**Greenwich Crisis Care Concordat Action Plan**

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| 1. **Commissioning to allow earlier intervention and responsive crisis services**
 |
| **No.** | **Concordat outcomes** | **Deliverables /Actions** | **who** | **By when** |
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| **Improved partnership working and matching local need with a suitable range of services** |
| **1** | Reduction in the use of urgent care pathways including emergency and urgent care services in Greenwich Improved responsiveness offered to people with a mental health problem in crisis by ensuring that patients have the right care at the right time | * Establish and Review protocols to ensure that a coordinated approach is offered across care pathways to patients who need mental health crisis support.
* Where someone presents with a mental health crisis, they are diverted to appropriate services for further advice, support and treatment
* Crisis services should also include people across the lifespan with autism, personality disorder, alcohol and substance misuse services, people who are homeless, have a learning disability and are in contact with the police and criminal justice system
 | L and G trust NHS OxleasLBGNHS Greenwich  | on-going |
| **2** | Reduction in the number of people in contact with mental health services using crisis services | * Development of person centred personalised crisis and contingency plans to support self-care and awareness and how to access services earlier in the patient pathway before crisis develops and takes hold
* Building greater resilience and support in primary care to ensure that patients carers and staff recognise triggers and relapse indicators and respond in good time preventing the need for onward referral into crisis services
 | NHS OxleasNHS Greenwich  | completed |
| **3** | Improved responsiveness of mental health services to people in crisis  | * Provision of integrated crisis planning across health and social care shared across agencies and amongst providers delivering care to patients
* Improved access to 24/7 crisis and home treatment services with patients offered a multi-disciplinary response
* One assessment across the crisis care pathway to reduce unnecessary delay and create a seamless service across community and inpatient acute pathway
* NHS Greenwich CCG is working to develop a business case to support a Crisis and Respite house in the borough.
 | All partners | on-going |
| **Improving mental health crisis services** |
| **4** | Improved patient experience | * Review of mental health services across Greenwich in partnership with the Local Authority and NHS Oxleas. Establishment of service user engagement programme to evaluate crisis services and deliver improvements in the acute pathway
* All patients are assessed by the crisis and home treatment team when in crisis with a view to preventing admission to hospital and providing care in the least restrictive environment.
* Evaluate response times to Lewisham and Greenwich referrals of patients presenting in crisis in A and E and UCC
* Dependent on resources and an audit of presentations in a and we will work towards providing A&E liaison services across all three acute providers which are 24/7 365 days a year
 | NHS Greenwich and partners | September 2015On-goingSeptember 2015 |
| **5** | Improved response time to patients presenting in crisis  | Strategic review of crisis and acute pathway will clarify response times to crisis and the need to develop a ‘gold standard response to patients, their carers and relatives. This will include early assessment within community services to prevent the need for onward referral into acute services |  |  |
| **6** | Use of Section 136, section 135 and section 4  | Audit the use of emergency sections and warrants under provisions of the mental health act and the use of crisis and home treatment services at assessments | RBG | September 2015 |
| **7** | Improved response time for patients in police custody | * Greenwich is part of a pilot to support early assessment and diversion of patients held in police custody to mental health services and will be seeking to support an evaluate the service and the need for further development
* Community forensic services are working on a business case to support street triage services in Greenwich which will be presented to commissioners of health and social care for consideration in future commissioning plans
 | NHS Greenwich and MHS OxleasNHSG NHS Oxleas | September 2015September 2015 |
| **8** | Children and Young people | * NHS Greenwich commissions a tier 3.5 service which supports children and young people at risk of having a mental health crisis and support increased resilience early in the patient pathway. The service is also designed to reduce the need for onward referral into crisis and tier 4 acute in[patient services
* NHS Greenwich CCG have responded to recent evidence that has shown that there is an increase in children presenting in crisis as a first presentation of mental ill health at A and E and UCC. Commissioning plans now reflect the need for a self-harm service in tier 3.5
* NHS Oxleas are undertaking an audit of C and YP presenting in crisis following an incident of self-harm and this will also support changes in commissioning of services and better inform responses to incidents of self-harm
* Children and young people transitioning into adult service will be identified 6 months before they attain the age of 18 and then and their relatives and carers will be included in all plans for transfer and will expect robust crisis and contingency planning and be made aware of how to access services outside normal working hours
 | NHS GreenwichNHS OxleasNHS GreenwichNHSG and NHS Oxleas | CompleteTo be confirmedCompleteComplete |
| **9** | Improve clinical and practice staff understanding of the needs of people experiencing mental health crisis in primary care | * Primary care services are experiencing an increase in demand and there is a clear change in the direction of travel towards patients being supported within primary care and only being referred into secondary care when a specialist assessment and treatment is being sought
* Enhance and offer more support to GP’s and practice staff in the care and management of mental health service users with complex health and social care needs
* Review with the local LMC of resource gaps in primary care and around management of mental health crisis and commission mental health training within primary care and the development of a mental health ‘specialist’ in each practice
 | NHSGNHSGMH clinical lead | On-goingDecember 2015TBC |
|  **2. Access to support before crisis point** |
| **No.** | **Concordat Outcomes** | **Deliverables/outcomes** | **who** | **By when** |
|  **Improve access to support via primary care** |
| **9** | Improved service user and carer experience | * Ensure that all staff working with service users and carers are adequately and appropriately trained to identify and respond to the needs of mental health service users in crisis.
* Develop resilience in primary care and the third sector to support service users in crisis and at risk of requiring onward referral into acute pathways
* Develop and deliver greater resilience and preventive focus within training offered at the Recovery College
 | All partnersNHSG | On goingOn going |
|  **Improve access to and experience of mental health services** |
| **11** | Access to care before a crisis starts | * as part of our strategic review of mental health services we will be assessing what mental health information is available to the public in GP surgeries and other locations
* we will also be consulting with service users to establish what good information and advice looks like and what works well and less well
* we will be publicising the Concordat Action plan across primary and secondary care and as in integral part of promoting World Mental Health Day
* Consider the creation of a virtual ward of frequents attenders at A and E to interrogate crisis presentations and put crisis prevention plan in place
 | NHSGNHSGAll partners | December 15 |
| **12** | Early intervention  | * Improve access and response times for mental health assessments within secondary MH services
* Early access to specialist information and support in secondary care and the establishment of pathways for GP’s and primary care services to follow
* Development of information and advice outside normal working hours
 | NHS OxleasNHS OxleasNHS Oxleas | CompleteCompletecomplete |
| **3. Urgent and emergency access to crisis care** |
| **No.** | **Action**  | **Deliverables/outcomes** | **Led By** | **By when** |
| **Improve NHS emergency response to mental health crisis** |
| **13** | Ensure that patients receive a prompt response during a crisis  | * As part of the review of mental health services we will consider the response times from services to people in mental health crisis within mental health and urgent care servicers
* Monitor and review the use of places of safety and access to mental health acute inpatient beds
 | NHSGRBG | December 15On-going |
| **14** | Reduce blue light activity – reduce use of 999/111 and emergency care (A and E and UCC) | * Ensure that all patients have an up to date crisis and contingency plan which is up to date and reviewed by patients, relatives and carers and available to health care professionals
* Involve LAS in the review of mental health services and in the commissioning of the Greenwich Mental health service model and crisis care pathway
 | All partnersNHSG | On-goingDecember 2015 |
| **15** | Improve timely access to mental health crisis beds in the community and within acute inpatient settings | * Monitor Mental health acute trust performance around access and availability of beds and the use of community crisis services to reduce acute crisis bed usage
 | NHSG and RBG | On going |
| **Integration across health and social services and impact on mental health crisis services** |
| **16** | Reduce admissions to hospital | * We will develop the business case to support the Crisis and Respite service in Greenwich. This service will support primary care to identify patients at risk of relapsing who need early intervention and support to prevent crisis care becoming a real possibility
* Greenwich coordinated care project will improve multi-disciplinary working in primary care to support patients with complex needs
* Consider how shared ownership across acute and community services can facilitate reduced admissions and earlier discharges
 | NHSGAll partners | December 2015On going |
| **17** | Building greater resilience for patients and carers to enable and empower  | * Increase the ability of service users to manage long term conditions as well as their mental health at an earlier stage that is currently possible
* Joint Commissioning to ensure that directories of services including accurate referral information and tiers of need and support are available to all professionals in all services including inpatient settings
* Through cooperation across health and social care crate an integrated patient pathway which will promote recovery and empower patients to access primary and community services early in the patient pathway to prevent relapse
* Improve education, self-help and access to support that will enable patients to recognise risk and trigger factors and manage these appropriately
* In cases where patients need specialist interventions within secondary mental health a single assessment service through a single point of access will be maintained. This will be provided by an MDT which will improve patient experience and improve joint care planning and outcomes
 | All partnersAll partnersAll partnersAll partnersAll partners | On goingOn goingOn goingOn going |

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| **4 Improved quality of response when people are detained under Section 135 and 136****of the Mental Health Act 1983** |
| **No**  | **Concordat Outcomes** | **Deliverables/Actions** | **who** | **when** |
|  **Improved information and advice available to front line staff to enable better response to individuals** |
| **18** | Support for Police | * Partners to understand the level of mental health training provided to local police and consider the provision of training to include how to work with patients who have dual diagnosis
* Increase confidence and competence in police to manage people presenting with mental health problems in an appropriate way
* consider the results of the Department of health street triage pilots and consider if a service should be developed locally
 | All partnersAll partnersNHSG |  |
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|  **Improved information and advice available to front line staff to enable better response to individuals** |
| **19** | Improve staff understanding of the needs of people with mental health problems to support the delivery of better outcomes for people in crisis and for those who care for them | * Evaluate education and awareness training in mental health partner agencies
* Consider changes in care pathways as a consequence of the implementation of the Care Act
 | Public healthNHSG RBG |  |
|  | Identify mental health leads in all patient facing organisations | * Consider the development of a local register of mental health leads to act as contacts around training and concordat developments
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| **Improved training and guidance for police officers** |
| **20** | Increase awareness of mental health resources in the borough | * Explore the possibility of providing and information pack to local police to illustrate local crisis services and how to access information and advice via single point of access to services provided by mental health provider
 | All partners |  |
| **21** | Local provision is evolving and the speed of change may not have been communicated to local officers  | * Appraise senior offices around changes in local mental health provisions
 |  All partners | On going |
| **Improved services for those with co-existing mental health and substance misuse issues** |
| **22** | Dual diagnosis | * Monitor training through contract monitoring to ensure that all staff have improved awareness of the link between substance misuse and self-harm behaviour
* Conduct an audit of patients presenting in crisis with substance misuse services into acute mental health services
* Construct business case to support provision of substance misuse diversion services to reduce impact on acute services, support improved engagement in community drug and alcohol services and reduce the number of presentations to MH services in crisis
* Audit effectiveness of dual diagnosis diversion service
* Audit the number of acute inpatient Detox in acute inpatient settings who do not have a primary mental health problem
* Develop improved access to substance misuse services
* Explore how better integrated working across mental health and substance misuse services can be established and improved upon
 | NHSG and RBGNHSGNHSG RBGRBGNHS OxleasMHS OxleasAllAll | On-goingCompleteCompleteDec 15On-goingOn-going |

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| **5. Recovery and staying well / preventing future crisis** |
| **No.** | **Concordat Outcomes** | **Deliverables/outcomes** | **Who** | **By when** |
|  **Joint planning for prevention of crises** |
| **23** | Integrated care planning and the provision of robust crisis and contingency plans | * All patients their carers and relatives to sign up to the provision of care plans which will have relapse indicators and triggers and detailed plans around how and when to access services before a condition reaches crisis point
* Patients who are discharged back to primary care can expect a detailed summary of how to access services when they feel at risk of relapse and this will have been shared with the patients GP prior to discharge
* Patients who have been discharged from secondary care services should be made aware of what alternatives to secondary care services are available within the patient pathway. In the event that relapse occurs information should include an awareness of how access preventative services
 | NHS OxleasNHS Oxleas All partners | On goingOn goingOn going |
| **24** | Provision of a Recovery College and improved social prescribing in Greenwich | * Commission a local Recovery College in Greenwich
* Expand the Recovery College to become a model of social prescribing with a range of health and social care interventions and programmes that will empower patients and create a setting that encourages peer learning and expert by experience programmes that are service user led
* The Recovery College to become a model that is a viable alternative to referral on to specialist secondary care services which will create self-determination in service users and establish a platform where self-care and self-learning replace uncertainty and stigma associated with a diagnosis of mental illness
 | NHSGAll partners | CompletedApril 2016 |
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