

REFERRAL AND ASSESSMENT FOR ADMISSION

1. INTRODUCTION

The experience of the commissioner during a referral will often be key to the ongoing relationship with the provider. Optimizing the process from the first point of contact to the safe admission of the patient provides that essential level of reassurance that choosing the provider was the right decision.

This procedure places the responsibility on the assessing unit to manage the relationships with the referrer, the commissioner, family and those other agencies involved in the patient's care pathway. The emphasis is on speedy decision-making, challenging response-times and clear communication throughout.

The quality and frequency of communication during the referral process are key to establishing a positive relationship with the referrer and their commissioner. Each hospital should ensure that a key contact is identified so that in each case, the hospital maintains consistent and responsive communication between PiC and its customers. The key contact may change as the referral becomes an admission, though the change should not interrupt the exchange of information.

Most referrals are uneventful and lead to admission. These procedure notes provide guidance on the referral and assessment process, admission to the service, and outline the procedures to be followed in the event that doubts arise in respect of the appropriateness of a referral or, following assessment, of admission.

There should be local and current documented procedures on how to safely manage routine referrals, emergency referrals (if applicable) and out of hours contact with the service. The procedures should be available to all appropriate persons / authorities including patients / residents (if appropriate), carers, general practitioners, health service providers, social services and voluntary agencies. All admissions will be subject to this policy and the procedures in it.

The hospital will also have an identifiable process for ensuring decisions regarding suitability for assessment and admission are reached without unnecessary delay.

This policy should be implemented within the context of the PiC Values:

- Valuing people – respecting our staff, patients, their families and communities
- Caring safely – for ourselves, our patients, our customers and communities
- Working together with everyone
- Uncompromising integrity, respect and honesty
- Taking quality to the highest level

2. SUMMARY OF ROLES AND RESPONSIBILITIES

The **Registered Manager** will be responsible for maintaining effective communication throughout the referral and assessment process. Locally, some responsibilities will be devolved to the Referrals Manager.

When doubt exists around the suitability for assessment or admission, the Registered Manager will ensure that the case is reviewed locally with the senior team and, where a local solution is not considered appropriate, will refer the case to the **Regional Executive Director (RED)**. If the RED cannot agree a solution within region, they will ensure the case is referred to **the Central Referrals Manager**.

In the unlikely event that no PiC service can offer an admission, the Central Referrals Manager will review the case with the Executive Medical Director before a formal rejection is made.

Where service alternatives are not available elsewhere within the Group e.g. Brain Injury Services, the ability to offer secondary options will be limited, though the referrer may be assisted with clinical management advice.

Rejection of a referral will only be agreed once this process has been exhausted. In this instance, the **Registered Manager** will be responsible for providing the appropriate feedback to both referrer and commissioner.

3. VALIDATING FUNDING

The all-important first step is to ensure that the referral has the endorsement of the commissioner and that funding approval is in place should a bed be offered.

Upon receipt of the referral request, the Referrals Manager must ensure that the Specialised Commissioning Group (SCG) (or the responsible commissioning authority) has endorsed the referral and that the requisite 'Access Assessment' has taken place. If the referral is not the responsibility of the SCG, the responsible local commissioning authority must confirm that funding is in place. In either case, a note of that funding approval must be recorded by the Referrals Manager in the Referral Form under 'Referral Administration' – 'Comments' on the Electronic Patient Record.

4. THE REFERRAL

The referral will normally be in the form of a letter, including the reason for the referral and current presenting problems. Where further information is required, the Referrals Manager will liaise with the referrer and/or the commissioner. **Emergency referrals** may be made by phone call with little or no initial supporting documentation. This should not be a barrier to arranging an assessment. It should normally be possible to assess suitable emergency referrals within hours.

Upon receipt of the referral, the Referrals Manager will establish with the Registered Manager, whether a bed will be available as required by the referrer. **If not**, the Referrals Manager, upon advice from the Central Referrals Manager, will agree an alternative assessing hospital with the commissioner.

Agreeing suitability for assessment (Diagram 1)

If, following discussion between the Referrals Manager, Clinical Director and

Registered Manager, the view is the patient is unsuitable for assessment, the Registered Manager should refer the case to the Regional Executive Director.

Possible reasons a patient might be unsuitable for assessment:

1. Does not require admission
2. Requires High Security
3. Needs non-PiC service
4. Requires alternative PiC service – greater security

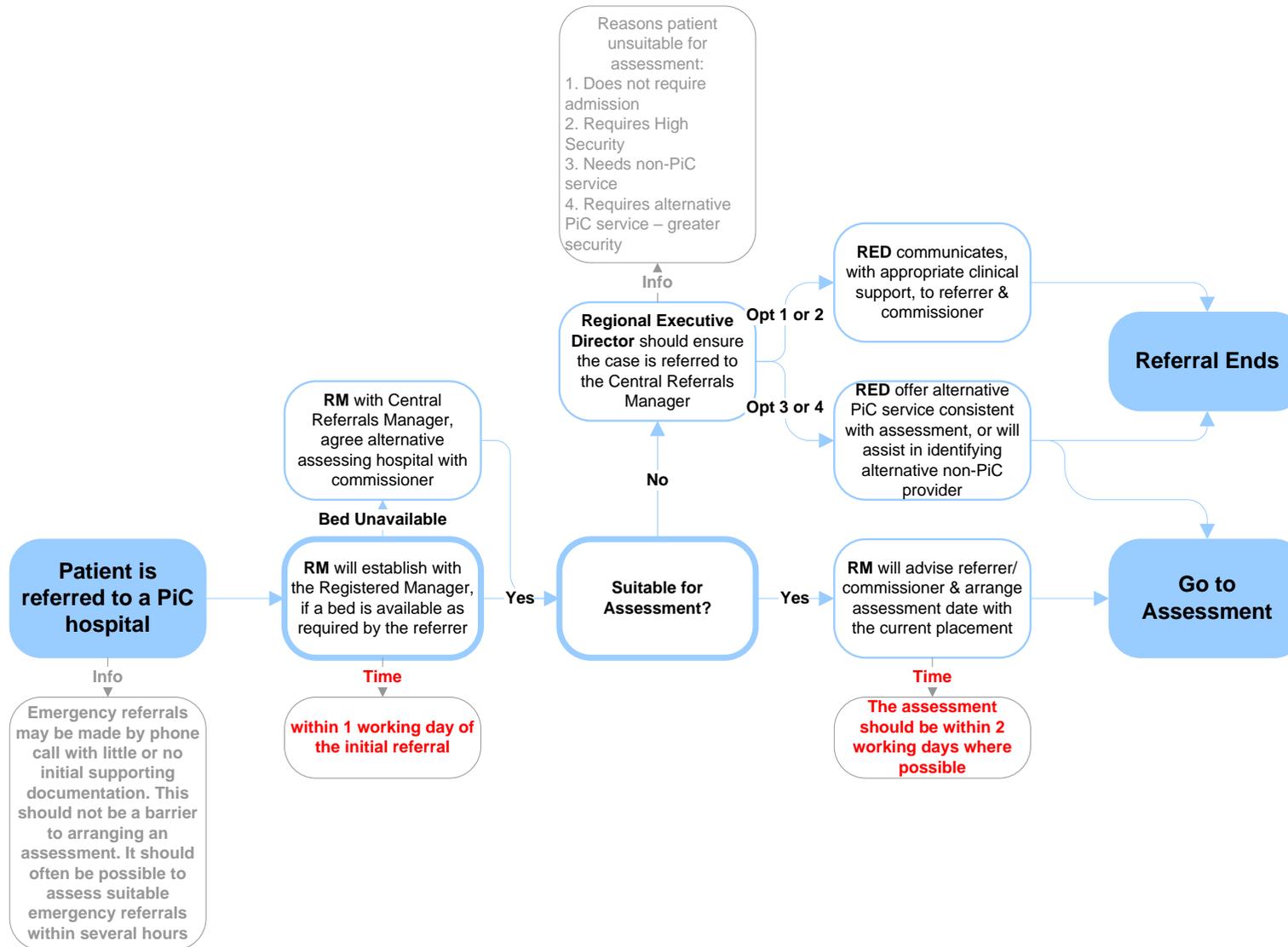
In any of these unusual cases, if the team cannot agree to assess, the **Regional Executive Director** should ensure the case is referred to the **Central Referrals Manager** for advice.

If it is then agreed that option 1 or 2 apply, the Regional Executive Director will ensure the decision not to assess is communicated, with appropriate clinical support, to both referrer and commissioner.

If options 3 or 4 apply, the Regional Executive Director will ensure the referrer and commissioner are offered an alternative PiC service consistent with the assessment, or will assist as appropriate in identifying an alternative non-PiC provider. A decision NOT to assess must be taken ONLY following discussion with the **Central Referrals Manager**. It will be the responsibility of the **Regional Executive Director** to ensure the decision is communicated to the referrer and the commissioner.

The referrer must be advised of suitability for assessment within 1 working day of the initial referral.

Diagram 1



5. THE ASSESSMENT

The **Referrals Manager** will advise the referrer / commissioner and arrange the assessment date with the current placement. **The assessment should be within 2 working days** where possible. The **Referrals Manager** should liaise with the current placement, agree an assessment date and obtain updated information about the patient's presentation.

Pre-admission assessments will be completed using the tool below, unless a specific alternative tool has been agreed with the PiC Medical Director.

- [Referral Assessment Report Template](#)

If suitable for admission the Referrals manager (Diagram 2)

- Informs the referrer and commissioner and ensures the assessment report is submitted to the commissioner **within 5 days of the assessment**
- Liaises with commissioner / case manager to facilitate the submission of the funding pack and provides any subsequent information as required by the commissioner to obtain the funding agreement
- Requests details of the **local care coordinator** from the commissioner
- Ensures all paperwork related to admission (including Ministry of Justice permission) is obtained
- Adds the patient to the waiting list and an admission date is agreed

The assessing team should commence the transitional plan for admission. This should include immediate clinical collaboration with the current placement team. This should inform the initial care pathway planning process.

Transitional plans and the pre-admission needs formulation plans will be developed using the following tools (please note the difference in documentation between England and Wales). For further guidance on using these tools, please refer to the [Clinical Process Quick Reference Guide](#).

- [Pre Admission Needs Formulation Plan - English Patient](#)
- [Pre Admission Needs Formulation Plan - Welsh Patient](#)

If not suitable for admission (Diagram 2)

If, following discussion between Referrals Manager, assessor and Registered Manager, the view remains that the patient is unsuitable for admission, the Registered Manager will discuss the case with the Clinical Director and Regional Executive Director. (Evaluation of suitability might include review of existing resources and the possibility of service reconfiguration.)

Possible reasons a patient might be unsuitable for admission:

1. Patient does not require admission
2. Patient requires High Security

3. Patient needs non-PiC service
4. Patient requires an alternative PiC service

If admission cannot be agreed by the Regional Executive Director and Clinical Director, the former will ensure the case is discussed with the **Central Referrals Manager** and alternatives considered.

One of the following options should be discussed with the referrer within **1 working day**.

Option 1 or 2

Assessing psychiatrist will be responsible for ensuring clinical rationale for non-admission is communicated to the referrer. The Registered Manager will ensure the commissioner is advised of the same. If required, advice will be offered to the current placement whilst alternative arrangements are made.

Option 3

As option 1 and 2, but the Registered Manager will assist the onward referral to the non-PiC core service.

Option 4

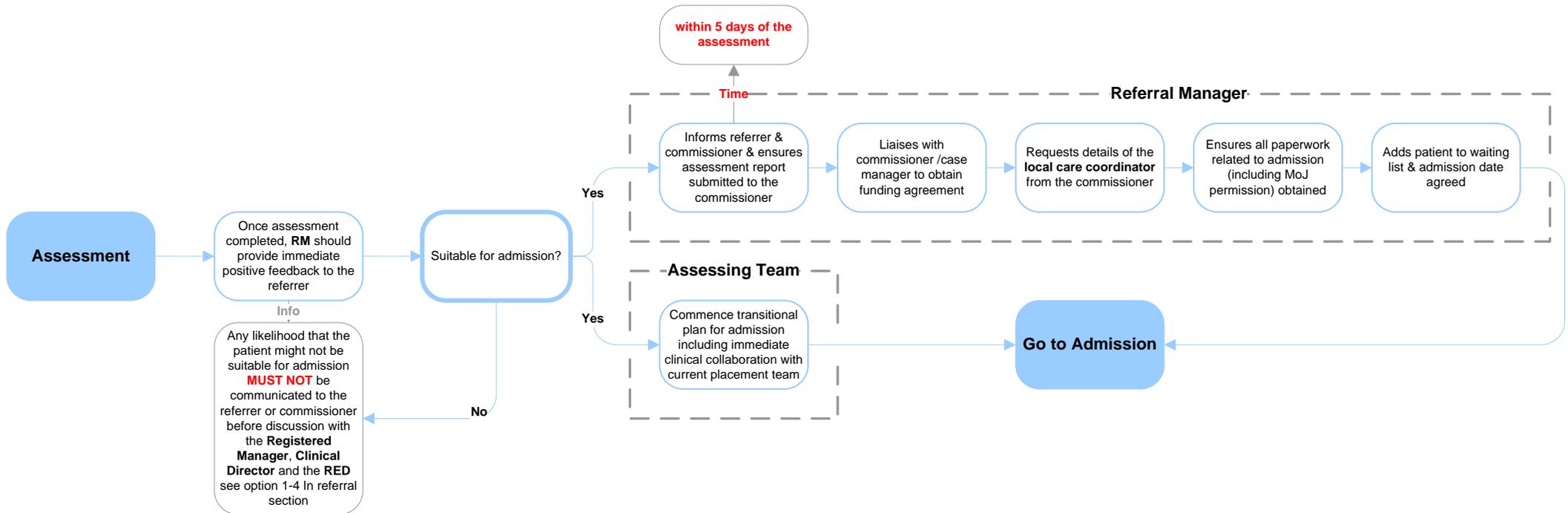
The rationale for an alternative PiC service will be given by the assessing psychiatrist to the referring doctor. If agreement is reached the admission can proceed. The assessment papers should be passed to the admitting team, the referrer updated and liaison commenced with the current placement.

In most cases, no further assessment will be required for admission to an alternative PiC service. There may, however, be circumstances when the alternative hospital team needs to assess the patient further. In such cases, the Registered Manager should be mindful of the need to minimize delay for the referrer and inconvenience to the patient.

If agreement cannot be reached, the referral ends, though the clinical team will offer appropriate advice whilst alternative arrangements are made.

The assessment report should be provided within 5 working days.

Diagram 2



6. THE ADMISSION

Once admission is agreed, the Referrals Manager will inform the referrer and commissioner and ensure clinical contact is made with the current team.

The patient may be placed on the waiting list if immediate admission is not possible. During the period leading to admission, the PiC **key contact** will maintain communication with the referrer, commissioner and current placement team. This will include updating them during the process of admission and will include a post-admission update to the commissioner with a clinical update on the patient's response and any intervention required by the escorting team or the hospital upon arrival. As has been identified previously, transitions are a critical point in the secure pathway, associated with risks and vulnerabilities for the patient. Such transitions will include the plan for continuing any existing treatment programmes, ensuring that resources are available for meeting individual needs and taking account of any ongoing SOVA issues, or additional support that might need to be provided for patients moving from CAMHS to Adult Services.

Where an immediate admission is not possible and the patient is on a waiting list, it is important to retain close links with the existing placement, both to update them with progress as to the patient's position on the waiting list, and to maintain ongoing dialogue between the respective clinical teams. This will ensure that up-to-date information on the patient's mental state and progress is available, and that support can be provided to the patient to enable a supported transition to the PiC Service. Such arrangements may include:

- An opportunity for the patient to visit the PiC service and to meet key members of the clinical team, including their allocated Primary Nurse. Where appropriate, such visits may include the patient's next of kin / carers.
- PiC staff spending time at the current placement so that they can review current management plans, maintain an ongoing relationship with the current care team, and reassure and provide information to the patient.
- Where possible, during such a time period as described above, it would be beneficial for members of the PiC team to attend any CPA meetings, or Ward Round / MDT meetings where transitional arrangements and support plans can be arranged and agreed upon with the current care team.
- It is essential to ensure that when the patient is first admitted to the PiC service, that a 72 hour Care Plan is in place that addresses immediate risk concerns and assists the patient's supported transition to the service.

