've sat really, really well. But I know I've gone straight down into a deep sleep. I'm virtually dead. And then I wake up again. I feel terrible. So all sorts of weird things are happening as well already. And then on top of that, you pile on the fact that you can't sleep because you keep waking up every 5 minutes and going sort of meerkat mode like this. You know, you can't go back to sleep again.

I probably have ADHD as well, which doesn't help but.

Claire Webster (SCIE) 10:02

But it's again something that's usually quite expected as well, so.

So.

R 10:06

So.

So yeah, there are there are lots of interesting. It's very, very interesting. The whole research, you know, in the whole kind of what's going on is so interesting with it. But anyway, yes, there are lots of. Yeah, I do. I wouldn't. I wouldn't wish that experience on anybody.

R 10:59

And obviously then it's it's communicating, you know, so I'm chatting to you. It's fine. But I I do. I do get to sit when I'm tired or stressed. I find it very difficult to communicate. And if I you know I do. I have to make it my To Do List is like you know to actually communicate with my children my grown up children it's effort it's kind of hard.

R 11:19

It's so stupid. My eldest, my eldest son and I run a business together for a while and he was constantly you don't communicate, mum. You don't communicate.

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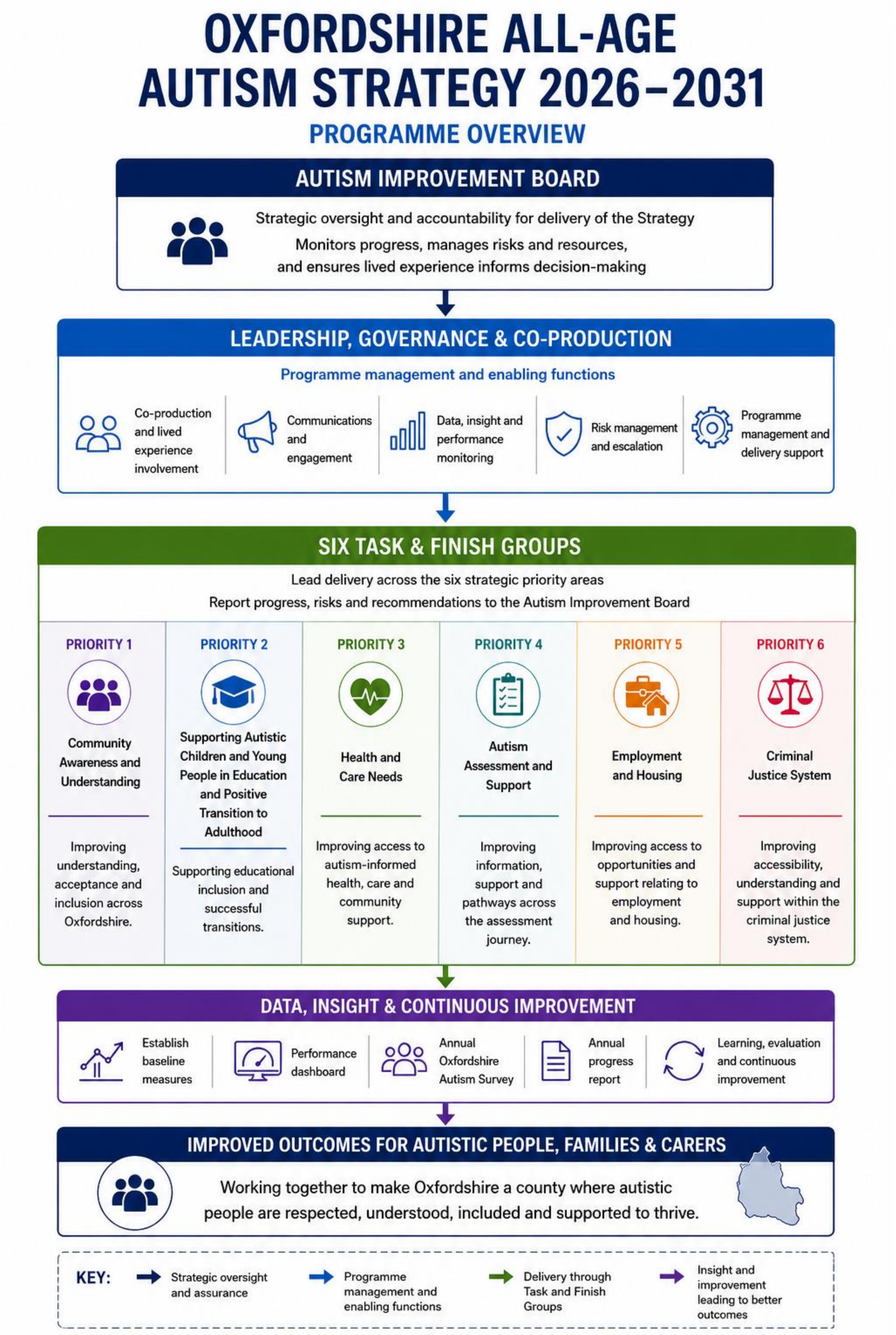
<u>All- Age Autism Strategy – Overview and Year 1 Overarching Delivery Plan</u>



OXFORDSHIRE ALL-AGE AUTISM STRATEGY 2026–2031

PROGRAMME OVERVIEW

AUTISM IMPROVEMENT BOARD

Strategic oversight and accountability for delivery of the Strategy

Monitors progress, manages risks and resources, and ensures lived experience informs decision-making

LEADERSHIP, GOVERNANCE & CO-PRODUCTION

Programme management and enabling functions

- Co-production and lived experience involvement
- Communications and engagement
- Data, insight and performance monitoring
- Risk management and escalation
- Programme management and delivery support

SIX TASK & FINISH GROUPS

Lead delivery across the six strategic priority areas

Report progress, risks and recommendations to the Autism Improvement Board

PRIORITY 1	PRIORITY 2	PRIORITY 3	PRIORITY 4	PRIORITY 5	PRIORITY 6
Community Awareness and Understanding	Supporting Autistic Children and Young People in Education and Positive Transition to Adulthood	Health and Care Needs	Autism Assessment and Support	Employment and Housing	Criminal Justice System
Improving understanding, acceptance and inclusion across Oxfordshire.	Supporting educational inclusion and successful transitions.	Improving access to autism-informed health, care and community support.	Improving information, support and pathways across the assessment journey.	Improving access to opportunities and support relating to employment and housing.	Improving accessibility, understanding and support within the criminal justice system.

DATA, INSIGHT & CONTINUOUS IMPROVEMENT

- Establish baseline measures
- Performance dashboard
- Annual Oxfordshire Autism Survey
- Annual progress report
- Learning, evaluation and continuous improvement

IMPROVED OUTCOMES FOR AUTISTIC PEOPLE, FAMILIES & CARERS

Working together to make Oxfordshire a county where autistic people are respected, understood, included and supported to thrive.

KEY:

- ➔ Strategic oversight and assurance
- ➔ Programme management and enabling functions
- ➔ Delivery through Task and Finish Groups
- ➔ Insight and improvement leading to better outcomes

CROSS-CUTTING FOUNDATIONS FOR YEAR 1

OBJECTIVE	MEASURE
Establish governance and accountability arrangements	Autism Improvement Board and working groups operating with agreed governance arrangements
Strengthen co-production and lived experience involvement	Co-production arrangements reviewed and strengthened
Develop performance monitoring and reporting	Baseline measures agreed and annual Oxfordshire Autism Survey established
Review resources and capacity required for delivery	Capacity review completed and support requirements identified
Establish communications and engagement arrangements	Communications plan implemented Oxfordshire Autism Information Hub development progressed Social media channels established and actively maintained Regular public updates provided on Strategy delivery, engagement opportunities and information

Oxfordshire All-Age Autism Strategy

Year 1 Delivery Plan 2026/27

Purpose

This Year 1 Delivery Plan provides a clear implementation framework from a commissioning perspective, for the first twelve months of the Oxfordshire All-Age Autism Strategy. It is intended to support board-level oversight by setting out the initial priorities for delivery, the partnership arrangements needed to progress them, and the measures that will provide assurance on whether implementation is on track. The focus in year one is on establishing governance, confirming baselines, starting a limited number of high-value actions, and embedding co-production in delivery and review.

Governance and Assurance, Delivery Plan

Delivery should be overseen by the Autism Improvement Board, reporting through agreed partnership governance routes. In year one, the Board should focus on maintaining strategic oversight, confirming delivery ownership across partner organisations, ensuring that autistic people and carers are involved in decision-making, and reviewing progress against a small set of outcome and activity measures. Thematic task-and-finish groups can support delivery where detailed work is needed, but accountability for progress should remain clear and visible through a single reporting framework.

Delivery plan year 1 (Delivery plan to be overseen and supported by a project management resource)

Priority	Year 1 Focus	Lead partners	Timeline	Assurance measures
Governance	Confirm Autism improvement board TOR and reporting into routes	Joint chairs of the Autism Improvement Board	04/06/2026 to 31/08/26	TOR in place and board operating as expected
Governance	Set up sub-groups for the workstreams	Strategic Commissioner from Live and Start Well	04/06/2026 to 31/08/26	Confirmation that the chairs are allocated and sufficient support in place to ensure that all meetings are in the diary with agreed timelines
Governance	Agree co-design approach and membership arrangements	All sub-group Chairs	01/09/2026 to 31/08/26	Groups are functioning in a way that allows for input from all members

Governance	Develop baseline reporting template for each working group	Project Manager resource	30/06/2026 to 31/08/26	Templates in place and functioning
Governance	Develop a template TOR for the sub-groups	Derek Gravett-Smith Ruby Sweetman	04/06/2026 to 31/06/26	TOR templates in place ready for the first sub-group meetings to be booked in
All	Map existing training and awareness offers	Derek Gravett-Smith Ruby Sweetman Andrea Cochrane Kerrie Evans	04/06/2026 to 18/12/26	Existing training mapped with reports delivered to Autism Improvement Board
Community Awareness	Develop a plan for shared awareness and communication plan	Community Awareness sub-group chair	01/09/2026 to Ongoing	Plans agreed with Autism Improvement Board
Community Awareness	Begin rollout of the awareness and communication plan, this may be via a website or portal	Community Awareness sub-group chair	01/09/2026 to Ongoing	Rollout plan in place and resourced effectively
All	Review current information pathways	Derek Gravett-Smith Ruby Sweetman Andrea Cochrane Kerrie Evans	04/06/2026 to 18/12/26	Present information setting out what is currently in place to influence planning
All	Identify gaps and duplication from the review of pathways and training	All sub-group Chairs	01/09/2026 to 31/03/27	Updated plans based on the findings of the review of current pathways
Community Awareness	Agree improvements to communication and sharing of best practice and good pockets of work that are currently taking place	Community Awareness sub-group chair	04/06/2026 to 31/03/27	New systems in place for communicating

All	Identify immediate improvement opportunities, based on what is already available and on the statements within the autism strategy	All sub-group Chairs	31/08/2026 to Ongoing	Quick wins identified and implemented with report going to Autism Improvement Board
Governance	Agree escalation routes for issue from sub groups through to senior leadership members of organisations	Autism Improvement Board	04/06/2026 to 31/08/26	Firm well set out proven escalation routes in place to support the work of the sub-group chairs
Diagnosis/Confirmation	Start targetted pathway understanding, mapping and exploring improvement opportunites	Diagnosis/Confirmation sub-group chair	04/06/2026 to 31/03/27	Plans are reported on for ways in which any improvements might be made to pathways with agreed deliverables
Community Awareness	Identify practical inclusion priorities for year one	Community Awareness sub-group chair	01/09/2026 to 18/12/26	Reported on inclusion priorities into the Autism Improvement Board for discussion and agreement
Housing and Employment	Link strategy delivery with wider community and employment initiatives	Housing and Employment sub-group chair	01/09/2026 to 18/12/26	Understand and report on what is already in place and how that currently maps to the deliverables in the strategy
Housing and Employment	Develop actions with partner organisations on accessability and inclusivity	Housing and Employment sub-group chair	01/09/2026 to 31/03/27	Reports developed with actions from the sub-group reported to Autism Improvement Board
DATA	Identify available data sources what is currently happening and map those against known deliverables from the strategy	Derek Gravett-Smith Ruby Sweetman	04/06/2026 to 18/12/26	Reports developed and fed back to the Autism Improvement Board with actions resulting from this work with any gaps

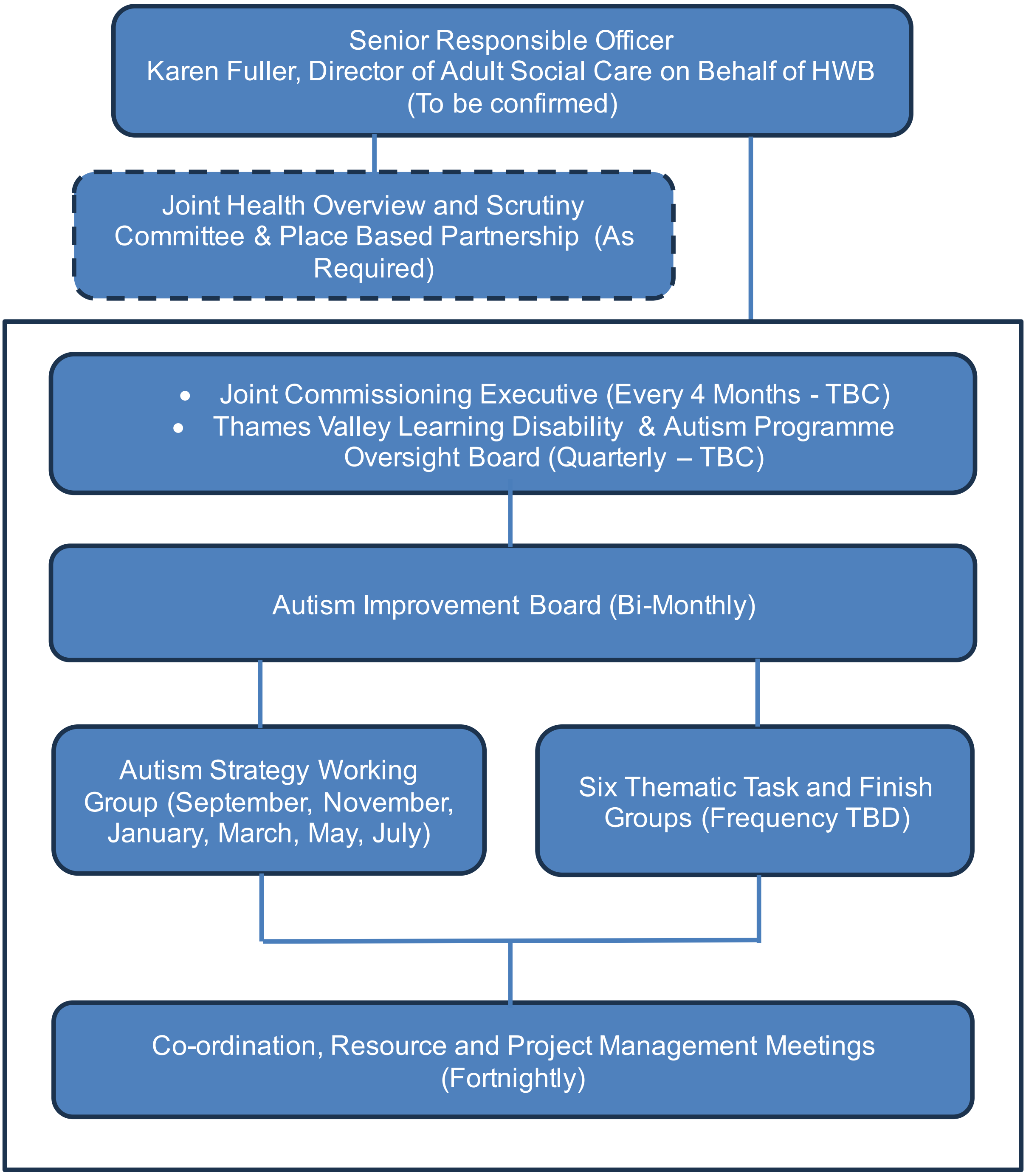
Deliver	Complete paperwork ahead of the Health and Wellbeing board	All	04/06/2026 to 12/06/26	Paperwork ready to be sent out to the Health and Wellbeing board ahead of the meeting on the 9th of July
Deliver	Attend Health and Wellbeing board for sign of to the draft strategy	Bhavna Taank	09/07/2026 to 09/07/26	Agreement in place to agree to the strategy being put into action
Launch	Create a lite version of the Autism Strategy	Strategic Commissioner Start Well	10/07/2026 to 31/08/26	Lite version in place ready for launch
Launch	Agree to a launch date and event after confirmation that the strategy has been agreed and is ready to be published	Autism Working Group	10/07/2026 to 31/08/26	All age autism strategy launched and made live on public websites

Immediate Next Steps

Board members are asked to note the proposed Year 1 delivery approach, confirm the governance and reporting arrangements for implementation, and support the early mobilisation actions needed to establish delivery in the first quarter. A more detailed operational tracker can then sit beneath this document for programme management purposes, with formal progress updates brought back through the agreed governance route.

Governance & Reporting Structure (Draft)

for the Oxfordshire All-Age Autism Strategy 2026-2031



Senior Responsible Officer
Karen Fuller, Director of Adult Social Care on Behalf of HWB
(To be confirmed)

Joint Health Overview and Scrutiny Committee & Place Based Partnership (As Required)

- Joint Commissioning Executive (Every 4 Months - TBC)
- Thames Valley Learning Disability & Autism Programme Oversight Board (Quarterly – TBC)

Autism Improvement Board (Bi-Monthly)

Autism Strategy Working Group (September, November, January, March, May, July)

Six Thematic Task and Finish Groups (Frequency TBD)

Co-ordination, Resource and Project Management Meetings (Fortnightly)

Oxfordshire County Council

Equalities Impact Assessment

All Age Autism Strategy

10/02/2026

Contents

Section 1: Summary details

Directorate and Service Area	HESC – Children's & Adults
What is being assessed (e.g. name of policy, procedure, project, service or proposed service change).	Oxfordshire All Age Autism Strategy
Is this a new or existing function or policy?	Current Strategy is outdated and due updating.
Summary of assessment Briefly summarise the policy or proposed service change. Summarise possible impacts. Does the proposal bias, discriminate or unfairly disadvantage individuals or groups within the community? (following completion of the assessment).	Developing an Autism Strategy to reflect the population need, co-designing with local organisations and experts by experience. Possible impacts are: The strategy may not cover all eventualities, we will mitigate this by being broad and inclusive when writing the final version and being transparent with stakeholders, ensuring we consulted with a wide range of people. Stakeholders may not feel they have been thoroughly included in the process, we will mitigate this by undertaking detailed stakeholder mapping and keeping a record of actions taken to be inclusive. Access to engagement/content/material, due to personal circumstances such as their network, limited access to the internet, those whose first language is not English. We will mitigate this by approaching a variety of community groups, providing content in alternative formats.
Completed By	Ruby Sweetman, Commissioning Officer, Live Well.
Authorised By	

Date of Assessment	10/02/2026

Section 2: Detail of proposal

Context / Background Briefly summarise the background to the policy or proposed service change, including reasons for any changes from previous versions.	The current Autism strategy for Oxfordshire is outdated, 2013-17. The purpose of developing a new strategy is to co-design with local organisations and experts by experience. It is not the intention to have a commissioning strategy, but rather a document to inform actions for an inclusive society. This will mean actions for statutory services, third sector, businesses, and local people.
Proposals Explain the detail of the proposals, including why this has been decided as the best course of action.	Developing the new strategy with the view for it to be an inclusive document is a different approach to previous documents, it ensures that this strategy will serve Oxfordshire residents to Live Well in the community, by knowing how and where to access advice/support/services. Co-designing an autism strategy has been agreed as the best course of action because this is a shared responsibility to enhance the lives of Autistic people and their families, it is imperative that this is done right. There are nationally led objectives to incorporate, therefore, co-production was not an option.
Evidence / Intelligence List and explain any data, consultation outcomes, research	Consultations with local stakeholders including, voluntary sector organisations, experts by experience, public sector organisations. Data collection (limited available due to how autism is reported). Engagement sessions & surveys to be carried out.

findings, feedback from service users and stakeholders etc, that supports your proposals and can help to inform the judgements you make about potential impact on different individuals, communities or groups and our ability to deliver our climate commitments.	
Alternatives considered / rejected Summarise any other approaches that have been considered in developing the policy or proposed service change, and the reasons why these were not adopted. This could include reasons why doing nothing is not an option.	The current strategy is outdated and doing nothing was not an option as well as having national objectives to incorporate within a local strategy, commissioners have had extensive conversation with experts by experience (both autistic people and parents/carers of autistic people). A common theme has been identified that families feel there is no joined up or collaborative working around services for autism, therefore, co-designing a new strategy with stakeholders and designing it in a way that allocates actions for statutory services, third sector, businesses, and local people alike is the most impactful way to deliver this strategy.

Section 3: Impact Assessment - Protected Characteristics

Protected Characteristic	**No Impact**	**Positive**	**Negative**	**Description of Impact**	**Any actions or mitigation to reduce negative impacts**	**Action owner*** (*Job Title, Organisation)	**Timescale and monitoring arrangements**
Age	☐	☒	☐	People of all ages can be impacted by autism and an all-age strategy will reduce the inequalities by ensuring that people of all ages can access the support/services/advice laid out within the strategy.	Ensure that the strategy is available in various formats and accessible.		
Disability	☐	☒	☐	People of all abilities can be impacted by autism and this strategy will reduce the inequalities by ensuring that people of all abilities can access the support/services/advice laid out within the strategy, in various formats that are inclusive.	Ensure that the strategy is available in various formats and accessible.		

Gender Reassignment	☐	☒	☐	People of all genders are impacted by autism and this strategy will be inclusive to all, whilst ensuring that people of all genders can access the support/services/advice laid out within the strategy.	Ensure that strategy is inclusive of gender reassignment and considerate with language used. Work with partners that demonstrate inclusivity towards protected characteristics.		
Marriage & Civil Partnership	☒	☐	☐	This strategy should not impact marriage & civil partnerships.	Monitor engagement and consultation with stakeholders as this could change.		
Pregnancy & Maternity	☐	☒	☐	This strategy may impact pregnancy & maternity for autistic people, by ensuing reasonable adjustments are made to support autistic parents through the pregnancy milestones and for maternity care.	Work closely with health partners to include aspects of pregnancy and maternity care in the strategy.		

Race	☐	☒	☐	People from all racial and cultural backgrounds can be impacted by autism and this strategy can reduce the inequalities by ensuring that people from all cultures can access the support/services/advice laid out within the strategy.	Ensure that the strategy is available in various formats and accessible. Work with partners from different communities to spread awareness of the strategy.		
Sex	☐	☒	☐	People of all genders are impacted by autism and this strategy will be inclusive to all, whilst ensuring that people of all genders can access the support/services/advice laid out within the strategy.	Ensure that strategy is inclusive of sexes.		
Sexual Orientation	☐	☒	☐	People of any sexual orientation are impacted by autism and this strategy will be inclusive to all, whilst ensuring that everyone can access the support/services/advice laid out within the strategy.	Ensure that strategy is inclusive of sexual orientation.		

Religion or Belief	☐	☒	☐	People from all religions and backgrounds can be impacted by autism and this strategy can reduce the inequalities by ensuring that people from all cultures can access the support/services/advice laid out within the strategy, regardless of their beliefs.	Work with partners from different communities to spread awareness of the strategy.		

Section 3: Impact Assessment - Additional Community Impacts

Additional community impacts	No Impact	Positive	Negative	Description of impact	Any actions or mitigation to reduce negative impacts	Action owner (*Job Title, Organisation)	Timescale and monitoring arrangements
Rural communities	☐	☒	☐	Some autistic people may find travel from rural communities difficult when using public transport. The strategy should increase awareness of the challenges faced by autistic people and help to open up alternative routes.	Make adjustments to meetings or appointments where possible, provide travel guidance. Offer online alternatives.		
Armed Forces	☐	☒	☐	People from all backgrounds can be impacted by autism, Oxfordshire has armed forces bases within the county and in surrounding counties, there are likely to be families that have moved into the area and are joining Oxfordshire services.	Work with partners to have a pathway for these families to access.		
Carers	☐	☒	☐	Carers (parents) can also be greatly impacted by autism and this strategy can ensure that carers from all areas can access the support/services/advice laid	Work with partners from different communities to spread awareness of the strategy. Make adjustments to meetings or appointments where possible. Offer online		

Additional community impacts	**No Impact**	**Positive**	**Negative**	**Description of impact**	**Any actions or mitigation to reduce negative impacts**	**Action owner** (*Job Title, Organisation)	**Timescale and monitoring arrangements**
				out within the strategy as it is there to support their needs also as a parent/carer.	alternatives as this may work around caring responsibilities.		
Areas of deprivation	☐	☒	☐	People from all backgrounds can be impacted by autism and this strategy can reduce the inequalities by ensuring that people from all areas can access the support/services/advice laid out within the strategy, regardless of their social situation.	Work with partners from different communities to spread awareness of the strategy.		

Section 3: Impact Assessment - Additional Wider Impacts

Additional Wider Impacts	**No Impact**	**Positive**	**Negative**	**Description of Impact**	**Any actions or mitigation to reduce negative impacts**	**Action owner*** (*Job Title, Organisation)	**Timescale and monitoring arrangements**
Staff	☐	☒	☐	Oxfordshire CC staff will have a recent document, developed with stakeholders to use to support autistic people in situations that may arise in their life.	Clear communications to go out internally. Excellent engagement with stakeholders when pulling the document together.		
Other Council Services	☐	☒	☐	Services will have a recent document, developed with stakeholders to use to support autistic people in situations that may arise in their life.	Clear communications to go out internally & externally. Excellent engagement with stakeholders when pulling the document together.		
Providers	☐	☒	☐	Providers will have a recent document, developed with stakeholders to use to support autistic people in situations that may arise in their life.	Clear communications to go out externally. Excellent engagement with stakeholders when pulling the document together.		

Additional Wider Impacts	**No Impact**	**Positive**	**Negative**	**Description of Impact**	**Any actions or mitigation to reduce negative impacts**	**Action owner*** (*Job Title, Organisation)	**Timescale and monitoring arrangements**
Social Value [1]	☐	☒	☐	This will impact on the population of Oxfordshire in a positive way as it will add empowerment into aspects of their lives, it will give clear information, how to access services, who to contact and how to get involved in local groups & projects.	Excellent engagement with stakeholders when pulling the document together.		

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[1] If the Public Services (Social Value) Act 2012 applies to this proposal, please summarise here how you have considered how the contract might improve the economic, social, and environmental well-being of the relevant area

Section 4: Review

Where bias, negative impact or disadvantage is identified, the proposal and/or implementation can be adapted or changed; meaning there is a need for regular review. This review may also be needed to reflect additional data and evidence for a fuller assessment (proportionate to the decision in question). Please state the agreed review timescale for the identified impacts of the policy implementation or service change.

Review Date	**10/02/2027**
Person Responsible for Review	**HESC Live Well commissioning team**
Authorised By	

Data Protection Impact Assessment (DPIA) Template

A DPIA is designed to describe your processing of personal and sensitive data, and to help manage any potential harm to individuals in the use of their information. DPIAs are also important tools for demonstrating accountability, as they help you as a Controller to comply with the requirements of the Data Protection legislation. Non-compliance with DPIA requirements can lead to fines imposed by the Information Commissioners Office (ICO); this includes not carrying out a DPIA at all.

Background information	
Completion date of DPIA	12/09/2024
Title of the activity/processing	All-Age, All System Autism Strategy: Autism Mapping and Engagement Project
Who is the person leading this work?	Derek Gravett-Smith/Bhavna Taank
Who is the Lead Organisation?	Oxfordshire County Council (Live Well Joint Commissioning Team, HESC)
Who has prepared this DPIA?	Ruby Sweetman / Alex Wheeler
Who is your Data Protection Officer (DPO)?	Simon Harper
Describe what you are proposing to do (Include as much background information as you can about why the new system / change / sharing / processing is required.)	There is a national requirement for the council to have an Autism Strategy in place. The Council has commissioned an external provider to carry out the data gathering, gap analysis, and engagement work as part of gathering information to help produce the All-Age, All System Autism Strategy.
Are there multiple organisations involved? (If yes, list them and their key contact for this work.)	The HESC Commissioning Teams – Start Well and Live Well will be working with the external provider to share data and information on services for autistic people, council data and there may be some anonymised information or data required to support with the data gathering, gap analysis and engagement work required with stakeholders. The All-Age, All System Autism Strategy will cover Oxfordshire ICB and Health. Social Care Institute for Excellence, Claire Webster
Are there any other Key Stakeholders that should be consulted or involved in this DPIA? (If yes, list them and their key contact for this work.)	Start Well Commissioning Team – Children's.
Has anything similar been undertaken before?	Yes, there have been other strategies in place, The Transforming Care Plan 2016-2019. There was also an Oxfordshire Learning Disability Strategy – The Big Plan 2015 – 2019 which included some information for Autism. This strategy will solely cover Autism.

There are situations where a DPIA **should be considered** or where a DPIA is a **legal requirement**. If you tick the criteria below it is highly recommended that you undertake a DPIA; and if you decide not to, you must document the reasons for your decision.

You as Controller **MUST** carry out a DPIA where you plan to:	Tick or leave blank
Use **profiling or automated decision-making** to make significant decisions about access to a service or benefit	☐
Process **special category data or criminal offence data** on a large scale	☐
Monitor a publicly accessible place on a large scale	☐
Use **innovative technology** in a way that may be considered intrusive	☐
Carry out **profiling** on a large scale	✓
Process **biometric or genetic data**	☐
Combine, compare or match data from multiple sources	✓
Process personal data **without providing a privacy notice** directly to the individual	☐
Process personal data in a way that involves **tracking** individuals' online or offline location or behaviour	☐
Process **children's personal data** for profiling or automated decision-making or for marketing purposes, or offer online services directly to them	✓
Process personal data that could result in a risk of physical harm in the event of a security breach.	☐

You as Controller should **consider** carrying out a DPIA where you:	Tick or leave blank
Plan any major project using personal data	☐
Plan to do evaluation or scoring	☐
Plan any systematic monitoring	☐
Process sensitive data or data of a highly personal nature	☐
Process data on a large scale	✓
Include data concerning vulnerable data subjects	☐
Plan to use innovative technological or organisational solutions.	✓

If you do not think you need to complete a DPIA after reading the two checklists above please submit this to the **information management team** for review and approval, otherwise please complete the rest of section 1 before submission.

Information Management Team Use

Review completed by		Date
DPIA not required approved by	Required	

1. Categories of data, legal basis, responsibility, confidentiality, purpose, collection and use

1.1. Categories of data

What data/information will be used? (Tick all that apply.)	Tick or leave blank	**Go on to complete:**
Personal Data	✓	1.2 below
Special Categories of Personal Data	☐	1.2 AND 1.3 below
Personal Confidential Data	☐	1.2 AND 1.3 AND 1.6 below
Sensitive Data (usually criminal or law enforcement data)	☐	1.2 below AND speak to your IG team
Pseudonymised Data	✓	1.2 below. Consider at what point the data is to be pseudonymised
Anonymised Data	✓	Consider at what point the data is to be anonymised
Commercially Confidential Information	☐	Consider if a DPIA is appropriate
Other	☐	Consider if a DPIA is appropriate

1.2. Legal basis

Processing must have a lawful basis. Identify which of the following you believe justifies your processing and explain why in the relevant box. You can select more than one if applicable.

UK GDPR Article 6 (1)	
a) the data subject has freely given their clear consent *Consent must be freely given, clear and unambiguous. The data subject must know what they are consenting to; or give consent by proxy where they do not have capacity to give it themselves. Remember, consent can be withdrawn at any time.*	**Tick or leave blank** ✓
Why are you relying on consent? What is the process for obtaining and recording and withdrawing consent? *How, where, when, by whom, including tracing withdrawal through any systems/sharing.* As part of gathering information the Service Provider will be undertaking / hosting Engagement Sessions with stakeholders – including experts by experience. It is not planned for the Service Provider to directly contact individuals but will provide promotional information which will be shared with organisations and providers to send out to people who they work with. During Engagement sessions, case studies and people's experiences may be captured. This may have some identifying information for example the person's first name. Individuals will provide this information and be informed of what it is being captured for. Consent forms will be available for people to complete. Photography may be taken during engagement sessions and notices for this will be displayed and consent forms completed should photographs be used. The Council's policy / best practice guidance will be followed of coloured stickers to indicate if people are not happy for photographs of them to be taken.	
b) it is necessary for the performance of a contract to which the data subject is party *The contract needs to be between the Controller and the individual and not concern data being processed due to someone else having a contract with the Controller.*	**Tick or leave blank** ☐

c) it is necessary under a legal obligation to which the data controller is subject *A legal obligation mandates processing of data as a task in itself.*	**Tick or leave blank** ☐
What legislation or legal obligation requires you to undertake this processing?	
d) it is necessary to protect the vital interests of the data subject or another natural person *This only applies when you need to process data to protect someone's life. It must be necessary and can also apply to protect another person's life. Emergency interventions are likely to fall into this category, but planned care would not. You may need to process a parent's data to protect the life of a child. The individual concerned is unlikely to be able to provide consent physically or legally; if you are able to gain consent then vital interest will not apply.*	**Tick or leave blank** ☐
How will you protect their vital interests by undertaking this activity? Click here to enter text.	
e) it is necessary for the performance of a task carried out in the public interest or under official authority vested in the Controller *This is different to Legal Obligation. If you are processing data under Public Interest then you should be able to identify a specific task, function or power that is set out in law. The processing must be necessary to achieve that task set out in law.*	**Tick or leave blank** ☐
What statutory power or duty does the Controller derive official authority from?	
f) it is necessary for the legitimate interests of the Controller or third-party *Public authorities can only rely on legitimate interests if they are processing for a legitimate reason other than performing their tasks as a public authority.*	**Tick or leave blank** ☐
What are the legitimate interests you have? Click here to enter text.	

1.3. Sensitive data

When using special categories of personal data, a condition for processing under Article 9 of the UK GDPR must be satisfied in addition to a legal basis under Article 6.

Article 9 (2) conditions are as follows:	
a) the data subject has given their explicit consent to the processing of their personal data for one or more specified purposes *Requirements for consent are the same as those in section 1.2 above.*	**Tick or leave blank** ✓
b) it is necessary for the purposes of employment, social security or social protection *See Data Protection Act 2018 Schedule 1 Part 1 for detail on how this applies.*	**Tick or leave blank** ☐
c) it is necessary to protect the vital interests of the data subject or another natural person where they are physically or legally incapable of giving consent	**Tick or leave blank**

Requirements for vital interest are the same as those in section 1.2 above.	☐
d) it is necessary for the operations of a not-for-profit organisation such as political, philosophical, trade union and religious body in relation to its members *This is not applicable for public authorities, nor does it relate to voluntary and charitable sector partners.*	Tick or leave blank ☐
e) the data has been made public by the data subject *This may be published or provided or otherwise made public by the data subject, or in the public domain as a result of their actions, not other persons or actions.*	Tick or leave blank ☐
f) for the establishment, exercise or defence of legal claims or for courts acting in their judicial category *This is only applicable in certain circumstances and will be specifically for a required legal purpose, not the day to day business of proceedings.*	Tick or leave blank ☐
g) substantial public interest, proportionate to the aim pursued and with suitable and specific measures to safeguard the rights and interests of the data subject *See Data Protection Act 2018 Schedule 1 Part 2 for detail on how this applies.*	**Tick or leave blank** ☐
h) it is necessary for the purposes of preventive or occupational medicine, for the assessment of the working capacity of the employee, medical diagnosis, the provision of health or social care or treatment or the management of health or social care systems and services *See Data Protection Act 2018 Schedule 1 Part 1 for detail on how this applies.*	**Tick or leave blank** ✓
i) it is necessary for reasons of public interest in the area of public health, such as protecting against serious cross-border threats to health or ensuring high standards of quality and safety of health care and of medicinal products or medical devices *See Data Protection Act 2018 Schedule 1 Part 1 for detail on how this applies.*	**Tick or leave blank** ☐
j) it is necessary for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes (in accordance with Article 89(1)) *See Data Protection Act 2018 Schedule 1 Part 1 for detail on how this applies.*	**Tick or leave blank** ☐

NB: the data legislation allows that government may maintain or introduce further conditions, including limitations, with regard to the processing of genetic data, biometric data or data concerning health (UK GDPR Article 9.4). This is the case e.g. with COPI (Control of Patient Information).

1.4. Data Controller(s) and Data Processor(s)

Confirm who the Data Controller(s) and Data Processor(s) are. Confirm whether the Controller(s) are solely or jointly responsible for the data processed.

Name of Organisation	**Role**
Oxfordshire County Council	Sole Controller
Service Provider - SCIE	Processor
Click here to enter text.	Choose an item.

Click here to enter text.	Choose an item.
Click here to enter text.	Choose an item.
Click here to enter text.	Choose an item.
Click here to enter text.	Choose an item.

1.5. Purpose of Processing

What is the core purpose for processing this information?

The information is required to complete data analysis, mapping and for engagement sessions. The information will be used towards the Autism Strategy and inclusion of key data for identified themes.

1.6. Pseudonymisation and Anonymisation

Are you applying any pseudonymisation (reversible) or anonymisation (irreversible) technique or encryption to any of the data to make it non-identifiable and preserve the confidentiality of any information?

Yes

The data collected will be anonymised, from the point of collection. Participants are asked to complete a questionnaire that holds no identifiable questions, it is a questionnaire to establish people's experiences of life in Oxfordshire as an autistic person and as a parent/carer of an autistic person.

1.7. Ethics and Research

Are there any Ethics requirements or Research Data requirements to this activity?

No

1.8. Business Continuity and Disaster Recovery

Review your business continuity or contingency plans around this activity. Are there any risks to your business if you lost access to the data? Or any risks to the data if you work alternatively?

No. Data has been uploaded onto a Teams Channel which the Council is the owner of.

1.9. Training

What training is planned to support this activity and ensure compliance around the data?

The Service Provider must have Data Protection Training as mandatory for all staff. The Service Provider is required to meet the Data Protection Legislation requirements to the correct level.

Information Management Team Use

Review completed by		Date
DPIA approved at stage 1 by		Date
IM comments –		

2. Data processing, linkage, flows, sharing, reports, and managing data from other organisations such as health services

2.1. Data processing

Describe exactly what is being processed, including datasets, categories or fields, why you want to process it, and who will do any of the processing?

Data gathered on service provisions, expenditure on services. The information is to be used for data analysis, mapping and engagement sessions for the All-Age, All System Autism Strategy. Data on some of the relevant Council service provisions have been obtained for Council systems, including performance reports from ContrOCC and LAS. Some data obtained is public information including: ASCOF, JSNA, POPPI and PANSI. The external provider will be processing the information obtained to complete the data analysis and service mapping. Collating engagement reports from information obtained during engagement sessions with stakeholders – including experts by experience.

2.2. Data flows

What are your data flows, into the business, out of the business and within the business? Can you trace the data through your processes? Please provide details and attach a data flow map.

Information from Council sources will be uploaded onto a Teams Channel which the Council is owner and set people from the external provider commissioned to work on this project / contract will have access to the Teams Channel.

SCIE (asking questions) → Expert by Experience (providing data) → SCIE (collating data, anonymising) → OCC Commissioning Team (writing strategy from anonymised data collected and shared).

2.3. Collecting data

How will you collect the data, e.g. verbal, electronic, paper? (If you need to provide more, simply copy and paste the box and select your option.)

Face to face - in person
Face to face - Video enabled
By e-mail
Electronic form
By telephone

If you have selected 'Other' please describe what that method is:
Click here to enter text.

2.4. Volume of data

Approximately how many people will be the subject of the processing?

Unclear at this stage – Public drop-in sessions are being hosted.

2.5. Combining data

Are you proposing to combine any data sets?

No

If yes, please give details here:
Click here to enter text.

2.6. Sharing data

What data are you planning to share? At what stage of your process? With whom? On a routine or ad-hoc basis? What volume? Why is this data being shared? Is this covered by a contract, data sharing agreement, or Memorandum of Understanding? How will you share it?
Consider and detail all means of sharing, including cloud, email, Teams, paper, etc.
The data will inform the creation of the local autism strategy, it will be in a Word document report from SCIE with some additional PowerPoint slides with key figures. SCIE have a contract with OCC to collect, collate and present this data.
The 1st draft of the Strategy will go out for public consultation, we are likely to use the ‘Let’s Talk’ platform, this will be over a maximum period of 8 weeks.

2.7. Microsoft Teams and other sharing platforms
Are you planning to use Microsoft Teams or another similar online networking/meeting solution that may have the facility to store or record conversations or related data as part of data sharing?
Detail how you have considered any privacy risks of using one of these solutions.
Yes, Microsoft Teams Channel will be used for file sharing and encrypted email. The Council is the owner of this channel and will only be adding those who are working on this project. SCIE is in a short term contract with the Council to deliver this piece of work.

2.8. Editing data
How will you edit the data?
The data will only be edited to anonymise.

2.9. Data quality
How will you check and maintain the quality of the data?
SCIE and Commissioning will be reviewing responses received and this will be a one-off data collection.

2.10. Duty of Confidentiality
Do you owe a “duty of confidentiality” to any health or legal or financial data?
The common law duty of confidentiality exists in addition to the data legislation: you must keep in confidence information disclosed to you about another without their knowing, except where they have given their explicit consent, you have a legal obligation, or overriding safeguard.
Yes

2.11. Health data
Are you proposing to use data that may have come from NHS Digital?
Yes
Anonymised diagnosis data that is publicly available.

2.12. National Data Opt-Out
Where you are processing health data, it may be subject to the National Data Opt-Out where the data subject has asked not to process their data for any means beyond their direct patient care. Is your data subject to the National Data Opt-Out?
No - it is not subject to the national data opt out

3. Data Processors, IG Assurances, Storage, Access, Cloud, Security, Non-UK processing, Processing agreements

3.1 Third Parties and supply chain
Are you proposing to use a third party, a data processor or a commercial system supplier?

Yes

If yes, please add their details including their official name and address. If there is more than one, include all organisations.
Social Care Institute for Excellence, Claire Webster, Isosceles Head Office, 1 High Street, Egham, TW20 9HJ
Click here to enter text.
Click here to enter text.
Click here to enter text.
Click here to enter text.

3.2 Information Commissioner's Office (ICO) registration
Is each organisation involved registered with the Information Commissioner?
(Copy and paste the last empty row in the table to add organisations where required.)

Name of organisation	Registered	Registration details or comments if not
SCIE	Yes	Z2280951
Click here to enter text.	Choose an item.	Click here to enter text.
Click here to enter text.	Choose an item.	Click here to enter text.
Click here to enter text.	Choose an item.	Click here to enter text.
Click here to enter text.	Choose an item.	Click here to enter text.

3.3 What IG assurances have been provided and does any contract contain IG clauses that protect you as Controller?
E.g. terms and conditions, contracts, tender submission.
(Copy and paste the last empty row in the table to add organisations where required.)

Name of organisation	Brief description of assurances obtained
SCIE	SCIE are in contract with OCC for this project.
Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.

3.5 Accessing data
How is the data accessed and how will this be controlled? What audit trail does the access provide?
Engagement Stage: Commissioning Team → Teams channel/SharePoint (only people working on project will have access) → SCIE → Commissioning Team.

Consultation Stage: Engagement team → Let's Talk Online Portal → Commissioning Team.

3.6 Storing data

How and where will the data/information be stored? (Consider your answer to 2.7 and the potential storage of data in any online meeting or networking solution).
Private Teams Channel/SharePoint

3.7 Using the Cloud
Is there any use of Cloud technology?
Yes

If yes add the details here.
Private Teams Channel/SharePoint

3.8 Security measures
What security measures will be in place to protect the data?
OCC IT protection, only accessing when needed, only allowing access to those who need it.

3.9 International transfers
Is any data transferring outside of the UK? (The DPIA will not be approved without this answer, so only select 'Don't know' if you have further investigations to make.)
No

If yes, describe where and what additional measures are or will be in place to protect the data.
Click here to enter text.

3.10 Data Processing Agreements
Is a Data Processing Agreement in place to instruct organisations processing on your behalf? If not, what agreement will there be (e.g. contract, MoU) and who is responsible for managing it?
Yes a contract is in place with SCIE and OCC.

4. Privacy Notice, Individual Rights, Records Management, Direct Marketing

4.1 Privacy Notice
Describe any changes you plan or need to make to your Privacy Notice.
N/A

4.2 Data Subject Rights
How will this activity impact on individual rights under the data legislation? (Consider the right of access, erasure, portability, restriction, profiling, automated decision making).
All data will be collected and used anonymously.

4.3 Retention period
How long is the data/information to be retained?
Data will be used in the Autism Strategy, that will be a live document that will last for 5 years. All data collected will be stored only in line with the council's retention policy.

4.4 Archiving data
How will the data/information be archived?
The data will be archived digitally in SharePoint and deleted in accordance with the Council's retention policy.

4.5 Disposal of data
What is the process for the destruction of records? Who is responsible? Communicate that it is done, present destruction certificate.
The Commissioning Team will hold this data for the retention period and will delete when appropriate. SCIE will return all data collected during their contract.

4.6 End of activity
What will happen to the data/information if any part of your activity ends?
Data will be retained in line with policy and deleted when appropriate.

4.7 Direct marketing
Will you use any data for direct marketing purposes? (The DPIA will not be approved without this, so only select don't know if you have further investigations to make.)
No

5. Risks and Issues

5.1 Identifying risks
What risks and issues have you identified? The Information Governance team can provide advice to help complete this section and consider any measures to mitigate potential risks.

Describe the source of risk and nature of potential impact on individuals. Include associated compliance and corporate risks as necessary. (Copy and paste the complete bottom row to add more risks.)	Likelihood of harm	Severity of harm	Overall risk
Person attending the drop-in session may see someone they know and may overhear their experience.	Possible	Minimal	Low
Click here to enter text.	Choose an item.	Choose an item.	Choose an item.
Click here to enter text.	Choose an item.	Choose an item.	Choose an item.
Click here to enter text.	Choose an item.	Choose an item.	Choose an item.

5.2 Mitigating risks
What mitigations can you put in place? The Information Governance team can provide advice to help complete this section and consider any measures to mitigate potential risks.

Identify additional measures to reduce or eliminate risks identified in 5.1				
Risk	**Options to reduce or eliminate risk**	**Effect on risk**	**Residual risk**	**Measure approved (SIRO)**
Person attending the drop-in session may see someone they know and may	Make sure people feel comfortable sharing their experiences and have	Reduced	Low	Choose an item.

overhear their experience.	space between each station.			
Click here to enter text.	Click here to enter text.	Choose an item.	Choose an item.	Choose an item.
Click here to enter text.	Click here to enter text.	Choose an item.	Choose an item.	Choose an item.
Click here to enter text.	Click here to enter text.	Choose an item.	Choose an item.	Choose an item.

5.3 Other factors
What if anything would affect this piece of work?
Not able to collect and collate information, which would lead to the Autism Strategy not being delivered by April 2025.

5.4 Additional comments
Please include any additional comments that do not fit elsewhere in the DPIA?
Click here to enter text.

6. Consultation

6.1 Consulting stakeholders
Have you consulted with any internal services about this DPIA?
Yes

Have you consulted with any external organisations or groups about this DPIA?
Yes

If yes, who did you consult and what was the outcome?
If no, detail why consultation was not felt necessary.
Consulted with other departments that will be involved, Start Well Commissioning and SCIE.

6.2 Consulting the Regulator
Will you need to discuss this DPIA or activity with the Information Commissioner's Office? (Your Information Governance team can help you with this.)
No

7. Data Protection Officer Comments and Observations

Click here to enter text.

8. Review and Outcome

Based on the information contained in this DPIA along with any supporting documents, you have determined that the outcome is as follows:
Choose an item.

If you have selected item B), C) or D) please detail why.
Click here to enter text.

Based on the risk assessment we believe there are:
Choose an item.

If you have selected item B) or C) please list these below and consider additional measures you could take and include these in the green boxes below.

Residual risks and nature of potential impact on individuals. Include associated compliance and corporate risks as necessary. (Copy and paste the complete bottom row to add more risks.)	**Likelihood of harm**	**Severity of harm**	**Overall risk**
Click here to enter text.	Choose an item.	Choose an item.	Choose an item.
Click here to enter text.	Choose an item.	Choose an item.	Choose an item.
Click here to enter text.	Choose an item.	Choose an item.	Choose an item.
Click here to enter text.	Choose an item.	Choose an item.	Choose an item.

Additional measures you could take to reduce or eliminate residual risks identified as medium or high risk above (B and C)

Risk	**Options to reduce or eliminate risk**	**Effect on risk**	**Residual risk**	**Measure approved (SIRO)**
Click here to enter text.	Click here to enter text.	Choose an item.	Choose an item.	Choose an item.
Click here to enter text.	Click here to enter text.	Choose an item.	Choose an item.	Choose an item.
Click here to enter text.	Click here to enter text.	Choose an item.	Choose an item.	Choose an item.
Click here to enter text.	Click here to enter text.	Choose an item.	Choose an item.	Choose an item.

9. Authorisation and Signatures

Signed and approved on behalf of Click here to enter text.

Name: Click here to enter text.

Job Title: Click here to enter text.

Signature: Click here to enter text.   Date: Click here to enter a date.

Signed and approved on behalf of Click here to enter text.

Name: Click here to enter text.

Job Title: Click here to enter text.

Signature: Click here to enter text. Date: Click here to enter a date.

Important Notice:
You should ensure that your Information Asset Register is updated where this is relevant.

This DPIA should be kept under review and revisited when necessary. A new DPIA should be carried out if you decide that there is significant enough change to what you originally intended.

There is no requirement to share a DPIA, however a report of it may be shared with parties involved in this activity or in making agreements (contract, DSA, DPA, MoU) for this activity. If there are any exemptions or redactions, ensure they are removed before sharing.

This DPIA may be disclosed if requested under the Freedom of Information Act (2000). If there are any exemptions that should be considered to prevent disclosure detail them here:
Click here to enter text.

HEALTH AND WELLBEING BOARD

09 JULY 2026

PROGRESS ON EMBEDDING MARMOT APPROACH TO ADDRESS HEALTH INEQUALITES IN OXFORDSHIRE

Report by Ansaf Azhar

RECOMMENDATION

1. **The Health and Wellbeing Board is RECOMMENDED to**

a) **NOTE** the progress made in embedding the Marmot approach, using the 8 Marmot principles as a framework for understanding inequalities, and strengthening system-wide action on health inequalities in Oxfordshire.

b) **NOTE** the next phase of delivery, focused on converting insight and deep-dive recommendations into agreed actions, clear ownership and measurable outcomes.

c) **AGREE** that Marmot related equity measures should be embedded within the refreshed Health and Wellbeing Strategy outcomes framework to strengthen oversight and accountability.

Executive Summary

2.1.1 Oxfordshire continues to develop its Marmot Place approach, working in partnership with the Institute of Health Equity (IHE) to tackle health inequalities across the county.

2.1.2 Progress over the past year has focused on embedding a shared health equity approach across organisations by identifying good practice and leading targeted projects that demonstrate the value of addressing inequalities. This has included strengthening system leadership and aligning existing programmes to the Marmot principles. Activity has been prioritised across 3 key Marmot Principles:

- Giving every child the best start in life
- Creating fair employment and good work
- Ensuring a healthy standard of living

2.1.3 The next phase will focus on translating this approach into measurable outcomes, by agreeing actions to be owned in various existing structures across the system, strengthening accountability, and responding to emerging recommendations from IHE deep dives.

3. Background and Context

3.1 Oxfordshire became a Marmot Place to take coordinated, system-wide action to reduce health inequalities, recognising that health outcomes are shaped largely by the conditions in which people are born, grow, live, work and age.

3.2 The Marmot approach provides an overarching framework to bring together existing strategies, programmes and partnerships, ensuring a consistent focus on the wider determinants of health.

3.3 This work is closely aligned to the Oxfordshire Health and Wellbeing Strategy and Council Plan which identifies tackling health inequalities as a core, cross-cutting priority.

4. Governance and Delivery Approach

4.1 Delivery is supported through a system-wide governance structure, including:

- Marmot Advisory Group
- Marmot Steering Group
- Marmot Project Hub
- Thematic workstreams aligned to Marmot principles

The Health and Wellbeing Board provides strategic oversight and accountability for this work.

4.2 This approach brings together local authorities, NHS partners, voluntary and community sector organisations, and wider system partners to drive coordinated action.

4.3 The programme focuses on embedding a consistent health equity approach across organisations, rather than creating new standalone workstreams. Health equity specific measures will form part of the revised Health and Wellbeing outcomes framework so that progress can be monitored.

5. Progress Across Priority Workstreams

5.1 Best Start in Life

5.1.1 The Starting Stronger, Fairer Futures in Oxfordshire - IHE is ready for publication following extensive system wide engagement.

5.1.2 The report makes a series of recommendations on pages 11 and 12 to improve health equity in maternity, babies, children and young people. The recommendations address all the Marmot principles, and therefore reach beyond services focused on children young people.

5.1.3 Agreed actions are being developed and progress has been made to adopt these actions into existing governance structures. For example, work to reduce inequalities in Good Level of Development is reporting to the Children's Trust Board. It is proposed that the Health and Wellbeing Board maintain oversight of the evolving delivery plans.

5.1.4 Work is underway with a broad range of stakeholders to develop action and implementation plans that are aligned with existing strategies and programmes. This is being progressed through workshops with a joint subgroup of the Marmot Advisory Group and Steering Group.

5.2 Fair Employment and Good Work

5.2.1 This Marmot Principle is the focus of the next Institute of Health Equity deep dive.

5.2.2 A business sector roundtable chaired by Robin Rogers, Director of Economy and Place at Oxfordshire County Council, with presentations by the Institute of Heath Equity and Legal and General, took place at the end of April 2026.

5.2.3 Key themes and opportunities identified included:

- strengthening links between schools and employers – opportunities for employers to meet with school leavers and share openings for entry level roles
- earlier touchpoints for children to consider for career aspirations
- traditional pathways into employment are changing.
- barriers posed by GCSE requirements and opportunities with functional skills
- rethinking work experience – give young people the chance to experience a day at work, and time closer to working life

5.24 SOFEA, a local charity who help young people into work when opportunities are limited, reflected that moral support and guidance is a key part of helping young people into employment where multiple barriers are in place.

5.2.5 It is recognised that there are various pieces of work happening in the county around this topic, both in understanding the barriers to access work, and in programmes to address this such as Connect to work and Thrive at work Oxfordshire. Therefore, an initial mapping exercise will provide links to build on existing work, with a focus on health equity. As with the children and young people work, ensuring alignment within existing programmes will be critical to any success achieved.

5.2.6 There are strong links with the existing work of the Oxfordshire Inclusive Economy Partnership and IHE will ensure this work supports and aligns with their priorities. IHEs aim is to ensure they add value to existing work on inclusive employment with this deep dive, whilst proposing opportunities based on their expertise from working with other areas across the UK.

5.3 Healthy Standard of Living

5.3.1 Housing

5.3.2 There is a number of active programmes driving progress of the Health and Wellbeing Strategy priority 9, “healthy homes”. These include Better Housing Better Health and the Heat Safe Homes Programme. Evaluation of these programmes is ongoing to understand both the impact and where the programmes should be targeted.

5.3.3 A Housing Health Needs Assessment (HHNA) was undertaken in 2025 leading to development of the housing chapter in the Joint Strategic Needs Assessment. Based on the recent Department of Health and Social Care framework, the HHNA captures the impacts of poor housing on specific groups, therefore directly addressing health inequalities.

5.3.4 Partnerships with Housing Associations

One of the recommendations of the HHNA was to explore closer partnership working with Social Housing providers, of which there are around 70 in Oxfordshire. The Housing Association Charitable Trust (HACT) were commissioned to explore opportunities to strengthen collaboration between health, public health and social housing providers.

5.3.5 HACT held conversations with 17 system stakeholders, to understand the landscape for building relationships. It identified the following insights:

A strong shared purpose although a cautious appetite for partnership, beyond what exists currently.

A fragmented but active system with a strong convergence around a small number of areas where joint action would add most value:

- prevention and early intervention, including connection with Neighbourhood Health
- children and young people affected by housing instability
- people experiencing multiple disadvantage, including mental health challenges
- housing quality, including damp, mould and fuel poverty

Relationships matter more than structures. - Stakeholders emphasised the need for clarity of purpose and independent facilitation, rather than new formal structures.

Data frustration but with insight potential. - Stakeholders favoured better shared interpretation and use of insight, including lived experience, rather than ambitious data-sharing arrangements.

Pragmatic definitions of success. - Success over the next 12–18 months will be defined by improved relationships, clearer pathways, a small number of shared priorities and tangible changes in frontline experience.

5.4 The next step in response to this will be implementing a learning programme for housing associations to understand the health and public health priorities and ways of working, over the summer. In early Autumn this will be followed up with an event to allow health and public health to hear from Housing Associations.

5.4.1 Financial Security in Families

5.4.2 The Low Income Family Tracker (LIFT) is a tool which identifies families who are not receiving support they are entitled to, enabling councils to help the families to improve their financial security.

5.4.3 Cherwell District Council have mapped campaigns on the tracker to the Marmot principles, to help them to extend support to more people who need it.

5.4.4 As the inequalities deep dives continue, this will further highlight populations who may not be accessing support with potential to expand the targeting for the use of LIFT.

5.4.5 Inclusion health

11 community led grant funded projects are delivering preventative support for inclusion health groups. A systemwide workshop with the Institute of Health Equity has identified key priorities and themes which will inform next steps.

6. Rural Inequalities

6.1.1 Rural inequalities work is now moving from insight generation into the next phase of analysis and reporting. Work to narrow down rural areas for the scoping work identified 14 priority rural areas for targeted community engagement, informed by local intelligence as well as district council and deprivation data.

6.1.2 Community engagement was delivered between January and April 2026, led by Healthwatch Oxfordshire and Community First Oxfordshire, with support from the rural inequalities working group comprising of district councils and wider partners. The engagement approach included a mix of methods such as surveys, focus groups, outreach in local settings, and engagement through community networks to reach a broad range of residents.

6.1.3 Through this, over 800 residents completed surveys, alongside qualitative insight gathered through focus groups and targeted outreach activity. The engagement has provided a richer understanding of the experiences of people living in rural areas, including the barriers they face in accessing services, transport, housing and wider opportunities. It has also highlighted the importance of local context, community assets and the role of local networks in shaping outcomes.

This insight is now being analysed and will inform set of recommendations aimed at reducing rural health inequalities.

7. Local Policy Lab

7.1.1 The Local Policy Lab continues to progress delivery of projects aligned to Marmot priorities, with Fellows working alongside council officers and academic partners to apply research to real-world challenges. A programme showcase is scheduled for 15th July, after which a more substantive update including confirmed project outputs and emerging recommendations will be brought to the Health and Wellbeing Board in September.

8. Addressing Inequalities in Oxfordshire Most Deprived Wards

The public health led part of the community insight profiles (CIPs) work has now completed with 14 areas having profiles and support from community health development officers and grants to enable local wellbeing activities.

The DPHAR annual report 2025/26 celebrates the impact of this work, through an interactive website which also provides a place to share grassroots stories of the local initiatives to address inequalities. This will remain a dynamic website to which new local stories will be added.

Going forward opportunities to roll put the CIPs approach are being planned, informed by the wider Marmot approach and based on needs presented by Local Government Reform and neighbourhood health geographies.

9. System Engagement and Social Movement

9.1.1 There has been a clear focus this year to develop a “social movement” for health equity to help partners understand their role in health equity and ensure collective action to reducing health inequalities are embedded in services, programmes and policies.

9.1.2 Engagement activity has continued to build momentum across the system through workshops, webinars and other events that raise awareness of health equity and support partners to apply it in practice.

9.1.3 Newsletters and other communications help ensure regular updates are available to a wide ranging audience.

9.1.4 The Health Equity Network is a closed networking space for Oxfordshire, and part of the Institute of Health Equity. It offers a collaborative space for sharing information and best practice relating to Health Equity. The group is being promoted through the Marmot Steering Group as a useful forum for asking questions and sharing relevant information.

9.1.3 Awareness-raising activity is supporting cultural change across organisations. A Quick Refence Guide has been produced by the Marmot Project Hub and aims to help partners understand how applying the Marmot Principles in policy and service design can promote fairness and health equity. The Quick Reference Guide is enclosed in Annex 1.

10. Monitoring impact

10.1.1 The Health and Wellbeing Strategy indicators are currently being reviewed. For each strategic priority, identified outcomes and targets will be underwritten with an indicator based a health equity observed for that outcome. Therefore, Marmot (health equity) indicators will be embedded into the Health and Wellbeing Strategy indicators.

10.1.2 Progress and activity output indicators will be included in the action plans to ensure impact can be seen in a shorter timescale.

11. Next steps for the year ahead

11.1.1 Priorities for the next phase include:

- Strengthening partner commitments and system accountability, through local government and NHS reorganisations, as the partnership with Institute of Health Equity draws to a close. This will include ensuring partnership arrangements are fit for the transition period, to maintain health inequalities firmly on strategic priorities.
- Maintaining dynamic and responsive action plans to respond to the IHE deep dive reports, to ensure we achieve maximum benefit from the insight these have provided.
- Ensuring health equity specific outcomes are developed as part of the refreshed Health and Wellbeing Board outcomes framework / indicators framework
- Continuing the with social movement approach to ensure all staff across the system understand health inequalities and the impact of these in their line of work.

Corporate Policies and Priorities

The Marmot work aligns with the Oxfordshire Health and Wellbeing strategy and indicators.

Financial Implications

The approved core costs of the Marmot Place support from Institute of Health Equity have been detailed below for information, and are covered by the Oxfordshire County Council Public Health Wider Determinants budget:

Payments to University College London, Institute of Health Equity.

Financial year	Payment amount
2024/25	£90,275
2025/26	£51,300
Total	£141,575

Costs of services and interventions which increase focus on health equity will be covered by existing funding sources, in line with Oxfordshire's commitment to the Marmot approach.

Comments checked by:

Stephen Rowles, Strategic Finance Business Partner,
Stephen.rowles@oxfordshire.gov.uk

Legal Implications

1. This report provides an update on the work being undertaken to embed the Marmot principles as a framework for understanding inequalities in Oxfordshire. By embedding the Marmot Principles, communities aim to reduce health inequalities, improve social determinants of health, and create sustainable, equitable environments for all residents.

2. The use of Council funds for grants and contracts must comply with the Council's Contract Procedure Rules (where applicable), as well as any applicable legislation such as procurement and/or subsidy control legislation. Legal Services will be consulted to ensure that all grant agreements and contracts comply with legislation. Agreements between the Council and its partners will also need legal support with respect to negotiation, drafting and completion.

3. When using public health grants, local authorities must consider reducing inequalities in health between people in their area.

Janice White Principal Solicitor Janice.White@oxfordshire.gov.uk
Busola Akande Solicitor Busola.Akande@oxfordshire.gov.uk

(Legal Services)

Staff Implications

The Marmot workstream is led by the Public Health team in OCC, within existing resources.

Equality & Inclusion Implications

The purpose of this report is to demonstrate how health inequalities are being addressed.

Sustainability Implications

There are no sustainability implications in this report

Risk Management

This report is not presenting new risks which are not already assessed.

Consultations

There is no consultation required for this report

NAME
Ansaf Azhar (Director of Public Health)

Annex: **Annex 1 Marmot Quick Reference Guide**

Background papers: Starting Stronger, Fairer Futures in Oxfordshire - IHE
DPHAR annual report 2025/26

Other Documents: None

Contact Officer:
Kate Holburn - Interim Deputy Director of Public Health
Angela McRury - Public Health Senior Policy Officer

July 2026

Oxfordshire, A Marmot Place

Quick reference guide

OXFORDSHIRE,
A Marmot Place

OXFORDSHIRE,
A Marmot Place

Purpose

- This quick reference deck is designed to give colleagues across the system a high-level, easy-to-digest introduction to the Marmot approach in Oxfordshire.
- It provides a shared understanding of what being a Marmot Place means, why health equity matters, and how social determinants shape health outcomes locally.
- The guide is intended to spark interest and confidence in health equity conversations and help build an understanding of how to apply the Marmot principles, rather than provide detailed guidance.
- Follow-up activity can then include more tailored discussions and support for specific directorates or departments, focusing on how the Marmot principles can be applied in practice.

OXFORDSHIRE,
A Marmot Place

Marmot places

- A Marmot Place is an area committed to reducing health inequalities by addressing the Social determinants of health, through systemwide collaboration and commitment to long term action through embedding the 8 Marmot Principles.
- Oxfordshire became a Marmot Place in 2024, embarking on a collaborative partnership to drive local activity to reduce health inequalities, guided by the University College London, Institute of Health Equity.
- The approach is named after Professor Sir Michael Marmot, author of The Marmot Review, which highlighted the link between socioeconomic conditions and health outcomes.
- The aim of a Marmot Place is to reduce unfair and avoidable health inequalities, improve life expectancy and create healthy communities by addressing the root causes of ill health such as poverty, poor quality housing and inadequate access to education.

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A Marmot Place

Marmot Philosophy: Proportionate Universalism, support for all with extra help for those who need it most.

The Marmot Principles

1. **Give every child the best start in life**

2. **Enable all children, young people and adults to maximise their capabilities and have control over their lives**

3. **Create fair employment and good work for all**

4. **Ensure healthy standard of living for all**

5. **Create and develop healthy and sustainable places and communities**

6. **Strengthen the role and impact of ill health prevention**

7. **Tackle racism, discrimination and their outcomes**

8. **Pursue environmental sustainability and health equity together**

OXFORDSHIRE,
A Marmot Place

Health inequalities

If you live in a poor-quality, damp and cold home, this may have negative impact on your health.

- Health inequalities are avoidable and measurable differences in health in people and communities.
- The social determinants, often referred to as the ‘building blocks’ of health are the conditions in which people are born, grow, work, live and age, and the wider forces that shape the conditions of daily life.
- Most of our health is determined by these non-medical root causes of ill health, which include quality education, access to nutritious food, and decent housing and working conditions.

OXFORDSHIRE,
A Marmot Place

Oxfordshire picture

If you are a female born in the most deprived area you could live around 9 years less than if you were born in the least deprived area.

- In Oxfordshire, stark health inequalities exist, a male in the most deprived area will live around 7 years less than a male in least deprived area and a female in the most deprived area will live around 9 years less than the least deprived area.
- This is called the life expectancy gap.
- Professor Sir Michael Marmot emphasises the importance of health equity as a moral imperative.
- He argues that health inequalities are unjust and should be addressed to create a fairer and healthier society.
- Whilst fantastic work has been done, we can and should go further to narrow the life expectancy gap.

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A Marmot Place

Partnership with IHE

- By bringing together health and individual partner organisations, the Institute of Health Equity will work to further advance the Oxfordshire system in tackling inequalities by building on existing plans and actions, identifying gaps, and recommending ways to achieve positive change.
- There will be high-quality, evidence-based external review of Oxfordshire's activities to tackle health inequality, inform potential gaps, and form recommendations to go further as a system.
- There is plans for Health Equity indicators to be embedded into the Oxfordshire Health and wellbeing strategy outcomes framework.

The Marmot programme will serve as a unifying force, connecting system-wide initiatives.

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A Marmot Place

Understanding communities

- The Community Insight Profiles and associated Development Framework can help people across the system better understand the people and places they serve.
- By bringing together local data and lived experience, they provide a clear picture of community needs, strengths and priorities.
- The profiles can be accessed by any groups / organisations wishing to explore insights to inform policy, service design, commissioning and grant applications.
- The insights helps target resources where they will have impact.

Data insight allows us to work effectively to reduce inequalities and improve outcomes for local communities.

OXFORDSHIRE,
A Marmot Place

Using data to understand our population needs

- The Joint Strategic Needs Assessment helps partners across the system understand health inequalities across Oxfordshire.
- It brings together evidence on population needs, outcomes and the wider factors that shape health.
- It can be used to inform policy, service planning and decision-making, ensuring action is focused where inequalities are greatest and has the greatest potential to improve health and wellbeing.

Get in touch to learn more about how health inequalities could inform your work.
Marmot@oxfordshire.gov.uk

OXFORDSHIRE,
A Marmot Place

Tools to help

- For major developments, developers are encouraged, through planning policy via the Oxfordshire Joint Leaders Committee to complete an Oxfordshire Health Impact Assessment Toolkit.
- Similarly, the Local Transport and Connectivity Plan (LTCP) sets an expectation that transport schemes include a Health Impact Assessment. You can explore this toolkit for any policy / project.
- Another useful tool for health equity is the Health Equity Assessment Tool (HEAT). It can be completed at the start of a work plan or any stage of a project / programme cycle, to help you consider its potential effects.
- The next slide gives a flavour of possible considerations.

A Community research How to Guide by Healthwatch Oxfordshire gives valuable insights into the important role of research and working with communities.

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HEAT tool process

Stage 1

PREPARE

1. Define the scope and objectives of your work or programme

2. Identify key stakeholders and current efforts to reduce inequalities

3. Gather data and evidence on health inequalities (quantitative, qualitative, local insight)

Stage 2

ACCESS

1. Examine how your programme or service may affect different groups

2. Identify potential risks or unintended consequences

3. Consider barriers to access or participation

4. Use structured prompts to highlight equity-related issues

Stage 3

REFINE AND APPLY

1. Adjust your plans or services to reduce inequalities

2. Implement actions that promote fairness and inclusion

3. Ensure changes are practical, achievable, and measurable

4. Engage stakeholders and communities to co-design improvements

Stage 4

REVIEW

1. Evaluate the outcomes and impact of your programme or service

2. Identify areas for further improvement or learning

3. Update plans or guidance based on feedback and evidence

4. Share lessons with partners to support ongoing equity-focused practice

OXFORDSHIRE,
A Marmot Place

Source: HEAT Training Resource : Office of Health Improvement and Disparities

Resources

- Keep up to date with developments and receive invitations to webinars and events. Subscribe to Marmot mailing list.
- Join The Health Equity Network, a closed group for Oxfordshire and a collaboration space to share best practice and ideas.
- Check out the 2026/27 Director of Public Health Annual Report.
- It celebrates progress made on tackling health inequalities in Oxfordshire since the publication of the 2019/20 Oxfordshire County Council's Director of Public Health Annual Report.

For any general enquires, email the team at Marmot@oxfordshire.gov.uk

OXFORDSHIRE,
A Marmot Place

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Divisions Affected – All

OXFORDSHIRE HEALTH AND WELLBEING BOARD

9 JULY 2026

PREVENTION OF HOMELESSNESS DIRECTOR'S GROUP UPDATE

Report by Caroline Green, Chair of Prevention of Homelessness Directors Group & Chief Executive (Oxford City Council)

RECOMMENDATION

The Health and Wellbeing Board is **RECOMMENDED** to **NOTE** the report.

Executive Summary

1. This report sets out countywide progress over the last six months and priorities in tackling homelessness and rough sleeping across Oxfordshire. It highlights the work being driven by the Prevention of Homelessness Directors Group (PHDG) as the strategic leadership forum for housing, health, and social care partners working together to tackle homelessness. PHDG has been focused on five key priorities over the last six months, aligned to the Countywide Strategy:

    1. Delivering a countywide consultation to inform the implementation of Oxfordshire's Homelessness and Rough Sleeping Strategy Refresh 2026-2028.
    2. Establishing and convening the Oxfordshire Registered Providers Forum to increase partnership working across housing providers.
    3. Strengthening Joint Work between Adult Social Care and Housing
    4. Co-commissioning Opportunities between Health and Homelessness
    5. Future of the Oxfordshire Homelessness Alliance

Background

2. Oxfordshire continues to experience high and rising homelessness pressures, particularly among single adults with complex needs. While rough sleeping numbers have stabilised compared to previous years, the use of temporary accommodation remains at record levels, with many individuals placed in hotels and other nightly charged accommodation for extended periods. This creates significant challenges for housing authorities and places additional strain on health and social care systems.

3. The Oxfordshire Countywide Homelessness and Rough Sleeping Strategy was implemented in 2021 for a five-year period, following a feasibility study led by Crisis during the COVID-19 pandemic. It was signed by all Oxfordshire local

authorities—Oxfordshire County Council, Oxford City Council, Cherwell, Vale of White Horse, South Oxfordshire, and West Oxfordshire District Councils—together with the NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board.

4. The strategy introduced a shared vision and five key priorities focused on prevention, rapid response, person-centred support, timely move-on, and securing the right home in the right place. Furthermore, it responded to the Oxfordshire Safeguarding Adults Board's Thematic Review of Homelessness (2019), which examined the deaths of nine individuals experiencing multiple exclusion homelessness in 2018–19. This review underscored the need for a system-wide shift in how homelessness is prevented and addressed. The Countywide Homelessness Steering Group (CHSG) was established to support the delivery of Oxfordshire Countywide Homelessness and Rough Sleeping Strategy. CHSG provides direction and coordination for joint work across partners, ensuring that actions and activities undertaken by the system contribute meaningfully to the countywide strategy.

5. The Prevention of Homelessness Directors Group (PHDG), established around five years ago under the Oxfordshire Safeguarding Adults Board, transitioned to the Health and Wellbeing Board in 2024 and was relaunched in April 2025 with refreshed Terms of Reference that reaffirm its role as the key strategic interface between housing, health and adult social care. The group benefits from multi-agency membership, enhancing system-wide collaboration. PHDG provides strategic oversight of the transformation of homelessness services, as set out in the Oxfordshire Homelessness and Rough Sleeping Strategy, ensuring strong integration across housing, health and social care systems to prevent homelessness and end rough sleeping. It plays a central role in shaping both strategic direction and operational delivery, including informing commissioning processes, with a clear focus on addressing key barriers to achieving countywide priorities. The group works in close alignment with the Joint Management Group (JMG) and Countywide Steering Group (CSHG) to support the effective delivery and transformation of adult homelessness services.

6. Homelessness support services are jointly commissioned through a partnership between the District and City Councils, Thames Valley Integrated Care Board, and the County Council, using a pooled funding arrangement. This commissioning partnership, a key innovation of the Countywide Homelessness and Rough Sleeping Strategy, oversees a delivery partnership of agencies working across Oxfordshire to provide non-statutory homelessness support services for single homeless adults. The services provided include prevention, outreach and supported accommodation. This group of service providers is known as the Alliance, with the organisations listed below.

   - A2Dominon
   - Aspire Oxfordshire
   - Connection Support
   - Elmore Community Services
   - Homeless Oxfordshire

- St Mungo's

Key updates

Delivering a countywide consultation to inform the implementation of Oxfordshire's Homelessness and Rough Sleeping Strategy Refresh 2026-2028

7. In October 2025, the Prevention of Homelessness Directors Group (PHDG) requested a refresh of the Countywide Homelessness and Rough Sleeping Strategy 2021-2026 to ensure it reflects current priorities and responds to the evolving local homelessness landscape.

8. The refreshed strategy is structured around five core priorities: Prevention first – Strengthen early intervention and tailored prevention to stop homelessness and rough sleeping before it occurs.

   - Housing-led accommodation – Continue our shift away from reliance on traditional supported accommodation models toward a focus on rehousing people into permanent accommodation, with wraparound support when required.
   - Rapid move-on – Reduce time spent in temporary and supported accommodation by accelerating access to settled housing options, enabled by increased supply of affordable housing options.
   - Person-centred approach – Embed trauma-informed, strengths-based practice and ensure services are tailored to individual needs, with a particular focus on long-term rough sleepers.
   - Strong partnerships – Deepen collaboration across housing, health, social care, and voluntary sectors to deliver integrated solutions for individuals.

9. In December 2025, the government launched a new strategy, 'A National Plan to End Homelessness', which sets out a clear national vision focused on prevention, earlier intervention, and improved coordination across housing, health, and support services. The priorities within this plan closely align with Oxfordshire's own approach, particularly around partnership working, reducing rough sleeping, and delivering person-centred, sustainable housing solutions. This shows that the approach that we are taking and have taken is the right approach.

10. A draft strategy was developed in partnership with key stakeholders and endorsed by PHDG for wider engagement. A public consultation was subsequently undertaken to ensure that voluntary sector partners, people with lived experience, and residents had the opportunity to inform and shape the final priorities. The consultation launched on 27 March and ran for 10 weeks, closing on 6 June. A total of 136 responses were received. Feedback has been analysed and is informing the final iteration of the strategy.

11. The refreshed strategy also prepares for forthcoming changes associated with Local Government Reorganisation, ensuring a focus on stability, continuity of services, and a clear set of shared countywide priorities to support the transition.

12. A multi-agency project group has been established to design a strengthened performance and reporting framework for the strategy and its associated action plan. A refreshed action plan is in development and will launch in July to support immediate delivery. This approach is intended to enhance accountability across partners and drive measurable progress against shared priorities.

13. A suite of key performance indicators (KPIs) has been proposed to PHDG, with a focus on developing clear, consistent countywide measures of success. These include:

    - The number of individuals rough sleeping on a single night
    - Delivery of one-bedroom affordable homes
    - Expansion and impact of Housing First provision

    Targets and performance against them will be set out in future reports.

14. The next steps:

    - Once the finalised version of the refreshed strategy has been agreed, it will need to be approved under the relevant governance structures of the seven strategy partners.
    - The new strategy will be launched in Autumn 2026 (dependent on approval of seven partners).
    - Countywide KPIs to be approved by PHDG in July and implemented to coincide with the launch of the refreshed strategy.

Establishing and convening the Oxfordshire Registered Providers (RP) Forum to increase partnership working across housing providers.

15. Following feedback from the Housing Summit in December 2024, focusing on the supply of homes across the county, it was agreed that an Oxfordshire Registered Providers Forum be established. The first of these took place on 15th January 2026 chaired by the Chief Executive of South Oxfordshire Housing Association (SOHA). Membership consists of 12 Registered Providers who operate in Oxfordshire.

16. The Forum has been established to strengthen strategic collaboration between local authorities and Registered Providers in response to significant and increasing housing and homelessness pressures across Oxfordshire. It provides a mechanism to align priorities, share intelligence, and develop coordinated, system-wide responses.

17. As a structured platform for regular engagement, the Forum supports partners to:
    - **Increase the supply of affordable housing** across Oxfordshire
    - **Rebalance the mix of supported accommodation**, aligning provision with a “housing-led” approach that prioritises settled homes with wraparound support
    - **Maximise the use of existing housing stock**, including exploring opportunities to repurpose or make more effective use of current assets

- **Support delivery of countywide ambitions**, including the Homelessness and Rough Sleeping Strategy, the Oxfordshire Housing Summit priorities, and the work of the Prevention of Homelessness Directors Group
- **Strengthen shared understanding** of pressures, challenges, and opportunities across RP portfolios in the county

18. The Forum also acts as a collaborative space for continuous improvement, enabling partners to share strategic updates, exchange best practices, and address key cross-cutting issues. These include lettings and allocations, tenancy sustainment, property and asset management, tenant engagement, and repairs.

19. Early meetings have focused on establishing a shared understanding of the scale of housing need and identifying opportunities for joint working. The January meeting set the strategic direction and highlighted key system challenges and collaboration opportunities. The April meeting included an interactive workshop on acute demand and temporary accommodation pressures, alongside a focused discussion on social and economic value, supported by examples of emerging good practice.

20. The Forum will now meet on a six-monthly basis, providing ongoing strategic oversight and momentum. Future sessions will focus on key system priorities, including Local Government Reorganisation and the strategic allocation of housing stock, with the next meeting scheduled for October.

Strengthening Joint Work between Adult Social Care and Housing

21. This programme of work sets out a series of jointly agreed priorities, established through the PHDG, to strengthen partnership working between Oxfordshire County Council's Adult Social Care (ASC) and district and city housing teams. The focus is on improving outcomes for individuals with complex needs through more coordinated, multi-agency responses.

22. The approach has been shaped through PHDG oversight, a review of complex cases undertaken in summer 2025, and subsequent senior-level discussions. Partners have committed to progressing a shared programme of work to address system challenges, clarify roles and responsibilities, and develop a more effective and integrated approach to service delivery.

23. To strengthen system-wide risk management, a new Multi-agency Risk Management (MARM) Officer role has been developed in partnership with the Oxfordshire Safeguarding Adults Board. Funded by Oxford City Council and hosted within the Safeguarding Adults function, this role will work closely with housing services to coordinate responses to complex cases. This investment reflects a shared commitment to ensuring that risk is actively managed across the system rather than held within individual services. Recruitment is currently underway for a fixed-term post.

24. Following a multi-agency case review in August 2025, partners agreed actions to strengthen shared understanding and practice between housing and ASC. These

include delivering joint training, clarifying escalation pathways, and strengthening multi-disciplinary working approaches.

25. The development of a countywide homelessness database remains a priority, as set out in the Homelessness and Rough Sleeping Strategy 2021–2026. This programme aims to improve data sharing, system visibility, and evidence-based decision-making across partners. While progress has slowed following initial development work, partners have reaffirmed the importance of delivering a solution that is robust and fit for purpose.

26. PHDG has also committed to strengthening the system’s approach to learning from complex cases. Following a multi-agency case in winter 2025, partners agreed to implement a lessons learned process. This will support understanding of roles and responsibilities, escalation and decision-making processes, and enhance the interface between housing, health and social care services. The process will be overseen at a senior level and will result in a clear set of actions to drive system improvement.

27. Overall, this programme represents a significant step towards a more integrated, partnership-led approach across housing, health and social care. It is designed to ensure services are better aligned around individual need, improve system effectiveness, and support the delivery of shared countywide priorities.

Co-commissioning Opportunities between Health and Homelessness

28. As referenced in the December report, a cross-organisational group comprising Oxford Health, the City Council and the County Council is now meeting regularly to oversee this programme of work, reporting to PHDG. This update reflects progress to date.

29. A research project has mapped current provision of mental health and homelessness supported accommodation, tracked move-on destinations and flow rates over a six-month period, and assessed the support needs and future housing options of people currently in residence.

30. Early analysis of the data suggests that a significant proportion of individuals currently living in supported accommodation could potentially maintain a more independent lifestyle and accommodation type with lower-intensity interventions, for example visiting or floating support. At the same time, the study suggests that some people living in our services may benefit from a more bespoke, specialised form of supported accommodation. The research group is currently conducting 'deeper dives' into these areas of need.

31. There is an opportunity to use this data to help us redesign our health and homelessness provision - with greater integration, shared accountability and, potentially, co-commissioned services that align with an equitable, housing-led approach and deliver better outcomes for people.

32. The study so far has identified and reinforced a number of emerging system priorities to support a more effective and sustainable model:
    - **Establishing a clear, system-wide move-on proposition** to increase access to settled accommodation and unblock flow, supported by a coordinated approach across local authorities, Registered Providers and the private rented sector.
    - **Rebalancing provision towards lower-intensity support,** transitioning from a predominantly supported accommodation model to housing-led and flexible support offers tailored to individual need.
    - **Improving flow through temporary and supported accommodation** by accelerating move-on and ensuring support is proportionate and enables independence.
    - **Strengthening multi-agency working and risk management**, including housing, health, Adult Social Care and voluntary community and social enterprises (VCSE) organisations.
    - **Prioritising early intervention, particularly for younger cohorts,** to reduce future demand and long-term system pressures.
    - **Developing a shared language and more integrated services,** including common datasets, to improve consistency, coordination and overall system performance.
    - **Mapping and better integration of wider service provision,** including drug and alcohol services, to address gaps and support more joined-up delivery.
    - **Translating insights from analysis of data into clear commissioning propositions**, aligned to funding opportunities and system priorities.
    - **Leveraging Local Government Reorganisation (LGR)** as an opportunity to embed a more aligned, countywide approach to commissioning and delivery.

33. Further work is required to identify the key drivers of success for clients moving on, as well as to ensure meaningful involvement of people with lived experience. Proposals for a co-commissioned approach will be presented at the next PHDG on 29th July, and will include recommendations and timelines.

Oxfordshire Homelessness Alliance Transformation

34. Following the service reviews and revising of service specifications, new service offerings have begun to be mobilised. Current progress includes:

35. Prevention
    - The prevention of homelessness service has been mobilised; Aspire and Connection are delivering the service across Oxfordshire.

    - The service is providing short term intervention and long term case work to prevent people from becoming homeless.

36. Outreach
    - To ensure equitable outreach provision across the County, Alliance providers have been invited to submit expressions of interest to deliver a single, countywide outreach service. This will replace the current two-provider model, in line with recommendations from the outreach review group to improve consistency. Applications will be assessed this month, with the new service launching in September service specification is being developed to ensure that

a more equitable service is delivered across the county, with different options on delivery models

37. Move on
- A move on panel to review people who have been in supported accommodation for over two years has been established. This will enable move on and further improve understanding of move on barriers.
- We are working with colleagues within Mental Health services to share our approaches and the resources developed for front line staff and residents to enable move on. We share some of the same systemic and cultural challenges which have merit in being addressed collectively.

38. Housing led support
- The housing-led support service has been mobilised, the service supports individuals who no longer need to live in supported accommodation to move on to more suitable independent accommodation, saving funds and increasing capacity in the system. There is ongoing support for individuals, to help them sustain their new tenancy, and avoid repeat homelessness.

Financial Implications

39. There are no direct financial implications arising from the report.

Stephen Rowles, Strategic Finance Business Partner,
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Legal Implications

40. The report provides a progress report on the work being undertaken to address homelessness across Oxfordshire and as such there are no specific legal implications arising from the same.

41. Nonetheless it is worth noting that District and City Councils have statutory responsibilities to provide homelessness and housing advice services, and it is not permissible to circumvent the statutory framework for the provision of such services. It is possible however to utilise the authority’s wider powers to support those with particular vulnerabilities or needs, prevent the development of needs for care and support and promote the general well-being of the local population: for example, using the prevention powers of the Care Act 2014 (s2), the powers as to improvement of public health of s2B (1) NHS Act 1996 and the general power of competence set out in the Localism Act 2011.

Janice White – Principal Solicitor, ASC, SEND and Education

Caroline Green
Chair of Prevention of Homelessness Directors Group & Chief Executive (Oxford City Council)

Background papers: Nil

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July 2026

Agenda Item 10

Healthwatch Oxfordshire Report to Health and Wellbeing Board – July 2026

Since the last Health and Wellbeing Board (HWBB) meeting 14 May 2026:

Healthwatch Oxfordshire reports to external bodies

Since the last Health and Wellbeing Board (HWBB) May meeting we attended:

- Health Improvement Board
- Oxfordshire Joint Health Overview Scrutiny Board (June 2026)
- Oxfordshire Safeguarding Adults Board.

Any reports to external bodies we attend can be found online at https://healthwatchoxfordshire.co.uk/reports-to-committees We attend Oxfordshire Place Based Partnership monthly, and attended the Thames Valley Integrated Care Board (TV ICB) Quality Committee.

We attend Primary and Community Board, Neighbourhood Health working groups, and Oxfordshire Health Inequalities Forum and Oxfordshire Marmot Place meetings.

We published our priorities and focus for the coming year 2026-27 here: https://healthwatchoxfordshire.co.uk/our-priorities

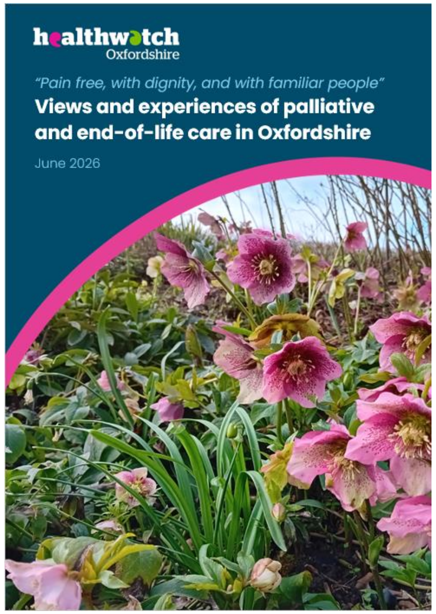
We have published Healthwatch Oxfordshire responses to Oxford University Hospitals NHS Foundation Trust's Quality Accounts 2025-26, Sue Ryder's Quality Accounts 2025-26 and Oxford Health Quality Accounts 2025-26 (jointly with Healthwatch Bucks) here: https://healthwatchoxfordshire.co.uk/correspondence

- ➢ We held an online event to **showcase Healthwatch Oxfordshire's work over the last year 2025-6**. If you were unable to attend a recording and the full annual impact report will be available here: https://healthwatchoxfordshire.co.uk/annual-impact-reports1

Hearing from residents - Healthwatch Oxfordshire research & insight reports

Our research reports focus on making sure the voice of people who use services is directly linked to recommendations of improvement or change. Hearing from people is carried out using a variety of methods, including online, face to face, and targeted work, linking to community groups, and on the streets. All our reports and written responses to our recommendations from commissioners and providers can be seen here: healthwatchoxfordshire.co.uk/reports
All reports are available in summary and Easy Read. To see more about the **impact** of our reports and how we ensure people's voice makes a difference see here: healthwatchoxfordshire.co.uk/impact/impact-of-our-research/
We follow up on recommendations and action with providers or commissioners at six months.

- We heard from **851 people** across **14 rural settlements** working in partnership with Community First Oxfordshire as part of the **Marmot focus on health inequalities**. Healthwatch Oxfordshire was commissioned by Oxfordshire County Council (OCC) to support engagement on this aspect of the Marmot focus. Our report is due to be published in September.
- **Views and experiences of palliative and end-of-life care in Oxfordshire** shares what we heard from **over 110 people** about what is important to them towards the end of their lives, and what might support people to have conversations about their wishes with family, friends, and health and care professionals. We also heard about people's experiences of end-of-life and palliative care services. Insights give lived experience perspectives, and valuable indicators for health and social care services as they navigate the shift to Neighbourhood Health.
- We heard that many people had clear and consistent priorities about what mattered to them most at the end of life, but there was limited awareness of advance care planning and ReSPECT and people said they would appreciate more support and information about how to have end-of-life conversations. People told us about positive experiences including good symptom management, joined-up care and being treated with dignity and compassion, but we also heard about challenges including gaps in communication, difficulties accessing support, and a lack of coordination and continuity of care between providers.



healthwatch
Oxfordshire

"Pain free, with dignity, and with familiar people"

Views and experiences of palliative and end-of-life care in Oxfordshire

June 2026

Community research

Healthwatch Oxfordshire continues to bring our expertise in supporting **community and participatory research** and working with communities to explore issues and voice issues of importance to them.

- ✓ We presented our community research into the experiences of **older Chinese people** at the Oxfordshire Community Research Network, and supported **Black Women in Maternity** to present their community research findings
- ✓ We produced translated summaries of community research with **Sunrise Multicultural Project** in Banbury, including key information about **breast health and screening**, in Urdu and Punjabi for women who took part in the research to share with their communities
- ✓ See our website for links to all community research supported by Healthwatch Oxfordshire, as well as resources, and local links to other community research https://healthwatchoxfordshire.co.uk/community-research
- ✓ Healthwatch Oxfordshire shared insights on our journey, case studies and experience of community research with the Thames Valley Research Engagement Network (REN) in an interview piece here: https://researchengagementnetwork.notion.site/Stories-and-updates-272f5d0ad77d8051a753da07454ce6a1)
- ✓ We are an active member of **Oxfordshire Community Research Network** and continue to contribute to its development.

Participatory research is supported by Healthwatch Oxfordshire working alongside community members.

We continue to promote the **How to Guide for Community Research** (e.g. at Oxford University public engagement in research event, and community led presentation at the Oxfordshire Community Research Network), and are working with the Oxfordshire Community Research Network to develop a training offer for community researchers to run alongside use of the How to Guide.

Enter and View visits and reports

Staff and lay representatives make Enter and View visits to healthcare settings to collect evidence of what works well and what could be improved to make people's experiences better. Based on the feedback of patients and members of staff, we highlight areas of good practice and suggest improvements.
See https://healthwatchoxfordshire.co.uk/enter-and-view-reports

Since the last meeting we have published the following Enter and View report:

- **Katharine House Hospice**

Katharine House Hospice
Enter and View Report
May 2026
healthwatch
Oxfordshire

Other activity summary

- See here: https://healthwatchoxfordshire.co.uk/our-impact/ with examples of how our work has had an impact
- Recordings to watch and slides, and joining details for our future **public webinars** can be seen here https://healthwatchoxfordshire.co.uk/our-webinars.
- Our next webinar will be on **Tuesday 15th September from 1-2 p.m. on End of Life and Palliative Care** with speakers from Oxford Health and Oxford University Hospitals NHS Foundation Trust.
- **Community Marmot Event**
  We supported development of a community led event to hear from grassroots communities about the activity they are doing to support Marmot objectives, and to hear from decision makers about the collaborative efforts' county wide. This was planned in conjunction with Oxford Community Action, Melissa Latchman, and Oxfordshire Community and Voluntary Action (OCVA) and Community First Oxfordshire (CFO). Unfortunately, this event was cancelled on the day due to maintenance problems with the venue, but attendees made the most of the much-needed opportunity to network over coffee and cake and build relationships between communities and health and care services and decision-makers.

Aspects of the event have been positively incorporated into part of the Director of Public Health annual report launch on 10th July as part of the wider focus on tackling health inequalities.

- **We publish bi-monthly news bulletins** to bring up to date health and care information to the public (to read previous issues and to sign up to receive a copy see https://healthwatchoxfordshire.co.uk/our-newsletter), as well as active social media platforms, website and sharing communications via local news and community networks.
- We carry out active listening, engagement and **ongoing outreach** to community groups, at events and on the street and other settings across the county, and gain insights into experiences and views on health and care along with via phone and our online feedback centre. We have a rolling programme of hospital visits to speak to the public. Outreach in the last quarter (Apr-Jun 2026) included:
  - Outreach to parent groups to hear about maternity services, including in Abingdon, Barton, Cowley and Charlbury
  - Eid Extravaganza in Blackbird Leys and Oxford Sanctuary Fair in Florence Park.
- Key themes we have been hearing since May include good communication and high quality care across several services, difficulty getting appointments including GP practices, physiotherapy and mental health services, and limited follow-up medical care after discharge from hospital.
- We continue actively working with **Patient Participation Groups** (PPGs) across the county, attended PPG meetings and sending news updates, and supporting involvement in development of Neighbourhood Health.

Forward Work Plan:

24th September 2026 Meeting:

1. Joint Strategic Needs Assessment.
2. Family Hubs Update.
3. Update from independent patient/resident voice working group.
4. Health and wellbeing board strategy Indicator review.
5. Marmot Update - Rural inequalities.
6. Health and Wellbeing Strategy Update - building blocks - financial wellbeing / healthy jobs.
7. Neighbourhood Health Plan Update.

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