**Section 1: Access Assessment for Inpatient Services for Children & Young People**

| 1. **Personal Details** | |
| --- | --- |
| Full name: | NHS No: |

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| --- | --- |
| **Details of person completing this form – please note that section 6 must be signed** | |
| Full Name (printed): | NHS Trust name: Leeds Community Healthcare |
| Position: Operational Manager | Access assessing unit name or team: Little woodhouse Hall |
| Date: | Job Title: Operational Manager and Core Trainee Psychiatry |
| Email: | Tel: 01133057200 |

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| 1. **Access Assessment considerations** |

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| The access assessment should answer the following key questions provided below as a minimum. Any appropriate considerations affecting the decision to admit a patient should be included. |
| What is the provisional diagnosis or presenting problem: |

| Considerations: *tick as appropriate* | Yes | No |
| --- | --- | --- |
| Will an inpatient admission address the mental health needs of the young person? | ☐ | ☐ |

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| Details: |

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| **Are there any risks to the young person by an admission to hospital?** (For instance, that the admission is likely to cause more harm than good)**:** | Yes  ☐ | No  ☐ |

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| Details: |

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| **Are there are any suitable or preferable least restrictive alternatives** (can the young person be treated effectively and safely in the community or current setting?): | Yes  ☐ | No  ☐ |

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| Details: |

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| Are there specific risk factors as identified by the referrer which may include the following?   * Risk of self-harm * Risk posed to others * Previous history within T3 CAMHs and T4 services (or within other statutory and/or criminal justice provision) | Yes  ☐ | No  ☐ |

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| Details: |

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| Are there needs, for example the requirement for a specific programme of intervention, health, education, welfare needs and safeguarding issues, to be addressed? | Yes  ☐ | No  ☐ |

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| Details: |

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| **Other considerations:** | Yes  ☐ | No  ☐ |

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| Details: |

| 1. **Outcome of Assessment** | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Is the young person appropriate for an admission? | | | | **Yes** | **No** | *Comments:* | | | |
| If the young person is being admitted due to lack of community services or provision, please detail what is missing to enable management in the community | | | | |  | | | | |
| If the young person requires a specialist assessment before an admission or a decision about an admission can be made, please detail | | | | |  | | | | |
| **Please indicate the most appropriate environment for this young person to receive treatment** *tick as appropriate* | | | | | | | | | |
| Children < 13 | General Adolescent | PICU | Learning Disability | | | | Eating  Disorder | Low secure | Medium secure |
| **☐** | **☐** | **☐** | **☐** | | | | **☐** | **☐** | **☐** |

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| --- | --- | --- | --- |
| Emergency admission | Y  **☐** N  **☐** | Planned admission | Y  **☐** N  **☐** |
| Recommendations of assessor to the referrer, if inpatient admission is not supported? | | | |
|  | | | |
| Recommendations of assessor to the CAMHS Tier 4, if inpatient admission is supported? | | | |
|  | | | |
| What outcome/s should be achieved by an admission? | | | |
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| 1. **Inpatient placement** | | |
| --- | --- | --- |
|  | Yes | No |
| Has an inpatient placement been identified that will admit the patient? | ☐ | ☐ |

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| Name of Hospital: | Address: |
|  | Postcode: |

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| 1. **Access Assessment Completion – the assessment process was completed by:** |

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| --- | --- |
| Review of Referral paperwork | Face to Face Assessment |
| **☐** | **☐** |

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| 1. **Signature of Access Assessing Clinician** | | | |
| Full Name (printed): | | Signature: | |
| Date: | Email: | | Tel: |

| 1. **Emergency Out of Hours Access Assessment – the assessment process was completed by:** |
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| --- | --- |
| Review of Referral paperwork | Direct conversation and sharing of clinical information by Tier 3 |
| **☐** | **☐** |
| Name of referring clinician: | Trust name: |
| Job Title: | Tel: |
| Name of community Consultant: | Tel: |
| Name of Director authorising admission: | Email address: |

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| **NHS ENGLAND USE ONLY** | |
| CAMHS Case Manager Full Name (printed): | Signature: |
| Date received: | Date approved: |

**Access Assessor**

FORM 2 needs to be sent to the NHS CAMHS Case Manager and the referrer by the Access Assessor when the above has been completed and signed.

If a placement has not been identified at the point of the access assessment being completed, the referrer will need to advise both the NHS CAMHS Case Manager and the Access Assessor once identified.

In the event that an Out of Hours Unplanned Admission is required and the nominated Access Assessors are unavailable, the escalation or Out of Hours approval process detailed within the localised information within the Operating Handbook should be followed and section 7 completed.

**Referrer**

FORM 2 should be sent to the NHS England CAMHS Case Manager and the receiving hospital (if different from the unit undertaking the access assessment) when identified. The NHS England CAMHS Case Manager informed immediately of the name of the hospital and location to enable the internal paperwork of NHS England to be completed to facilitate the bed being funded.

**Section 2: TO BE COMPLETED BY THE RECEIVING HOSPITAL**

| 1. **Personal Details** | |
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| Name of provider: | Name of admitting ward: |
| Home postcode: | Date of admission: |

| 1. **Admission decision** |
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| Is the referral appropriate for admission to this particular hospital? | **Yes☐ No ☐** if No give reason below |

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| Reason for admission being declined: |
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| Have clear measurable admission goals been agreed with the young person and their parents/carers and where appropriate with the referring team (is treatment likely to be effective and are they likely to engage?) **Yes ☐ No ☐ Please detail below:** |

| 1. **Hospital details** | |
| --- | --- |
| Hospital name: | Ward name: |
| Hospital postcode: | Ward type:  Acute / PICU / Eating Disorder / Acute LD / low secure / medium secure |

| 1. **Initial Management Plan** | | |
| --- | --- | --- |
| **Plans for admission:** | | |
| Is the young person in agreement with the plan? | Yes | No |
| Are the parents/ carers in agreement with the plan? | Yes | No |
| Young person and/or carer’s parents decline admission to CAMHS T4 services | Yes | No |

**Receiving hospital**

Please return a completed copy of Section 2 to the NHS England CAMHS Case Manager and the Referring Clinician. FORM 1 provides the names and contact details of the NHS England CAMHS Case Manager and Referring Clinician.