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| **St John’s Hospice****Specialist Palliative Care Service****Referral Criteria** |

These criteria are for Healthcare Professionals caring for patients who may need referring to Specialist Palliative Care services within the Doncaster locality.

Services Covered within these Criteria**:**

* Inpatient Unit:
* Community Specialist Palliative Care Team
* Day Hospice
* Hospice at Home:

The above services operate within the general framework described here, however service provision may vary slightly and so we request you also look at the appropriate section. These criteria cover an overview of service provision; more information is available on the hospice website [**www.stjohnshospicedoncaster.co.uk**](http://www.stjohnshospicedoncaster.co.uk)

**All referrals:**

* Phone Number 01302 566666 (advice)
* Fax Number 01302 566665 (referral form)
* Tasks can be sent via TPP to SPC Triage task group (referral form saved in

Communications and Letters)

* Email referral form

These numbers/emails are monitored Monday to Friday - 8.30am and 6pm

Saturday, Sundays and Bank Holidays - 8.30am to 4.30pm RDASH.SPCTriage@nhs.net

**Introduction**

Specialist Palliative Care (SPC) is an approach that aims to improve the quality of life for patients and their families facing complex problems associated with a life-threatening illness. Complex problems can be defined as those that affect multiple domains of need and are severe and intractable, involving a combination of difficulties in controlling physical and / or psychological symptoms (NICE, 2004) .

It is important to remember that many patients with a life-limiting illness do not experience complex symptoms and receive quality care within their own home without the need for specialist input.

**St John’s Specialist Palliative Care**

* St John’s Hospice services aims to deliver specialist palliative care for adults aged 18yrs and over, who have complex needs associated with advanced, progressive, incurable, malignant or non-malignant disease and are living in the Doncaster locality.
* Specialist Palliative Care endeavours to work alongside health professionals in primary and secondary care settings. Professionals should consider referral to specialist palliative care services if the level of need is considered beyond the scope of the current caring team.
* Referral should be considered by a Healthcare Professional for people with:
	+ Complex, distressing and uncontrolled symptoms (pain, nausea, vomiting, breathlessness)
	+ Complex Psychological concerns (e.g. overwhelming anxiety related to their disease, crisis intervention)
	+ Spiritual concerns (e.g. requiring help in adjusting to diagnosis or prognosis)
	+ End of Life Care for the dying patient

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| **St John’s Hospice is Unable to Provide Services for Patients Whose**:* Needs are mainly social in nature
* Current clinical problems are not related to their life-limiting illness
* Immediate care needs would be best met in an acute setting e.g. Neutropenic Sepsis
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| **The Referral Form:*** Complete the Common Referral Form (See Appendix).
	+ *To ensure a seamless service please complete the referral form, giving as much relevant detail as possible –- incomplete forms cause a delay in patient care and are an inappropriate use of resources. Please call a member of the team if you need advice with completing the form or need to discuss the appropriateness of the referral.*
* Ensure accurate and current information is available – please send (where relevant) recent letters, blood and scan results.
* Please identify the specific Specialist Palliative Care need on the referral form and where possible, indicate what the patient wants/expects from the service*.*
* Please indicate what treatments/medications have been tried.
* Ensure that the Patient has consented to the referral. If the patient does not have mental capacity, then please discuss the referral with the next of kin and family (as appropriate).

Please note: Referrals made for urgent assessment will be considered on an individualised basis. Please ensure that all relevant information is available, identifying the urgency and indicate when the patient was last seen. |

Where patients do not meet the referral criteria, the referrer will be contacted and signposted to other appropriate agencies/services.

All patients accepted by the Specialist Palliative Care Service will be discussed at the weekly Multidisciplinary (MDT) meeting and the details will be entered on to the patient’s electronic record.

**Inpatient Unit (IPU) Referrals Fax 01302 566665**

The 10 bedded IPU at St. John’s Hospice is dedicated to providing patients with the highest standard of specialist care and comes under the umbrella of the Multidisciplinary Team. Unfortunately, we are unable to accommodate indefinite lengths of stay; please discuss this with the patient and their family prior to the referral.

All referrals to the inpatient unit will be triaged on a daily basis where patients will be prioritised on a needs led basis. If the team are unable to admit a patient that day due to limited bed capacity, Triage will review the circumstances and alternative support may be offered until a bed becomes available. Whilst the hospice is not an emergency service, urgent referrals will be considered on an individualised basis and following discussion with the Triage/Medics and IPU team.

Admission for End of life Care at St John’s Hospice means that a patient’s condition has progressed significantly and life is not expected to extend beyond two weeks.

An in-patient referral should be considered if a patient has:

* Complex, uncontrolled or difficult to manage symptoms
* Symptom management is required in a controlled specialist environment e.g. complex pain management regime, complex psychological issues related to their disease or intractable nausea and vomiting.
* The patient is nearing the end of life and has chosen the hospice as their preferred place to die.

With the exception of patients who are admitted for care in the last days of life, discharge planning commences on admission. Any issues which impact on timely discharge will be identified through the admission assessment process and action will be taken to address these issues. Completion of NHS Continuing HealthCare assessment prior to admission will support this process.

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| **Request for In-Patient Unit Out of Hours Admissions*** The hospice is working toward 7 day admissions, admissions at the weekend and bank holidays are classed as out of hours and will be considered on a clinical needs basis, and are dependent on bed capacity, medical and nursing cover.
* Patients will be considered for Out of Hours admission if:
	+ Urgent symptom control required and home not appropriate for overnight
	+ Emergency same day treatment required, e.g. for hypercalcaemia (this is based on patient state, not blood test results)
	+ Patient is dying and hospice is Preferred Place of Death and unlikely to be fit for travel the following day
	+ Should ensure hospital is not a more appropriate place of care (e.g. recent oncology treatment and oncology treatment related problems or escalation of care is appropriate)
	+ It is the exception, rather than the rule that patients are admitted OOH from another safe place of care, e.g. Hospital
* Completed referral forms should to be sent to:
	+ Phone Number 01302 566666 (advice)
	+ Fax Number 01302 566665 (referral form)
	+ Tasks can be sent via TPP to SPC Triage task group (referral form saved in

 Communications and Letters)* Email referral form RDASH.SPCTriage@nhs.net
* The hospice is unable to accommodate overnight admissions.
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**Community Palliative Care Clinical Nurse Specialist Fax 01302 566665**

The Community Specialist Palliative Care Team has been developed from an integration of two palliative care services, previously known as Community Macmillan Nurses and Hospice at Home.

The service aims to be more responsive to patients’ needs by providing seven day specialist palliative care advice and expertise, with Specialist Palliative Care Triage, and seven day community visits.

We recognise the palliative care skills already provided by the Primary Care Team. Not all patients with a malignant disease or life threatening illness will require intervention from the Community Specialist Palliative Care Team. The primary care team are often best placed to identify when they need help with a palliative care patient.

Referral should be with the patient’s consent and made for:

* Patients with complex symptoms where:
	+ The district nurses and the GP have attempted to manage the symptoms without success.
	+ The patient has been discharged from hospital or the hospice with known complex symptoms that have required the help of the specialist palliative care team during the inpatient stay.
	+ Attempts have been made by generalist staff, for example, at outpatient clinic, to manage symptoms before referral to the specialist palliative care team.
* Patients and their relatives/carers requiring specialist information at the time of diagnosis of progressive disease or recurrence. This would be in addition to the palliative care information and support provided by the general primary care team. It would also be in addition to the information and advice provided by hospital teams.
* Patients and their relatives/carers requiring additional specialist palliative care social, spiritual and psychological support over and above that provided by primary carers, where there are assessed complex needs.
* In addition we are able to offer patients and families requiring more palliative input and support to facilitate remaining in their preferred place of care by the provision of enhanced support. Care will be predominantly be provided by healthcare assistants, supported by the Palliative Care staff nurses within the team. Patients will have palliative care needs but additional care is required to support existing community services.

Examples include:

* Uncontrolled symptoms, requiring close monitoring in partnership with the Community Specialist Palliative Care Nurses if appropriate
* Rapidly deteriorating condition, resulting in the need for more support.
* Carer unable to cope with changing/unpredictable demands in patient care, where the ceiling of care has been reached with existing community services.
* Breakdown in care will lead to an in-patient admission and a significant step up in care is required to support the patient and carer to remain in their preferred place of care
* Rapid discharge from in-patient settings where Preferred Place of Care/Death is identified as patient’s own home and additional care is required to support existing Community Services.
* Patients living alone whose preferred place of death is their own home

If input is required up until the time of death, the carer will be offered a post bereavement contact and assessed for specialist bereavement support. Referral to further bereavement support will be made if required, and then the carer will be discharged from this service.

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**Day Hospice Services:** **01302 798472 Fax 01302 566665**

The specialist palliative day hospice based at St. John’s Hospice aims to improve the quality of life of those attending by providing a therapeutic programme of interventions and activities. The day hospice is funded for fifty patients per week who are given the opportunity to access a variety of services in the same place.

* All patients attending the Specialist Palliative Care hospice are initially offered a 12 consecutive week placement.
* During the placement patients are assessed using the SPARC tool (Sheffield Palliative Assessment and Referral to Care) and an individualised treatment plan is devised and agreed with the patient for their onward management.
* The patient centred approach used in the day hospice encourages patients to become involved in choices about their treatment and care.
* The service aims to promote independence by maximising the patient’s ability to function as they adapt to the limitations of their illness
* Patients need to be well enough to attend the day hospice.

For patients who do not meet the referral criteria, the following procedure will occur:

* A telephone discussion with the referrer within 5 working days of identification of inappropriateness. A copy of the referral criteria will be offered in paper form or directed to the website. Any discussion will be confirmed in a letter to the referrer within two working days of the telephone call.

**Discharge Criteria**

Discharge from one or all services will be considered when:

* The patient’s complex needs have been resolved and they can be cared for in a less specialised environment or without community specialist input.
* When, upon assessment, it is agreed that the input of another specialist service would more appropriately meet the needs of the patient.
* When it is recognised and agreed that the Primary Health Care Team are able to continue the management of the client’s care without Specialist Palliative input.
* When a patient requests no further intervention.

Following the agreed discharge, a letter of notification will be sent to the referrer and G.P.

Many patients receive more than one service within the scope of Specialist palliative care; discharge from one service does not mean discharge from all Specialist Palliative Care input.

**Additional Services Provided by St John’s Hospice:**

Additional complementary services that are provided by St John’s Hospice but fall outside of the scope of these criteria are in the list below. Please refer to the website for additional information regarding these services and how to make a referral.

* **Counselling and Bereavement Service** - Offers a comfortable and supportive environment to all patients, carers and families involved with any of our specialist teams and for patients with a new diagnosis of cancer
* **Chaplaincy Service** - The Chaplaincy team is available to support patients, their families and friends, staff and volunteers. The purpose of the team is to meet the spiritual and religious needs of individuals of any or no faith.
* **St John’s Information & Support Centre -** Houses an Information Team that offers advice, help and support via the telephone, leaflets/booklets or on a 1-1 basis at the centre about cancer and other life limiting conditions. Additional information is available about finances, benefits and medical aids etc.

**Bibliography and References:**

Association for Palliative Medicine of Great Britain and Ireland et al (2012) *Commissioning Guidance for Specialist Palliative Care – helping to deliver commissioning objectives.* Southampton. Association for Palliative Medicine of Great Britain and Ireland

NHS England (2012) *National Cancer Peer Review Programme - Manual for Cancer Services: Specialist Palliative Care Measures.* Lndon. NHS England.

NHS England (2013) *Specialist Palliative Care - Findings from 2012/2013 Self-Assessment.* London. NHS England.

NICE (2004) *Guidance on Cancer services: Improving Supportive and Palliative Care for Adults with Cancer – The Manual.* London, NICE.

RDASH (2013) *Specialist Palliative Care Multidisciplinary team Operational Policy.* Available on the Intranet