York Teaching Hospital NHS
NHS Foundation Trust

Referral & Discharge Guidelines

Selby and York

Specialist Palliative Care Team

19th May 2015

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Referrals to the Specialist Palliative Care Team:

A referral to the Specialist Palliative Care teams can be made by any health or social care professional, with the agreement of the patient. It is preferable that the patient is aware of their diagnosis/prognosis.

The patient and carers MUST require additional specialist support over and above that already provided by the existing care team.

Referral should be made for:

- Patients with a diagnosis of cancer or life threatening illness e.g. end stage heart failure, who additionally have problematic pain or other uncontrolled symptoms regardless of stage or outcome. The patients will have active progressive disease
- Patients and their carers who require specialist psychosocial/family or spiritual support
- Patients requiring specialist rehabilitation to enable them to adapt to the limitations of their condition and to maximise their quality of life.
- Staff requiring support in order to continue caring effectively for patients as outlined above.
- Health and social care professionals should make the referral and ask patients consent to do so. They should not advise the patients/carers to contact the team directly.

Our aim is to ensure that all patients/carer with specialist palliative care needs receive appropriate treatment or support irrespective of their race, sex, disability, colour, nationality, ethnic origin, religion, marital status, sexual orientation or age.

Depending upon the reason for referral, or the needs of the patient / carer, several levels of intervention are available:

Level 1	Advice, information and support only.
Level 2	Involves a single consultative visit which may be joint visit with the referrer. The focus is advice to enable the referrer to manage patient's problems effectively.
Level 3	Short term interventions in relation to specific unresolved problems. The intervention will be to discharge the patient from the service back to the referrer when the patients need have been resolved.
Level 4	For patients with multiple complex problems that need specialist input over a long period of time.

The team will assist the key worker in assessing the needs of patients and will not take over the care but will act as a specialist resource.

The Specialist Palliative Care Teams are keen to discuss potential referrals with referrers and if necessary to signpost to more appropriate agencies or sources of support.

A referral form is used across the locality and is in **Appendix A**

Contents of a Referral letter/form:

Clinical details are required to allow appropriate assessment and prioritisation of the referral. Referral details should include:

- Administrative details (name, age, address, date of birth, telephone number, NHS number)
- Diagnosis
- Summary details of disease and treatment to date
- Outline of reason for requesting specialist palliative care team input
- A list of current medications
- Service required
- Key workers already involved (GP, main consultant, specialist nurse etc. including contact details)
- Telephone number of referrer
- Patient agreement to referral**.**

Discharge from the Specialist Palliative Care Team:

Patients on referral to the service will be given information on the role and that when specialist needs are meet they will be discharged from the teams caseload to the ongoing care of the key worker. Patients will be discharged from the Specialist Palliative Care Team Service when:

- The patient no longer has a specialist palliative care need eg pain controlled or presenting issue resolved
- The patient/carer moves out of the area. Referral will be made to a specialist palliative care service in the area where the patient will be resident if appropriate.
- The patient/carer is referred to another professional organisation and it is appropriate that they oversee care i.e. hospice day care
- The patient/carer no longer wishes Specialist Palliative Care Team input.
- Where a contractual arrangement exists with a patient/client whereby the period of support reaches a previously agreed end point.
- When there has been no contact with the patient/carer for six weeks.

On discharge from the service the appropriate health care professional will be notified by letter. Copies of the letter will be sent to patients at their request

Re-referral can be made at anytime, when and if problems reoccur by following the referral procedure.

Codes for discharge are seen in **Appendix B**

Contact arrangements for Specialist Palliative Care Teams within Selby and York locality are seen in the evidence file

Teams have slightly varying working hours. The hospital and community team are only available Monday to Friday. The answer phones for non urgent messages are checked daily Monday to Friday.

Community Team members can be contacted by mobile phones during office hours.

For urgent messages, CNSs based in York Hospital can be contacted urgently on a bleep.

The Palliative Medicine Consultant in the hospital can be contacted by mobile or radio pager via hospital switchboard or via Team Secretary on 01904 725835.

Base/ Locality	**Core Service Hours**	**Telephone No**	**Fax No**
York and Selby Community Palliative Care team The Lodge St Leonard's Hospice 185TadcasterRd York YO24 1GL	08:30 - 16:30	01904 724476	01904 777049
Hospital Palliative Care team York Teaching Hospital Wigginton Road York YO318HE	08:00 - 16:00	01904 725835	01904 777049

Out of Hours (OOH) medical telephone advice is available by contacting St Leonard's Hospice on 01904 708533 and asking for the doctor on call.

If the doctor in the hospice requires further advice from the Consultant on call, this can be found on the Palliative Medicine Consultant duty rota . Enclosed in the evidence file

Consultants participating in the rota are from York, Scarborough, Harrogate and Dove House, Hull.