West Dunbartonshire
Health & Social Care Partnership

Supplementary Agenda

West Dunbartonshire Health & Social Care Partnership Board

Date: Wednesday, 5 August 2020

Time: 14:00

Venue: Video Conference

Contact: Nuala Borthwick, Committee Officer
Email: Nuala.borthwick2@west-dunbarton.gov.uk

Dear Member

ITEM TO FOLLOW

I refer to the agenda for the above Meeting of the West Dunbartonshire Health & Care Partnership Board which was issued on 28 July 2020 and now enclose a copy of the undernoted report which was not available for issue at that time.

Yours faithfully

BETH CULSHAW

Chief Officer of the Health
& Social Care Partnership

Note referred to:-

6 DEMENTIA AND AUTISM STRATEGIES 95 – 122

Submit report by the Integrated Operations Manager Mental Health providing an update on the progress made in relation to the Dementia and Autism Strategies.

Distribution:-

Voting Members

Allan Macleod (Chair)
Denis Agnew
Marie McNair
John Mooney
Rona Sweeney
Audrey Thompson

Non-Voting Members

Barbara Barnes
Beth Culshaw
Jonathan Hinds
Chris Jones
John Kerr
Helen Little
Diana McCrone
Anne MacDougall
Kim McNab
Peter O'Neill
Selina Ross
Julie Slavin
Val Tierney

Senior Management Team – Health & Social Care Partnership

Date of issue: 31 July 2020

West Dunbartonshire Health & Social Care Partnership Board

5 August 2020

Subject: Dementia and Autism Strategies

1. Purpose

1.1 The purpose of this report is to update the Health and Social Care Partnership Board on the progress made in relation to the Dementia and Autism Strategies.

2. Recommendations

2.1 The Partnership Board is asked to note the appointment of a lead officer responsible for the implementation of the Dementia Strategy

2.1 The Partnership Board is asked to note the appointment of a lead officer responsible for the implementation of the Autism Strategy and note the re-establishment of the Autism Strategy Steering Group and the draft Terms of Reference for the group. Attached as an appendix.

3. Background

Dementia

3.1 Dementia is a national public health priority, as identified by the third Scottish Government's National Dementia Strategy (2017-20), which directly influenced the development of support for people with dementia and their carers and families in West Dunbartonshire.

3.2 The Vision- Get it Right for every person living with dementia, and their carers, in West Dunbartonshire; support our whole community to be aware of the benefits of early recognition and diagnosis of dementia; and empower people to work together to provide the best support possible.

3.3 Key anticipated outcomes from the National Dementia Strategy (2017-20) were:

3.3.1 More people have an increased say and control over their dementia diagnosis and are diagnosed early enough that they can take as full a part as possible in their own care planning.

3.3.2 More people get earlier access to good quality, person-centred post-diagnostic support in a way that meets their needs and circumstances.

3.3.3 More people with dementia are enabled to live well and safely at home or in a homely setting for as long as they and their family wish.

3.3.4 More people get timely access to good quality palliative and end of life care

3.3.5 During the process of diagnosis and through all parts of the care journey, the critical input of family carers is encouraged and facilitated, and carers' own needs are recognised and addressed.

3.3.6 People with dementia's right to good quality, dignified, safe and therapeutic treatment, care and support is recognised and facilitated equally in all care settings - at home, in care homes or in acute or specialist NHS facilities.

3.3.7 There are more dementia-friendly and dementia-enabled communities, organisations, institutions and initiative

3.4 The implementation group has regular representation from LENS group, Carer Centre, Statutory Mental Health Services and Alzheimer Scotland representatives.

3.5 Achievements

3.5.1 The roll out of Wellbeing Nurses, which is a unique service within NHSGGC funded by Action 15 money, to every GP Practice in West Dunbartonshire. The aim of this service is to support people with common mental health problems including early identification of dementia without the need for an initial GP consultation. These experienced Band 6 Psychiatric Nurses provide a 30 minute consultation booked via the GP Practice reception staff. Currently three GP Practices within Clydebank and Old Kilpatrick have support. The remaining practices are expected to have Wellbeing Nurses in place by September 2021.

3.5.2 HSCP funded Post Diagnostic Link Workers have introduced a group model of providing Post Diagnostic Support within the Alzheimer Scotland Resource Centre in Clydebank.

3.5.3 HSCP Psychology and Care Home Liaison Nurses have supported NHS education for Scotland to deliver NES Essentials in Psychological Care in Dementia training within our council and private care homes within West Dunbartonshire.

3.5.4 The HSCP, with support from people with lived experience of dementia and carers, have measured our current Post Diagnostic pathways against the “I hub Quality PDS Improvement framework.” This had led

to changes in how local statutory services communicate with our patients and carers especially in diagnosis education and resource information.

3.5.5 Carer Support Workers are now embedded in Older People and Mental Health services.

3.5.6 The Joint Working approach between Mental Health Nurses and Alzheimer Scotland has led to a local Dementia Carers group to deliver support and education to carers of people with Dementia.

3.5.7 We have supported the education of our staff including the Senior Charge Nurse of our Dementia Assessment Fruin Ward within the Vale of Leven Hospital completing the 18 month NES Dementia Specialist Improvement Leaders equipping her to drive and effect change improvements in specialist dementia care. This has led to change in our dementia care including better use of information technology to support improved patient communication.

3.5.8 Additional resources have supported new Consultant Psychologists posts across NHS GG&C Dementia Inpatient Services including our local wards.

Background

Autism

3.6 In 2011 the Scottish Government published its Strategy for Autism, outlining their commitment at local and national level to improving the lives of Autistic people. This was refreshed in 2015 to reflect an Outcomes approach.

3.7 Within Specialist Children's services, referral data and feedback from carers has demonstrated increasing recognition of the prevalence of Autism. In addition to this, there is a need for services to be delivered to meet the needs of children and young people with Autism, in line with the Scottish Government's 4 key strategic outcomes:

- A healthy life
- Choice and control
- Independence
- Active citizenship

https://www.gov.scot/publications/scottish-strategy-autism-outcomes-priorities-2018-2021/

3.8 The HSCP has prioritised the needs of young people in transition from Children to Adult services, through the establishment of the Transitions Group

(TAG). This group has improved transitions for young people with learning disabilities, physical disabilities and diagnosed mental illness. However, the group has identified gaps in provision for young people with Autism, for whom there may be no equivalent provision in Adult Services.

3.9 In 2017 the Scottish Government Mental Health strategy highlighted the links between Autism and Mental ill health, and reinforced the need for improved understanding of Autism within Mental Health services. Furthermore, feedback to the Scottish Government from Autistic people, their families and carers, focussed on the need for appropriate training and education for staff in all public services, including NHS, Local Authorities, Education, Police Scotland, Higher Education, Criminal Justice services and crucially among the general public.

4. Main Issues

4.1 Dementia: There is recognition within the Dementia Implementation Group that further strengthening is required. We intend to do the following:-

- Embed Self-directed support and personalised care
- Better understand and consider the needs of people with a Learning Disability and Dementia
- Target Health Improvement activity on interventions and lifestyle changes which may reduce or slow progress of dementia
- Work with Housing partners to improve housing and housing services for people who are at risk of or have dementia

Main issues

4.6 Autism: The development and implementation of a West Dunbartonshire Autism Strategy has been delayed, but there is cross-service commitment to address this as a matter of urgency. Provision of consistently Autism-aware services in West Dunbartonshire is dependent upon the development of a clear strategy, delivered by a cohesive partnership of committed services.

4.7 Whilst it is clear that there are some areas of good practice, there are also opportunities for improvement: particularly around transition from children to adult services and across service interfaces.

4.8 The Autism Strategy Steering Group (ASSG) will lead this work on behalf of the HSCP and Community Planning Partnership. The work of this group will be prioritised by all members in order that it has a demonstrably positive impact on the lived experience of Autistic people and their families. The terms of reference detail the commitment required of group members, as well as reporting structures and timescales for the development and implementation of the Strategy.

4.9 The Partnership Board is therefore asked to note the appointment of an operational lead, the Head of Service for Mental Health, Learning Disabilities and Addictions. The lead will be supported by the Strategy and Transformation Team. The ASSG will be accountable for reporting to the Senior Management Team and IJB in relation to the delivery of the West Dunbartonshire Autism Strategy and Delivery Action Plan.

5. People Implications

5.1 None

6. Financial and Procurement Implications

6.1 There are no direct financial implications arising from this report.

7. Risk Analysis

7.1 The lack of executive accountability for dementia services and accountability for delivery and performance leaves the HSCP exposed in terms of reputational risk.

7.2 The absence of an Autism Strategy and Implementation plan leaves the HSCP open to challenge on the provision of autism aware services.

8. Equalities Impact Assessment (EIA)

8.1 An equalities impact assessment has not been undertaken as part of the production of this report as none of the recommendations impact on the protected characteristics.

9. Environmental Sustainability

9.1 Strategic Environmental Assessment (SEA) is not required and has not been undertaken.

10. Consultation

10.1 A full consultation will be undertaken by both working groups with support from Health Improvement colleagues and in conjunction with Community Partners.

11. Strategic Plan

11.1 This work is in line with the HSCP's five key strategic priorities:

- Early intervention
- Access
- Resilience
- Assets
- Inequalities

Name Marie Rooney
Designation Integrated Operations Manager Mental Health
Date: 28 July 2020

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Appendices: Dementia Strategy Implementation Plan
Autism Strategy Terms of Reference

Getting it Getting it Right for People with Dementia and their Carers in West Dunbartonshire

West Dunbartonshire Dementia Strategy Implementation Plan

2017 – 2020

Getting it Right for People with Dementia and their Carers

This West Dunbartonshire's Dementia Strategy Implementation Plan (Plan) outlines the commitment from West Dunbartonshire Health and Social Care Partnership (HSCP) in Getting it Right for people with dementia and their carers. We understand that a diagnosis of dementia can be stressful, confusing and overwhelming; as such we recognise that information, advice, support, care and treatment need to be available for people living with dementia, their families and carers.

As such, West Dunbartonshire's vision is that we:

> *Get it Right for every person living with dementia and, their carers, in West Dunbartonshire; supporting our whole community to be aware of the benefits of early recognition and diagnosis of dementia, and empowering people to work together to provide the best support possible*.

Dementia is a national public health priority, as identified by the third Scottish Government's National Dementia Strategy (2017-20), which directly influences the development of support for people with dementia and their carers and families in West Dunbartonshire.

This Plan thus takes cognisance of existing frameworks and policies including the National Dementia Strategy for Scotland and Dementia Care Standards. The Promoting Excellence Framework developed by the Scottish Social Services Council and NHS Education Scotland defines four levels of learning about dementia: informed, skilled, enhanced and expert.

The HSCP's second Strategic Plan 2016 – 2019 reflects the key commitments for West Dunbartonshire in supporting and caring for people living with dementia and their carers through their dementia journey, within the framework of the National Health and Wellbeing Outcomes and the new National Health and Social Care Standards.

As defined by Promoting Excellence, the four stages of the dementia journey are:

The National Dementia Strategy is underpinned and reinforced by a number of related policies, namely the Health and Social Care Delivery Plan, the National Clinical Strategy, Integration of Health and Social Care and Primary Heath Transformations, Self-Directed Support, Housing Strategy and the Palliative and End of Life Care Strategic Framework.

Key anticipated outcomes from the National Dementia Strategy (2017-20) are:

- More people have increased say and control over their dementia diagnosis and are diagnosed early enough that they can take as full a part as possible in their own care planning
- More people get earlier access to good quality, person-centred post-diagnostic support in a way that meets their needs and circumstances
- More people with dementia are enabled to live well and safely at home or in a homely setting for as long as they and their family wish
- More people get timely access to good quality palliative and end of life care
- During the process of diagnosis and through all parts of the care journey, the critical input of family carers is encouraged and facilitated, and carers' own needs are recognised and addressed
- People with dementia's right to good quality, dignified, safe and therapeutic treatment, care and support is recognised and facilitated equally in all care settings - at home, in care homes or in acute or specialist NHS facilities
- There are more dementia-friendly and dementia-enabled communities, organisations, institutions and initiative

This Plan lays out how we aim to support people with dementia and their carers across West Dunbartonshire; focusing on:

- Early identification and delayed impact of dementia
- Flexible, high quality post-diagnostic support
- Community support services, including palliative and end of life care
- Specialist provision
- Programme of awareness raising and training for staff and volunteers from all sectors.
- Specialist support for unpaid carers including the provision of short breaks, peer support and training.

Additionally, we recognise that as people age, and specifically for those living with dementia, their housing needs change. We are seeking to support people to live as independently as possible at home or in a homely setting; this is reflected within our Housing Contribution Statement and West Dunbartonshire's Local Housing Strategy

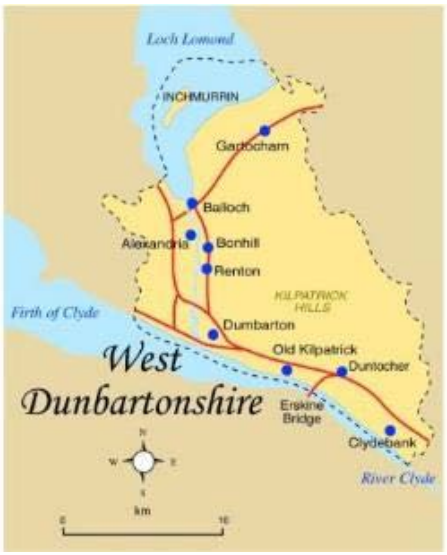
and we continue to work closely with the local housing sector to build upon existing robust and effective mechanisms for appropriate housing options for people dementia and their carers.

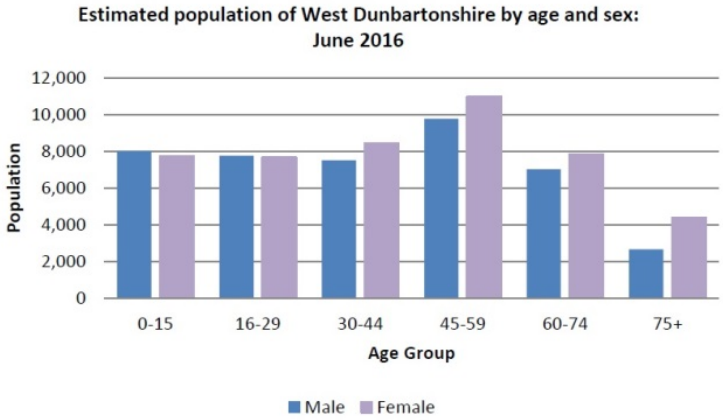
This Plan is built on the following key principles:

- A client/patient-centred approach appropriate to individual needs through an emphasis on informed self-care, co-production and personalisation of services
- Effective and safe services that draw upon the best available evidence and local feedback from service users/patients.
- Acceptability of service provision informed through constructive engagement with local stakeholders
- Affordable and efficient services that continue to be reflective of the relative demands across the West Dunbartonshire population as a whole
- Effective connectivity across health and social care services.

Our Population

With a population of 89,860, West Dunbartonshire is one of Scotland's smallest local authorities. It is an area of geographical contrasts and diverse communities; from remote rural villages to the densely populated former industrial areas on the River Clyde.

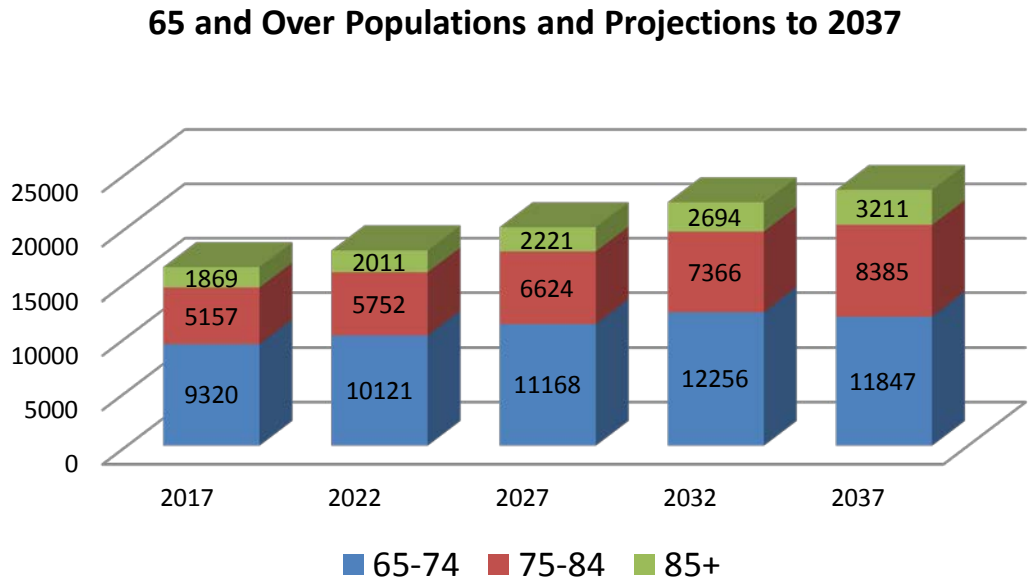




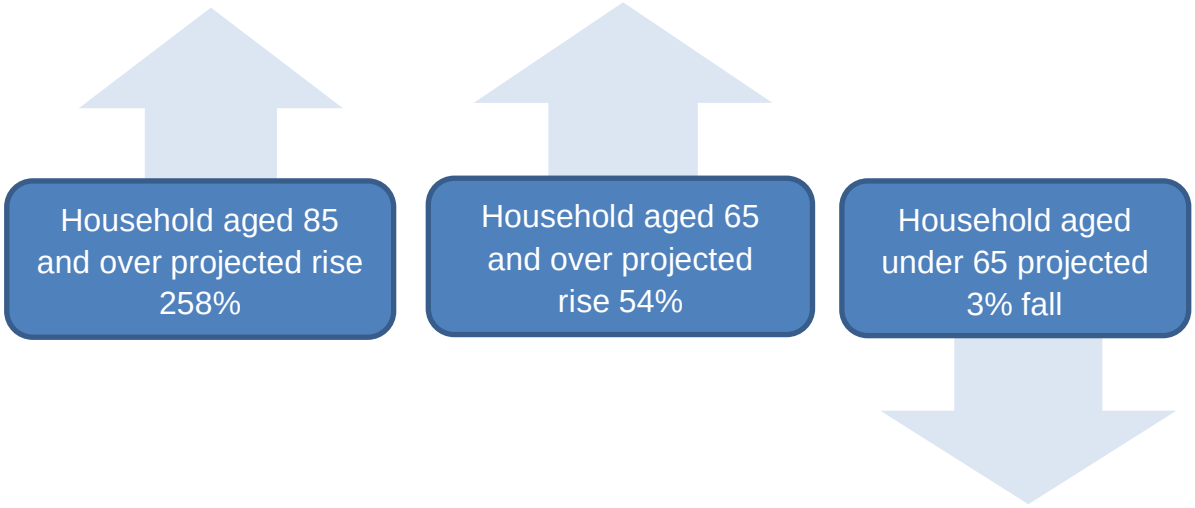
Population estimates show a gradual decline in the number of West Dunbartonshire residents aged 16 and under from 16,720 to 16,694, a 0.2% decrease. Over the same period there was an increase from 21,205 to 21,345 people aged 60 and over a 0.7% increase.

0-16 years	60 years and over
0.2%	0.7%

So, whilst our population has continued to gradually fall, there is an increasing proportion of the West Dunbartonshire population aged over 65 years, as reflected across Scotland, which is anticipated to continue to rise:



The National Records of Scotland also predict that the number of households headed by people aged 65 and over will increase by 54% between 2012 and 2037, with a 3% fall in those under 65. The number of households headed by some on over 85 is projected to rise from 77400 to 200,000, a 258% rise, in the same period.

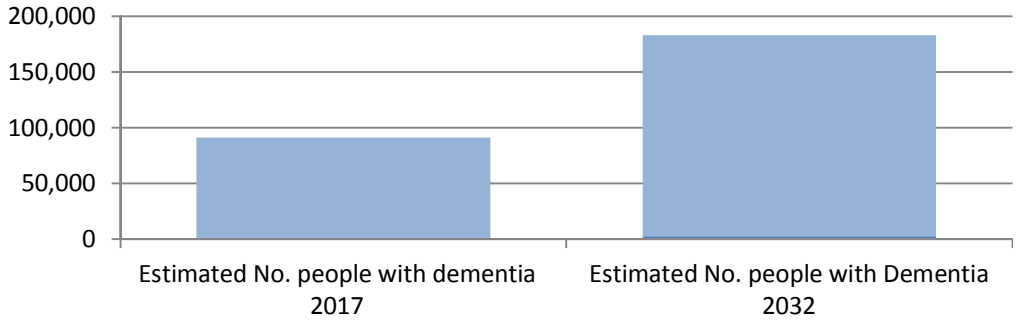


This trend can already be seen in current population shifts nationally. The fall in birth rate, together with simultaneous improvements in mortality, has reduced the relative size of the child population, and increased the relative size of the pensioner population.

Age composition of our population is thus one of the most important aspects of demographics; changes to different age groups will have different social and economic impacts. This upward shift in the average age of society has significant economic implications; including the potential to have an impact on all sectors of the

health and care sector. These increases in the number of elderly people in the population will place a greater demand on our health and care services.

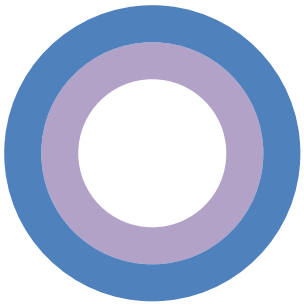
As reported in Scotland's Dementia Strategy 2013-16, dementia is one of the foremost public health challenges worldwide. As of 2017, the number of people in Scotland with dementia is estimated as at between 65,000 (Dementia UK/ NHS England)) to 90,000 (Eurocode model/ Scottish Government/Alzheimer's Scotland). Reflecting the projected aging of our population, this is expected to double in the next 25 years.



It is no surprise then that in West Dunbartonshire we have increasing numbers of people living with and being diagnosed as having dementia. In 2017 there were 809 people with a dementia diagnosis, compared to 613 in 2014.

We recognise that there will also be people living in West Dunbartonshire with dementia but having had no formal diagnosis, and so whilst we can identify the number of people with a diagnosis, we should also plan to identify and support those without diagnosis.

The national statistics on dementia would estimate that in 2017 West Dunbartonshire has up to 1400 people living with Dementia, indicating a potential deficit of up to 600 people living with dementia and without a diagnosis.



Projected number of people living with Dementia in West Dunbartonshire – approximately 1400

People living with Dementia Diagnosis in West Dunbartonshire - 809

Projected -People with dementia without diagnosis- 600

We know that supporting early positive diagnosis and timely post diagnostic support provide better outcomes for people living with dementia. This Plan thus reinforces our commitment to increase the confidence of both professionals and individuals to approach the process of diagnosis more timeously. By raising awareness of dementia and the ability to successfully live with the condition, citizens are empowered to be more willing to seek diagnosis and support, rather than avoid this.

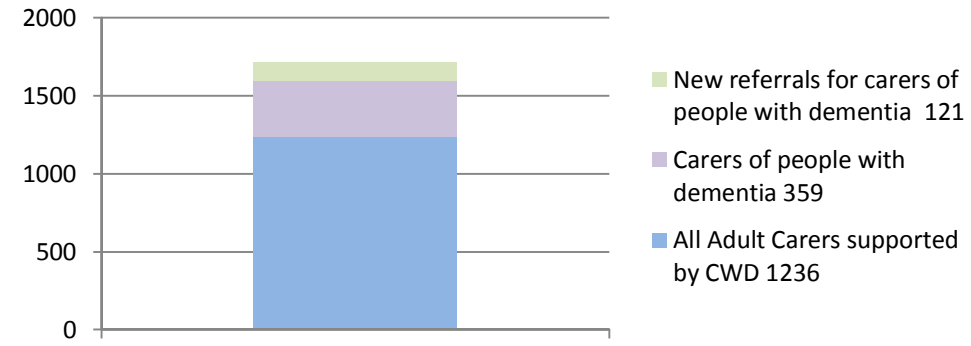
The majority, 63.5%, of people with a dementia diagnosis in West Dunbartonshire live at home in the community, with 36.5% of people living in care homes.
Based on current prevalence it is estimated that up to 70% of people living in care homes may have dementia:

The increasing number of people being diagnosed, and living, with dementia presents a challenge for the statutory and voluntary sector services that provide care and support. For example, the expected number of referrals to our Primary Care Dementia Liaison Service has far exceeded the target numbers over the past three years.

HSCP Primary Care Dementia Liaison Service	Referral Target	Actual Referrals
2014/15	48	84
2015/16	51	148
2016/17	53	191

The Promoting Excellence and NES Palliative Care Enriching and Improving Experience Frameworks reflect the importance of End of Life Care and Dying well for people with Dementia. Many people living with dementia are supported in care homes and ward based settings as their condition becomes palliative. This Plan reaffirms our commitment to ensuring that people with dementia receive compassionate and person centred End of life and palliative care.

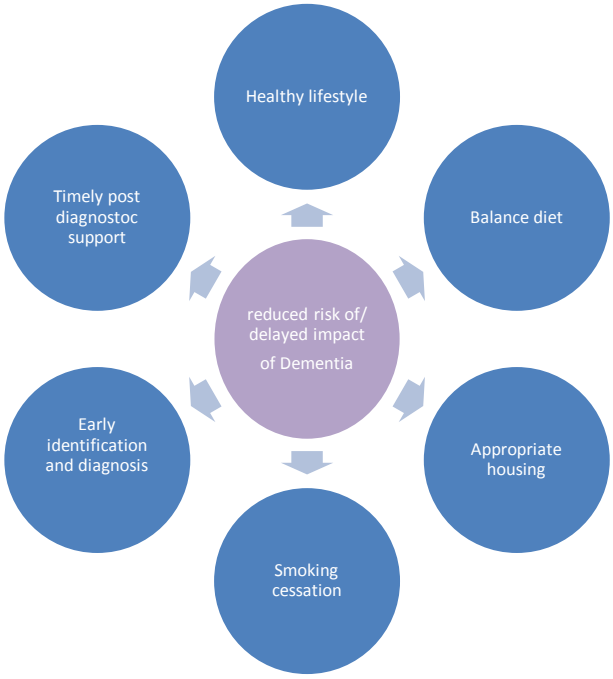
We recognise the essential role of unpaid carers as equal partners in, and our responsibility to work in partnership with them to sustain them in their caring role. Carers of West Dunbartonshire provided support to 359 carers of people with dementia assessed in the 2016/17, of these 121 were new referrals to the service. Carers of those with dementia on average accessed 3 types of support or intervention throughout 2016/17.



Carers of people with dementia in West Dunbartonshire 2016/17

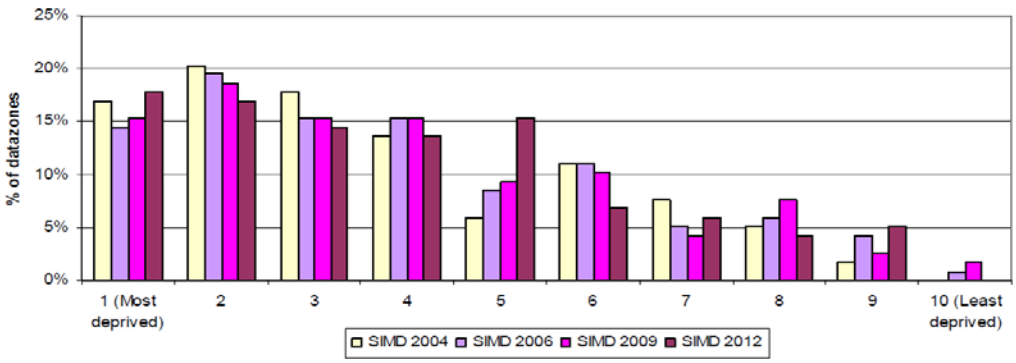
The interplay between the benefits of a healthy lifestyle and the increasing risk of developing dementia with age is complex and difficult to assess. There is evidence that healthy living behaviours, such as healthy diet or regular physical activity and stopping smoking may reduce the risk of a person developing dementia or delay its onset.

Educating communities in Health Literacy- to increase understanding, recognition and early identification of dementia - requires increased understanding of what dementia looks like, its impact on individuals and the positive roles that the community can play in this.



The increase in life expectancy, also a consequence of healthy living behaviours is the main factors behind the increasing number of people in West Dunbartonshire with dementia. More work is needed to understand these interactions at a population level moving forward, though the benefits to the individual of healthy living are clear.

However, the ScotPHO Health & Wellbeing Profile for West Dunbartonshire confirms the relatively higher levels of poor health within the area compared to Scotland as a whole, reflecting the relatively pervasive and high level of deprivation across the area, with most of West Dunbartonshire's datazones being found in the more deprived deciles in SIMD.



As reflected in the priorities that this Plan is based on we are committed to Co-production, bringing together professionals and citizens to make the best use of each

other's assets, resources and contributions to bring about better outcomes for our residents.

The Dementia Friendly West Dunbartonshire is a collaborative approach between WDHSCP, Alzheimer's Scotland, Scottish Care and West Dunbartonshire CVS. It has provided a range of engagement and training opportunities for community groups, third sector organisations and individual community members including people living with dementia and their carers to work together to support positive behaviour change at everyday activity level, with the common goal of a better quality of life for people living with dementia and their carers.

Dementia friendly communities have the power to change the way we think about living with dementia, and allow a broadening of focus from meeting the physical and health needs to supporting the achievement of the best quality of life possible. Only by engaging the widest community can the rights of people living with dementia be protected and promoted making West Dunbartonshire a more dementia friendly place to live, work and visit.

Scottish Care will continue to support the Dementia Friendly Community initiative by participating in the delivery of training and awareness raising, both at a local level and promoting the good practice of West Dunbartonshire.

This Plan reflects our commitment to respond to the complex and changing environment of dementia in West Dunbartonshire and nationally, and to plan effectively for the future.

Key Outcomes for People with Dementia and their carers

- More people have increased say and control over their dementia diagnosis and are diagnosed early enough (that they can take as full a part as possible in their own care planning.
- More people get earlier access to good quality, person-centred post-diagnostic support in a way that meets their needs and circumstances
- More people with dementia are enabled to live safely and with as good a quality of life as possible at home or in a homely setting for as long as they and their family wish
- More people get timeous access to good quality palliative and end of life care earlier
- People with dementia's rights to good quality, dignified, safe and therapeutic treatment, care and support are recognised and facilitated equally in all care settings – at home, in care homes or in acute or specialist NHS facilities
- There are more dementia-friendly and enabled communities, organisations and institutions and initiatives.
- Carers of people living with dementia will feel valued and that their role as carer is highly regarded
- Carers of people living with dementia feel confident and supported to continue in their caring role.
- Carers of people living with dementia will feel that they have a life outside of their caring role.

Key commitments to meet national outcomes for People with Dementia and their carers

1. We will embed focus on early diagnosis, personalisation and personal outcomes.
2. We will review the outcome of Primary Care based dementia pilot sites and deliver a local response and adapt services based on these findings.
3. We will embed dementia diagnosis and Post Diagnostic Support within HSCP's key actions on delayed hospital discharge, reducing unscheduled bed days, improving palliative and end of life care and strengthening community care
4. We will support safe and supportive home environments and the importance of the use of adaptations and assistive technology, in maintaining the independence and quality of life of people with dementia and their carers.
5. We will support and promote best practice in advance care planning, the assessment of capacity to consent to treatment and adherence to proper procedures for making decisions for people with dementia who lack capacity.
6. We will continue to improve staff skills and knowledge through national and local approaches to educating, training and developing staff on dementia

7. We will ensure that the views and input of the carer will be encouraged and assimilated during the diagnosis process and through all parts of the care journey,
8. We will include service users and carers in service development and individual care.
9. We will provide support to carers of people living with dementia based on the carer's identified need.

West Dunbartonshire Dementia Strategy Implementation Plan 2017-20				Status
This high level implementation plan reflects the five key elements which are central to supporting a person after their diagnosis, and reflects our agreed local priorities, activity and the implementation of National Health and Care Standards and National Dementia Strategy. It is supported by a detailed work plan accountable to our quarterly Dementia Strategy Implementation Group. 				
Pillar One: Help to understand the illness and manage its symptoms				
National Dementia Strategy Commitments	**National Health and Care Standards**	**Key Local Outcomes**	**Key Local Activities**	

1.1 We will embed focus on early diagnosis, personalisation and personal outcomes.	Principle: Responsive Care and Support Standard 1: I experience high quality care and support that is right for me.	Avoid emergency admissions Support independent living Support people at end of life	Deliver assessment and diagnosis of dementia across care settings on a timely and person centred basis. 1) Wellbeing Nurses are to be situated within GP practices as part of a 4 year roll out programme. These nurses will be involved in early screening and promotion. – In progress 2) Measure our current Post Diagnostic pathways against the "I hub Quality PDS Improvement framework". Completed= Action Plan in progress- <u>Remaining Actions</u> Lived experience Service User and Carer service experience feedback Questionnaire prepared. To be reviewed by Mental Health Network	Implementation Phase Completed

			LENS group prior to rollout. To be repeated on an annual basis commencing on Sept 2020 https://ihub.scot/media/4005/fod_pds-qif_sep18-v10.pdf 3) Required development of a Community Awareness Strategy on Dementia Awareness and prevention strategies. 4) Implement SDS Agenda. 5) Review PDS LINk Worker Service within Community Mental Health Services.	

1.2 Support the HSCP's key actions on delayed hospital discharge, reducing unscheduled bed days, improving palliative and end of life care and strengthening community care	Principle: Responsive Care and Support Standard 1: I experience high quality care and support that is right for me.	Reduce hospital delays Avoid emergency admissions Support independent living	Continue to embed support across integrated health and social care provision for people with dementia, including post diagnostic support and reflecting the HSCP priorities to reduce delayed discharge, unscheduled bed days and improve palliative and end of life care. **Action Plan-** 1) Local Short Working Group convened- Aim to reduce unnecessary admissions and reduce unnecessary length stay. Expected end of October 2020 1) Raising awareness of POA and Guardianship processes and consider any necessary improvements.	In Progress

			2) Understand Palliative Care and End of Life care deficits.	

1.3 We will support safe and supportive home environments and the importance of the use of adaptations and assistive technology, in maintaining the independence and quality of life of people with dementia and their carers.	Principle: Wellbeing , Responsive Care and Support Standard 2: I am fully involved in all decisions about my care and support	Reduce hospital delays Avoid emergency admissions Support people at end of life	Continue to expand the use of Technology Enabled Care (TEC) to support people living with dementia in the community, both in terms of enabling detailed assessments, and tailoring the provision of equipment and sensors to individual need. . 1) Housing strategy to explore how we future proof against increase in dementia	Completed
1.4We will continue to improve staff skills and knowledge through national and local approaches to educating, training and developing staff on dementia	Principle: Be Included Standard 1: I experience High Quality care and support that is	Avoid emergency admissions Support independent living	Improve and sustain knowledge and skills across HSCP and community planning partner practitioners and services through educating, training and developing staff on dementia and delirium 1) Develop a training plan for all partners involved in dementia care including wider community partners.	In progress

	right for me		Action Training analysis plan being prepared by MH Psychology.	

WD Health and Social Care Partnership

Autism Strategy Steering Group

Draft Terms of Reference as at July 2020

Aim of the Group

The Autism Strategy Steering Group will bring together representatives from the HSCP and partners to lead on the service improvements relating to the needs of Autistic people and their families.

Purpose of the Group

- Develop an Autism Strategy which aligns to the Scottish Government's strategic outcomes.
- In collaboration with partners, agree a plan which will deliver inclusive Autism aware services.

Remit of the Group

- Assume a lead role in the implementation and review of the HSCP Autism Strategy.
- Monitor the implementation and report on the related performance of the HSCP Autism Strategy.

Membership

Membership to include representation from:

- HSCP Senior Manager (Lead)
- Representation from all service areas across HSCP
- Educational psychology representative
- WDC housing representative
- Finance representative
- Performance Team representative
- Organisational development representative
- Carers of West Dunbartonshire representative
- Y Sort-it Representative
- 2 x Adult carer reps*
- 2 x Young carer reps*
- Police Scotland representative(consultative)
- GP representative(consultative)
- Admin support

*support and training will be provided where necessary to develop capacity required to undertake role

Responsibilities

Members are expected to:

- Attend all meetings or send a suitably briefed substitute with authority to make any decisions where appropriate
- Draw upon experience and expertise to contribute to and develop work streams where appropriate, ensuring decision making is transparent and evidence-informed.
- Effectively represent their organisation and / or stakeholder group, ensuring communication flows both from and to the ASSG efficiently and effectively.

Accountability

- The group is accountable to the Health and Social Care Partnership Strategic Leadership Team and the Integration Joint Board.

Meetings

- Meetings will take place every month, dates to be set for a year in advance.
- Agenda items will be circulated at least 7 days prior to the meeting.
- The group will be chaired by the HSCP lead officer with an agreed substitute.
- Minutes will be circulated no later than 7 days after the meeting.