National Autistic Society

Mendip House: Learning from mistakes

What are the lessons for our charity and the care sector?

Report of consultation event

Contents

1. Overview

In May 2016, our charity became aware of cruel and abusive treatment at Mendip House, a residential care service we ran in Somerset. We took immediate action to safeguard the people living there: dismissing five staff, bringing in a new staff team and repaying the people we support the money that previous staff had wrongly taken from them. We then closed Mendip House.

As well as taking immediate action and apologising sincerely to everyone affected, we looked at what we could do across our organisation to make sure this mistreatment and abuse didn't happen again. We made changes to recruitment, training, quality monitoring, whistleblowing and safeguarding procedures among others.

And we committed to being open, honest and transparent about what had gone wrong. We therefore organised a consultation event to talk about what actions we had taken, what else we could do and the principles that participants thought that all social care providers should live by. The event was attended by autistic people, family members (including the family of one of the Mendip House residents), other providers, representatives of the statutory sector and other autism professionals. (Appendix 4 gives more details about how this event was organised.)

This short report reflects those discussions, as well as the results of a survey ahead of that event, in which we asked a wider audience for their thoughts.

It explores the following themes:

- organisational culture
- monitoring the quality of services
- transparency and learning when things go wrong

And the need for adequate funding cut across all these themes.

Within these themes, we look not only at the actions our charity took or should take, but also at those actions people think the wider care sector should take. Many providers will already be following this good practice, but we believe they are important, so are worth repeating.

(There is a timeline and summary list of our actions since May 2016 in appendices 1 and 2, on pages 9 and 10.)

2. Creating a good organisational culture and making sure the right staff are in place

Having a culture that promotes respect, professional development and quality is vital. It's also important to foster a culture where individuals, families and staff are able - and encouraged - to challenge the way that things are done and feel that this will be acted on.

One key failing at Mendip House was that we allowed a negative staff culture to develop without effective challenge. It was uncaring, bullying and run for the benefit of a group of support workers, not for the people they were supposed to care for. This was not dealt with properly by service-level managers nor escalated to more senior management. In addition, our systems didn't flag the drop in professional practice, behaviour and the standards of support.

What our charity has done

Since 2016, at the National Autistic Society, we have:

- Changed how we **assess values** when we recruit new staff, focusing on an assessment of their attitudes, as well as their skills
- Put in regular sessions for staff to **reflect on their practice** – what's working well, and what they may need to change
- Introduced a **'Lessons from Mendip House'** workshop for frontline staff and managers
- Put in more **coaching, mentoring and training** for managers
- Strengthened our **whistleblowing systems** – including an independent service that staff can call – and made sure staff are confident about whistleblowing if they see anything that isn't of the standard we'd expect
- Run benchmarked **staff surveys** to check that staff in each service feel motivated and identify any problems that need to be fixed.

Principles

There are wider principles that discussions at the event and the survey highlighted as important if providers are going to create a culture that supports best practice and good quality care. These should apply to any provider and many, including our charity, try to live by them. However, in order to create and maintain a positive culture, it's vital that we all remain constantly mindful of the following:

- There needs to be an **open and listening culture led from the top**. This is about having straightforward conversations with staff and managers about what's expected from them, or what needs to change if things go wrong. This means setting a tone of openness to more junior staff and making sure that senior staff are accessible so that more junior staff feel able to discuss issues with them. It also means being as open as possible with external audiences when things go wrong, for instance on social media and in blogs,
- Staff need to **feel supported**. It can be a tough if rewarding job to support autistic people with complex needs. It is important to look at how to build up staff resilience, and to consider running mentorship or buddying programmes. Staff need to feel that the organisation celebrates successes, both big and small. Staff need 'thank yous' and need to feel involved in decision-making. Equally, staff need debriefs at the end of shifts about the wellbeing of the person supported and their own wellbeing.
- At the same time, it is essential that **when staff's performance isn't right**, there is quick action. Staff need to be clear about their employers' expectations, and those of the people they support and their families. And they need to understand that, when they fail to meet these expectations, it could lead to them being disciplined or dismissed.
- Staff need to be **well trained**. Training should be regularly reviewed and tested to make sure it is having the expected impact. It should include specific training on working positively with the families of people who are supported. It is important for families to feel welcome in services and to be understood by staff as partners. There also needs to be a greater understanding of the 'journey' that families have been on and the fights they have had up to this point. It may be possible to use the apprenticeship levy better to attract good staff and offset training costs.
- Autistic people and families need to be **involved** in designing training, supporting recruitment and providing 360 feedback. Staff and managers may need training or guidance on how to successfully achieve this. This approach will also need to be championed and prioritised by managers and leaders within organisations.
- Providers need to make sure that they are carefully considering which staff **members should work with which individuals**. Autistic people need to be supported by people who not only understand autism, but get to know them as a person. This could include things like shared interests or experiences, as well as particular levels of training or skillsets.
- Providers need to consider **pay and opportunities for progression** as well as training to encourage more motivated staff into – and to stay in – the sector.
- Providers need to make sure they are properly articulating what current needs are for an individual to commissioners, so that **the right package** can be put in place and funded adequately.

System-wide issues

There are also system-wide issues that shape the environment that care providers are working in:

- The challenges of **recruiting and retaining** the right staff in the current climate was recognised in the event. Money is a key issue and providers often want to pay more for staff but aren't able to as there isn't enough money in the budgets they receive from commissioners. A better recognition of the value of this workforce is needed.
- **'Social care' is misunderstood** as a term and the positive aspects of a career supporting disabled adults with complex needs is not promoted sufficiently. We need to better harness the positive experiences of people who use services as well as staff currently working in care as ambassadors for recruitment.
- A key issue around pay is that, when funding is limited, commissioners are unable to always **meet the staffing levels** or training required to appropriately support disabled adults with complex needs.
- There is also no wider **strategic look at workforce issues**. Money is coming in to a service from multiple councils, but there is no 'system-level' look at where that money is going and how staff are being recruited, supported and trained.
- A more system-level approach is needed to look at **career pathways** and identify what sort of workforce we want and how we might get there.
- There is **little available provision** for autistic people who don't have a learning disability.

3. Monitoring, having the right systems and ensuring a focus on quality

Senior management – and trustees in charity providers – need to be assured that the services they are providing are of a good quality and safe. They also need to be able to track progress that their services are making in becoming better, or to identify early when standards are starting to slip.

One of the key things that went wrong at Mendip House was that our systems weren't joining up data to identify patterns of behaviours and activities, and key issues weren't being flagged up to more senior management. The systems weren't in place to make this happen.

What our charity has done

The main steps that our charity has taken to address these issues include:

- Established an **independently-chaired safeguarding board** that reports directly to trustees.
- Set up **Quality Improvement Teams** in each of our six adult service regions.
- Established a new system to **link complaints, whistleblowing, safeguarding and conduct** information to ensure it is monitored, reported on and patterns can be identified and action taken quickly where necessary.
- Introduced a new **quality assurance process** for our services which gives greater ownership to service managers and focuses on the things that really matter to the people being supported. The process includes: audits at service, area and organisational level, overseen and scrutinised by a sub-committee of our charity's board which includes autistic adults and families; quality assurance managers take responsibility for ensuring quality action plans in each area are followed through and any issues are either resolved or escalated; unannounced visits by senior managers to all services.
- Our research and evaluation team **proactively phones families** of those we support to ask about quality of care.
- Establishing an **independent whistleblowing phone line** – staff surveys show a significant increase in staff saying they know how to report problems and concerns.
- Making sure we **take action** where services don't meet our standards, including more robust performance management of registered managers.
- **Improving investigation** training so that managers are better able to conduct rigorous investigations.

Principles

There were further principles and ideas to support quality monitoring that came up in discussions at the event and the online feedback from autistic people, family members, other providers and representatives from the statutory sector. These included:

- Providers could consider employing **experts by experience** to support them with quality assurance and any audits. Bodies like the Care Quality Commission sometimes use experts by experience when they carry out visits and inspections. It can help provide valuable insight about the environment and support at a service.
- Families and people supported by services should be **involved and engaged** with the day-to-day running of services.
- Make sure that there is a **positive relationship with families** so that they feel able to confidently provide feedback. Some families were anxious that, if they complain, their family member might suffer or be moved to a different service. Maintaining a good relationship could be done through more informal communication: frontline staff and local managers should just pick up the phone to families to discuss how things are going.
- We heard of an example where families could log on to an **online diary** to see what their family member is doing. This can help open dialogue about what is and isn't happening with their loved one's care.
- Make sure that formal methods of feedback and whistleblowing are clear and that there is **a clear process for reporting back** what actions are being taken as a result. This applies for staff, individuals and families.
- Developing quality teams that were **independent of the services** – like the ones we have developed – was identified as key by Dimensions.
- Providers should carry out their own **spot checks** and unannounced inspections, which should include telling families about the inspection in advance. Providers could also have registered managers from one service visit other services run by the provider (or other providers) to carry out checks. These kinds of partnerships with other providers for visits would also support sharing skills and knowledge.
- Providers could consider the use of **CCTV in parts of their services**, with appropriate safeguards and authorisation, if this was felt to be proportionate.
- Making sure a **range of indicators** are considered. If a service has particularly high or low turnover of staff for example, investigate why that is. However, providers should make sure that any new monitoring doesn't start to produce a culture of fear, nor increases paperwork and stops creativity. (The points raised above about culture will be important to make sure this doesn't happen.)
- Ensure there's an accessible way for people we support to **feed back**, including independent advocates.
- Carry out **detailed exit interviews** with staff to help identify what is and isn't working.
- Have shared **high expectations** for what good quality services look like, all the way from senior managers and trustees to staff on the ground.

System-wide issues

Again, there are system-wide issues that came up in the event and survey:

- Commissioners need to be more hands-on and have a better understanding of **what they are commissioning** and do more regular checks on the services they are paying for to ensure they're meeting individuals' needs. This needs to include out of area placements.
- Commissioners also need **greater autism expertise**. They should bring in experts by experience to the commissioning process.
- There was a suggestion that **Skills for Care training** could be developed to upskill commissioners as well as staff.

4. Being open when things go wrong and making sure we are genuinely learning from mistakes

The right systems and culture can stop a lot of mistakes from happening, but they can't remove the risk entirely. Where mistakes have been made, it's vital there is transparency about what happened and that it is genuinely used as an opportunity to learn.

The consultation event and the online feedback form were an opportunity to gather feedback on what we have done since closing Mendip House and ask about the best ways to make sure providers respond properly when things go wrong.

What our charity has done[1]

The key things that we have done are:

- We said **sorry**.
- We **spoke with autistic people we support**, their families, our partner organisations, our supporters and our staff about what happened, and what we were doing.
- We set out a clear timeline of events and what we were doing next on **our website**, which we shared widely on digital channels and **contacted our members and supporters** proactively to tell them what happened and what actions we were taking.
- We **supported the individuals** living in Mendip House to move once the decision to close it had been identified.
- We have spoken **at other events** about what happened at Mendip to allow abusive practice and what we have done to address this, and responded openly to requests for information from the media.
- Organised **this consultation event** to ensure input from autistic people, families and the sector, and to provide wider scrutiny of our actions and learning from the mistakes we made.
- We have set up a new **independently-chaired safeguarding board** that reports to our charity's trustees. As well as ensuring independent scrutiny and that our trustees are in the best possible position to exercise their responsibilities for our charity's work, this also supports learning across all our services from best practice or where we have had to introduce changes or improvements.

1 Autism Accreditation: A question was raised at the event about whether there was a conflict of interest in the National Autistic Society running Autism Accreditation, which accredits our own services in its role providing an autism-specific quality assurance programme. For more information about how Autism Accreditation assesses services, go to our website. Note: Accreditation is withdrawn from any service, including our charity's, under investigation or which receives a poor regulatory inspection and grading. Also, Accreditation is granted against standards developed by a panel involving external experts, including autistic people and families.

Principles

In the discussions at the event and the online feedback, we heard from autistic people, family members, other providers and representatives from the statutory sector that they would like to see more openness and willingness to learn from our charity and other providers. We believe these principles are important and strive to meet them:

- Make sure that we maintain positive and **open communications with families**, so that it makes it easier to contact them and let them know what has happened.
- Where things go wrong, it's vital that there is a **clear communications plan** – that might need to be multiagency – so that the right people are told the right information, at the earliest opportunity and in the right way.
- Make sure that providers **aren't defensive** when they communicate. Don't trade on past glories, be honest and open. Admit fault, say sorry, take responsibility.
- Make sure there is a clear and **thorough investigation** and tell families and people using services what the next steps are, and how they can raise any issues. Make sure families and autistic adults affected know where they can go to ask more questions.
- **Follow up actions** are committed to and adhered to rigorously ('you said, we did' is a helpful model).
- **The language** that's used is important, as well as tone. Use real and not corporate language in communications.
- It is also important to strike the right balance between **pace and rigour.** There might be an expectation to change lots at once, but then this won't be done well if not implemented properly.
- If there have been allegations of abuse, it is important to make sure that autistic people who might have been affected can **access support** they might need to deal with this. Support may also be needed for families.
- Consider use of **independent advocates** to support people in the service.
- **Visible leadership** is important when things go wrong so that support staff know who they can talk to and feel supported.
- Similarly, independent **emotional support** should be made available to staff in the services at all levels.
- Be responsive on **social media** to help explain to the wider community what has happened.
- **Consider sharing** learning from service failings publicly.

Appendix 1

Mendip House timeline

- **3 May 2016**, a member of staff at Mendip House alerted a manager at a different house within the service, initially about unprofessional rather than abusive behaviour (playing on a Playstation rather than attending to someone we supported) that they had observed on 1 May. That manager initiated an investigation, quickly escalating it when she realised the seriousness of the allegations.
- **3 May 2016**, a second member of staff informed the CQC about abusive behaviour by some members of staff towards the people we supported at Mendip House. These are the extremely distressing accounts of abuse detailed in the SAR report.
- **5 May 2016**, Area Manager and Director of Adult Services are informed. Three staff suspended and new staff put in place.
- **From 5 May 2016**, we had made sure everyone living at Mendip House was safe and properly supported by staff who knew them and their needs well. The staff identified as responsible for the abuse were immediately suspended and a disciplinary investigation started, which resulted in their dismissal.
- **6 May 2016**, Nominated Individual (NI) informed.
- **6 May 2016**, Chair of Services Quality and Development committee informed via the NI's weekly confidential update.
- **9 May 2016**, statutory notifications made to CQC, safeguarding and police.
- **In May 2016**, we undertook a full review of all previous safeguarding alerts and supplied this to the CQC. The CQC inspected Mendip House. Somerset County Council, as the agency responsible for safeguarding in the area, started a safeguarding inquiry process, including placing a team at Somerset Court for several months.
- **In June 2016**, identified that money had been taken from the people who lived at Mendip House by staff who had been getting them to pay for their meals when out on trips. We calculated how much was owed, making sure that no-one would be out of pocket, then repaid them (in August).
- **In July 2016**, our trustees took the difficult decision to close Mendip House because of the depth of the problems we had discovered there.
- **In August 2016**, the CQC published their report, which found the service inadequate in all areas. We apologised publicly and acknowledged that we'd 'failed badly' at Mendip House.
- **In early November 2016**, Mendip House closed, after the last of the people who had been living there moved to their new home.
- **In March 2017**, the Somerset Adult Safeguarding Board commissioned the Safeguarding Adults Review (SAR). We worked with the review author, council staff, the Care Quality Commission, the Clinical Commissioning Group and the police to contribute to lessons learnt from what had gone wrong at Mendip House. The report was based on a review of other investigations, minutes of meetings, etc.
- **8 February 2018**, The Safeguarding Adults Board published the SAR report. (See Appendix 3 below.)
- **June 2018**, CQC initiated investigation into financial abuse at Mendip House.
- **November 2018**, first meeting of our new Independent Safeguarding Board.
- **January 2019**, CQC issued our charity with a Fixed Penalty Notice of £4,000 because of the failure to comply with regulations which 'ensure systems and processes must be established and operated effectively to prevent financial abuse of service users'. We accepted and paid this penalty notice.

Appendix 2

Summary of main actions taken by our charity

From when the situation at Mendip House first came fully to light in early May 2016, we've worked to understand what went wrong and do all we can to ensure it doesn't happen again. The charity has learned and we have changed a lot about our own practice. The key changes we've brought about are:

- **Mendip House workshop** – Immediate learning from the event that starkly brings to life the consequences of not acting. What happened at Mendip House had an immediate and powerful impact on our practice. Frontline staff and managers all attend a one-hour 'Mendip House Workshop' which we started rolling out from autumn 2016. It shows what can go wrong and highlights the necessity of all staff and managers taking responsibility and acting when they see practice deteriorating as it did at Mendip.
- **Reinforcing the central place of the people we support:** Always part of our practice, but staff are now clear that this must be at the centre of providing a quality service, whether through 'I statements', dedicated inclusion events, or good communication with parents and guardians.
- **Capacity to mobilise resources from the centre.**
  - Quality improvement teams in each area (autism practice facilitators, behaviour support, learning development, studio 3, health and safety).
  - Reinforced quality assurance systems (recording, monitoring, reporting), streamlined to: link different data (safeguarding, complaints, whistleblows, disciplinaries) to see full picture, identify trends, and make sure we follow up on actions. Helping to prevent things going wrong and picking up on any problems quickly.
  - Improved Quality Monitoring Visits.
  - Reduced reliance (and weighting in monitoring) on regulator score.
- **Improving culture and embedding our values:** for instance through value-led recruitment and reflective supervision. Although this will take time, we've already seen a **13% increase** year-on-year (to 71%) in those agreeing that: 'Our charity has strong values which are put into practice'.
- **More effective procedures and related training, reporting and monitoring:** all our policies were audited within two months. They're now clearer and more closely monitored, including trends in safeguarding, complaints and whistleblowing. Our October 2017 staff survey showed an increase of 14% in the number of staff saying: 'I know how to report poor practice'. Now at **89%, 7% higher than similar benchmarked charities**. (And in South West where Mendip House is located, it is at 99% - 17% higher than benchmarked charities.)
- **Leadership and governance:** There is now clearer reporting through the management and governance line, with attention to performance at every level.
- **Improving real skills:** Not only improving training (eg for better investigations), but also responding to feedback from trainers about people's performance and attitude.
- All of which increases **safety and quality of care.**
- **CQC grades** have improved.

Appendix 3

Recommendations from Safeguarding Adults Review[2]

Somerset Safeguarding Adults' Board should recommend that:

i the Department of Health, NHS England and the Local Government Association are requested to:

- prepare consultations to regulate commissioning;
- include in those consultations the role of 'lead commissioner' who will assume responsibility for coordination when there are multiple commissioning bodies of a single service and assume responsibility for ensuring that individual resident reviews start with principles and make the uniqueness of each person the focus for designing and delivering credible and valued support;
- include in those consultations the expectation that commissioners must notify the host authority of prospective placements;
- set out in guidance the remit, powers, structure and enforcement resources of all agencies immersed in the task of achieving better lives for adults with autism;
- assert a new requirement to discontinue commissioning and registering "campus" models of service provision
- assert a new requirement for (a) formal consultation with Local Authorities with Social Services responsibilities and Clinical Commissioning Groups regarding all planning applications for building residential services that would require registration with the Care Quality Commission to operate, and (b) to decline planning permission for types of service provision for which there is no local demand and which fail to "think small" and "think community."
- to fund essential monitoring and reviewing processes;
- fund residents' access to local health services, most particularly community health services;
- identify a lead commissioner.

ii the Department of Health, NHS England and the Local Government Association be advised of the actions that Somerset County Council intends to take to address the detrimental persistence of "place hunting" by commissioners. That is, to require commissioners to:

- fund essential monitoring and reviewing processes;
- fund residents' access to local health services, most particularly community health services;
- identify a lead commissioner.

iii Since it is unlikely that the Care Quality Commission would register this model of service now, Somerset Safeguarding Adults' Board should write to the Care Quality Commission requesting that it (a) makes this fact explicit in its inspection reports; (b) undertakes more searching inspections of such services; and (c) does not register "satellite" units which are functionally linked to "campus" models of service provision.

iv A Memorandum of Understanding is negotiated by Somerset County Council whereby the aggregate-level information concerning grievances, disciplinaries and complaints, for example, gathered by providers is shared with the Care Quality Commission and pooled with that of local authorities' safeguarding referrals, the "soft intelligence" of Clinical Commissioning Groups, the police and prospective commissioners. The "search costs" of information seeking, negotiating access, processing and storing are excessive – this is most particularly the case when Section 42 inquiries are invoked.

v The Care Provider Alliance, with the support of the Care Quality Commission and Skills for Care, issue its members with guidance on how the role of responsible or nominated individual in supervising the management of the regulated activity83 should be performed in respect of quality assurance and safeguarding.

vi In addition to the recommendations made by the report author the Somerset Safeguarding Adults Board has also agreed:

vii For the Somerset Safeguarding Adults Board to review assurance arrangements for all people currently placed outside of Somerset, and to monitor the implementation of any actions identified through this work.

2 Flynn, M. (2018). *Safeguarding Adults Review: Mendip House*. Somerset Safeguarding Adults Board

Appendix 4

About the online survey and consultation event

Autistic people and families' views

Too often autistic people and families are left out of debates about quality of services and the discussions centre more on systems, processes, policies and legislation than what people want. As part of this process, we wanted to hear what expectations autistic people and family members have of service providers.

Online survey

We used an online survey to set out the changes we had already made since closing Mendip House. We asked people what they thought of those changes and what other ideas they also had. Sixty-four people filled out the feedback form.

Event format

The event opened with a presentation from the then CEO of the National Autistic Society, Mark Lever, who outlined what went wrong at Mendip and what our charity had been doing to put things right. This was followed by a question and answer session from participants.

The CEO of Dimensions, Steve Scown, then outlined what Dimensions had ensured they had in place since they had been prosecuted by the Health and Safety Executive and how they had put continuous improvement into their services.

The rest of the event was taken up with discussions in smaller groups and feedback.

Appendix 5

Examples of good practice

We asked people in the survey and at the event to tell us if they had any examples of good practice that they thought we, and others, could learn from. Below is a list of some of the suggestions they made. (Note, these have not been validated.)

- The NHS's Ask, Listen, Do programme was identified as a positive scheme for supporting organisations to improve their engagement with autistic people and those with a learning disability.

  Key aims of the programme are that organisations work to make sure that they are proactively asking for feedback as this helps people feel more confident if they need to make a complaint, that they allow complaints to be made in a way that is most appropriate and that the organisation takes action based on the complaint and also feeds back what they have done.

  Ask, Listen, Do have developed resources for families and individuals on how to give feedback and make complaints. These resources could be used across social care.

- Alzheimer's Society – good service evaluation model and measures. The suggestion on our survey, from an autistic adult who does not receive support, was: 'It would be helpful to look at your mechanism of data collection for your service users; is the person that is collecting the data someone who is directly involved in their care, if so it is a significant risk that the service users will falsely report due to concerns with repercussions. It might be helpful to look at how other organisations do this, Alzheimer's Society have a very good model of service evaluation and improvement. The Demqual proxy reported PROMS measures for dementia also offer a validated approach that adjusts proxy scores of wellbeing to get more accurate views and feedback on patient wellbeing....'

- Dimensions – evidence based practice. 'Having an organisation commitment to Positive Behaviour Support, Person Centred Active support and capable environments. Ensuring all staff understand how these evidence based approaches link with their roles, provide training and ongoing coaching and mentoring to ensure they are able to implement these approaches within their services. Look at the Dimensions Activate approach'. - Adult social care professional.

- David Lewis Centre – Regulations and sanctions. 'My son is at the David Lewis Centre. Staff there know that if they do not report even a suspicion of ill treatment by staff that they will be considered to have broken their own contract and there will be consequences for them too.' - Adult social care professional and relative of autistic adult using services.

- Blaydon Lodge (Gateshead Council). 'Blaydon Lodge at Gateshead Council is good at this. Ongoing training and autism awareness around various aspects in particular not just what it is in a nutshell.' - Autistic adult who works in social care.

- Association of Campshill communities. 'Have a core team of staff resident on site in residential care, supported living, village / intentional community settings to ensure continuity of care and to be aware of what is happening beyond their contracted hours / worked shift.' - Relation of autistic adult in social care.

- The charity Respond can help with providing support to autistic people and people with learning disabilities who have suffered abuse.

The National Autistic Society is here to transform lives, change attitudes and create a society that works for autistic people.

We transform lives by providing support, information and practical advice for the 700,000 autistic adults and children in the UK, as well as their three million family members and carers. Since 1962, autistic people have turned to us at key moments or challenging times in their lives, be it getting a diagnosis, going to school or finding work.

We change attitudes by improving public understanding of autism and the difficulties many autistic people face. We also work closely with businesses, local authorities and government to help them provide more autism-friendly spaces, deliver better services and improve laws.

We have come a long way but it is not good enough. There is still so much to do to increase opportunities, reduce social isolation and build a brighter future for people on the spectrum. With your help, we can make it happen.

Find out more at:
www.autism.org.uk

National Autistic Society