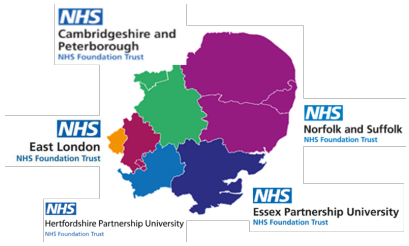

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Guidance for completion
Referral for Adult Secure Services

Please note that any referrals that do not follow guidance issued may result in delays

Referrals will only be considered for patients deemed to be from the East of England.

Please complete the form on the following page, ensuring all mandatory fields are completed and any supporting documentation attached to the referral prior to submission to the Patient Flow Hub **hpft.ncmsecurereferrals@nhs.net**

Urgent referrals: The decision regarding whether a referral is urgent or routine is made by the receiving access assessment team but could include a request from a prison setting where a prisoner requires urgent transfer to hospital, either because of an immediate risk to others or themselves, or is presenting with an immediate risk of serious harm which can only be contained in a secure hospital setting.
A community patient, subject to the restrictions of the Ministry of Justice or CTO (Community Treatment Order), presenting with an immediate risk of serious harm which can only be contained within a secure hospital setting. Other types of referrals may be considered as urgent, in these instances rationale must be provided.
An access assessment must take place within a maximum of **two days** of receipt of referral (NHSE standard). A concise summary of initial findings must be made available within **24 hours of assessment**, with final written report shared within **five days** of an assessment taking place. All associated documentation is to be made available as supporting information to the referral.
East of England Provider Collaborative will respond within a maximum of **24 hours** of receipt of referral or sooner if nature of the referral dictates.
Non-urgent referrals: A request from a consultant psychiatrist, a delegated clinician (who has assessed the patient in their current setting and/or knows the patient well) or a referral received through any criminal justice routes (to be discussed on a case by case basis).
All relevant clinical and supporting information (eg risk assessments, CPA reports) is to be provided at the time of referral.
Timescales are dictated on the basis that all required information has been sent by the referrer.
A written response regarding appropriateness of referral will be provided within a maximum of **7 days** of receipt of referral or sooner if nature of referral dictates. The proposed timeframe of an access assessment will be discussed and agreed with the referrer and should take place within a maximum of **21 days**, with a final written report shared within **7 days** of the assessment.
Referrals should be made, reviewed by a senior clinician, and approved by a consultant psychiatrist or Responsible Clinician/Responsible Person prior to submission.
Details of any risk behaviour/incidents must be provided, and any relevant additional information submitted in conjunction with the referral.
Referrers must identify which level of security is required within the appropriate section of the referral form.
Details of the index offence plus any relevant additional information regarding offending behaviour should be submitted in conjunction with the referral. To assist decision making, information from the PNC record of previous criminal offences (and MG5 charge sheet for remand prisoners) accompanies all referrals from Prison.
In the case of prisoners being transferred from prison to hospital, the NHSE standard from receipt of referral to admission is 28 days.

If you have any queries or concerns whilst completing the form, please contact the Patient Flow Hub at hpft.ncmsecurereferrals@nhs.net

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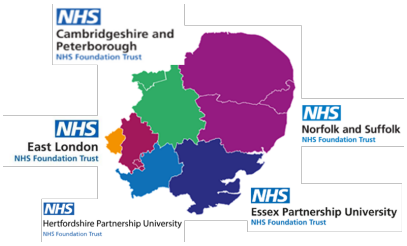
Please submit completed referral and all supporting information to hpft.ncmsecurereferrals@nhs.net



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Referral Form
Adult Secure Inpatient Services

SECTION A: CRITICAL INFORMATION ***CHECKLIST: It is mandatory to attach all required evidence at point of referral submission.*** ***Failure to do so may lead to delays in referrals being processed.*** **Please submit information to hpft.ncmsecurereferrals@nhs.net**		
Completed Referral Form		☐
Care & Treatment Review (CTR) report	See Section B	☐
LD / Autism – ADOS/ADI-R Report	See Section B	☐
Offending History	PNC, MG5, offence information, SystmOne notes, discharge summary, tribunal report (See Section B)	☐
Patient psychiatric Report	Family, personal, psychosexual, psychiatric, medical, substance use, and forensic history	☐
Clinical records of current circumstances & progress	If in hospital or prison	☐
CNOMIS report	Please ensure this is included when submitting the referral	☐
Other Supporting information	e.g risk assessments or most recent HCR-20, hospital admission, imprisonment circumstances & progress, management reports, current medication (where appropriate)	☐

SECTION A: CRITICAL INFORMATION
REASONS FOR REFERRAL *(Mandatory field)*
Please clearly define reason(s) for referral to secure services including history of presenting state, evidence of mental disorder, diagnosis, current medication, current circumstances, any past psychiatric history, substance misuse, alcohol history (not exhaustive list).

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SECTION B : PATIENT DETAILS (All fields mandatory unless specified)		
Full Name *(BLOCK CAPITALS - include any alias):*	**Marital Status:** Single ☐ Married/Civil Partnership ☐ Separated ☐ Divorced/Dissolved ☐ Widowed ☐	
Known As *(if different to above):*	**Sex Assigned at Birth:** Male ☐ Female ☐ **Gender Identity:** Male ☐ Female ☐ Non-Binary ☐ Other ☐	
Date of Birth:	**Preferred Pronoun:** He/Him ☐ She/Her ☐ They/Them ☐	
NHS Number:	**Ethnicity:**	
Responsible funding ICB: *(formally CCG)*	**Communication considerations:** Yes ☐ No ☐ **Details:** *(e.g preferred language verbal and written)*	
Local Authority: *(Assumed)*	**Local Authority Contact details:**	
Current/Last known Home Address: No Fixed Abode ☐		
Next of Kin Details: *(name, address, contact details)* Not Applicable ☐	**Relationship to patient:**	
Current Legal Status / Location / Placement: *(specify)*	**Admission date:**	**Expected Discharge Date (EDR):** Not Applicable ☐
Diagnosis: *(expand upon in Section B)*	**Detained under MHA / Detention order:** *(specify)* Not Applicable ☐	
	Expiry Date of MHA Section: Not Applicable ☐	
GP Practice Name & Address:	**GP Practice Telephone / Email:**	

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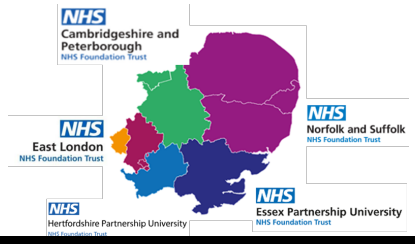

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SECTION C : REFERRER DETAILS (All fields mandatory unless specified)	
Referrer Name *(BLOCK CAPITALS):*	**Job Title:**
Referrer Address / Base:	**Referrer Contact Telephone Number:**
	Email address:
Current RC / Consultant Psychiatrist (*BLOCK CAPITALS):* As above ☐	**RC / Consultant Psychiatrist Contact Telephone Number:** As above ☐
	Email address: As above ☐
Case has been discussed with RC / Consultant who fully supports referral Yes ☐	
RC / Consultant Signature:	**Date:**

SECTION D : REFERRAL INFORMATION (All fields mandatory unless specified)				
Current Location:	**Community** ☐	**Hospital Setting** ☐	**HM Prison** ☐	**Immigration Removal Centre IRC** ☐
Security Level Required:	**Low Secure** ☐	**Medium Secure** ☐	**High Secure** ☒	**Unsure** ☐

Is the Referrer aware of the patient having any of the following:			
Learning Disability	Yes ☐ No ☐	**Autism / ASD**	Yes ☐ No ☐
Hearing Impairment	Yes ☐ No ☐	**Acquired Brain Injury (ABI)**	Yes ☐ No ☐
Organic Brain Injury	Yes ☐ No ☐	**Personality Disorder**	Yes ☐ No ☐
If yes to any of above, please specify evidence of which diagnosis was made:			

Care & Treatment Review CTR *(Mandatory field):* ***Not applicable for MoJ urgent recall / HMP referrals***	
Preadmission CTR completed: Yes ☐	**Preadmission CTR supports referral:** Yes ☐
CTR attached to referral: Yes ☐	**Date of CTR:**
Care Co-ordinator Name / Organisation: (*BLOCK CAPITALS):*	**Contact Telephone Number:**
	Email address:
Intended outcome from the secure admission/ discharge destination from secure care:	
If no to any of the above, please provide rationale:	

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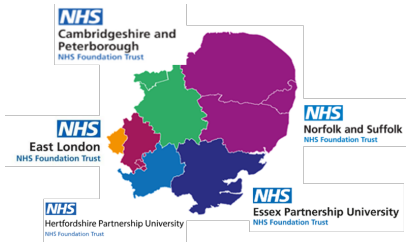

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SECTION D : REFERRAL INFORMATION (All fields mandatory unless specified)				
Learning Disability and Autism Diagnostic Tools *(Mandatory field Learning Disability & Autism):*				
Does the patient have LD and/or Autism / ASD diagnosis: Yes ☐ No ☐ N/A ☐		**ADOS / ADI-R completed:** Yes ☐ No ☐ N/A ☐ **IQ Testing:** Yes ☐ No ☐ N/A ☐ **Date:**		
If yes to any of above, please provide evidence: *(IQ test outcome, ADOS, ADI-R report)*				
Offence History *(Mandatory field HM Prison):*				
Offence(s): *(index, current)*		**Sentenced (date):** Yes ☐ No ☐ **Date:** **Remand (date):** Yes ☐ No ☐ **Date:**		
		Assessment Care in Custody & Teamwork (ACCT): Yes ☐ No ☐ N/A ☐		
PNC information attached: Yes ☐		**MG5 attached:** Yes ☐		
Multi agency Public Protection Arrangement (MAPPA) level	**Category 1** ☐ Sexual Offender	**Category 2** ☐ Violent offender	**Category 3** ☐ Other dangerous offender	**N/A** ☐
MAPPA Coordinator Name (*BLOCK CAPITALS):*		**MAPPA Coordinator Contact Telephone Number:**		
		Email Address:		
Please provide status of any legal proceedings *(where applicable)*				
Solicitor name / company address: *(BLOCK CAPITALS)*		**Contact telephone / email:**		
Discharge summary/tribunal report attached: Yes ☐ No ☐ N/A ☐		**Court details and dates:**		
Attached Supporting Information: *(e.g PNC, MG5, offence information, SystmOne notes, discharge summary, tribunal report)*				

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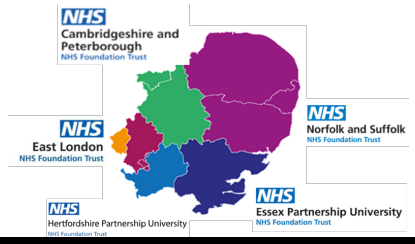

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SECTION E : PATIENT RISK HISTORY *(Mandatory field)*
Please clearly define risks and any associated risks including family history, personal history, relationships, behaviours, chronology of risk incidents.

SECTION F: PATIENT RISK ASSESSMENT *(Mandatory field)*	
Current Risk to self:	Current Risk to others:
AWOL Risk / History:	Completed Risk Tool:

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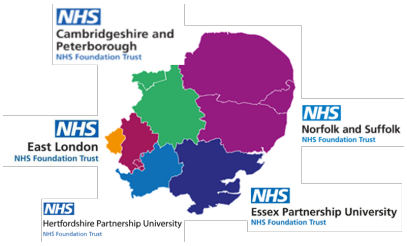

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SECTION G: OTHER INFORMATION	
Patient / Carers View about referral:	Significant dates: *(e.g court, EDR, sentencing etc)*
Victim issues: *(if applicable)*	What barriers may arise when considering discharging this person:
Any additional information in support of the referral:	

SECTION H: PATIENT FLOW HUB ADMINISTRATIVE USE ONLY	
Date & Time referral information received:	
Date uploaded on to NCMS:	
Date of Assessment:	
Referral accepted or declined? Date?	*If declined, please give reason*
	If accepted, date assessment arranged
Date of Admission/Transfer	

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