Referral & Discharge Guidelines

Selby and York

NHS Specialist Palliative Care Team

December 2017

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Who can refer to Specialist Palliative Care Team?

In **community** referrals can be made by GP, District nurses and the specialist palliative care team.

Urgent referrals are accepted from the hospital services, but **non urgent must go through the GP or district nurse.**

In **hospital** referrals can be made by Consultants, Specialist Palliative Care Teams and Cancer CNS (for urgent referrals only).

Any Health care professional can ring and discuss a referral and be signposted to the potential appropriate referrer or service.

Referral criteria

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.

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

Referrals 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.

Non-urgent referrals should fit above criteria and will be contacted within 2 working days.

Urgent referrals should fit the above referral criteria **plus**

- **Rapidly escalating symptoms.**
- **Rapidly deteriorating.**
- **Patient/carer at risk of harm.**
- **Vulnerable social/psychological situation.**

Community To discuss urgent community referrals please ring duty CNS in community via 01904 724476 and complete a referral form to be sent via sleho.spcreferral@nhs.net

Urgent referrals will be contacted within 24 hours

Hospital To discuss urgent hospital referral contact 01904 725835 but you still need to complete an electronic referral via CPD

Levels of intervention

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.

An electronic referral form is used across the locality and is to be sent sleho.spcreferral@nhs.net **See Appendix 1.**
Referrals to Specialist palliative on weekends and bank holidays **See Appendix 2**

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 any time, when and if problems reoccur by following the referral procedure.

Codes for discharge are seen in **Appendix 3**

Availability of service and contact details

The hospital and community team are available **7 days a week**,

The hospital team available 08:00 to 16:00 and the community team available 08:30 to 16:30. The answer phone is for non urgent messages, and checked daily.

Community Team members may be contacted

a) Monday to Friday by patients on 724476 or by professionals on mobile phones
b) Saturday and Sunday by patients and professionals via weekend mobile 07990526890.

York Hospital CNSs can be contacted on 01904 725835 or urgently via a bleep held by team secretary or with switchboard.

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

Base/ Locality	**Core Service Hours**	**Telephone No**	**Fax No**
Community Palliative Care team The Lodge St Leonard's Hospice 185 Tadcaster Rd York YO24 1GL	08:30 to 16:30	01904 724476	01904 777049
Hospital Palliative Care team York Teaching Hospital Wigginton Road York YO318HE	08:00 to 16:00	01904 725835	01904 726440

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.

Appendix1

St Leonard's Hospice
Caring for Local People

York Teaching Hospital NHS
NHS Foundation Trust

Referral Form - Specialist Palliative Care Services

(Please complete as thoroughly as possible or the initial assessment may be delayed)

Service Required (Please tick the appropriate box) Please email completed form to: SLEHO.spcreferrals@nhs.net	
Community Palliative Care Team Referral ☐ St Leonard's Hospice, 185 Tadcaster Road, York YO24 1GL **Referral Criteria** click here Urgent ☐ (ring to discuss) Non Urgent ☐ **Tel 01904 724476**	**St Leonard's Hospice** 185 Tadcaster Road, York YO24 1GL **Tel 01904 708553** **Inpatient Unit Referral** ☐ **Hospice@Home Referral** ☐ **Sunflower Centre (Outpatient services) Referral** ☐ **Lymphoedema Referral** ☐ (for patients with a cancer diagnosis)

Patient Details (Please print if handwritten)			
NHS No:	Hospital No	Title:	DOB:
Surname:	First Name:	Preferred Name:	Marital Status:
Address			Postcode:
Tel:		Mobile:	
Current Location if not at home address:			
Occupation:		Lives alone? Y ☐ N ☐	
Please specify any potential risk to a lone worker:			

Next of kin / Main Carer Details		
Full Name:	Relationship:	
Address: (if different from above):		Postcode:
Tel:	Mob:	

Disease Status	
Diagnosis and extent of disease (including date of diagnosis):	
Patient aware of diagnosis: Y ☐ N ☐	Main carer aware of diagnosis? Y ☐ N ☐
Current/Planned Treatments:	
Does the patient need a side room for infection control purposes? (eg clostridium difficile, MRSA infection). Please give details:	
Does the patient have any specialist equipment need? (eg. high flow oxygen, hoist, bariatric bed, intrathecal pump, non-invasive ventilation, PEG feeding etc). Please give details:	
Does the patient require any mobility aids? (eg stick, frame, wheelchair, hoist)	
Other significant co-existing condition (include cognitive impairment and sensory impairment):	

Phase of illness:	Stable ☐ Patient problems and symptoms are adequately controlled by the existing plan of care.	Unstable ☐ An urgent change in the plan of care or emergency treatment is required because they are experiencing a new problem that was not anticipated in the existing care plan or a rapid increase in the severity of a current problem.	Deteriorating ☐ The patient's overall function is declining and they are experiencing anticipated and gradual worsening of existing problems.	Dying ☐ Death is likely within days to short weeks
Has DS1500 been applied for? Y ☐ N ☐				

St Leonard's Hospice
Caring for Local People

York Teaching Hospital NHS
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Referral Form - Specialist Palliative Care Services

Reason for Referral	
Please outline the main Physical/Psychological/Social/ Spiritual Issues:	
Consent agreed for referral? Y ☐ N ☐	Date of referral:
Please note that referrals will not be accepted unless the patient or main carer has consented to the referral	

Professionals Involved		
Consultant Name:	Hospital:	Tel:
Usual GP:	Practice:	Tel:
Other:		Tel:
Known to District Nurse? Y ☐ N ☐	Known to Social Services? Y ☐ N ☐	

Advance Care Planning
DNA CPR Status in place? Y ☐ N ☐
Preferred Place of Care:
Preferred Place of Death:
Are anticipatory drugs for end of life care in place? Y ☐ N ☐ **The following drugs should normally be available in the home for subcutaneous use; appropriate Opioid, Levomepromazine, Haloperidol, Midazolam, Hyoscine Butylbromide. Please refer to the cross setting syringe driver chart and last days of life care plan (click here) for more details.**
Has the patient got a written Advance Care Plan statement? Y ☐ N ☐ See RSS Palliative Care Guidance
Please provide details:

Referrer Details	
Name:	Role:
Work base:	Tel:
Ensure District Nursing Team is informed of this referral • SystmOne practices if patient **known** to District Nursing Team send task for information • SystmOne practices if patient **not known** to District Nursing Team send email to SPA yhs-tr.YorkSPA@nhs.net • EMIS practices send email to SPA yhs-tr.YorkSPA@nhs.net	

Medications
For hospital referrals, please provide a list of current medications and allergies if not up to date within CPD. For GP and community referrals, please attach a **brief** computer summary of the patient's history.

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Responsible Authors: Sarah Wilcox, Dan Cottingham	Responsible Consultants: Sarah Wilcox, Kath Sartain	

Appendix 2

Weekend / bank holiday Specialist Palliative Care arrangements

- Referral to the service at weekends and bank holidays should meet the referral criteria of the service provided Monday to Friday
- The service should be for patients with any life limiting illness, regardless of diagnosis whose level of palliative care need is considered beyond the scope of the current caring team
- Patients requiring review at the weekend or bank holiday are those who are perceived to have immediate needs that cannot wait until the next working day
- New referrals can be taken but assessment will only take place over the weekend and bank holiday when issues are considered to be urgent otherwise they will be passed on for the appropriate staff on the next working day
- Patients known to the service will be contacted or visited the same day if they have on going urgent symptoms or emotional needs that require review.
- Immediate needs only will be addressed

Suggestions for referral on a weekend or bank holiday would include

- Escalating or intractable pain or symptoms which have not been resolved by giving appropriate treatment eg intractable vomiting, dyspnoea, acute agitation
- Medication advice for patients already on specialist or unusual drug regimes
- Support for complex social and emotional carer needs that cannot be resolved by telephone contact

Who can make contact?

- Professionals involved with the patient and family
- Individuals already known to the palliative care service

Operational Guidance

- Operational hours of service are 08.30 to 16.30 (community)/ 08.00 to 16.00 (Hospital)
- Service is provided by 1 clinical nurse specialist per clinical area
- Contact for the York community is via mobile on : 07990526890
- Contact for Hospital palliative care team is : 01904 725835
- In the event of sickness the team member will telephone their community / hospital colleague who will follow the procedure for unexpected absences at a weekend.
- The base for working is York hospital team office /York community team office.

Appendix 3

Discharge Codes and Reasons

DC1	No further specialist needs at the present time, currently stable
DC2	Transferred to another care setting (hospital/hospice/nursing/care home)
DC3	Transferred out of area
DC4	Declined input
DC5	Inappropriate referral
DC6	Information only
DC7	Post bereavement work, patient deceased
DC8	Unable to contact
DC9	Deferred referral due to ongoing treatment
DC10	Deferred referral due to patient refusing to discuss/acknowledge prognosis
DC11	Declined input due to patients wishes to support own children
DC12	Patient on waiting list for another service
DC13	No further financial input available
DC14	Referred to another service
DC15	Achieved goals of planned treatment