south ayrshire
health & social care
partnership

Summary Adult Community Mental Health Strategy 2017 – 2022

May 2017

NHS Ayrshire & Arran

south AYRSHIRE COUNCIL

Contents

Foreword 3
Introduction 4
Background 5
Who we are 6
Our Vision 6
Our Mission 6
Our Values 6
Strategic Outcomes 7
Our People and Partners 8
Population Needs 9
Available Resources 10
Developing the Strategy 11
Strategic Outcomes and Implementation Plan 12
1. Flexible, Tailored Provision and Coordinated Approaches 12
2. Prevention 19
3. Recovery 24
4. Addressing Social Stigma 29
5. Choice and Control 33
6. Safety 38
7. Carers' Needs 42
What We Will Do Next 46
How We Will Know We Have Made a Difference 47
Glossary 48

Foreword

Providing effective support for people to maintain and recover good mental health in ways that address their personal outcomes is a priority for the South Ayrshire Health and Social Care Partnership. Whenever possible, we will work to support people to live healthily and well within their local communities with their families and friends. We will seek to enable people to enjoy good physical and mental health, making use of facilities and activities available locally, in partnership with local groups and provider organisations from across the sectors.

We recognise that the ways in which we have traditionally supported people needs to change. We will seek to provide people with greater choice and control and offer maximum flexibility for them to live their lives in the way they want and which best meets their personal aspirations.

We also live in a time when the funding available to support people is reducing. The changes that we make will also have to be informed by this reality which faces all Health and Social Care Partnerships in Scotland. We are in a landscape where demand is increasing, while the money available to fund this demand is decreasing.

We will be sensitive to the challenges that this creates. We know we need to ensure that people are well and safe. We will seek to balance the support that we can fund to meet individual and organisational aspirations with the resources that we have for this purpose.

Our aim remains to ensure that staff employed by us and our partners are open and transparent with service users, carers, families, and partner organisations. Where changes are necessary we will communicate clearly and we will engage and seek views before acting.

Tim Eltringham

Director of Health and Social Care

May 2017

Introduction

This document outlines the Community Adult Mental Health Strategy for South Ayrshire for the period 2017 to 2022. It sets out key strategic outcomes identified through discussions with service users, carers, staff, and the South Ayrshire Mental Health Strategic Planning Group.

Support will be designed and delivered in ways that:

- Offers flexible, tailored, and coordinated support to those receiving services.
- Prevents escalation of need and supports people to remain at home.
- Promotes recovery, well-being, and self-management.
- Minimises the potential for social stigma associated with mental health issues.
- Offers choice in the way that services are managed and control by those who receive them.
- Is safe, and ensures the safety of vulnerable members of society.
- Addresses Carers' needs.

The Mental Health Strategic Planning Group (part of the South Ayrshire Health and Social Care Partnership) developed this strategy and its associated implementation plan with support from Health Improvement Scotland. A strategy to address needs and provide services for those with dementia will be developed by South Ayrshire Health and Social Care Partnership following the finalisation of a national strategy by the Scottish Government.

Background

The intention of this document is to set out the broad strategic outcomes for the development of Adult Community Mental Health Services. These are set in the context of both national and Partnership strategies, especially the nine national outcomes for Health and Wellbeing [http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Outcomes]. Although framed in this policy context, the needs identified in South Ayrshire will inform the planning and delivery of activity to support these outcomes.

The strategic ambitions are a product of an exercise which considered earlier consultation with service users and incorporated the views of service managers, representatives from public health, third sector providers, advocacy services, clinicians, and carers' services (via the South Ayrshire Mental Health Strategic Planning Group).

When considering these strategic ambitions, the South Ayrshire Mental Health Strategic Planning Group recognises that routes other than statutory services provided by NHS Ayrshire and Arran and South Ayrshire Council will contribute to their delivery. As well as pursuing means to deploy integrated resources, consideration of informal interventions and the effects of the wider environment, particularly housing, under employment, poverty and inequality is needed to support improved wellbeing throughout South Ayrshire. Many of the collective benefits of these activities are broader than the scope of improved mental wellbeing, and address physical health and general welfare concerns for collective benefit.

The means to address these aims will be considered in the Implementation Plan set out at the end of this document.

Who we are

The South Ayrshire Health and Social Care Partnership brings together a wide range of community and primary care health and social work services into a single operational delivery unit. In South Ayrshire, the Partnership includes Adult Services, Children's Services, and Criminal Justice Services. The Partnership is governed by the Integration Joint Board (IJB). The IJB has members from NHS Ayrshire and Arran, South Ayrshire Council, representatives of the 3rd Sector, Independent Sector, staff representatives and others representing the interests of patients, service users and carers.

The Board is a separate legal entity from both South Ayrshire Council and the NHS Ayrshire and Arran Board. It is responsible for planning and overseeing the delivery of a full range of community health and social work/social care services, including those for people with mental health issues. The IJB is responsible for allocating the integrated revenue budget for health and social care in accordance with the policy priorities set out in its Strategic Plan.

In practice, this means that services will work more closely together to deliver streamlined and effective support to people that need it.

Our Vision

- 'Working together for the best possible health and wellbeing of our communities'.

Our Mission

We will work with you to improve health, support social care, tackle health inequality, and improve community wellbeing. We will work in partnership with local communities to offer services that are:

- Easily understood
- Accessible and timely
- Well-coordinated
- Safe and person centred
- Effective and efficient

Our Values

In our work, we, and those that work on our behalf will uphold the following values:

- Safety
- Integrity
- Engaged
- Caring
- Individually focused
- Respectful

The Integration Joint Board has approved Strategic Objectives and Policy Priorities which have been designed to deliver progress locally against the National Health and Wellbeing Outcomes.

Strategic Outcomes

- We will work to reduce the inequality gradient and address health inequality.
- We will protect children and vulnerable adults from harm.
- We will ensure children have the best possible start in life.
- We will support people to live independently and healthily in local communities.
- We will prioritise preventative, anticipatory, and early intervention approaches.
- We will proactively integrate health and social care services and resources for adults and children.
- We will develop local responses to local needs.
- We will ensure robust and comprehensive partnership arrangements are in place.
- We will support and develop our staff and local people.
- We will operate sound strategic and operational management systems and processes.
- We will communicate in a clear, open, and transparent way.

The Integration Joint Board's policy priorities include the following:

- Tackling Health Inequalities and their causes.
- Early Intervention and Prevention to prevent deteriorating health and wellbeing.
- Personalisation and Self-Directed Support Designed to meet the outcomes important to individuals.
- Co-production- work with individuals, communities, and organisations from across the sectors to provide support.
- Technology Enabled Care – use of technology to support people to live at home in the community.
- Anticipatory Care Planning – to keep individuals safe at home and out of hospital whenever possible.
- Integration of Staff and Services – to provide support that is joined up more efficiently.

The approach set out in this Strategy will be built around the principles of the Christie Commission on the Future Delivery of Public Services which published recommendations that:

- public services are built around people and communities, their needs, aspirations, capacities, and skills, and work to build up their autonomy and resilience.
- public service organisations work together effectively to achieve outcomes - specifically, by delivering integrated services.
- public service organisations prioritise prevention, reduce inequalities and promote equality. and
- all public services constantly seek to improve performance and reduce costs, and are open, transparent, and accountable.

Our People and Partners

This strategy requires strong relationships and partnerships with agencies, services and the people who provide and receive them in South Ayrshire. Our ability to address the outcomes set out will largely be dependent on how well founded these relationships are and how well they are integrated into the Partnership's Strategic Planning process.

The Partnership has made clear its intentions to establish new relationships with the public, thus ensuring that they are much more active participants in shaping their own health and social care in the future. The work of the Partnership depends on active communities and families taking steps to improve their own health and to provide neighbourly care and support.

This approach is often termed 'co-production' which includes supporting service users and carers to be equal partners in, and contributors to, their own care and support. The Partnership will put in place 'structural' arrangements for ensuring good joint work, for example, building on the work that has been done to establish cross sector locality planning groups within communities in South Ayrshire. The workforce, including employees of both Health and Council services, is the main resource for the delivery of quality outcomes for people in South Ayrshire and the Partnership will support staff to be motivated, committed, skilled and valued. In delivering this strategy it is vital that strong internal connections with Council and non-delegated health services are not lost or weakened. In planning Mental Health Services this includes: Education and Early Years; Housing and Housing Support Services; and Primary Care.

As the primary universal service for most people, General Practice is a vital component in the work of the Partnership. General Practitioners are already engaged in a range of work programmes that support the objectives of this Strategy. The Partnership recognises the centrality and importance of this work and consequently has sought to strengthen its relationship with General Practitioners through formal structures at locality level, and in the way it shapes and manages its services. The Third, Community and Independent Sectors play an important role in supporting the delivery of this strategy. In South Ayrshire, there has been significant strengthening of the valuable role of these sectors and there is a positive relationship in place which provides a solid foundation for future work. At the strategic level, Voluntary Action South Ayrshire (VASA) plays a key interface role in ensuring that 3rd Sector organisations are part of the strategic planning process. Similarly, arrangements are in place to ensure Independent Care Providers are engaged. A Providers' Forum has been formed to engender good engagement and to discuss how future services and support could be best commissioned.

The strategy will inevitably affect clinical and care pathways that lead to and from general and psychiatric inpatient services. The North Ayrshire Health and Social Care Partnership is the Lead Partnership for Mental Health Services and as such operationally manage all in-patient Mental Health Services, some pan Ayrshire community services such as Liaison Psychiatry and the Crisis Service as well as Child and Adolescent Mental Health Services and Psychology. Although these services are not within the scope of this strategy, the South Ayrshire Partnership will contribute to their development on behalf of the people of South Ayrshire.

This Strategy is closely linked with The South Ayrshire Alcohol and Drug Partnership's (ADP) Alcohol and Drug Strategy http://www.south-ayrshire.gov.uk/adp/reports.aspx. The South Ayrshire Alcohol and Drug Partnership strategic approach recognises that factors such as socio-economic circumstances and other existing lifestyle risk factors and health conditions have a role to play in determining the harm resulting from alcohol and drug misuse. The strategic approach is considered in the context of national and local strategies which are focused on addressing these issues.

Population Needs

The findings from the Epidemiological Mental Health Needs Assessment for Ayrshire and Arran informed this strategy (an epidemiological approach measures directly the incidence of diseases and the prevalence of risk factors). Wider literature estimates that 15% of the Scottish population experience common mental health problems. The distribution of mental wellbeing and mental health problems across the population of Scotland is unequal. GP presentations and episodes of psychiatric and learning disability inpatient care are higher among those living in the most deprived areas. Alcohol and drug related harm and suicide are also higher in deprived areas.

Reviewing the national survey data and primary and secondary health care data the report concluded:

- NHS Ayrshire & Arran has significantly lower levels of wellbeing than Scotland and higher levels of potential psychiatric illness.
- Local analysis of primary care data suggests an upward trend in numbers of people recorded with dementia, new diagnosis of depression, and severe and enduring mental illness over time. This may in part be due to changes in coding over time, but was a consistent finding.
- Local analysis found that people with common mental health problems had relatively high levels of recorded physical illnesses.
- Over the period 2011-2015, there was an increase in the number of people admitted to a general hospital with a mental health diagnosis. In South Ayrshire, this was in large part a consequence of increased care episodes among older patients.
- Over the last five years, local rates of psychiatric hospital admission fell substantially.
- Further work is needed to establish the reasons for these changes in admission trends.
- Despite high levels of reported mental illness, South Ayrshire has one of the lowest rates of completed suicide in Scotland. Historically, Scotland has a higher rate of suicide than other countries within the UK.
- Drug deaths have increased in Ayrshire and Arran, and more widely across Scotland, over the last decade among both males and females.
- Alcohol deaths are more numerous than drug deaths. They have declined in recent years, but remain at relatively high levels compared to the 1980s.

Further information on the mental health needs of the South Ayrshire population is set out at Appendix 2.

Available Resources

The most significant challenge going forward will be the need to make considerable savings in what we spend on services while the significant demand them is maintained.

The following summarises total spend on Adult Community Mental Health Services in South Ayrshire for the last three years:

£000's	2014-15	2015-16	2016-17
Community Mental Health Teams			
SAC	3,362	3,336	3,362
Health	2,181	2,356	2,565
Total Budget	5,543	5,692	5,927
Addictions			
SAC	957	863	868
Health	772	853	856
Total Budget	1,729	1,716	1,724
Combined Budget			
SAC	4,319	4,199	4,230
Health	2,953	3,209	3,421
Total Budget	**7,272**	**7,408**	**7,651**

Some examples of issues that will put pressure on the provision of Adult Community Mental Health Services include:

- Increasing demand for and expectation of services.
- Implementation of the living wage increases.
- Recent judgement in relation to sleepover payments.
- Cost of prescription drugs.

We need to develop models of intervention and service provision which are increasingly cost effective and efficient. Early intervention will be the keystone of our approach and we will endeavour to maximise choice and control for people with mental health issues. However, we have a responsibility to be clear that because of changing and in some cases increasing needs, together with the scale of financial challenges faced, this will lead to a significant shift in what people can expect. This means people being supported to a greater degree within the community and our emphasis will be on working in partnership with communities in relation to how this shift can be achieved and supported.

Developing the Strategy

We have based this strategy on evidence that we gathered in several ways:

- engagement events for people with mental health issues and their families and carers;
- staff surveys for managers and frontline workers across the health, social care and the Third and Independent Sectors;
- interviews with the leads of the strategy sub-groups established as part of the exercise to develop this new document:
    - Choice, control, safety, and carers.
    - Co-ordinated flexible tailored provision.
    - Prevention, recovery, and reducing stigma.
    - Performance Management;
- through the summary of strategies and policies (see Appendix 1) that direct how our services should work; and
- through additional consultation and engagement with service users, carers, families, provider organisations; Health and Social Care Partnership managers, clinicians and staff; Trades Unions and NHS staff-side; General Practitioners' Stakeholder Group; the Strategic Planning Advisory Group; South Ayrshire Adult Mental Health Providers' Forum; Locality Planning Groups and the Integration Joint Board.

Strategic Outcomes and Implementation Plan

The methods that are adopted and commissioned by individuals, communities, and professionals in South Ayrshire under the provisions of this Strategy will be in line with the following Strategic outcomes:

1. Flexible, Tailored Provision and Coordinated Approaches

I want services that are accessible.

I want a wide set of options for my care and support to be available, including clinical and non-clinical interventions.

I want services to be consistent.

Service design will take note of the current and projected mental health needs of the population of South Ayrshire (see Appendix 2).

To deliver maximum benefit to the people of South Ayrshire, coordination of activity and approaches to service delivery and wider wellbeing are essential, for instance in addressing the effects of housing needs, under employment, poverty, and the interaction between statutory, independent and third sector services throughout the Partnership area.

While this strategy does not include services other than those specifically related to Adult Community Mental Health, the effects of previous interaction e.g. with children's services will be considered when planning transition between services.

What We have Achieved

- Partnership working with GPs in Maybole to provide earlier mental health assessment to determine need for onward referral into specialist services.
- Income Maximisation.
- Employment Support – roll out of Individual Placement Support (IPS) Project.
- Introduction of Community Link Practitioner role within Primary Care.
- Improved joint working both within the Mental Health Teams via Senior Managers Meeting and Statutory and Third Sector with inclusion of the Older Adults Mental Health Team Leader in wider Service Hub Meetings

Strategic Focus

1. Services will be designed, commissioned, and delivered in a way that meets the identified needs of individuals.
2. Service design will be based on the needs and demands expressed locally, in a way that takes account of differences between localities.
3. Embed recognition that mental health and wellbeing are connected to services provided elsewhere, e.g. housing, education and employment support and develop links with these

services, as well as supporting individuals to engage effectively with support that may be of benefit to them.

4. Evaluate links between Mental Health needs and inequality, e.g. income maximisation, employment support, etc.
5. Ensure effective links between Community Mental Health Services, Primary Care, and wider supports in pursuit of general wellbeing.
6. Links will be made between services to ensure that transitions are well planned and managed.
7. People will be supported and be fully involved at periods of transition across all Mental Health Services.

Case Study of Coordinated Approaches in South Ayrshire

What was the situation?

Colin went to his GP reporting a real crisis in his mental health. His GP referred him on to a Community Mental Health Nurse (CMHN). He lived with anxiety and depression and other physical health conditions, had a poor private housing situation (with no heating) and 5 months of rent arrears. Colin was unemployed and had made attempts to attend the Job Centre, but his anxiety prevented him getting through the door. Eventually this led to him losing all entitlement to benefits.

Colin's CMHN referred him on to a local Community Link Practitioner (CLP) because he thought many of Colin's mental health issues were the result of other life circumstances that needed to be addressed.

How was he supported?

The CLP provided a range of practical support for Colin including assisting him access a crisis grant to allow him to buy gas and electricity, referring him to a foodbank and enabling Colin to apply for appropriate benefits (included back dated ones).

Colin was further supported by the CLP and his own family to apply for housing benefit (also back dated) and a rebate payment from his bank.

He was also encouraged to use Living Life, an on-line Cognitive Behavioural Therapy Service. This proved positive for Colin and he now engages with this on a weekly basis.

What have been the outcomes for Colin?

Colin was able to pay his landlord and sustain his tenancy. He hasn't felt ready yet to try to secure employment but, to increase his self-confidence, he has secured a volunteer role with a local charity. He volunteers 2-3 days per week.

He feels more stable, more in control of his life and values being able to help others. He knows that he is only a part of the way on a journey but feels he has the right level of support to enable him to continue to grow.

Outcome:	Flexible Tailored Co-ordinated Provision	Sub Group Lead:	Carol Fisher
Strategic Focus:	1. Services will be designed, commissioned, and delivered in a way that meets the identified needs of individuals. 2. Service design will be based on the needs and demands expressed locally in a way that is proportionate and takes account of differences between localities. 3. Embed recognition that mental health and wellbeing are connected to services provided elsewhere, e.g. housing, education and employment support and develop links with these services, as well as supporting individuals to engage effectively with support that may be of benefit to them. 4. Whenever possible provide training and development opportunities that are multi-disciplinary to improve learning and understanding between services 5. Evaluate links between Mental Health needs and inequality, e.g. income maximisation, employment support, etc. 6. Ensure effective links between Community Mental Health Services, Primary Care, Housing, and wider supports in pursuit of general wellbeing. 7. Links will be made between services to ensure that all transitions are well planned and managed whether due to age, change of needs or health. 8. People will be supported and be fully involved at periods of transition across all Mental Health Services.		

The Strategy Objectives will be delivered through the completion of the following measurable tasks:

Strategic Focus Number	Action	Responsible Officer	Target Date(s)	National Outcomes Delivered	Funding Source
1	Current services, population needs and demand information will be analysed to provide the basis for evidence based commissioning.	Senior Manager Planning and	30 June 2017	Resources are used effectively and efficiently in the provision of health and	HSCP Integrated

Strategic Focus Number	Action	Responsible Officer	Target Date(s)	National Outcomes Delivered	Funding Source
		Performance		social care services.	Budget
2 + 5	A collaborative commissioning approach will be developed and implemented by the Partnership, providers, people who use services and their carers.	Senior Manager Planning and Performance	31 Oct 2017	Resources are used effectively and efficiently and are centred on helping to maintain or improve the quality of life of those who use those services.	HSCP Integrated Budget and Provider Orgs
5	Access to Income Maximisation and Employment support will be prioritised for people with mental illness	Team Leader SW	Ongoing review progress on a 6-monthly basis	People are able to look after and improve their own health and wellbeing and live in good health for longer; Health and social care services are centred on helping to improve the quality of life of people who use those services; Health and social care services contribute to reducing health inequalities.	HSCP Integrated Budget
2	Progress with the development and implementation of locality based models to meet mental health and wellbeing needs within communities. Support GPs with alternatives, for example, anti-	Senior Manager MHS	31 Mar 2018 and annual review to	People are able to look after and improve their own health and wellbeing and live in	HSCP Integrated

Strategic Focus Number	Action	Responsible Officer	Target Date(s)	National Outcomes Delivered	Funding Source
	depressant prescribing.		2022	good health for longer; People including those with disabilities or long term conditions or who are frail are able to live as far as reasonably practicable independently.	Budget
1 + 2	Review the MHO structure and process within the partnership to the needs identified in localities.	Head of Community Health and Care Services	30 Sept 2017	People who use health and social care services have positive experiences of those services and have their dignity respected; People who use health and social care services are safe from harm.	HSCP Integrated Budget
5 + 6	Complete the integration of Adult Community Mental Health Teams in South Ayrshire.	Senior Manager MHS	31 Mar 2019	People who work in health and social care feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	HSCP Integrated Budget

Strategic Focus Number	Action	Responsible Officer	Target Date(s)	National Outcomes Delivered	Funding Source
				Resources are used effectively and efficiently in the provision of health and social care services.	
6	Collaborate with Pan Ayrshire Inpatient services and community services within East and North Ayrshire to ensure effective communication and pathways for patients.	Senior Manager MHS	Ongoing review progress on a 6-monthly basis	People who work in health and social care feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide; Resources are used effectively and efficiently in the provision or health and social care services	HSCP Integrated Budget
6 + 7 + 8	Improve the multi-agency transition processes between all mental health services to ensure continuity of service.	Service Manager, MHS	30 September 2018	Improve health & wellbeing; Positive experiences of services; Support unpaid carers; Effective resource use.	H&SCP Integrated budget. Staffing for review
8	Develop and implement transition guidelines that ensure communications between services is effective	Service	30 September	Improve health & wellbeing; Positive experiences of	HSCP Integrated

Strategic Focus Number	Action	Responsible Officer	Target Date(s)	National Outcomes Delivered	Funding Source
	and people with mental health problems and their family and carers are well informed.	Manager MHS	2018	services; Support unpaid carers; Effective resource use.	Budget
7 + 8	Provide SDS Information at each transition stage to promote opportunities for choice and control and to improve how people interact with service provision.	Team Leader, SW	Ongoing review progress on a six-monthly basis	Improve health & wellbeing; People are safe from harm; and Effective resource use.	H&SCP Integrated budget
1 + 5	Commission a new service which meets the on-going needs of the individuals currently located within the Lochranza Ward at Ailsa Hospital	Snr Manager MHS	31 March 2018	Improve health & wellbeing; People are safe from harm; and Effective resource use.	NHS Ayrshire & Arran HSCP Integrated Budget Provider(s)

2. Prevention

I want information about all the things that might support my mental health to be available.

I want people to value the strengths and assets that I bring to my own care and offer opportunities to nurture and develop these.

The theme of prevention and independence from formal service delivery is consistent with the direction of national and local policy. The benefits to individuals are clear, enabling people, where possible, to retain independence from service interventions. Likewise, there are clear benefits in minimising unnecessary contact for pressured services. Preventative work in a mental health context recognises the importance of wellbeing and promotion of good physical and mental health.

What we have achieved

- Implementation of Staying Well Group which provides education and assistance in completing Staying Well Plans and promotes self-management.
- Physical health monitoring for patients prescribed Neuroleptic medication to support those with dual mental and physical health issues to stay as healthy as possible.
- Activity Groups: walking, badminton, art groups - to support those with mental ill health to stay active and healthy.
- Treatment option such as Mindfulness, Behavioural Activation, Behavioural Family Therapy
- Peer Volunteers and Carers Groups to allow those with mental health or wellbeing issues to select from a range of options in order to find the one that might suit them best.
- Attending local education establishments open days to promote mental health and wellbeing and reduce stigma, thus increasing the likelihood of early treatment or support.
- Choose Life suicide prevention sessions for the Fire Service to give the wider public sector organisations, likely to meet people with mental health issues, an awareness of the signs of mental ill health and reduce the stigma of mental health.
- Community Links Practitioners helping people to re-engage in local community groups and encourage meaningful activity.
- Regular contact with Third Sector agencies to secure volunteering opportunities for clients.
- Occupational Therapists have a clinic in the Department of Work and Pension (DWP) aiming for early intervention and prevention of further mental health difficulties.
- The use of informal groups in both Girvan and Troon that allow for peer support, low level monitoring of relapse and attendance of other services such as Income Maximiser, Nursing Staff, when necessary, for advice and guidance.

Strategic Focus

1. Services will be coordinated in ways that take account of preventative activity, and promote the strengths of individuals and communities and potential parallels with emerging work in Learning Disability Services.
2. Support will be based primarily on supporting the health and wellbeing of people, rather than on clinical interventions to address a condition.
3. Services will improve the physical health of people with mental health problems and improve the mental health of those with physical health problems.

Case Study of Prevention in South Ayrshire

What was the situation?

Four people with a variety of complex mental health issues and learning disability have been living in a block of flats owned by their care provider for many years. They receive individual support and each have a good sense of independence. They did not share any facilities but are comfortable together, they are however getting older and frailer and the block contains steep stairs.

Further, the care provider has indicated they need to carry out extensive renovations to the block which could result in the residents being out of the building for several months while this work takes place.

How were they Supported?

Consideration was given about long and term short term options regarding this group of people. It was agreed that a temporary housing solution for several months was important to prevent anxiety and reduce the risk of relapse. This would need to be a carefully planned piece of work. As a consequence, Advocacy Services were requested to make sure the views of the tenants were taken into consideration.

A meeting was held with the landlord/care provider, housing, and social work services from the Partnership and Advocacy Services to plan this temporary accommodation.

It became apparent however that a longer-term solution might be available. New build houses were being built locally in the area close to where they currently lived and it was possible they would be suitable as permanent moves.

This seemed an exceptional opportunity but it had to be dealt with sensitively and with the rights of the residents to say no in mind. Advocacy and the support team allowed them to visit the tenancies before they were completed on several occasions and just after completion. Following some obviously hard thinking they agreed to the move. The support was increased as the time of the move arrived and will continue to be in place for a short time afterwards.

What have the outcomes been for them?

This has meant the tenants will not have to move again due to physical frailties. They have a new home and are aware this is permanent and feel secure in their tenancy. It has prevented any admissions to hospital due to anxiety in the short term and potential difficulties due to physical health problems in the longer term. All the houses are individual tenancies on a ground floor.

It has prevented the need for the residents to move far away due to availability of accommodation and the need for them to risk losing the support and carers they have known for quite some time.

By working together in a multi-disciplinary team, we have prevented this temporary move from becoming a significant stressor and ultimately turned it into a very positive outcome for those who may have initially seen this as a real area of concern.

Outcome:	Prevention	Sub Group Lead:	Liz Ferries/Lynn Seaton
Strategic Focus:	**1.** Services will be coordinated in ways that take account of preventative activity, and promote the strengths of individuals and communities and potential parallels with emerging work in Learning Disability Services. **2.** Support will be based primarily on supporting the health and wellbeing of people, rather than on clinical interventions to address a condition. **3.** Services will improve the physical health of people with mental health problems and improve the mental health of those with physical health problems.		

The Strategy Objectives will be delivered through the completion of the following measurable tasks:

Strategic Focus Number	Action	Responsible Officer	Target Date(s)	National Outcomes Delivered	Funding Source
1 +2	Promote self-management by working in collaboration to complete Staying Well Plans, care plans and encouraging self-referral to voluntary and third sector supports.	Service Manager MHS	Ongoing review progress on a six-monthly basis	People are able to look after and improve their own health and wellbeing and live in good health for longer; people who use health and social care services have positive experiences of those services, and have their dignity respected.	HSCP Integrated Budget
2	Test new models of service delivery within the Primary Care setting including Anticipatory Care Planning, Community Link Practitioner, and Practice base triage.	Service Manager MHS	Ongoing review progress on	People who use health and social care services have positive	HSCP Integrated Budget

Strategic Focus Number	Action	Responsible Officer	Target Date(s)	National Outcomes Delivered	Funding Source
			a six-monthly basis	experiences of those services, and have their dignity respected; Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services;	
1 + 2	A strengths-based, collaborative plan will be produced, that reflects the person, meeting their identified support needs.	Service Manager MHS	Ongoing review progress on a six-monthly basis	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services; Resources are used effectively and efficiently in the provision of health and social care services.	HSCP Integrated Budget
1 + 3	Work in partnership with Public Health to provide information and advice in localities to promote good mental health and wellbeing and to promote early intervention when required.	Senior Manager MHS	31 March 2018 and annually to 2022	People are able to look after and improve their own health and wellbeing and live in good health for longer	HSCP Integrated Budget NHS Ayrshire

Strategic Focus Number	Action	Responsible Officer	Target Date(s)	National Outcomes Delivered	Funding Source
				Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	and Arran
1	Embed the Community Link Practitioner model throughout South Ayrshire to promote mental health and wellbeing and assist with referral to the appropriate services and support available.	Senior Manager MHS	Ongoing review progress on a six-monthly basis	Health and social care services contribute to reducing health inequalities; Resources are used effectively and efficiently in the provision of health and social care services.	HSCP Integrated Budget Primary Care Transformation Fund

3. Recovery

I want to <u>really</u> be listened to and with sufficient time to talk about my experience.

I want opportunities to support and learn from others who are going through similar experiences

We will promote services which support people to maximise their independence and quality of life and which are consistent with the principles of recovery (see http://www.sri2.net/). The approach to recovery is supported through many of the strategic outcomes described in this strategy (e.g. choice, control, social interactions, and the role of carers) as well as those considered elsewhere e.g. by the Alcohol and Drugs Partnership.

What We have Achieved

- Partnership working to access Wellness Recovery Action Plan (WRAP) in the community, established Staying Well Groups and use of Staying Well Plans within Community Mental Health Team. These approaches embody the experience of the person, retaining control over everyday life. Encouraging recognition of when specialist mental health services are needed and accessing on a self-referral basis.
- Self-management classes for mood and anxiety where people learn from each other, sharing knowledge and skill in coping with experiences and supporting others in the process.
- Development of Community Link Practitioner service which supports Primary Care services by listening carefully to people, their experience, strengths, and aspirations. Encourage use of community resources to re-connect people back into their local communities, staying socially connected.
- Carers Group and Staying Well Group
- Physical Health Clinics
- Regular contact with the Community Learning and Development Team in each of the areas for opportunities for clients.
- Use of the Canadian Occupational Performance Measure which covers assessment of all areas of person's life and their interaction with the community, therefore identifying occupational goals and informing treatment.
- Recovery Groups such as Café Hope, Carers Group and Activity groups
- Peer volunteers
- Links with Ayrshire College
- Working together with patients sharing Care Plans and providing treatment options

Strategic Focus

1. Services will be based on the principles of recovery and recognise that clinical intervention is usually only necessary for a time-limited period in a person's life.
2. Crisis situations will be examined and managed with a focus on recovery planning, rather than reactive intervention.

3. Links will be made with services such as those considered by the Alcohol and Drug Strategy to support people to build on their strengths and reduce substance misuse.

Case Study of Recovery in South Ayrshire

What was the situation?

Emma is a Graphic Designer who has lived and worked in Glasgow for around 20 years. She struggled to cope with the fast-paced studio environment and in 2008 left her post due to stress. Her health continued to decline.

She lost contact from her friends and lost confidence as a result.

How was she supported?

About a year ago, Emma, through her contact with the Community Mental Health Team, was introduced to an Individual Placement and Support Worker who worked in Mental Health Services and in the Job Centre).

After building up a good, trusting relationship, the Worker encouraged Emma to develop her woodprint design work that she had been developing as a hobby (she also knew that Emma's background was in design). She planted a seed that this work could form the basis of a business.

The Worker then enabled Emma to access the DWP Flexible Support Fund to pay for Advanced Photoshop training, linking in to 2 local employers who agreed to exhibit her work and a local printing company. She also assisted Emma to set up a Facebook page and then supported Emma to develop a business plan. Ultimately this led to the development of a business web-site.

What were the outcomes for Emma?

When she launched her own web-site, Emma was extremely proud of the progress she had made.

She is now beginning to deliver design work for local companies.

She is grateful for the practical and emotional support she received from the Worker who, she reflects, gave her the motivation and encouragement to begin to use her talents again in a very positive way.

Outcome:	Recovery	Sub Group Lead:	Liz Ferries/Lynn Seaton
Strategic Focus:	1. Services will be based on the principles of recovery and recognise that clinical intervention is usually only necessary for a time-limited period in a person's life. 2. Crisis situations will be examined and managed with a focus on recovery planning, rather than reactive intervention. 3. Links will be made with services such as those considered by the Alcohol and Drug Strategy to support people to build on their strengths and reduce substance misuse.		

The Strategy Objectives will be delivered through the completion of the following measurable tasks:

Strategic Focus Number	Action	Responsible Officer	Target Date(s)	National Outcomes Delivered	Funding Source
1	Promote Resilience and self-management by, for example, the use of technology: i.e. web based supports and apps to enable care, promote resilience and self-management.	Service Manager MHS	Ongoing review progress on a six-monthly basis	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community; Resources are used effectively and efficiently in the provision of health and social care services.	TEC Budget HSCP Integrated Budget
1	All treatment is based on the achievement of optimum recovery for everyone.	Service	Ongoing review	People are able to look after and improve their own	HSCP Integrated

Strategic Focus Number	Action	Responsible Officer	Target Date(s)	National Outcomes Delivered	Funding Source
		Manager MHS	progress on a six-monthly basis	health and wellbeing and live in good health for longer; Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	Budget
3	Promote Individual Placement Support to create opportunities for paid employment tailored to individual outcomes.	Lead Occupational Therapist	Ongoing review progress on a six-monthly basis	People who use health and social care services have positive experiences of those services, and have their dignity respected; Health and social care service are centred on helping to maintain or improve the quality of life of people who use those services.	HSCP Integrated Budget Specific Grant Funding for this purpose
1 + 2 + 3	Encourage the use of peer support work that recognises the strengths and experiences of those in recovery from mental health and addiction issues.	Service Manager MHS	Ongoing review progress on a six-monthly	People are able to look after and improve their own health and wellbeing and live in good health for longer; Health and social	HSCP Integrated Budget ADP

Strategic Focus Number	Action	Responsible Officer	Target Date(s)	National Outcomes Delivered	Funding Source
			basis	care services are centred on helping to maintain or improve the quality of life of people who use those services.	Budget
2 + 3	Promote and increase participation in addiction recovery communities, RecoveryAyr, Cafe Hope, CareNShare.	Service Manager MHS	Ongoing review progress on a six-monthly basis.	People who use health and social care services have positive experiences of those services, and have their dignity respected; Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	HSCP Integrated Budget
1	Provide education and support to carers of those experiencing Mental Health issues, working with specialist carer groups and locality based carer support groups.	Service Manager MHS	Ongoing review progress on a six-monthly basis.	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.	HSCP Integrated Budget

4. Addressing Social Stigma

I want people to respect and communicate with me as an individual and not label me.

I want people to respect my rights, especially where fear or ignorance undermines their views.

Many people's problems are made worse by the stigma and discrimination they experience. Stigma and discrimination can also lead to a delay in getting help, treatment, and recovery. People with mental health problems are among the least likely of any group with a long-term health condition or disability to find work, stable relationships, decent housing, or general inclusion in society. Social isolation, poor housing, unemployment, and poverty are all linked to mental ill health – generating a cycle of illness. See Me is Scotland's programme to tackle mental health stigma and discrimination. Its focus is to enable people who experience mental health problems to live fulfilled lives. The goals of this project are fully endorsed by the South Ayrshire Health and Social Care Partnership. For further information regarding See Me click on the following link. https://www.seemescotland.org/&https://www.seemescotland.org/our-movement-for-change/power-of-okay/

What we have achieved

- Making Positive Connections and Addictions Training for all addictions service staff to give them the skills and awareness to support people in recovery from addictions
- Peer volunteers who are able to empathetically understand the experiences of the person.
- Individual Placement Support and Vocational Rehabilitation to support people in recovery from addiction issues in terms of confidence and opportunities for employment and other mainstream services.
- Mental Health staff involved in each of the Locality Planning Groups providing information to widen the local understanding of mental health in each area.
- Links with Education to increase understanding and reduce stigma of mental ill health sooner thus giving a better chance of early intervention and prevention.
- Participation in the Self-Management Groups has led to people challenging perceptions about mental health both within families and the wider communities.

Strategic Focus

1. Recognise and acknowledge the stigma faced by people with mental health issues.
2. Take steps to minimise the stigmatisation of those with mental health needs by their communities and society through effective communication and awareness raising.
3. Minimise the potential for social stigma associated with mental health issues, including all aspects of substance misuse and related harms and negative health outcomes including Blood Borne Viruses and Sexual Health.
4. Develop a commissioning strategy that focuses on services within people's communities and that recognises that input and support is best provided when outcomes are focused and time limited.
5. The development of supported accommodation models that meet the needs of those with mental ill health and which are orientated to a community based recovery.

Case Study on Addressing Social Stigma in South Ayrshire

What was the situation?

Julie is in her mid-40s and suffers from mental ill-health which means when she is unwell, her symptoms can be problematic. She lives in a rural part of South Carrick.

How was she supported?

In her small village, when Julie's behaviour is erratic or challenging, the local shop-keeper (there is only 1 shop) knows Julie's situation and can offer reassurance and a friendly conversation. Because of the good relationship, the shop-keeper has also enabled Julie to volunteer at the village church lunch club for older people.

What have been the outcomes for Julie?

Julie feels part of her community. She feels like a person who belongs to her village and respected for who she is. Because of Julie's volunteering, people in the village will often greet her in the street and give her a smile or a wave.

Outcome:	Addressing Social Stigma	Sub Group Lead:	Liz Ferries/Lynn Seaton
Strategic Focus	1. Recognise and acknowledge the stigma faced by people with Mental Health issues. 2. Take steps to minimise the stigmatisation of those with mental health needs by their communities and society through effective communication and awareness raising. 3. Minimise the potential for social stigma associated with mental health issues including all aspects of substance misuse and related harms and negative health outcomes including Blood Borne Viruses and Sexual Health.		

The Strategy Objectives will be delivered through the completion of the following measurable tasks:

Strategic Focus Number	Action	Responsible Officer	Target Date(s)	National Outcomes Delivered	Funding Source
1 + 2	Work in partnership with Locality Planning Groups to reduce social stigma of those experiencing mental health issues, to increase understanding of mental illness.	Senior Manager MHS	Ongoing review progress on a six-monthly basis	People who use health and social care services have positive experiences of those services, and have their dignity respected; Health and Social Care services are centred on helping to maintain or improve the quality of life of people who use those services.	HSCP Integrated Budget Participatory Budgeting
2 + 3	Provide training and education to staff and services within communities such as Making Positive Connections, Choose Life, Basic Drug Awareness and	Service Manager MHS	Ongoing review	People who use health and social care services have	HSCP Integrated

Strategic Focus Number	Action	Responsible Officer	Target Date(s)	National Outcomes Delivered	Funding Source
	Mental Health and Substance Use.		progress on a six-monthly basis	positive experience of those services, and have their dignity respected; Health and Social Care services are centred on helping to maintain or improve the quality of life of people who use those services.	Budget
5	Develop, in conjunction with colleagues in housing and homelessness, models of supported accommodation that are sustainable, affordable, and safe for those with mental ill health visibly within local communities.	Team Leader SW Housing Department Homeless Section		People who use health and social care services have positive experience of those services, and have their dignity respected; Health and Social Care services are centred on helping to maintain or improve the quality of life of people who use those services.	

5. Choice and Control

I want to have as much choice and control over my life as possible.

The Partnership will aim to ensure that people with mental health needs can exercise choice and control at every appropriate opportunity.

What We have Achieved

- We have taken steps to roll out Self-Directed Support and a range of self-management initiatives.
- We have supported the development of Locality Planning Groups with a focus on choices being made and control being taken at a local level.
- Our overall approach to choice and control has been in line with the HSCP Vision Statement of 'Working Together for the best possible health and wellbeing of our communities'.
- Access to designated Community Practice Nursing to provide specialised support for all diagnosed with dementia under 65. This includes additional training on SDS to increase support options for family and clients.

Strategic Focus

1. People who come into contact with Mental Health Services will be supported to take choice and appropriate control of their lives.
2. Opportunity will be provided for people to choose how they interact with services with a focus on prevention and recovery themes.
3. Self-Directed Support (Options 1 and 2) will be promoted and encouraged as a vehicle for people to make choices and to take control of service provision they may require.
4. Independent services such as Advocacy will be made available to people to support them to make choices and take control of their lives.
5. Technology Enabled Care (TEC) will be utilised to support people to manage their own health and wellbeing.
6. Service delivery across Mental Health Services will promote choice and control as part of a journey towards recovery and good health and wellbeing.
7. Clients will be supported to have good physical health alongside their treatment and recovery from mental ill-health. Services will support people to access health improvement services such as smoking cessation, weight management and promoting physical activity.

Case Study of Choice and Control in South Ayrshire

What was the situation?

Jimmy is 47 and suffers from very poor mental health which, recently, has been deteriorating. He was not washing, dressing, or engaging with services. This was concerning to his social worker and community mental health nurse. After a review of his care and support needs it was clear that he was feeling fed up of attending the same venues weekly and did not have the confidence to tell the staff he was not gaining any benefit from his social supports. He was stressed and unsure how to deal with his frustration and was in danger of being readmitted to hospital. He was really scared of this happening. Notwithstanding ongoing input from various professionals and a traditional support service, his personal outcomes remained unmet. His mental health was suffering, as was his physical health, and the combined inputs from his various social supports resulted in his personal outcomes being unmet.

How was he supported?

Jimmy's Social Worker discussed options through Self-Directed Support (SDS) which included using an individual service fund. This allowed Jimmy to begin to attend football matches, initially with support, and then, when he was confident, to join the supports club. He then joined a local darts team. His final aspiration was to find a job and through some support he managed to secure this.

What were the outcomes for Jimmy?

Jimmy is now independent of services. He now has purpose in life, a job, and friends who he relates to. He is active, feels independent, confident and offered respect.

Outcome:	Choice / Control	Sub Group Lead:	Steven Kelly
Strategic Focus:	1. People who come into contact with Mental Health Services will be supported to take appropriate control of their lives and have choice in how they are supported 2. Opportunity will be provided for people to choose how they interact with services with a focus on prevention and recovery themes. 3. Self-Directed Support (Options 1 and 2) will be promoted and encouraged as a vehicle for people to make choices and to take control of service provision they may require. 4. Independent services such as Advocacy will be made available to people to support them to make choices and take control of their lives. 5. Technology Enabled Care (TEC) will be utilised to support people to manage their own health and wellbeing. 6. People will be supported to have good physical health alongside their treatment and recovery from mental ill-health.		

The Strategy Objectives will be delivered through the completion of the following measurable tasks:

Strategic Focus Number	Action	Responsible Officer	Target Date(s)	National Outcomes Delivered	Funding Source
1 + 3 3	Increase opportunities for people with a mental health problem and their families and carers to access Self-Directed Support (SDS): We will achieve this by identifying people currently in receipt of services across the partnership and set up locality engagement events to provide them with information on how to access SDS and demonstrate how it can provide them with more choice and control in their lives.	Team Leader SDS	30 June 2017	Maintain & improve quality of life; Support unpaid carers; Engaged workforce; Effective resource use.	H&SCP Integrated Budget
3	In line with our statutory responsibility, SDS will continue to be offered and explained at every new assessment	Head of Community	Ongoing review	Maintain & improve quality of life; Support unpaid	H&SCP Integrated

Strategic Focus Number	Action	Responsible Officer	Target Date(s)	National Outcomes Delivered	Funding Source
	and review to increase opportunities for individuals to have more choice and control. This will be evidenced by recording on both the statutory annual review and at every new assessment.	Health and Care Services	progress on a six-monthly basis	carers; and Engaged workforce.	Budget
3	Staff from Mental Health Services attend the SDS workforce development group. The group will develop an action plan to implement the strategic outcomes set out in the national SDS Implementation Plan 2016-2018.	Team Leader SDS	Ongoing review progress on a six-monthly basis	Positive experiences of services; Maintain & improve quality of life; People are safe from harm; and Effective resource use.	H&SCP Integrated Budget
1 + 2 + 4	Advocacy: • Ensure that advocacy services are available and offered to people with mental health problems in the community, hospital and residential establishments. The uptake of advocacy services will be monitored to support people with mental health problems and their families and carers to have independent support.	Team Leader, SW	Ongoing review progress on a six-monthly basis.	Improve health & wellbeing; Positive experiences of services; Support unpaid carers; and Effective resource use.	H&SCP integrated Budget
4	• Advocacy services will promote choice and control for people with mental health problems and their families including providing information and advice on access to SDS.	Contracts and Commissioning Co-ordinator	ongoing review progress on a six-monthly basis.	Improve health & wellbeing; Positive experiences of services; Support unpaid carers; and Effective resource use.	
	Service User Engagement:	Senior Manager,	28 February	Positive experiences of	H&SCP

Strategic Focus Number	Action	Responsible Officer	Target Date(s)	National Outcomes Delivered	Funding Source
1 + 2 2	• Review and improve current arrangements for engagement with people with mental health problems and their families who use services. • We will develop and run a service user and carer engagement forum that will meet quarterly. The purpose will be to gather feedback and engage with people experiencing mental health problems, their families and carers and keep them up-to-date on service developments	MHS	2018 – Annual review of progress until 2022.	services; Maintain & improve quality of life; and Support unpaid carers.	Integrated Budget
5 5 5	Telecare and Telehealth: • Improve awareness about the benefits of Telecare (TEC) to support people with mental health problems. This will be achieved by providing training and awareness sessions to all frontline staff by Telecare staff. • Increase number of TEC solutions and assessment carried out across all mental health services. Focus the increased uptake of TEC to support self-management, recovery and building resilience for people with mental health problems. • Implement the 'Florence' Beating the Blues programme using text based approach to support people with depression utilising Cognitive Behavioural Therapy.	Service Manager MHS Service Manager MHS LTC/TEC Lead	31 December 2017 Ongoing review progress on a six-monthly basis. 31 March 2018	Improve health & wellbeing; Live independently; and Effective resource use. Improve health & wellbeing: Live independently; and Effective resource use. Improving health & wellbeing: Live independently; and Effective resource use.	H&SCP Integrated Budget H&SCP Integrated Budget TEC Budget

6. Safety

I want my support to be personal and support me to feel safe, taking into account my overall situation.

The services delivered by and on behalf of the Partnership must be safe for people who use them and for the staff who work in them. A significant number of the referrals received regarding vulnerable people are for those considered to have mental ill health – this is a pattern reflected throughout Scotland. Maintaining the safety of vulnerable people with mental health problems is a fundamental role of the HSCP in promoting individual health and wellbeing. Promoting safety across Mental Health Services involves balancing statutory responsibilities and risk management with individual responsibility, choice, and control.

What we have achieved

- This approach is reflected in our assessment processes which address risk and safety. It is discussed with the person and their carers etc. with a focus on prevention and self-management.
- We have formal, robust adult support and protection processes in place with a focus on ensuring people are safe from harm and exploitation. We use a multi-disciplinary risk assessment and meet frequently to discuss those most at risk. Secure information sharing is central to the protection plans developed.
- The safety of people who receive and deliver services is monitored through audit leading to a process of continuous learning and service improvement.
- We have developed strong working relationships with colleagues in the Scottish Fire & Rescue Service, Police Scotland and other emergency and public services in order to promote safety and prevention of harm.
- There has been an ongoing process of awareness raising and publicity, by a variety of methods, of risks to vulnerable people via the resources of the Adult Protection Committee.
- A Pan Ayrshire Mental Health Crisis Nursing team work during the day and out of hours to support people at the time of crisis. This service works in preventing unnecessary hospital admissions and facilitating early discharge from hospital providing people in crisis with support in their own home.
- We have a CPN duty team who work from 9am until 7pm. The Duty Service responds to existing services users in crisis who cannot reach their lead professional, care co-ordinator or deputy, urgent referrals from GP's, Social workers and other services. Requests for urgent assessments, as required. Those agencies/individuals who require advice, support or input relating to an urgent matter pertaining to mental health.

Strategic Focus

1. Carry out regular audit to inform and continually improve our approach to Adult Support and Protection.
2. Promote the health, wellbeing and safety of all people accessing Mental Health Services.

3. Continue to strengthen the links with other agencies working with vulnerable people in our communities or other places such as hospitals or prisons to improve their opportunities on release or discharge.

A calendar of training focused on identifying risk, prevention, choice, and rights will be delivered within Mental Health Services.

Case Study of Safety in South Ayrshire

What was the situation?

Peter is a 26-year-old man who has Type 1 Diabetes, suffers from anxiety and depression, a diagnosis of border-line personality disorder and a history of drug misuse. He is currently on a Methadone programme. Peter was reluctant to engage with services and did not attend regular health checks regarding his Diabetes which resulted in him managing his condition poorly and regularly being admitted to hospital. Peter felt very lonely and unneeded. He had suffered the loss of his mother when he was only 8 years old and his relationship with his father was strained; he felt this caused his depression. Peter lived alone in a one-bedroom private let and sought company through people with similar drug misuse problems. It was clear the people who frequented Peter's home took advantage of him. Items, such as medication, money, and belongings, were going missing on a regular basis. When Peter was in the company of these people he would relapse, and participate in taking other drugs.

Through a Social Worker (Criminal Justice) linked into Peter's GP Practice, he was referred to the Practice's Community Link Practitioner.

How was he supported?

Through 1:1 meetings and phone calls, a trusting relationship was established. Peter talked about his past including his mother's death and his poor relationship with his father. Through this long-term relationship, step by step, Peter has begun to turn his life around.

What were the outcomes for Peter?

Peter attends appointments reliably that address his Diabetes. He has begun to attend the dentist who is sorting out his dental problems. He attends all his monthly court reviews and meets his Addiction Worker and Social Worker regularly. He remains on the Methadone program but takes no illegal substances.

He is now able to budget successfully and is saving money. He has secured a council flat in another area and, recently, his relationship with his father has improved significantly.

In a recent meeting with his Drugs Worker he has asked to be considered for a home detox programme to allow him to withdraw from the Methadone Programme. On his last court visit, the court decided to discontinue his monthly reviews.

He is now considering volunteering.

Outcome:	**Safety**	**Sub Group Lead:**	**Steven Kelly**
Strategic Focus:	1. Carry out regular audit to inform and continually improve our approach to Adult Support and Protection. 2. Promote the health, wellbeing and safety of all people accessing Mental Health Services. 3. Continue to strengthen the links with other agencies working with vulnerable people in our communities or other places such as hospitals or prisons to improve their opportunities on release or discharge.		

Strategic Focus Number	Action	Responsible Officer	Target Date(s)	National Outcomes Delivered	Funding Source
1	The Adult Support & Protection (ASP) Co-ordinator and Service Manager will develop an Audit Schedule, identifying key themes to be subject to audit each year.	Service Manager, MHS	June2017 and annually thereafter to 2022.	Improve health & wellbeing; People are safe from harm; and Effective resource use.	H&SCP Integrated Budget
1 + 2	Case file audits will be carried out regularly to monitor the assessment and management of risk and also highlight areas for continuous service improvement.	Service Manager MHS	Ongoing review progress on a six-monthly basis	Improve health & wellbeing; People are safe from harm; and Effective resource use.	H&SCP Integrated Budget

1	ASP training will be designed and delivered specifically for staff working in mental health services across the Partnership	Co-ordinator, ASP	commencing October 2017 and on a rolling programme every 12 months until 2023	Improve health & wellbeing; People are safe from harm; Effective resource use	H&SCP integrated budget
2	The ASP multi-agency training calendar offering a range of training to manage risk and protect people from harm will be accessible across the Partnership and meet identified training needs.	Co-ordinator, ASP	Ongoing review progress on a six-monthly basis.	Engaged workforce; and Effective resource use	H&SCP Integrated Budget
3	Improve communication links between health and social care services in hours and with those services which are available for people with mental health problems out of hours, such as Social Work OOH, NHS 24, and Mental Health Crisis Team.	Service Manager, MHS	30 September 2017	Improve health & wellbeing; People are safe from harm; and Effective resource use.	H&SCP Integrated Budget
2	Training and awareness sessions will be delivered across services with a particular focus on primary and secondary school staff. A flowchart with supporting documents will be developed and implemented across all Primary & Secondary School Staff in South Ayrshire to identify and provide a consistent response for people who are at risk of harm.	Choose Life Co-ordinator	30April 2018	Engaged workforce; and Effective resource use.	H&SCP Integrated Budget

7. Carers' Needs

I want to establish positive and productive relationships with those who offer me care and support.

We want to be involved in a more comprehensive way, respecting the person we care for's individual wishes, but seeing us as a significant provider of their support

Effective support for enduring caring relationships offers potential to address recovery, control, and choice. The Partnership will take steps to implement the requirements of the Carers (Scotland) Act 2016 over the coming year.

What we have achieved

- By working in partnership with the South Ayrshire Carers Centre a range of information, advice and support services for carers are now in place in the South Ayrshire. These include face to face interviews, telephone contact, peer group support, health interventions, financial inclusion, short breaks, respite provision for young carers and young adult carers.
- Carers' support is also provided by the Older People's Mental Health Team and a range of Independent and 3rd Sector providers offering guidance, reassurance and for their voice to be heard
- A Carers Group has been established within the Community Mental Health Team and is continuously providing professional and peer support
- A Family Support Group established within Addiction Services that supports people who have family affected by addiction issues. This offers peer and professional guidance for those supporting people with addiction issues.
- Carers are provided with support and information in terms of their rights as a carer as part of the Carers Assessment to support them with this demanding role.

Strategic Focus

1. Support for caring relationships and the wellbeing of carers themselves will be supported and enhanced.
2. Co-production of service interventions in ways which recognise carers needs and expertise.
3. Carers will be involved in identifying services that will meet outcomes as part of the approach to developing new commissioning plans.

Case Study of Carers' Needs and aspirations in South Ayrshire

What was the situation?

George is in his 30's and has a diagnosis of Schizophrenia; his family were finding it difficult to support him and didn't understand his symptoms or how to help him. The Community Mental Health Nurse involved in his care provided information about the Carers Group run by the Community Mental Health Team.

How were the family supported?

The family attended the Carers Group which is held in the evening where they met with other Carers supporting family members or friends with mental illness.

The group members discuss with the group facilitators what sessions they would like such as information about certain illnesses or symptoms, medication, treatment options, benefits etc. and the group facilitators arrange these.

They also have time to talk about their experiences and provide support to each other. The last group session introduces members to wider carer support groups such as those run by South Ayrshire Carers Centre.

Outcomes for George and his family?

George's family feel less helpless and more able to support George, understand his symptoms and are less worried about saying or doing the wrong thing. They recognise that George has not changed and this has helped George self-manage his symptoms and include his family in his care and treatment.

His family feel supported and listened to. They are more confident in dealing with his symptoms and know they are not alone in dealing with these kinds of difficulties.

Outcome:	Carers Needs and Aspirations	Sub Group Lead:	Steven Kelly
Strategic Focus:	1. Support for caring relationships and the wellbeing of carers themselves will be supported and enhanced. 2. Co-production of service interventions in ways which recognise carers needs and expertise. 3. Carers will be involved in identifying services that will meet outcomes as part of the approach to developing new commissioning plans.		

Strategic Focus Number	Action	Responsible Officer	Target Date(s)	National Outcomes Delivered	Funding Source
1 + 3	We will develop and implement a carers' support plan that is outcome focused and meets the requirements laid out in the Carers (Scotland) Act 2016.	Senior Manager, MHS	31 March 2018	Positive experiences of services; Support unpaid carers; and People are safe from harm.	H&SCP Integrated Budget
1	We will increase the number of carers assessments/support plans carried out with a clear focus on supporting informal carers to look after their own wellbeing.	Service Manager MHS	Ongoing review progress on a six-monthly basis	Positive experiences of services; Support unpaid carers; and People are safe from harm.	H&SCP Integrated Budget

2 + 3	Carers will be fully involved in future planning and contingency arrangements at every assessment and review and their view will be recorded within the individual's support plan.	Senior Manager MHS	On-going review progress on a six-monthly basis.	Positive experiences of services; Support unpaid carers; and People are safe from harm.	HSCP Integrated Budget
1	TEC solutions will be considered as part of a carers support plan to provide respite, reduce risks, and support them to continue in their caring role.	Service Manager MHS	Ongoing review progress on a six-monthly basis.	Positive experiences of services; Support unpaid carers; and People are safe from harm.	HSCP Integrated Budget
1 + 2 + 3	Implement provisions of The Carers Act 2016.	Partnership Facilitator	31 March 2018	Positive experiences of services; Support unpaid carers; and People are safe from harm.	HSCP Integrated Budget

What We Will Do Next

We will:

- Deliver the outcomes-based Implementation Plan for this Strategy;
- Link the Implementation Plan to available resources;
- Ensure action items are Specific, Measured, Achievable, Realistic, and Timed;
- Identify risks to achieving the Strategic Outcomes and propose mitigation measures;
- Establish a steering group with responsibility to manage the delivery of the Implementation Plan with representation from the respective partners, including provider organisations;
- Confirm the reporting structure to clarify individual responsibilities;
- Develop Commissioning Plans for all services to be provided;
- Put in place robust monitoring and reporting arrangements;
- Collect outcomes based evidence across all services;
- Review the Implementation Plan annually; and
- Consult with people with mental health issues and carers as part of the mid-term review process.

How We Will Know We Have Made a Difference

We will measure performance, both qualitatively and quantitatively, against the Strategic Outcomes we have set and report on this every 6 months to the Health and Social Care Partnership's Performance and Audit Committee. This information will be publicly available to all stakeholders through the Health and Social Care Partnership website:

http://www.south-ayrshire.gov.uk/health-social-care-partnership/

We will be able to evidence:

- Upward trend in the uptake of Self-Directed Support Options 1 and 2;
- Young adults and their families are satisfied with their experience of Transitions planning processes;
- Improved partnership processes to respond to Adult Support and Protection referrals;
- More people with mental health issues will be in employment that they value;
- Increase in the range of supported accommodation models and the number of accommodation units available for people with mental health issues in South Ayrshire;
- Improved satisfaction levels from people with mental health issues and their families and carers in terms of the range of services and options available for them to participate in community, educational, employment and leisure activities;
- Higher levels of engagement and involvement of people with mental health issues in service design and re-design; and
- New and more modern approaches to supporting people with mental health issues within communities and across sectors, for example increasing referral and service uptake from the main statutory services.

Our Performance Framework is set out at Appendix 3 and details the systematic and robust approach we will adopt to demonstrate delivery against the Strategic Outcomes. We have also included a Strategic Risk Analysis at Appendix 4 and a full Equality Impact Assessment at Appendix 5.

A full report on the outputs from the engagement events and the surveys that were undertaken to inform this Strategy is available in a supporting document on the Health and Social Care Partnership website.

Glossary

CAMHS	Child and Adolescent Mental Health Services
CMHN	Community Mental Health Nurse
COPRODUCTION	A way of working whereby citizens and decision makers, or people who use services, family carers and service providers work together to create a decision or service which works for them all. The approach is value driven and built on the principle that those who use a service are best placed to help design it
HSCP	Health and Social Care Partnership
INDEPENDENT SECTOR	Private sector care providers.
MHO	Mental Health Officer
Neuroleptic	Antipsychotics also known as neuroleptics or major tranquilizers are a class of medication primarily used to manage psychosis (including delusions, hallucinations, paranoia, or disordered thought), principally in schizophrenia and bipolar disorder
RAS	Resource Allocation System
SDS	Self-Directed Support
TEC	Technology Enabled Care
THIRD SECTOR	Third sector comprises community groups, voluntary organisations, charities, social enterprises, cooperatives, and individual volunteers.
TRANSITION	Change in service delivery arrangements as a result of moving between stages of life, typically from adolescence to adulthood