Humber Teaching
NHS Foundation Trust

STANDARD OPERATING PROCEDURE
FORENSIC - SINGLE POINT OF ACCESS (SPA)

Document Reference	SOP23-016
Version Number	2.0
Author/Lead **Job Title**	Claire Moyser - SPA Lead Bekki Whisker - Forensic Services Community Clinical Lead
Instigated by: **Date Instigated:**	H&NY PC Operational Meeting November 2022
Date Last Reviewed:	4 June 2024
Date of Next Review:	June 2027
Consultation:	Maria Pink – CpaQT Laura Sheriff - CPaQT SPA H&NY Workstream attendees Hayley Brown - LYPFT Liz Hathway – SPA Data & Admin Manager Eloise Nicholson – Graduate Management Trainee Charlotte Haley – SPA Co-ordinator
Ratified and Quality Checked by: **Date Ratified:**	H&NY Ops Meeting 4 June 2024
Name of Trust Strategy / Policy / Guidelines this SOP refers to:	

VALIDITY – All local SOPS should be accessed via the Trust intranet

CHANGE RECORD

Version	Date	Change details
1.0	*May 2023*	*New SOP. Approved at H&NY PC Workstream Meeting (2 May 2023).*
2.0	*June 2024*	*Reviewed and fully updated throughout. Approved at H&NY Ops Meeting (4 June 2024).*

Contents

1. INTRODUCTION

The procedure details the Single Point of Access and day to day management of referrals into Humber and North Yorkshire secure services and the collection and reporting of data to support the flow of bed management and future service development.

The H&NY SPA aims to foster a system-wide approach by unifying referrals for secure beds and the Forensic Community Teams (FCT) across the H&NY ICS, thereby improving quality, governance, consistency, effective communication and service user experience.

The Aims of the H&NY SPA are as detailed below:

- To **avoid admission** wherever possible through flexible, innovative, bespoke community solutions and joint working
- To **triage, signpost and track** access assessments
- To support **the delivery of good quality Access Assessments**
- To **oversee bed management** across all providers based on up to date clinical and operational information
- To uphold **good communication** with service users, referrers and stakeholders at all points of the referral process
- To **support the outlining of clear treatment goals, explicit timescales and transfer/discharge proposals** before admission (urgent referrals may sit outside this aim)
- To **understand local population** needs via a data-driven approach
- To highlight **variation** in practice and service user experience with a focus on quality – especially to reduce repetitive, multiple or unnecessary assessments
- The SPA supports and oversees access assessments making decisions and recommendations considering the **whole care pathway for service users**, including alternatives to admission to secure care.

All activity within the SPA and the assessing services must conform to the model of care, service delivery, quality and consistency standards as defined in Appendix 2 of the Medium and Low Secure (Adults) specifications C02/S/a and C02/S/b, which were released in March 2018, unless stated otherwise in this document.

2. SCOPE

The SOP is intended to support and guide all members of the Humber and North Yorkshire Provider Collaborative. It encompasses procedures for both inpatient and community referrals; if procedures are not relevant to both referral pathways, this will be explicitly stated.

3. PROCEDURE STATEMENT

The SOP, together with associated procedures, policies and guidelines will aim to ensure

- Evidence based practice is adhered to.
- User involvement/co production is at the forefront of developing the SPA work.
- To review and revise as necessary at regular intervals

4. DUTIES AND RESPONSIBILITIES

For all levels of management across the Humber and North Yorkshire Provider Collaborative to be familiar with the agreement and arrangements relating to the Single Point of Access for inpatient and community referrals.

5. REQUIRED STAFFING FOR H&NY SPA

The SPA team is supported by an operational management structure which is shared with the HTFT Forensic Community Services. Whilst the team has core, specific roles (detailed below), it is a part of the wider H&NY provider collaborative for Adult Secure Services and will work closely with inpatient and community teams, Case Managers and Commissioners to support safe and effective transitions.

The H&NY PC, through HTFT forensic services, have recruited to the following posts to manage the SPA:

1.0 wte Band 8a Clinician (SPA Lead)
Key roles and responsibilities:
Development and delivery of an inpatient and community Single Point of Access (SPA); Provide strong, effective leadership and management in supporting the process of referrals for specified services within the HNY Provider Collaborative; Provide oversight of complex pathways and referrals; provide clinical and managerial support to the Spa Co-ordinator; Demonstrate advanced management skills and provide support and advice to case managers, services, service users, carers, staff, managers and other agencies; Representation of outcome data pertaining to the ongoing efficacy of the inpatient and community SPA; support the development and implementation of a digital data solution for SPA; Support the following of agreed processes within the HNY PC for ONCF bed requests and disputes and arbitration; Escalate issues with standards and pathways through appropriate channels.

1.0 wte Band 7 Clinician (SPA Co-ordinator)
Key roles and responsibilities:
Clinical triage of all referrals received; Process and direct referrals to the most appropriate provider; Clinical oversite of all access assessments on day to day basis; Clinical liaison with referrers and assessors as required; Attend H&NY Provider referral meetings; Oversee bed management within the H&NY PC and cases in beds ONCF; Support the following of agreed processes within the PC for ONCF bed

requests and Disputes and Arbitration; Report on required data and outcomes; Support SPA Administrator

1.0 wte Band 5 Data Manager and Administrator
Key roles and responsibilities:
Co-ordination and delivery of core business and administrative functions of the SPA, including developing systems, processes and analysing and reporting data; co-ordinate a range of meetings including agenda planning, collation of documentation, taking minutes and tracking actions; provide daily scrutiny and management of the referral inbox, populating all information onto referral databases; provide a lead in developing a digital solution to collecting data for the SPA and implementing this across services within the Provider Collaborative; fulfil management and leadership duties for existing SPA Administrators

0.5 wte Band 3 Administrator
Key roles and responsibilities:
Ensure daily scrutiny and management of the referral inbox; Manage referral database; Input all referrals onto HTFT Electronic Clinical System; Process all updates for the ONCF/INCF patient spreadsheet; Collate required data and outcomes; Minute SPA and other related meetings and provide admin support to the SPA Clinicians as required.

6. SPA MEETING

A SPA meeting, chaired by a representative from HTFT forensic services, will be held fortnightly on Microsoft Teams. All providers in the H&NY PC are required to attend or send a comprehensive report covering the key agenda items; the meetings will be rotated between forensic inpatient and forensic community agendas. The SPA Terms of Reference (see link below) provides details of the purpose, roles, membership and quoracy of the SPA Meeting.

The agenda (embedded below) will ensure that timely and accurate data and qualitative narrative is captured; this information will form the foundation of Clinical Outcomes and Quantitative Indicators reporting. Escalations from the meeting will be made to the Collaborative Planning and Quality Team (CPaQT).

SPA Community Terms of Reference
SPA Inpatient Terms of Reference

7. REFERRALS FOR SECURE BED ACCESS ASSESSMENTS

All referrals to and all Access Assessments completed by the H&NY PC services will continue to adhere to the standards set in the NHSE Adult Secure Mental Health & Learning Disability Inpatient Services Access Assessment Guidance 2019/2020 (see embedded document below).

Access Assessment Guidance 2019/2020
HNY Access Assessment Quality Standards

7.1. Process map for secure bed referrals

Bed Referral Process Map

7.2. Single inbox management

All access assessment referrals for H&NY patients or non-H&NY patients requiring a H&NY bed, will be processed through a single email inbox. The email address is

hnf-tr.hnyadultforensicreferral@nhs.net

Access to the single inbox will be restricted to the H&NY SPA team.

The inbox will be monitored between the hours of Monday to Friday 9am to 5pm (excluding Bank Holidays). Any emergency or urgent referrals submitted outside of these hours will be prioritised and triaged as soon as possible on the next working day. It is therefore imperative that referrers are familiarised with their own Trusts/services protocols for the safe management of patients who may require urgent admission to hospital (AMHS, S136 suite or PICU) or need to be remanded in custody due to the risk they pose to others. **Nb. patients cannot be admitted into a secure bed out of hours, even in an emergency, without having had an Access Assessment first.**

All referrals are triaged by a suitably experienced clinician, to ensure that referrals are directed to the most appropriate provider as efficiently as possible, to improve the experience of service users, and the monitoring arrangements for the H&NY ICS population.

Triage of referrals will include the following considerations:

- Is the patient the responsibility of a H&NY PC ICB? (GP spine check etc)
- Does the referral meet the standards requested on the referral form in terms of sufficient information?
- Does the information contained in the referral indicate that the patient meets the inclusion criteria?
- If the referral is for a H&NY PC bed at Clifton House or the Humber Centre, for a non-H&NY patient, is there written confirmation that the patients home PC have approved the referral being made and, is there a clear rationale for the referral? This will be determined from the completed form below and approved by the H&NY PC CPaQT before the referrers are asked to send supporting information and providers are asked to complete an assessment. This is not required for a non-H&NY patient referral to Stockton Hall but the referrals manager at Stockton Hall will inform the SPA of any referrals received from other Provider Collaboratives to ensure oversight of bed management.

Humber & North Yorkshire PC Adult Secure Bed for a Non-HNY Service User Request Form

7.3. Electronic system for the SPA

The H&NY will receive referrals through the hnf-tr.hnyadultforensicreferral@nhs.net inbox and all referrals, unless sent in error, will be logged by the SPA administrator on the HTFT Electronic Patient Record System (EPRS). Referral forms will be uploaded onto the system but supporting documents such as CPA minutes, reports etc will not; these will be stored in a secure folder accessible only by the SPA team. Each provider issued a referral will follow their own policy and procedures for logging and storing referrals and supporting documents on their own EPRS.

The SPA will continue to keep a referral open until it is agreed that the case has reached a conclusion. This could be when:

- the patient is admitted to a secure bed and the SPA has received the final Access Assessment report
- the SPA has received the final Access Assessment report stating that the patient does not require a secure bed and there is no dispute about this outcome
- any dispute and arbitration procedures are completed

The SPA will continue to keep the referral open until it is agreed that the case has reached a conclusion or where the request for access is withdrawn by the referrer. Data will be extracted from the HTFT EPRS via the SPA dashboard to inform performance and quality.

The SPA will hold information gathered on a named file within the SPA's V-Drive, which is only accessible by members of the team. This will be held for five years from the last referral before being deleted.

7.4. Minimum required information

The H&NY ICS SPA has a standardised MS referral form detailing the information required (see embedded document below). This form must be fully completed to ensure that the SPA has all the necessary information to assess and triage referrals appropriately. Failure to include all the relevant information, either within the referral form or by attaching relevant reports/letters, may result in a delay in the referral being processed. However, reports and letters alone will not be accepted as a referral.

The referrer will be sent a link to the SPA web page where they will find the referral form, guidance on how to complete it and what supporting information is needed.

SPA staff are unable to complete a referral form on behalf of an initial referrer but may support the CPaQT Case Managers in completing referrals to other PC's when seeking an ONCF bed.

SPA Referral Form

The 'clock', with regard to assessment timeframe standards, will not begin until sufficient information is received from the referrer and then passed on to the H&NY provider. Any referrals where further information has been requested, and not

subsequently provided by the referrer will be closed 4 weeks after the request for information. The SPA will notify the referrer of this.

The H&NY SPA will acknowledge the referral via email within 2 working hours for an urgent referral or 15 working hours for a routine referral, following an initial triage. The referrer will either be informed that further information is required before the referral can be processed to the provider for assessment, or that the referral has been accepted and processed accordingly. If further information is not received within 15 working hours of the request, then it will constitute as a delay for the purpose of data collection. Details of the allocated provider, next steps and an anticipated response time will be given to the referrer.

Following triage, the referral may be declined for several reasons:

- The referral does not meet the threshold for an Access Assessment
- The service inclusion criteria means the service cannot meet the needs of the service user.
- The service user referred does not fall under the responsibility of the ICBs (Integrated Care Boards) within Humber and North Yorkshire PC.

Following triage, should the SPA Clinician conclude that the referral does not meet the threshold for an Access Assessment, they will seek confirmation from the H&NY Clinical Lead that this decision is sound. In the absence of the Clinical Lead, the SPA Co-ordinator will seek confirmation from a senior clinician/consultant within the H&NY PC inpatient provider services. In such cases, the referrer will be notified of the reason/s for the referral being declined. Where possible, the H&NY SPA Co-ordinator will signpost and advise the referrer of the appropriate pathway for their service.

7.5. Referrals to non-H&NY providers for H&NY PC service users

Each adult secure PC has their own referral requirements and so any referral to another PC needs to adhere to these differing procedures. However, all referrals to other PC, for H&NY service users must still be processed through the H&NY SPA. The SPA can advise on what minimum documentation each PC requires and will keep oversight of the timeframes on behalf of the clinical team.

7.6. Referrals to other providers for non-H&NY PC service users

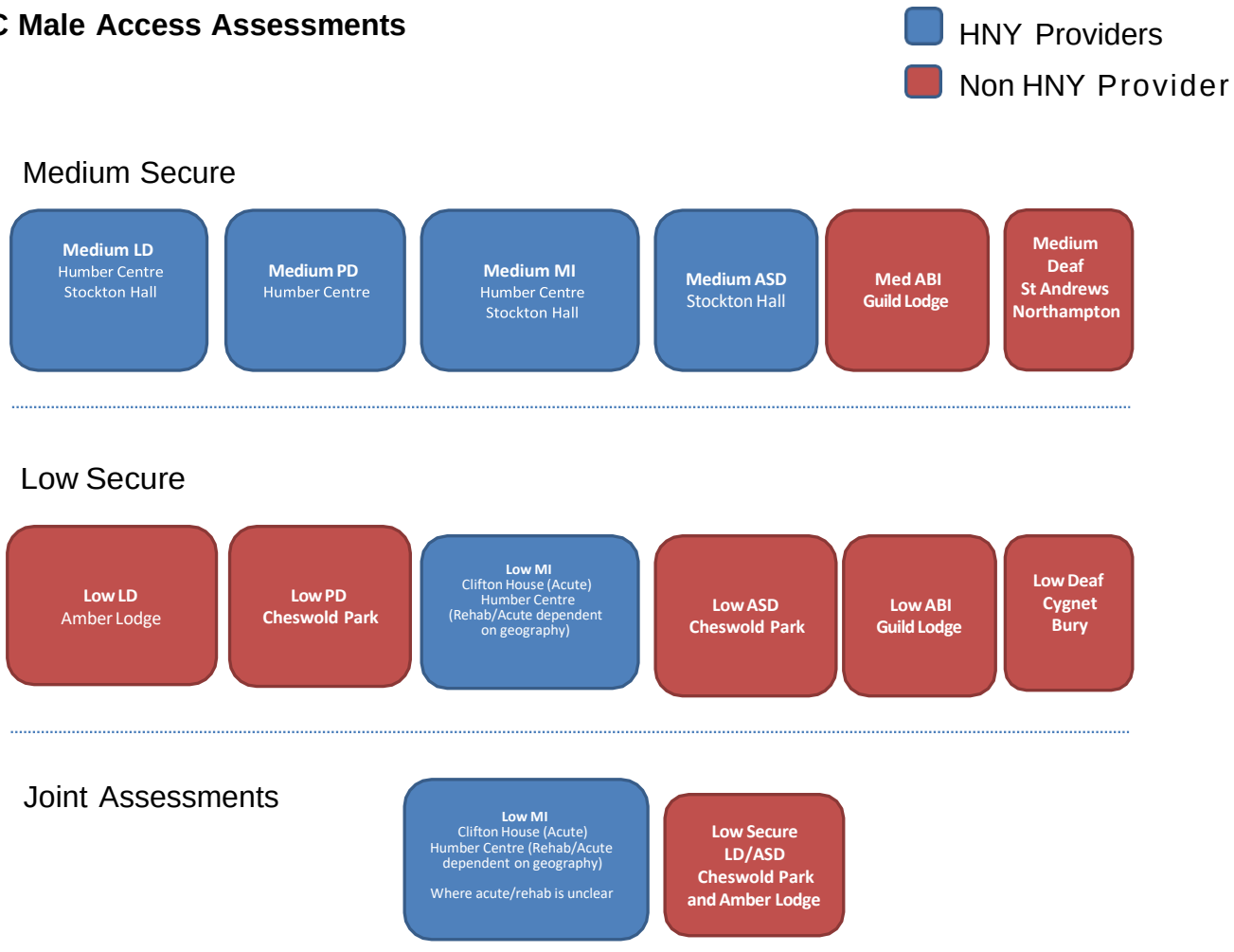
Such referrals do not need to be processed through the H&NY SPA but can be submitted directly to the responsible PC SPA for referrals. Clinical teams are, however, required to still inform the H&NY PC SPA of when these referrals are made so that there continues to be oversight of H&NY PC bed management.

7.7. Allocation of referrals

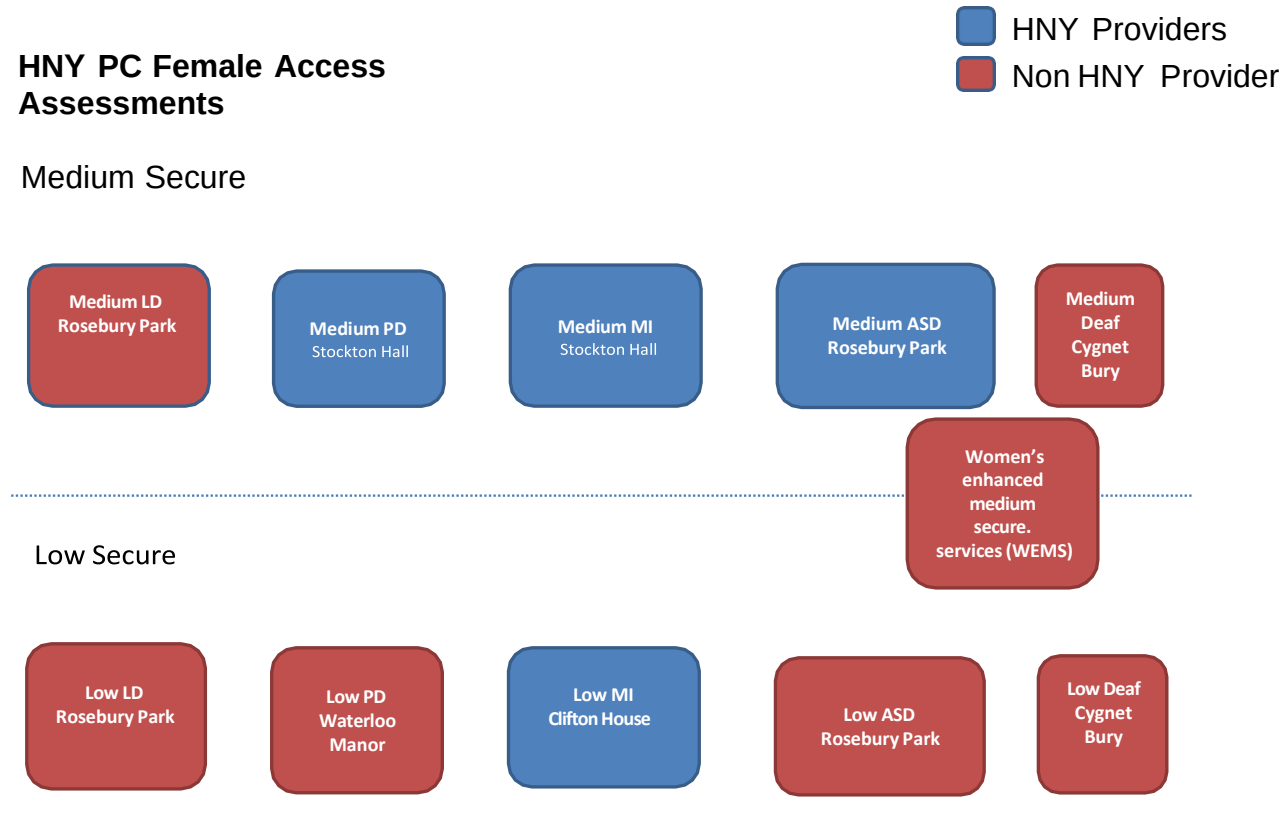
The SPA will ensure that respective assessments are conducted by the most clinically appropriate individual or team members but in general, all referrals will be triaged and sent to the respective services for access assessments as outlined in the diagrams below. Irrespective of the day providers hold their

weekly referral meeting, the timeframes for completing the access assessments will commence the next working day from receipt of the referral.

HNY PC Male Access Assessments



HNY PC Female Access Assessments



Allocation will also be decided after considering patients home area, bed availability, service acuity, patient choice and restrictions affecting placement. Providers requested to complete Access Assessments on behalf of the Humber & North Yorkshire PC, will not presume that the service user will be admitted to their service, if deemed appropriate for admission. Once a referral allocation is agreed the provider service will remain responsible for the referral process to point of completion e.g., making arrangements with the referrer to assess etc, however, it is also imperative that the SPA is also copied into any arrangements as referrers frequently request updates from the SPA.

For any referrals requesting admission or stepdown transfer to a low secure bed, except for prison referrals, the SPA will request that the appropriate Forensic Community Team (FCT) is aware of the referral by sending them the access assessment referral zip folder via email and make a request for them to be involved in any Access Assessment, where possible. The responsibility for linking in with the provider resides with the lead assessor. For non-H&NY assessments, the responsibility sits with H&NY commissioning service.

7.8. Access assessment standards

All Access Assessments completed by the H&NY PC services will continue to adhere to the standards set in the NHSE Adult Secure Mental Health & Learning Disability Inpatient Services Access Assessment Guidance 2019/2020. Concerns over quality assurance in terms of achieving the standards will be highlighted by the SPA clinicians, where it will be addressed with the author of the report. Should the amended version still not meet the quality standards, SPA clinicians will escalate this to the relevant case managers.

Access Assessments, where possible, will be completed by an MDT, identified by the provider. However, when necessary, if the potential pathway is not clear, the SPA Co-ordinator may request that the Access Assessment is undertaken by more than one provider in the H&NY PC. For assessments looking at step up or step down to a low secureservice, the SPA will request that the H&NY PC FCTs will be either involved in the Access Assessment or be consulted by the assessing inpatient provider to identify potential alternative pathways in the community. The SPA will initiate a referral to the relevant FCT, however as the lead provider, it is the responsibility of the inpatient team to link in with the FCT to make arrangements for the Access Assessment.

A specialist assessment team may be needed for service users with more complex presentation or diagnosis in order to capture all their needs and ensure the right individuals contribute to making decisions.

All Access Assessments will consider and report on the following Quality Standards:

- Allocation of access assessment to be based on clinical presentation.
- Assessment and report completed within the agreed timescale.
- Clear involvement from service user and their opinion is incorporated.
- Opinions of professionals and carers/family is sought and incorporated.
- Outcome from the access assessment is fed back to the service user.

- Clear articulation of how criteria to admission to secure care is met.
- Initial treatment aims and interventions are articulated.
- Structured risk assessment OR a risk formulation is included.
- For low MI/PD/LDA relevant community or pathway provider has been involved
- Multi-professional assessment is carried out, ideally on the same date, to avoid duplication of assessments.
- Multi-professional 'sign off' of report is done.
- There is a clear statement regarding the least restrictive level of security to meet the service user's needs.
- If admission is recommended, the level of urgency is articulated.

The SPA will audit the quality standards and consistency of the access assessment reports with the MS Quality Standards form (embedded below), reporting the findings back through the providers clinical governance framework and escalating any concerns to the CPaQT.

Quality Standards

7.9. Service user involvement & feedback

Following collaboration with service users and the Yorkshire & Humber InvolvementNetwork team, the following procedure and communication was agreed:

- Where clinically appropriate and when it is unlikely to escalate risk or distress, the allocated assessing provider will send the service user a letter with details of the Access Assessment, accompanied by a service user leaflet (see embedded documents below). Depending upon the timeframes, this information could be sent via secure email to the clinical team or in the post. The SPA should be included in all communications.

  Access Assessment Meeting Letter Template
  Access Assessment Meeting Leaflet

In most cases, service users should be engaged with Access Assessment process and theoutcome should be shared with them. The exception is where this has been assessed as having the potential to increase risk or distress, subvert prison security or cause increasedmedia attention.

Where feedback is appropriate, this will be initially communicated in a jargon free, written format, taking into consideration the service users' first language and any physicalor cognitive impairment. All feedback will be through the current clinical team so that they are able to support the service user with the outcome of the assessment.

The SPA admin team will send the service user a feedback questionnaire to capture their views and experience of the access assessment. This will be sent once the outcome of the access assessment is known and there has been

opportunity for the service user to receive details of the outcome or within a maximum timeframe of five working days from the report being sent to the referrer. If the service user is transferred to a different setting from where the access assessment took place, SPA admin will ensure the service user feedback questionnaire is sent to the current placement. The SPA will collate and report on the feedback received from service users who have undergone an access assessment within that quarter. The SPA will provide monthly updates to providers on service user feedback received. If the feedback requires more urgent attention, the SPA will send the feedback to the assessing team before the next working day.

Feedback will be sent to the following:

Stockton Hall Hospital – Hospital Director, Director of Clinical Services and Referrals Manager.

Clifton Hospital – Modern Matron, Advanced Nurse Practitioner and Clifton Admin (cliftonadmin.lypft@nhs.net)

Humber Centre for Forensic Psychiatry – Modern Matron/s, Inpatient Services Operational Manager and Humber Admin (hnf-tr.humbercentreadmin@nhs.net)

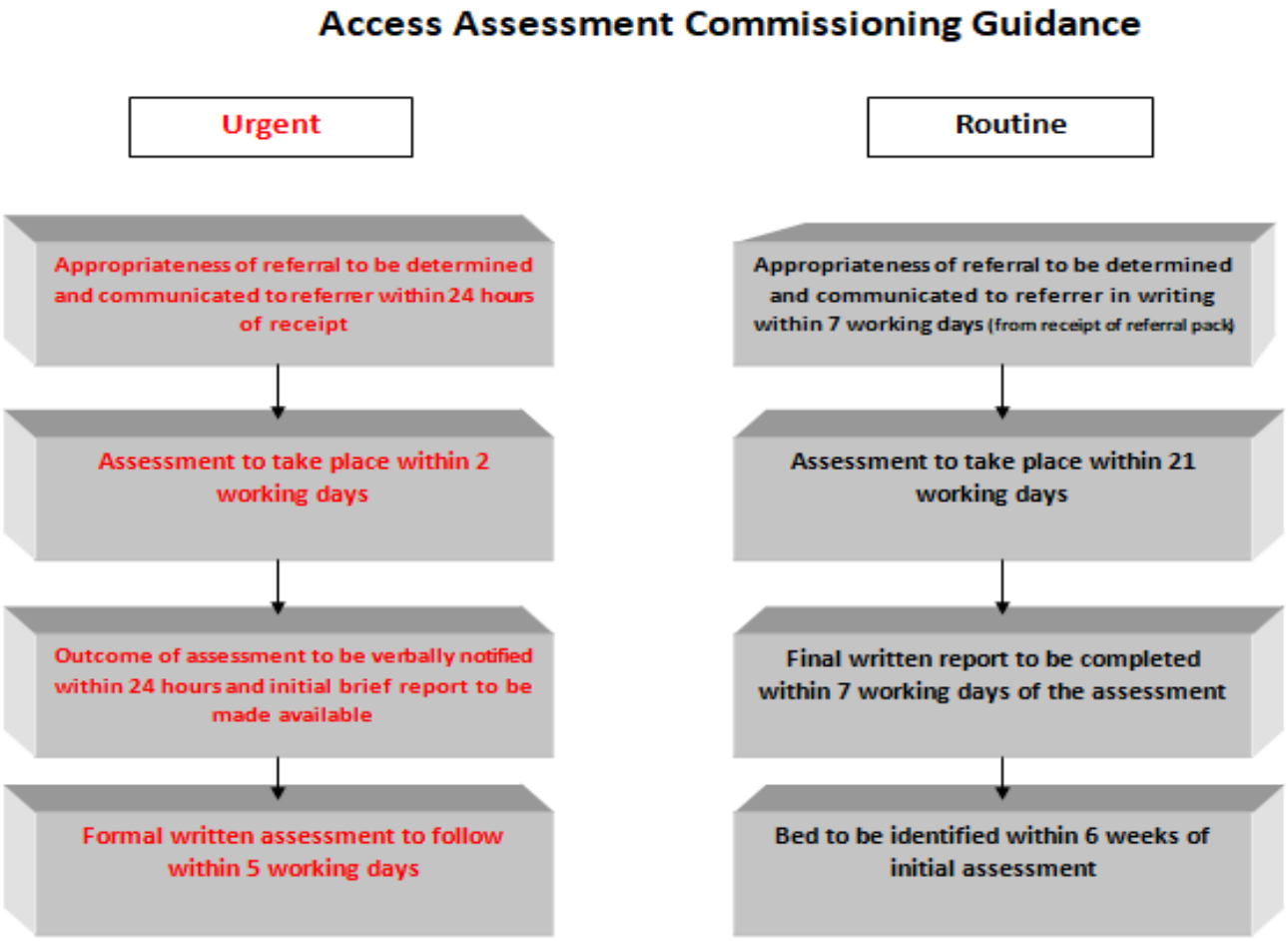
7.10. Inpatient Access Assessment feedback timeframes to referrers

The H&NY PC will aim to adhere to the timeframe standards below in all cases, where possible. The SPA team will collate qualitative and quantitative data regarding adherenceto these standards and feedback to the Collaborative Planning and Quality Team (CPaQT) in their quarterly report. Any significant nonadherence will be escalated via the identified route. The SPA team will prompt providers when end timeframes are approaching.

Once the assessing provider has completed an Access Assessment Report, in line with their own service templates, they are responsible for ensuring that the report is received bythe H&NY SPA; the SPA will be responsible for ensuring that the report is received by the CPaQT and, once the access assessment quality assurance checks have been completed, the SPA will distribute the report to the referrer. If the outcome of the access assessment is for a secure admission, SPA will also forward further details regarding the patient to the relevant case manager. The following guidance encapsulates the roles and responsibilities of the SPA and providers with regards to the referral process:

Humber & North Yorkshire PC Referral Process

No patients will be admitted to secure services until the H&NY SPA has received and reviewed the Access Assessment Report and discussed the recommendations with the relevant Case Manager, unless it is necessary based on clinical urgency and risk management. Service users must not be placed on the waiting list for specific providers without prior consent from the SPA Lead



8. BED MANAGEMENT AND OVERSIGHT

The SPA will hold a system wide view across the H&NY PC in relation to bed availability, waiting lists, patient movement and current issues of relational security (e.g., acute risk issues with patient mix, therapeutic environment being seriously jeopardised to the point of not being able to function effectively, fully occupied seclusion facilities) to ensure an appropriate consideration of operational and clinical issues when identifying pathways. Bed management information is gathered by the SPA at weekly referral meetings. If patterns emerge these will be escalated to the CPaQT for further exploration and discussion to ensure equitable and smooth pathways across the Provider Collaborative.

Should a patient be assessed as requiring a secure bed that the H&NY PC could provide, but there is a delay to that patient being admitted, the assessing provider will maintain regular communication with the patient's current clinical team and feedback any updates re presentation, risk etc to the SPA. The SPA Lead will monitor the length of delay to admission within the H&NY PC and, in consultation with the Case Managers, consider whether an ONCF bed is needed. This decision will be based upon the following criteria:

- Ability of current placement to manage presenting risk
- Deterioration to patient's health
- Clinical acuity and imminence of risk
- Concordance and engagement with treatment in current placement
- Patient choice
- Timescales for MoJ warrants and prison transfers

If an ONCF bed is necessary and unavoidable, the assessing provider will be expected to request this via the SPA/case manager where it will be presented to the CPaQT for approval. In these cases, the patient will remain on the waiting list of the most suitable H&NY PC provider until they are repatriated.

To ensure that the SPA has live oversight of the H&NY PC bed status, providers will inform the SPA and respective Case Manager of any planned admission and discharge dates and confirm that these have happened within 24 hours of them occurring via the SPA email inbox. The SPA team will also attend referral meetings where possible and update the live H&NY AS PC referral spreadsheet with key information shared by the assessing provider.

9. SPECIFIC PATHWAYS AND NEEDS

9.1. LD/ASD

For patients with a diagnosed LD and/or ASD, a pre-admission Care and Treatment Review (CTR) must have been undertaken by the patients originating ICB prior to an access assessment for secure care. The CTR must have been recently completed (within the past 6 weeks) and support the referral for a secure bed. Where possible, it is expected that LD FOLS and/or IST teams form part of the CTR process. This is to determine if hospital admission is required, or if an alternative setting is considered more appropriate. There are some occasions where it is appropriate for an access assessment to be undertaken without a pre- admission CTR taking place, e.g., prison transfers or for patients requiring urgent treatment.

Diagnostic assessments such as the WAIS, ABAS, ADI, and ADOS are helpful and will be provided if available. In the absence of diagnostic assessments there must be clinical evidence suggestive of a developmental disorder.

There is an expectation that the relevant LD FOLS team will have already been consulted about the person's risks, unless the referral is urgent, and that they contribute to the CTR. Should the LD FOLS teams not be involved in the service users current care, the SPA will suggest an immediate referral is made. The LD FOLS team should be involved in the access assessment process as part of a wider MDT.

The principles of the Transforming Care Programme will be followed.

9.2. Personality Disorder

Upon receipt of a referral for a person with a diagnosis of personality disorder, liaison between the H&NY SPA Co-ordinator and the Yorkshire and Humber (Y&H) PDS team will establish whether the service user is previously known to the PDS.

SPA and PDS will maintain communication around service users with a PD where applicable.

With regards to the prison Offender Personality Disorder pathway services, the SPA Co- Ordinator will liaise with the responsible OPD Case Managers, for any referrals that wouldfall under their remit, to ensure that the most appropriate pathway for the person is pursued.

Any referral for a prisoner with Personality Disorder as the primary diagnosis must demonstrate that the prison or probation/offender management OPD Services have been consulted to consider whether services delivered as part of the OPD pathway within prison estate would meet the need of the patient, rather than referring them to an MHLDA or personality disorder (PD) inpatient service.

9.3. To/from high secure estate

All patients deemed to require admission to the high secure estate must have had an Access Assessment completed by medium secure services first. The assessing medium secure provider will complete the referral to the high secure provider (Rampton for H&NY patients), sending it to the H&NY SPA who will submit it to the high secure provider inbox. The referral will remain live with the H&NY PC SPA until the patient has been assessed by the high secure provider and the outcome of that assessment been received in a written report.

Should a H&NY patient be admitted to the high secure estate, the SPA will notify the respective H&NY FCT and close the referral on the EPRS. However, the patients medium secure provider is still required to maintain oversight of the patient's pathway by attending CPA meetings and updating the SPA bed management spreadsheet. All invites to CPA's will be received and processed through the SPA. Where the pathway of a patient is not to be from high secure to the Humber Centre, consideration will be given as to which H &NY PC medium secure provider should attend their CPA to promote consistency and begin transition planning. Close liaison with the NHSE high secure case manager would also be key so quarterly updates will be requested for H&NY patients within the high secure and WEMS estate.

Referrals for step down to a medium secure service will be processed via the SPA, following the usual procedures and completion of the SPA referral form. H&NY patients deemed appropriate to step down from the high secure estate will be expected to spend a period of trial leave in their new placement (to be determined by the providers and Case Manager) and will remain on the caseload of the NHSE high secure case manager for this duration. At the end of this trail leave period, oversight of their pathway will at this point transfer to their local H&NY FCT and Case Manager.

Service Specification – Adult High Secure Services

9.4. To/From prison

All movement of prisoners in to and out of the H&NY PC services will continue to adhere to the standards and timeframes outlined in the National Prison Transfer and Remission Guidance 2021 (see document below).

Transfer and Remission of Adult Prisoners under the Mental Health Act 1983 Guidance

Referrals for Access Assessments for prisoners must be initiated by the prison Mental Health Team for transfers under sec 47/49 or sec 48/49 via the H&NY SPA email inbox (please see Prison Process Map below). The SPA Clinician will triage the referral and acknowledge the referral via email within the same working day it is received. The referrer will either be informed that further information is required before the referral can be processed to the provider for assessment, or that the referral has been accepted and processed accordingly. Details of the allocated provider, next steps and an anticipated response time will be given to the referrer.

Prison Referrals Process Map

Should a privately commissioned Psychiatric Report recommend a prisoner is transferred to hospital for assessment and or treatment, the assessing doctor will liaise with the prison mental health team and notify them of this and be evident with any communication coming in for an access assessment. The prison mental health team will review the prisoner and make the referral to the H&NY SPA if they concur with the recommendation. However, if the prison mental health team do not agree that transfer to hospital is necessary, the SPA will seek confirmation from the Case Manager/CPaQT that the referral is appropriate before processing it and sending it to the most suitable provider. Data will be collected about the number of referrals of this nature to be escalated in the relevant H&NY PC governance structure and discussion with Health and Justice commissioners where problematic patterns are emerging.

On occasions when legal teams for prisoners submit copies of any private defence reports recommending admission, they will be notified of the above procedure.

The threshold for the priority of a transfer is determined through a clinically informed discussion between the referrer and assessing service, considering the following issues:

- Is there evidence of a rapid deterioration in mental health presenting a significant risk to self, other prisoners and staff?
- Is there evidence of a rapid deterioration in physical health due to mental health problems?
- Is there a need for restrictive practices in prison to maintain safety due to mental health presentation?

A list of delayed transfers and remittals to/from prison will be collated by the H&NY SPA and shared with the CPaQT, as they occur. The SPA will monitor the reasons for such delays and report on key themes in the SPA meeting so that lessons can be shared and learned.

9.5. Transitions from Forensic CAMHS

The SPA will accept referrals for any young person that reaches 17 years and 6 months of age and is assessed as requiring the specialist input of forensic community or inpatient services. The SPA will facilitate liaison with the HNY PC CAMHS Case Manager, Forensic CAMHS team and adult forensic services, whilst adhering to local CAMHS transition policies.

9.6. Transgender and Non-Binary Pathways

Where service users identify as transgender/non-binary, cases will need to be assessed individually as to the most appropriate service to send their referral. Risk, vulnerability, stage of transition and service user preferences will need to be considered. SPA will adhere to Trust Policies regarding transgender/non-binary pathways, whilst acknowledging the circumstances and preferences of the individual. SPA will seek the guidance of case managers and consult with other professionals.

10. DELAYS IN PATHWAYS

It is the responsibility of each provider to identify delays in pathways, adhering to their own policies, protocols, and systems for identification, reporting and escalation of such cases. All H&NY inpatient and forensic community providers will report any delays in pathways, as soon as they arise, to the responsible Case Manager, and to the SPA team. The SPA will gather and collate information about delays in care pathways and share this with involved parties. This will include those Clinically Ready for Discharge (CRFD) and those created by criminal justice processes (e.g., service users awaiting trial dates, remittals to prison and those awaiting parole hearings following a tribunal).

Should the Case Manager not be able to resolve the barrier/s to the patients' pathway, the case will be escalated to the Collaborative Planning and Quality Team (CPaQT) to generate discussion with respective ICB's, Local Authorities and other Statutory Agencies and Stakeholders involved. The patient flow for secure pathways meetings will provide a forum to discuss delays in pathways.

11. ESTIMATED DATE OF DISCHARGE

All patients will be given an Estimated Discharge Date (EDD) upon admission/at their first MDT meeting; this will be determined by the MDT. At the 12-week CPA meeting the clinical team will review the EDD and amend it as needed, informing the service user of the rationale behind any amendments. The clinical team must inform both the Case Manager and SPA of any changes to a service users EDD. EDD's will be

reviewed and updated regularly with the providers and Case Managers to ensure the H&NY bed management is efficient and patient experience enhanced. FCT's are also key decision makers in the discharge pathway, and they will flag any EDD's that appear unrealistic or lengthy in the INCF/ONCF monthly meetings with the SPA. However, a service user must only have one EDD as identified by their current MDT.

12. CONDITIONAL DISCHARGE AND CTOS

Where a service user, subject to a Ministry of Justice (MoJ) restriction or Community Treatment Order (CTO) has been discharged from a secure service and then relapses, their clinical team may consider that they require admission to hospital. In these circumstances an Access Assessment is still required, the patient is not automatically admitted directly to secure care, unless this is a condition of the recall, imposed by the MoJ as the least restrictive option. The community clinical team need to liaise with the SPA prior to arranging any recall unless urgent. The pathway will be into acute services whenever possible to avoid further lengthy admissions.

13. PROPOSED PLACEMENTS OUTSIDE NATURAL CLINICAL FLOW (ONCF)

The aim of the H&NY SPA and providers is to avoid having to admit H&NY patients ONCFwherever possible, unless clinically indicated as in the service user's best interest.
However, there will be times due to bed capacity, staffing issues, acuity, no provision of appropriate service within natural clinical flow, lack of specialist offending behaviour workand exclusion zones, that this is unavoidable. In such cases, the SPA will manage the process for ensuring that the decision to admit to an ONCF bed is only made once other alternatives have been robustly considered.

Requests for placements ONCF may occur at three stages of a patient's pathway:

a) After an initial Access Assessment
b) After a period of treatment within a secure service that no longer meets thatpatient's needs
c) The patient requests a move ONCF

Where an access assessment has recommended an ONCF pathway, the assessing team will notify the SPA of such request. A discussion will take place between SPA, assessing provider and case managers to ensure that all pathway options havebeen exhausted to meet the clinical and risk needs within the H&NY footprint in a timelymanner. This will take a 'system-wide' perspective and once this group has fully considered the ONCF bed request there may be various outcomes:

- The need for an ONCF pathway is recognised and accepted
- Further details and discussion are needed with the assessing service before therecommendation can be accepted – this may include what

would need to be in place for the pathway to remain within H&NY

- The assessing service are asked to reconsider pathway recommendations with aclear rationale provided

Where agreement cannot be found, the dispute and resolution process can be instigated.The outcome will be recorded via the relevant process within the SPA.

If an ONCF bed is required, it is the responsibility of the Case Managers to source thisalthough, where possible, the SPA may provide administrative support.

13.1. Oversight of secure bed placements including outside natural clinical flow (ONCF)

In line with the 'Community to Community model' the pathway for all H&NY service users in secure bed placements will be overseen by the Forensic Community Team (FCT) for their ICB and the H&NY PC Case Managers. The SPA will notify the relevant FCT about a new admission to a secure service, providing background information where available. It is then the responsibility of the FCT to establish contact with the clinical team and service user to agree upon the frequency and type of 'in-reach' intervention provided, in accordance with their local policies and procedures.

The SPA team will chair monthly Patient Flow for Secure Pathways meetings with the FCT's and Case Managers to review all H&NY patients in H&NY secure beds and secure beds ONCF. The focus of these meetings will be to identify potential repatriations or discharges that are clinically appropriate, safe and timely. The meetings will also flag any barriers to patient pathways and be used to evidence bed status, population need and financial projection.

Terms of Reference – Patient Flow Meetings

The RAG rating document (embedded below) has been developed with the H&NY PC FCT's and the teams are encouraged to use this to report on patient pathways.

RAG Rating for Repatriation of Service Users back within H&NY ICS

Any H&NY patient in an ONCF secure bed, whose needs can be met within the H&NY PC, will still require the SPA referral form completing by their current clinical team, which will be processed via the SPA. Should the Forensic Community Provider encounter any barriers or disagreements with the ONCF provider whilst trying to promote safe, timely and clinically appropriate repatriation or discharge for their patient in an ONCF bed, they will follow the agreed escalation process (embedded below).

Process for Addressing Concerns in ONCF Reparation Pathways

14. DISPUTE RESOLUTION AND ARBITRATION

Dispute Resolution

On rare occasions, the referring clinical team may not agree with the outcome of, and recommendations made by the assessing service. In such circumstances the following steps will be taken:

i. The SPA will instigate a clinician-to-clinician discussion regarding any differences of opinion.

ii. If the respective clinicians are unable to agree an outcome, the referral, clinical information and recommendations made by the assessing service are reviewed by the Collaborative Planning and Quality Team (CPaQT) to establish the reasons for the dispute and a discussion involving the respective clinicians, Case Manager and Clinical Lead will occur

iii. A decision is made by the CPaQT that the access assessment provided by the service should stand or that the case should go forward to arbitration

iv. Where a dispute relates to a recall to hospital under the MHA, decisions can be made outside the dispute procedure so recall to hospital is not delayed.

Arbitration

If the Dispute Resolution process fails to resolve the difference of opinion, an arbitration process must commence. The outcome of arbitration determines the final position.

i. The arbitration process involves the CPaQT seeking advice from a Forensic Consultant Psychiatrist unconnected to the referrer or assessing service.

ii. The advising Forensic Consultant Psychiatrist must review all relevant clinical information, including the access assessment report and form a view on the suitability of the recommendations made. This view and subsequent recommendations must be shared with the PC ASC Clinical Lead and respective Case Manager.

iii. In providing advice, the independent consultant must clearly state the rationale for their decision. The independent consultant's recommendation is final.

iv. If the final recommendation is for the patient to be admitted to medium or low secure services, the Clinical Lead and Case Manager must notify the appropriate secure service.

v. Should the service not be able to admit, an alternative placement must be identified. If this placement is ONCF, the process outlined in section 9 above must be followed.

15. QUALITY ASSURANCE

The SPA will be supported by the Case Managers and Quality Lead for the H&NY ASC PC to identify systems and processes which demonstrate continuous improvement in quality and outcomes.

The SPA welcomes commissioner led quality reviews and will seek to establish peer reviews with other PC SPA services.

All service users subject to the H&NY SPA inpatient referral process will be asked to give their feedback via completion of a service user questionnaire.

The SPA administrator will manage the collection and reporting of all referrers' satisfaction with the H&NY SPA process, via a MS questionnaire.

Any complaints or concerns raised will be investigated as per the HTFT complaints policy and the outcome and any lessons learned shared with H&NY provider and CPaQT.

The SPA will work to the agreed SPA-specific service specification and quality metrics. The wider quality assurance for the PC will also be applicable to the SPA, including quality and contract meetings.

15.1. Data Monitoring

Key information about all referrals will be collated by the SPA Administrators. This information will be used to monitor and audit referrals with respect to gender, diagnosis, level of security, and outcome of referral and assessment. This data will form the basis for future service development and reconfiguration to meet the needs of the H&NY population. Data collected from the FCT's referrals will support service development providing information which will identify training needs, workforce development and identify trends in terms of locality needs.

The Single Point of Access service will also provide accurate and readily available data and information for the Trust, Commissioners, and other interested stakeholders with regards to bed status, use of ONCF beds, repatriation and patient pathways.

The SPA will produce a quarterly data report on the Outcome Measures and KPIs, as identified in the SPA Service Specification, section 3.6, pages 8 -14.

SPA Service Specification

15.2. Governance

Governance Structure

Complaints, incidents and serious incidents will be managed in accordance with the Humber Teaching Foundation Trust Policy addressing such matters.

Each inpatient and community provider will receive a monthly clinical governance report completed by SPA regarding adherence to quality standards as above.

15.3. Information governance

All providers within the Humber & North Yorkshire Adult Secure Service Provider Collaborative have agreed to adhere to the Single Point of Access Information Agreement (see link below).

Single Point of Access Information Sharing Agreement

The SPA service will need to communicate information that contains patient identifiable data, however, only the minimum necessary information relevant to the specified purpose will be shared and where possible aggregated or anonymised non-personal data will be used. The SPA service will use secure communication channels in line with Caldicott and Information Governance requirements and standards.

Information will be shared via encrypted email (between NHS mail users, using the NHS mail encryption feature or another encryption method) by telephone, by virtual meetings using NHS mail MS Teams or by face-to-face meetings.

16. COMMUNITY SPA

16.1. Scope

This section of the SOP applies to all providers of adult age FCT's within the Humberside and North Yorkshire region and complements the SPA SOP for HNY PC Adult Secure inpatient services and the HNY PC Community Forensic Team SOP. The community section of this SOP is likely to be amended once the national service specification for forensic community teams has been approved. It also applies to referrals made to the Pathway Development Service (LYPFT) for Humber & North Yorkshire patients, for the purpose of data collection.

Humberside Community Forensic Services SOP

Nb: The previous headings/sections of this SOP are not repeated in this section but are also applicable to community referrals.

Provider	Geography	Service
Care Plus Group	Northeast Lincolnshire	LD FOLS
Humber Teaching Foundation Trust	Hull & East Riding	LD FOLS
Humber Teaching Foundation Trust	Hull & East Riding	SCFT

Leeds and York Partnership Foundation Trust	York & North Yorkshire	MI FOLS
Navigo	York & North Yorkshire	SCFT
Rotherham, Doncaster & South Humber Foundation Trust	North Lincolnshire	SCFT & LD FOLS
Tees and Esk Wear Valley Foundation Trust	York & North Yorkshire	LD FOLS

Since the introduction of the Specialised Provider Collaborative in 2021 a review has been undertaken and it has been agreed by all partners that the Community Forensic Teams will work together to address the inequalities in service delivery across the region.

As a Collaborative we recognise the importance of continued development and, as the SPA continues to develop, the standard operating procedure will require regular review.
The introduction of a new community Single Point of Access (SPA) will enable community teams to collate and analyse referral data, as identified previously in this document.

The SOP provides an agreed regional framework for managing referrals to the community forensic services; it is acknowledged that each provider will require additional local guidance to support implementation of the process once the referrals have been triaged by the SPA clinicians.

16.2. Referral process

Community SPA Process Map

Referrers can make a referral to the HNY PC SPA for the Forensic Community Teams by contacting the HNY PC SPA via the SPA telephone number 01482 478702 and provide details of the service user they wish to refer to the SPA admin team.

Key Links:

Inpatient referral form: Humber & North Yorkshire Provider Collaborative - SPA Referral Form forsecure services (office.com)

Community referral form: Humber & North Yorkshire Provider Collaborative - SPA CommunityTeam Referral (office.com)

Once the initial information has been received, it will be passed to the duty SPA clinician who will then meet with the referrer and gather further information about the person being referred, the associated risks and expected outcome of the referral. This will be completed within 15 working hours of the referrer contacting the SPA – please refer to process map above for details ofnext steps.

Any HNY FCT provider service that receives a referral outside of the above process will direct the referrer to the SPA before offering any advice or intervention. Data cannot be collected for referrals which do not follow this procedure.

16.3. Who can refer?

It is envisaged that referrals will come predominantly from adult mental health services (community and inpatient) and secure inpatient services. However, referrals can be madeby other agencies such as probation, voluntary organisations, GP's etc for advice and signposting.

Community referrals to the HNY PC SPA can be received between the hours of Monday toFriday 9am to 5pm (excluding Bank Holidays); the service does not accept crisis or urgent referrals but can sign-post referrers to other agencies to manage risk in the short-term.

Following triage, the referral may be declined for several reasons:

- The referral does not meet the threshold for a consultation from a FCT
- The service inclusion criteria means the service cannot meet the needs of theservice user.
- The service user referred does not fall under the responsibility of the ICBs withinHumber and North Yorkshire PC

16.4. Eligibility criteria

The SPA will accept referrals for people:

- Who are thought to present a significant risk to others.
- Who are over the age of 17 years 6 months.
- Whose primary needs are related to complex mental health needs (MI, LD, A, PD, ABI.)

16.5. Exclusion criteria

The SPA will not accept referrals where:

- Substance misuse is the primary/sole problem.
- Antisocial/offending behaviour is not related to an identified mental disorder.
- Risk of harm is to self.

- The person is not on the caseload of a secondary mental health team (unless forsignposting or if this is accepted practice by the individual team.)
- the person is not on the caseload of a secondary mental health team (unless for sign-posting)

16.6. FCT referral meetings

The SPA clinician will attend the weekly FCT referral meeting to present any new referrals where cases will be discussed, accepted, or declined and allocated to a member of the team. If the case is declined by the FCT as not meeting their criteria, it is the responsibility of the FCT to notify the referrer of the reasons for this. The SPA admin team will also attend FCT referral meetings to ensure that data is collected for any ongoing referrals.

16.7. Data collection

It will be the role of the data manager within the SPA to provide the teams with data which reflects demographic and case stage data. The data will support service development providing information which will identify training needs, workforce development and identifytrends in terms of locality needs.

The data will be collected by the SPA team and will be reported to the HNY OperationalGroup, the data will also be available to all providers for governance and audit purposes.
The SPA will produce a quarterly data report on Outcome Measures and KPI's, as identified in the SPA Service Specification, section 3.6, pages 8 - 14 (see section 15.1 of the SPA SOP).

SPA clinicians will offer to attend FCT referral meetings to discuss any new referrals for consultation and SPA administrators will attend to collate caseload data. Monthly caseload data will be collated via a sitrep which will be circulated by SPA administrators.

The SPA will capture overall caseload number data split into care-coordination, consultation, assessment, and intervention. Intervention will include joint working, in reach and specialist intervention. The SPA will also capture data around demographics and primary risks.

As the SPA continues to develop, data collection is likely to change. When necessary, this will be reflected in future revisions of the SOP.

SPA will collate data for number of referrals received for PDS involvement.

Appendix 1 - Information about the clinical model

Trauma- informed, biopsychosocial framework

There are well established links between trauma/adversity and biological, psychological and social outcomes relating to mental health problems, risk potential and wider social determinants of wellbeing and non-recidivism, such as education, employment, housing and income. All this needs to be considered in clinical and risk planning through a multi-disciplinary lens. Trauma-informed services work to specific principles, including empowerment, collaboration and to avoid inadvertent re-traumatisation or iatrogenic harm, thus re-distributing power as much as is safe to do so.

Behaviours as driven by unmet needs in relationships

Offending behaviours and behaviours that challenge the system are often 'threat responses' or 'survival strategies' with unintended consequences that can keep difficulties or risks going. These 'threat responses' are easily activated most often in relation to how power, authority, dominance or control are experienced in social and relational contexts. Whilst the workforce will respond to challenging behaviours as best it can, scenarios can escalate leading to increase in distress and so risk, and delays or blocks in pathways. A key task for clinicians (and service users) is to understand and tend to **the unmet need underlying the behaviours**, regardless of diagnosis, offence type or the behaviour in question, and focus on how relationships with others can assist service users have those needs met in safe, appropriate, pro-social ways. This can modulate distress and so risk. Staff need careful support and containment to do this work. We expect ruptures in relationships and pay this careful attention together.

Clear structure, aims, roles, processes & timescales for everyone

An integral part of effective system functioning, and clinical pathways is structure. This includes clear treatment plans - what is hoping to be achieved, what needs to be done and by whom in order to attain this and what expected timescales are. When this is missing it can lead to drift, unrealistic expectations, confusion, hopelessness or despair. Effort needs to be made to ensure service users understand what is expected of them and why, with clear timescales for review. Similarly, professional accountability and clarity in operational and administrative processes are just as important. Drifting out of structure, process or timescales requires careful attention.

Values, environments and cultures

Values inform environments, which over time informs culture. When these are paid explicit and shared attention partnership work has an increased chance of success. Shared values, along with a focus on therapeutic environments, such as Psychologically Informed Environments (PIEs) or Enabling Environments (EEs) can help maximise the therapeutic potential of a pathway and whole system increasing the

change of long-term sustainable change for all involved. These approaches prioritise staff support and ‘thinking space’ and recognise the importance of staff well-being.

Whole systems approach and pathways

Pathways need to be as clear as possible, phased and stepped. Intervention aims based on clinical and risk factors need to be articulated at each stage. Each part of the pathway needs to be planned to consider what has come before and what will come next. The clinical model needs to help everyone see themselves as part of a network and bigger picture, service users and staff alike. Not only does this apply to other parts of the secure care pathway, but also the multi-agency approach needed to meet the needs to service users in a coherent, cohesive way, including the Criminal Justice System, Local Authorities, Voluntary Sector, ICBs, and FCAMHs.

System behaviour and complexity

Secure care operates having to take into account contradictory agendas and multiple statutory frameworks perhaps most significantly the Mental Health Act and Criminal Justice System, involving Tribunals, The Ministry of Justice and The Parole Board. Complexity is intensified via the vital multi-disciplinary and multi-agency approach. In addition, the way in which power and authority may become contested, re-distributed, unclear or challenged in truly collaborative forensic system working (sometimes provoking anxiety and so rigidity in the workforce) can mean that system behaviour can itself become distorted or defensive impairing optimum functioning. Conscious, deliberate attention needs to be paid to this by all (helping the system ‘mentalise’ by noticing itself) to support the workforce and systems to work in partnership as effectively and flexibly as possible for the sake of service users.

Learning and understanding together

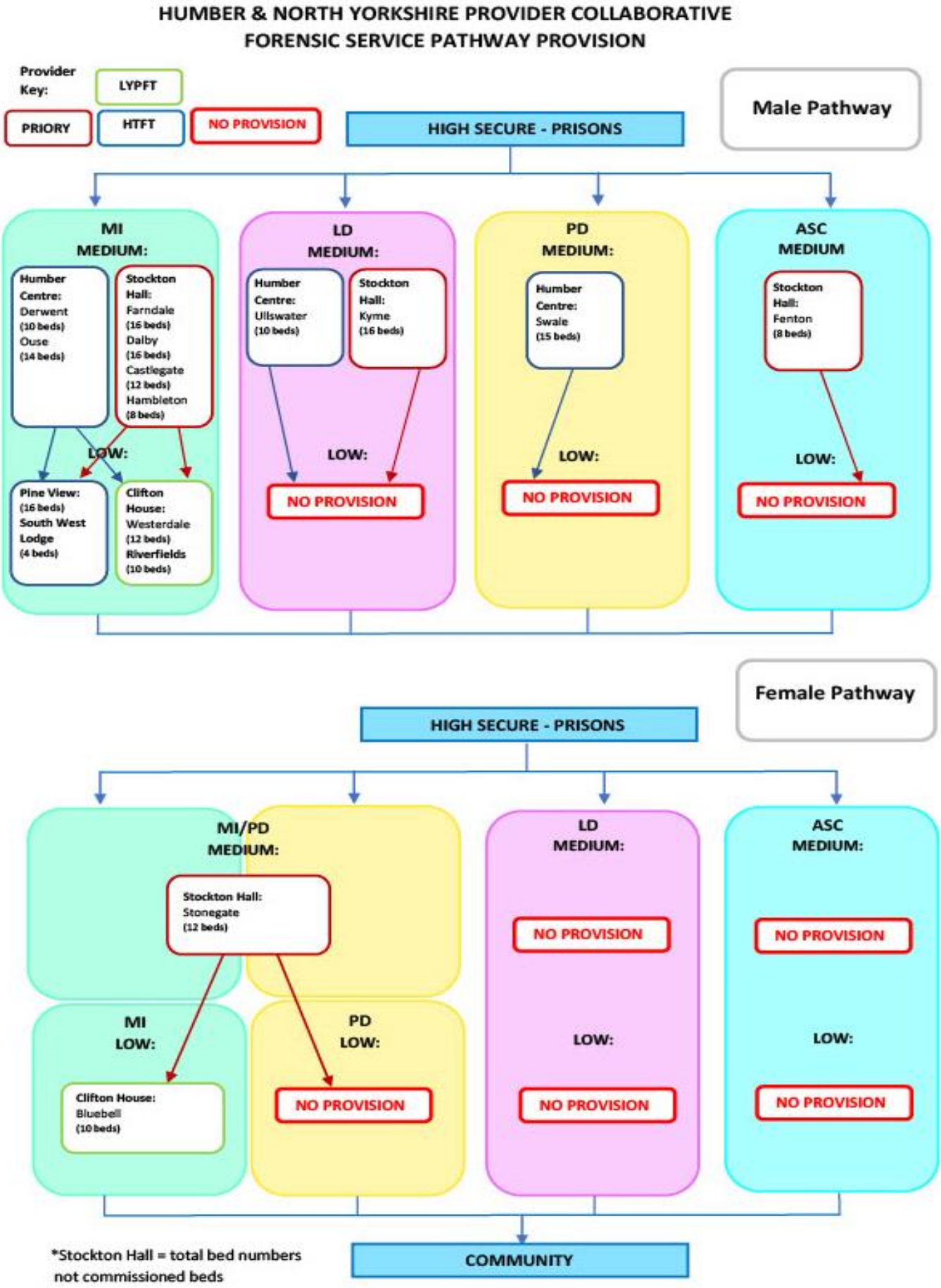
Involvement needs to be at the heart of learning together. At the clinical level we must work alongside service users to make sense of their distress, strengths and risk potential together and so help them find what works and what doesn’t for them to find a sense of safety and well-being and make progress back into the community. This principle also needs to be applied to provider collaborative work in secure care – collaboration, learning and understanding - where there are no firm conclusions about what ‘good enough’ looks like. The H&NY clinical model will need to foster a focus on cyclical learning as a key outcome – this means paying attention to quality, service user experience, staff wellbeing, workforce development, process and outcome evaluation, research and development, all underpinned by co-production with service users and staff

The goals of the clinical model will be achieved through:

- A shared, evidence-based understanding of complex clinical presentations and risks

- Individualised care and risk management based on individual need and risks in collaboration with service users as standard practice
- Service user representation and voice in all forums
- Relationships being given the emphasis they need for recovery and system health to be optimised
- A system wide focus on ‘community to community’ pathways through secure care
- Clear aims, roles and processes at all stages of a pathway both clinically and operationally
- System wide overview of success, blocks and flows on pathways, with support, accountability and healthy, respectful challenge as the norm
- Joint structures, processes and governance inclusive of all providers to focus and contain the complexity of the work both operationally and emotionally
- Increased attention to system interfaces, such as Offender health, Adult Mental Health, High Secure, Criminal Justice System, Local Authorities, ICBs, and FCAMHs
- Values, environments and cultures as crucial wider context in creating sustainable, long-term change and improvement in secure care
- Acknowledgement that system behaviour can impair service user care or risk management, usually inadvertently and as a result of unacknowledged pressures and anxieties in the workforce
- Developing a supported, invested, adaptable and skilled workforce across the provider collaborative, especially those with capacity or potential to lead and influence the wider system
- Acceptance that achieving ‘success’ in secure care as a provider collaborative is a new venture and so learning, evaluation and understanding in partnership, especially with service users, are key.

Appendix 2 - Humber & North Yorkshire Provider Collaborative Forensic Service Provision



Appendix 3 - Glossary

ABAS – Adaptive Behaviour Assessment System
ABI – Acquired Brain Injury
ADI – Autism Diagnostic Interview
ADOS -- Autism Diagnostic Observation Schedule
ASD – Autistic Spectrum Disorder
CETR – Care, Education and Treatment Reviews
CJS – Criminal Justice System
CPA – Care Programme Approach
CPaQT – Collaborative Planning and Quality Team
CTO – Community Treatment Order
CTR – Care and Treatment review
D – Deaf
DSH – Deliberate Self-harm
DToC – Delayed Transfer of Care
EDD – Estimated Date of Discharge
EDR – Expected Date of Release (for prisoners)
EPC – Enhanced Package of Care
EPRS – Electronic Patient Record System
FACE – Functional Analysis of Care environments (Assessment tool)
FCT– Forensic Community Team
FOLS – Forensic Outreach and Liaison Service
HCR-20 – Historical Clinical Risk Management 20 (Assessment tool)
HMPPS – Her Majesty's Prison and Probation Service
HoNoS – Health of the Nation outcome Scales
H&NY PC – Humber and North Yorkshire Provider Collaborative
HTFT – Humber Teaching NHS Foundation Trust
ICB – Integrated Care Boards
ICS – Integrated Care Services
INCF – Inside natural clinical flow
LA – Local Authorities
LD – Learning Disability
LSU – Low Secure Unit
LYPFT – Leeds and York Partnership Foundation NHS Foundation Trust
MAPPA – Multi Agency Public Protection Arrangement
MARAC – Multi Agency Risk Assessment Conference
MDT – Multi-disciplinary Team
MHRT – Mental Health Review Tribunal
MHLDA – Mental Illness, Learning Disability and Autism
MI – Mental Illness
MoJ – Ministry of Justice
MSU – Medium Secure Unit

NDD – Neurodevelopmental Disorder
NHSE – National Health Service England
ONCF – Outside natural clinical flow
OPD – Offender Personality Disorder Service
PD – Personality Disorder
PDS – Pathway Development Service
PICU – Psychiatric Intensive Care