Addendum 1

IMPROVEMENT ACTION PLAN

This Improvement Action Plan is a 3 year working document and will be used to monitor progress against actions. Performance measures will be collated and developed to aid the monitoring progress. As such, this plan will be regularly amended and updated to reflect current progress and newly emerging priorities.

The plan prioritises the areas which require action and these actions and outcomes will be delivered through each of the working groups who will report back to the Angus Older People's Mental Health Improvement Group (AOPMHIG). The plan includes example actions and outcomes. We would particularly welcome your thoughts and ideas on what specific actions and outcomes should be included within the plan. You can return this plan to:

Please return by Friday 30 November 2018 to:-

Lorraine Dickson
Open Plan Office
Susan Carnegie Centre
Stracathro Hospital
Brechin DD9 7QA

Or e-mail to;

lorrainedickson1@nhs.net

Angus Older People's Mental Illness Action Plan
2019 – 2021

Local Priority Area	Intention/Actions	Outcome	Responsible Forum	Timescale
1. Improving knowledge and understanding of mental illness in older people	Older people with mental illness, their families/friends/carers will inform strategic plans in relation to Older people with mental illness through effective engagement.	Strategies and local plans will reflect the views of Older people with mental illness and their families/friends/carers.		
	Awareness raising with the general public using community events in different localities and liaising with national organisations.	Increased awareness and understanding within the general public.		
Local Priority Area	**Intention/Actions**	**Outcome**	**Responsible Forum**	**Timescale**
2. Timely diagnosis and accessible post diagnostic support and treatment	The pathway to diagnosis and post diagnosis support for dementia is clear, transparent and communicated effectively within localities.	People are aware of the support available and receive the right support, at the right time by the right person.		
	Access to support following diagnosis for people with functional illness is clear, transparent and communicated effectively within localities.	People are aware of the support available and receive the right support, at the right time by the right person.		

Local Priority Area	Intention/Actions	Outcome	Responsible Forum	Timescale
3. Support for older people, their families, carers and others involved in providing support	Self-Directed Support to be effectively implemented.	Individuals and their families/carers have greater choice and control over support arrangements on an on-going basis and at times of crisis.		
	Raise awareness within Older People's mental health services of the support available to Older people with mental illness, their families/friends/carers.	People know where to access services and support.		
Local Priority Area	**Intention/Actions**	**Outcome**	**Responsible Forum**	**Timescale**
4. Improved information sharing between agencies and professionals	A solution is identified regarding shared Information Technology systems across key agencies.	Improved access to required information, improved collaboration and less duplication of work and reduced risk of error.		
	Identify improvements to existing communication, information sharing and co-ordination.	Improved communication, co-ordination and information sharing between all services and agencies involved with an older person with mental illness and their families/friends/carers.		

Local Priority Area	Intention/Actions	Outcome	Responsible Forum	Timescale
5. Planning and support during periods of transition	Information regarding transition is communicated effectively with the older person with mental illness, their families/friends/carers and the transition process is effectively co-ordinated and managed.	People will understand what to expect and when, during any period of transition and the principles of good transition planning are implemented.		
	Provide information and education to professionals regarding good practice in transition and the principle of good transition planning.	Staff have a greater understanding of the important benefits of a well-planned and co-ordinated transition and are aware of the good practice principles and how to implement them.		
Local Priority Area	**Intention/Actions**	**Outcome**	**Responsible Forum**	**Timescale**
6. Promote recovery, enablement and physical and mental wellbeing	Provide information and education to professionals, users of services and their families/carers.	People will understand what is meant by recovery and enablement.		
	Provide information and education to professionals, users of services and their families/carers regarding the benefits physical activity can have to mental wellbeing.	People will understand the correlation between physical activity and mental wellbeing.		

Local Priority Area	Intention/Actions	Outcome	Responsible Forum	Timescale
7. Supporting older people to live independently	Existing care home provision in Angus adapts to meet the needs of people with complex presentations.	Appropriate support and accommodation is available to people with complex stress and distress presentation at the time that they need it.		
	Provide information and education regarding self-management of Older people with mental illness to the individual, their families/friends/carers and relevant professionals.	People will understand the correlation, benefits and importance of self-management and independence.		
Local Priority Area	**Intention/Actions**	**Outcome**	**Responsible Forum**	**Timescale**
8. Workforce	Support the work of the Integrated Workforce Plan.	Work towards resolving the workforce challenges identified in the Integrated Workforce Plan.		