High Intensity Rehabilitation & Recovery

Ward 5 Newsam Centre

Referral Document

Last updated: 14 March 2025

Updated commissioning guidance for Rehabilitation services (NHSE 2023) classifies inpatient rehabilitations services as either Level 1 or Level 2 depending on the type of services they are able to offer. The terms open and locked rehabilitation are no longer in use.

# Level 1 Rehabilitation Services (Asket House / Croft)

Level 1 services are normally needs led and locally based, serving a local population. These services exist to meet the needs of people who have a mental health rehabilitation need that can only be treated within an inpatient environment.

Level 1 services are normally accessed via an adult acute mental health inpatient service, including those specifically for adults with a learning disability, or who are autistic.

Level 1 services are part of a clear, agreed pathway that includes community mental health rehabilitation teams and wider general and specialist teams, such as primary care, community learning disability, autism, or mental health teams.

They are staffed by a multidisciplinary team that have the appropriate training, skills and knowledge in mental health rehabilitation and should meet specialist need as required, for example, drug and alcohol support.

These services should be firmly connected to the wider resources and agencies within the community, for example, employment support, housing, and welfare.

# Level 2 Services (Ward 5 Newsam)

All the points above for level 1 services apply to level 2 services.

Level 2 services neither support nor encompass inpatient provision that may be described as ‘locked rehabilitation’, and they are not long-term placements, continuing care, or a ‘home’ by default.

The key difference between level 1 and level 2 mental health rehabilitation inpatient services is that a level 2 service can offer more intensive support to people to meet their needs; this may be relational and/or adapted environments and procedures.

# Advice for Referral

Before a referral is made to the High Intensity Rehabilitation & Recovery Service, please ensure the criteria is met. The referrer must ensure that all relevant documentation is completed and accompanies the referral. All items with a \* are essential elements of information. Any referrals that do not meet the referral criteria or fail to provide all requested information may result in delays in your referral being processed.

**If you are considering making a referral to Ward 5, Please contact the clinical team manager or nurse in charge in their absence.**

# Referral Process

**Please note**: Incomplete referral documents cannot be processed.

* Referrals are accepted via the Complex Rehabilitation email –

complexrehabreferrals.lypft@nhs.net

* New referrals will be triaged for suitability at the weekly Capacity & Flow meeting (CAF).
* If appropriate for Assessment – individuals will be seen, and assessment documentation completed within 21 days.
* If not suitable for ward 5 at the point of referral to be redirected back to the referrer following a conversation, rationale clearly documented on Care Director notes.
* Following assessment, the documentation will be completed and brough back to CAF for MDT discussion and agreement of next steps. Assessment should clearly document rehabilitation needs/goals, willingness to engage, risks, proposed moving on plan.
* If MDT in agreement the individual will be admitted to the next available bed. This will be clearly documented on Care Director and referrer informed. If ward is at 100% capacity the individual will be placed on the waiting list and reviewed with the referrer every 4 weeks. Any rehabilitation recommendations should be commenced where possible in the individuals current setting until transfer can be arranged.
* Where an individual has a pending tribunal or hearing a decision will not be made until the outcome of the tribunal/hearing is received.

# Referrer Information

|  |  |  |
| --- | --- | --- |
| \*Referrer’s Name: | Designation: | \*Tel No: |
| Date of Referral: | | |
| Address: | | |
| \*Service User aware of referral? Yes No | | |
| \*Has the service user previously been referred to Rehabilitation Services?  Yes No  If Yes, please provide details of the referral including the service, date of referral and the outcome of the referral: | | |

# Personal Information

|  |  |
| --- | --- |
| \*Name of person to be referred: (with aliases)  \*Ethnicity:  \*Civil Status:  \*Religion: | \*Last known GP: (address) |
| \*Date of Birth: | \*NHS Number: |
| \*Last known address: | \*Care Coordinator:  (Name & contact details) |
| \*Social Worker (Name & contact details) | \*Integrated Care Board contact: |
| \*Nearest Relative: | \*Carers Details: |
| \*MH Section/detention order:  Start date:  End date: | Current Placement/ location:  Living Status:  Accommodation Status: |
| \*Diagnosis: | Care Director ID number: |
| Care Planning Approach (CPA) Review date: | \*Other timescale to note: (MHRT, etc) |
| Employment Status:  Employment Type: | Other professionals involved: |

# Reason for Referral:

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| --- |
| **Reason for Referral:** |
| **What rehabilitation needs does the individual currently have?** |
| **Which goals does the individual have to meet their needs?** |
| **What goals does the treating team think the individual needs to meet?** |
| **Which of the goals mentioned can only be met in**   1. **an inpatient Complex rehabilitation service,** 2. **supported accommodation,** 3. **or community setting?** |
| **Briefly describe the discharge plans including which team will follow up in community, care coordinator, social worker and consultant Psychiatrist.** |

# The following documents must be provided with the referral or available on Care Director.

* Updated Face Risk Assessment
* HCR20 if applicable
* OT Assessments
* Social Circumstances Report
* Medical Discharge Summary / Tribunal Report
* Safeguarding Reports (Protection Plans, MARAC Reports, Social Services Reports, MAPPA)
* Psychological Formulation if available

# The completed form is to be emailed to:

[complexrehabreferrals.lypft@nhs.net](mailto:complexrehabreferrals.lypft@nhs.net)

**AND**: Ward Manager: Martin Borrick

If you need to discuss any aspect of the referral, please contact:

Ward manager – 0113 8556521.