St Ann's Hospice

every day makes a difference

Referral Handbook

A guide to referral criteria for St Ann's Hospice services

Inpatient Care

Day Therapy

Community Support




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SK8 3SZ
Tel: 0161 437 8136
Fax: 0161 498 9640
Email: nehgm.admissions-hg@nhs.net

St Ann's Hospice
Meadowsweet Lane, off Peel Lane,
Little Hulton,
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Manchester
M28 0FE
Tel: 0161 702 8181
Fax: 0161 790 0186
Email: stan.admissions-lh@nhs.net

Neil Cliffe Centre
Wythenshawe Hospital,
Southmoor Road,
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Referral Criteria

Introduction

General palliative care services are delivered by health and social care professionals providing day to day care and form the mainstay of support for patients with advanced illness and their families and carers . These patients may be cared for at home (home may be in a residential home, care home, or care home with nursing, community hospital or another place of care).

It is recognised that many patients with life-limiting illness do not experience complex problems; however there are times when generalist services cannot manage the complex needs of their patients or of their families encompassing physical, psychological, social and spiritual needs and may require additional support.

Complex problems are 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, the presence of family distress and social and/or spiritual problems (NICE 2004).

In response to managing patients with these complex problems St Ann's Hospice has, over the years, developed its specialist palliative care services.

St Ann's Hospice

St Ann's Hospice aims to deliver specialist palliative care for adults aged 18 and over who have a life-limiting illness, with complex needs and who require assessment and management by the multi-disciplinary team.

St Ann's is unable to provide services for patients whose:

- conditions are stable and their 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 the acute setting – e.g. neutropenic sepsis

Should you need further clarification as to whether your patient will meet these criteria or wish to discuss their needs, please contact the Admissions Officer who will arrange for you to speak to a senior nurse or doctor. The admissions offices are open Monday to Friday, 8am - 4pm; excluding bank holidays (see page 6 for contact details). It is important that you provide us with as much information as possible, as patients will not be entered on the waiting list until all relevant information is supplied.

Location of services

St Ann's Hospice has:

- Two inpatient hospice units based at Heald Green and Little Hulton
- Three day therapy units based at Heald Green, Little Hulton and the Neil Cliffe Centre
- A Community Specialist Palliative Care Team based at Little Hulton for patients registered with a Salford GP
- A Hospice at Home service for residents of Salford and Trafford

Service Provision

Inpatient specialist palliative care is for patients with complex problems which cannot be managed effectively by other healthcare professionals in other settings and who would benefit from the continuous support of the multi-disciplinary palliative care team.

Day therapy specialist supportive and palliative care provides an opportunity for specialist assessment and review of patients' needs enabling the provision of physical, psychological, social and spiritual interventions within the context of clinical settings e.g. supportive outpatients, daycare.

The Community Specialist Palliative Care Team (Salford) provides advice, assessment and support to patients registered with a Salford GP who have complex needs, in conjunction with their primary health care team.

St Ann's Hospice at Home service provides specialist palliative care to Salford & Trafford patients in their place of residence.

St Ann's Hospice services are delivered by specialist multi-disciplinary teams. These teams possess a wide range of expertise. Services are delivered by Consultants in palliative medicine, Doctors and Nurses with palliative care experience, Palliative Care Clinical Nurse Specialists, Physiotherapists, Occupational Therapists, Dietitian, Pharmacists, Social Workers, Chaplains and Psychological Support staff.

There is also close liaison and collaboration with our hospital and primary health care colleagues and other community health and social care services.

If you have any questions regarding this Referral Criteria Handbook, please contact the Registered Manager/Clinical Services Manager.

St. Ann's Hospice is committed to widening access and valuing diversity and positively welcomes people from different cultures and backgrounds.

Find out more about us

You can find out more about St Ann's Hospice on our website, or by emailing us:

Website: **www.sah.org.uk**

email: **enquiries@sah.org.uk**

Comments and feedback

We welcome your feedback: please visit **www.sah.org.uk/feedback**.
Formal complaints can be made in writing to our Chief Executive at our Heald Green address.

Referral criteria for hospice inpatient care

Referrals are accepted for patients with a diagnosis of an advanced, progressive life-limiting illness who have associated complex specialist palliative care needs.

Referral can be made for one or more of the following reasons:

- Complex symptom control e.g. intractable vomiting, pain and agitation
- Complex psychological and/or spiritual need e.g. severe anxiety and depression
- Complex social need e.g. crisis intervention
- Rehabilitation assessment following radiotherapy, chemotherapy, surgery or other palliative interventions
- Care of the dying patient with specialist palliative care needs

Some patients will require specialist inpatient care because of their immediate and difficult situations. It may be, however, that assessment via day therapy services e.g. medical outpatients or day care would be equally beneficial and prevent the need for admission.

The hospice is unable to accept patients for indefinite care and this should be made clear to the patient and family when hospice admission is being discussed by the referring healthcare professional. Most patients will be admitted for a period of assessment; length of stay will be dependent on complexity of need and with the exception of patients who are admitted for care in the last days of life, discharge planning commences on admission.

The hospice acknowledges the importance of advance care planning and recognises that patients may have preferences with regard to their preferred place of care/death. The hospice is required to prioritise access to all our services according to the complexity of need and therefore, unfortunately, we will not be able to accede to all such requests.

If it is clear from your assessment of the patient's condition that they will require medium to long- term care, we ask that you commence an NHS Continuing Healthcare Application prior to admission in order to facilitate timely, effective and supportive discharge from the hospice. NHS Continuing Healthcare documentation should be forwarded to the CCG.

Prior to referral, there is a requirement that the patient is assessed by either a medical practitioner or member of a specialist team, to identify specific specialist palliative care need. Members of the specialist team must also sign to confirm that the patient's medical lead has consented to the referral and that the patient and family where possible are all in agreement with the referral being made.

How to refer for inpatient care

The purpose of the hospice referral form is to ensure that we have the relevant information upon which to base our assessment of a patient's need for specialist palliative care and to prioritise accordingly. There should be direct discussion with the hospice team if any of the following apply:

- Oxygen requirements above 35%
- A requirement for blood products or intravenous medication
- Total Parenteral Nutrition
- PEG feeds
- A healthcare acquired infection
- A spinal line
- Confusion and is ambulant
- Mental health history
- Tracheostomy
- Chest drains

The referral form must be **fully** completed by the referrer – any incomplete forms **will** be returned and may result in delayed admission. The referral form may be submitted either by email, post or fax as detailed below.

Referrals for admission are reviewed on a daily basis (Monday – Friday excluding bank holidays). Patients for whom admission is required as soon as possible will be placed on the "active waiting list" and will be admitted dependent on the referral criteria above and bed availability. This decision will be communicated to the referring team by the Admissions Officer.

The hospice will endeavour to signpost the referrer to other services in the community able to support the patient until admission can be arranged. Symptom control advice is available from hospice nursing and medical staff, as is the telephone number of the 24hr Advice Line should further advice be required.

Contact details:

Heald Green Admissions Office
St Ann's Road North,
Heald Green, Stockport, SK8 3SZ
Telephone 0161 498 3608
Fax 0161 498 9640
Email: nehgm.admissions-hg@nhs.net

Little Hulton Admissions Office
Meadowsweet Lane, Off Peel Lane,
Little Hulton, Worsley, M28 0FE
Telephone 0161 702 5408
Fax 0161 790 0186
Email: stan.admissions-lh@nhs.net

If admission is required urgently, please contact the admissions office Monday to Friday, 8am - 4pm, excluding bank holidays.

Out of hours please contact the main hospice switchboard – Heald Green 0161 437 8136, or Little Hulton 0161 702 8181 and ask to speak to the nurse in charge.

Capacity and consent

If there is a reason to doubt the person's capacity to consent to admission to the hospice and there is no Lasting Power of Attorney for health and welfare or Court Appointed Deputy (in line with MCA), a capacity assessment will need to be carried out. If a person is assessed as lacking capacity to consent to admission to the hospice a best interest discussion or meeting will be required. Copies of capacity assessment and best interest discussion/meeting to be sent with the referral.

Referral response times
Monday – Friday

- Each referral received on Monday to Thursday will be reviewed at the referrals meeting the following morning.
- Referrals received on Fridays, out of hours, at weekends and on bank holidays will be reviewed at the referrals meeting on the next working day.
- Urgent referrals for admissions received during the working day will be discussed with the senior nurse and doctor on duty who will decide whether it is possible to admit the patient that day or advise of the earliest opportunity to admit. This will enable the referrer to make other arrangements if the hospice cannot admit the patient immediately.
- All other requests for admission will be prioritised by need and a bed offered within 1 to 3 working days if possible, subject to bed availability and staffing.

Out of hours

The ability to admit patients out of hours is limited. To request an admission out of hours the referrer must contact the nurse in charge who will liaise with the on-call doctor to determine the appropriateness of the request. The acceptance of admission will depend on clinical need, bed availability, medical and nursing cover. This must not be considered for respite or as an alternative to social care crisis.

Out of hours referral response times

- A response to request for out of hours admission will be made immediately by the nurse and doctor in charge.
- A bed, if available, will be offered within 24 hours.

Transfer of patients to the hospice

Planned admissions will normally occur between 9am - 3pm Monday to Friday excluding bank holidays. Wherever possible, the hospice will endeavour to give 24 hours notice of bed availability.

1. It is the responsibility of the patient's current healthcare team to:
    - Ensure the patient is fit to travel to the hospice. It may not be appropriate to transfer patients who are actively dying
    - Arrange suitable transport
    - Ensure that the patient and family understand that admission is not for indefinite care and that the length of stay will be determined by the patient's needs
2. The patient's current healthcare team should also inform the patient/carer of the admission arrangements.
3. Patients transferred from hospital/community care should be accompanied by a nurse/carer wherever possible. A copy of hospital/community notes, NHS Continuing Healthcare documentation, a list of current medication and transfer documentation including any wound care plans must always accompany the patient.
4. Patients transferred from home should be accompanied by a carer wherever possible. All current medications should be brought with the patient.

Discharge criteria

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 Health Care Assessments prior to admission will support this process.

Discharge will be arranged when:

- The patient no longer requires specialist inpatient care and their specialist needs can be met by other hospice services or by Community Specialist Palliative Care Teams
- The specialist needs of the patient have been met and any remaining needs can be met by the primary/social care team
- The patient's preference is to be cared for at home, even if their specialist palliative care inpatient needs have not been met

It is the responsibility of social services and community healthcare providers to meet the assessed social and healthcare needs of patients who meet hospice discharge criteria. This may be via a home care package, or a care home placement. The hospice Social Work team will offer information, advice and support to the patient and their family and will work with social services and the CCG to expedite discharge planning.

In the event of ongoing nursing care needs, the hospice Social work team can offer information, advice and support to arrange 24 hour care placement if required.

Day Therapy

Day Therapy provides a range of services for patients with a diagnosis of an advanced, progressive, life-limiting illness who have associated complex specialist palliative care needs. Due to funding arrangements, some day therapy services are only available in certain areas.

Referral criteria for all day therapy services

A referral can be made for one or more of the following reasons:

- Symptom control
- Psychological, spiritual and social need
- Rehabilitation assessment following radiotherapy, chemotherapy, surgery and palliative care interventions

The referral form must be fully completed. If we need to contact you for further details, there will be a delay in activating the referral.

The following information outlines the services available within the day therapy units (see contact details page 13)

Supportive Outpatients

Referral criteria for supportive outpatients

The supportive outpatient service provides outpatient support for patients/carers who are affected by a life-limiting illness.

The principal aims of supportive outpatients are to:

- Assist individuals to cope with a life-limiting illness and its treatments
- Provide assessment enabling the individual to identify their needs/objectives
- Plan a programme of supportive interventions with the individual to meet their specific needs/objectives. Supportive interventions will be subject to an ongoing review by the multi-disciplinary team
- Liaise with other health and social care professionals where appropriate

How to refer to Supportive Outpatients

1. Referral can be made by a GP, DN, hospital medical/surgical team or by specialist teams in the community or hospital.
2. The hospice referral form should be fully completed. The form may be submitted by post or fax.
3. Individuals wishing to access the service may self-refer by telephone or in person; however the GP will be notified of access to service.

Referral response times

- The patient/carer will be offered an appointment within 4 weeks from receipt of referral.

Discharge criteria

- When an individual's needs are met
- Outstanding needs do not fall within the referral criteria for supportive outpatient services
- There is no further scope to make an impact on their need

Referral criteria for hospice day care

Referrals are accepted for patients with a diagnosis of an advanced, progressive life-limiting illness who have associated complex specialist palliative care needs. Patients will need to be well enough to attend day care.

The day care service provides:

- Access to the multi-disciplinary team, co-ordinated by a keyworker
- A management plan which is discussed and agreed with the patient. The management plan will be subject to ongoing review by the multi-disciplinary team
- Liaison with other health and social care professionals (hospital/community)

Most patients will attend day care for 8 to 12 weeks. Each patient will have a nurse assigned as their key worker who will undertake an initial assessment, agree a management plan with the patient and refer the patient to relevant services in order to meet the patient's specific needs.

How to refer to day care

- Referrals can be made by a GP, DN, hospital medical/surgical teams or by specialist teams in the community or hospital.
- A hospice referral form should be fully completed by the assessing healthcare professional. For referrals from healthcare professionals other than the medical lead (GP/hospital consultant) they must also sign to confirm that the medical lead has been informed of the referral.
- The referral form may be submitted by email, post or fax.

Referral response times

- Verbal contact will be made with the referrer within 5 working days of receipt of referral.
- Patients will be contacted by the day care staff within 10 working days of receipt of referral.
- The GP will be notified within 10 working days of the patient's first attendance.
- We will aim to see patients within the day care unit within 20 working days of receipt of referral.

In the event that day care is at full capacity, or hospice transport is not available, a letter will be sent within 10 working days to the patient and copied to the referrer informing them that they will be placed on a waiting list. The patient will be contacted when a place/hospice transport is available.

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

- A telephone discussion with referrer within 5 working days of identification of inappropriateness. This discussion will be confirmed in a letter to the referrer within 2 working days of the telephone call.

Discharge criteria

- Individual patient needs are met.
- A patient's needs can be met by their primary and/or social care providers.
- The patient's outstanding needs do not fall within the referral criteria for day care.
- The patient is not well enough to attend.

Specialist Palliative Medical Outpatients

The specialist palliative medical outpatient service provides specialist assessment and a negotiated management plan for patients with cancer or other life-limiting illness where complex symptoms and / or other concerns have been identified or are anticipated. There is close liaison with other health and social care professionals (hospice/ hospital/community) involved in the patient's care. The patient must be well enough to attend the clinic.

Referral criteria to specialist palliative medical outpatients

Referrals are accepted for patients with a diagnosis of an advanced, progressive, life-limiting illness who have associated complex specialist palliative care needs. Patients need to be well enough to attend.

How to refer to specialist palliative medical outpatients

- A referral can be made by a GP or by members of specialist teams in the community or hospital.
- A hospice referral form should be fully completed by the assessing health care professional; for referrals from healthcare professionals other than the medical lead they must also sign to confirm that the patient's medical lead has been informed of the referral.
- The referral form may be submitted by email, post or fax.

Referral response times

- For urgent referrals, patients will be seen within 10 working days.
- For routine referrals, patients will be seen within 20 working days.

Discharge criteria

- When a patient's symptoms or other concerns have resolved or can be managed within another care setting.
- When a patient is no longer well enough to attend clinic.

Lymphoedema Management Service

The lymphoedema management service is available in an outpatient clinic setting. The principal aim of treatment is to improve the patient's quality of life by rehabilitation of mobility and functional levels.

A specialist assessment is carried out by a Lymphoedema Specialist Practitioner or Keyworker and lymphoedema management is planned with the patient. Education empowers the patient to develop self-care skills to manage their lymphoedema. Staff will liaise with relevant health and social care professionals in acute, community and voluntary sectors to facilitate an integrated pathway of care. Lymphoedema is an irreversible progressive condition but active management can improve or prevent deterioration. The majority of patients with a diagnosis of lymphoedema will continue to require intervention indefinitely.

Referral Procedure

Healthcare professionals can refer a patient using our referral form. Referral from members of the hospice MDT are made via EMIS as a linked episode. Self-referrals are accepted only from patients who have previously been treated and discharged for the service.

Referral Criteria

Referrals are accepted for patients who have

- Lymphoedema secondary to cancer or its treatment
- Primary lymphoedema, preferably following investigation by lymphoscintigraphy to confirm diagnosis
- Lymphoedema from other causes following completion of vascular assessment and if BMI less than 40 (moderate)

Response times

- Referrals are triaged by the specialist practitioner and recorded in the waiting list file. Contact is made with the referrer in the event of an inappropriate referral within 1 week of identification of inappropriateness.
- Referrals for patients with progressive disease are seen as urgent.
- Due to demands often exceeding resources, referrals are prioritised in which case non-cancer patients will remain on the waiting list longer than those with a cancer diagnosis.
- The patient and referrer are informed if the waiting list is longer than 3 months and will be notified of an alternative lymphoedema clinic.
- The patient is contacted verbally if an appointment is available within 2 weeks. Otherwise appointment letters are sent giving a minimum notice of 2 weeks.

Discharge criteria

Service users are discharged when any of the following criteria are met:

- The service user is free of swelling.
- The service user declines to further access the service, consistently does not attend their appointment without reason or refuses to comply with treatment plans.
- The service user is proficient in the self-care of oedema which is stable and uncomplicated and maintained for 2 years on their current treatment regime with compression garments available on prescription (FP10). The service user/carer understands their condition and the necessary approach if any abnormalities should occur.
- The service user has lymphovenous or gravitational oedema and can be managed within primary care. The patient will be assessed once, and maybe followed up once and then discharge for maintenance by primary care.

The assessing therapist will make a decision of discharge. The discharge will be documented in the medical notes and a letter will be sent to the referrer regarding any follow up care. A copy letter with discharge advice and a contact number in case of future problems will be sent to the patient.

Day Therapy units and contact numbers:

Day Care

Heald Green
Phone 0161 498 3612
Fax 0161 498 3672

Little Hulton
Phone 0161 702 5416
Fax 0161 790 0186

Lymphoedema Service

Heald Green
Phone 0161 498 3612
Fax 0161 498 3672

Little Hulton
Phone 0161 702 5416
Fax 0161 7900186

Supportive Outpatients

Little Hulton
Phone 0161 702 5416
Fax 0161 790 0186

Neil Cliffe Centre
Phone 0161 291 2912
Fax 0161 291 2968

Community Services

St Ann's Hospice at Home and Community Specialist Palliative Care Teams
Little Hulton
Phone 0161 702 5406
Fax 0161 790 0186

Medical Outpatients

Heald Green
Phone 0161 498 3612
Fax 0161 498 3672

Little Hulton
Phone 0161 702 5416
Fax 0161 790 0186

Neil Cliffe Centre
Phone 0161 291 2912
Fax 0161 291 2968

Outreach Complementary Therapy Service

Neil Cliffe Centre
Phone 0161 291 2912
Fax 0161 291 2968

Community Services

Community services provide a range of services for patients with a life-limiting illness that have associated complex specialist palliative care needs. These services are provided in conjunction with the Primary Care team. Due to funding arrangements, these community services are only available in certain areas. Community Services include:

- The St Ann's Hospice at Home service for residents of Salford & Trafford
- The Community Specialist Palliative Care Team for patients registered with a Salford GP
- St Ann's Hospice 24hour advice line
- Outreach Complementary Therapy Service

St Ann's Hospice 24hour advice line

The 24 hour specialist palliative care telephone advice line service is available to health and social care professionals, patients and their carers residing in Stockport, Manchester, Salford and Trafford. The aim of the advice line is to support colleagues, patients and carers in managing palliative and end of life care needs at home. It is also available to hospital medical and nursing staff within each CCG and to patients and carers.

Each inpatient unit at Heald Green and Little Hulton has a designated cordless telephone which is accessed via a freephone number:

0800 970 7970 (Heald Green)

0808 144 2860 (Little Hulton)

Outreach Complementary Therapy

This service offers complementary therapies to patients with a life-limiting illness and their carers in their own homes.

Referral criteria

- Patients must reside in central Manchester.
- Patients will be identified as being in the last few weeks of life or unable to access other hospice services because their condition prevents this. A total of 6 treatments will be offered.
- Carers will be caring for a patient with a life-limiting illness .

How To Refer To The outreach complementary therapy service

- Referrals are accepted from healthcare professionals only, by telephoning the Neil Cliffe Centre Monday to Friday 9am – 4.30pm, excluding bank holidays.

Referral response times

- Patients will be contacted by the service co-ordinator to offer an appointment within 5 working days from receipt of referral.
- Patients should receive a visit from a complementary therapist within 2 weeks from receipt of referral.
- Thereafter, the complementary therapist will arrange the next appointment.

Discharge criteria

- When a total of 6 treatments have been given
- When a patient declines further treatment
- When a patient becomes too ill to receive treatment

St Ann's Hospice at Home Service

This service is provided by a team of Registered Nurses and Healthcare Assistants who provide nursing care and psychological support to facilitate care at home in conjunction with existing community services.

Referral criteria for the Hospice at Home service

Referrals are accepted for the Hospice at Home service;

- To assist with end of life care where the preferred place of care is in the home (including care homes or other long-term care facilities)
- For crisis intervention
- To support rapid discharge from hospital/hospice

To access this service, a patient must either be registered with a Salford or Trafford GP. Patients referred should already be known to the DNs and the patient's GP should be aware of the referral.

How to refer to the Hospice at Home service

- Referral can be made by a GP, DN, hospital medical/surgical team, specialist team in the community or hospital, social care team or hospice team.
- A hospice referral form should be fully completed by the assessing healthcare professional; for referrals from healthcare professionals other than the medical lead they must also sign to confirm that the patient's GP has been informed of the referral.
- The referral form may be submitted by email, post or fax.
- Referrals can be discussed by telephone with the Hospice at Home Sister.

Referral response times

- Each referral received will be reviewed on a daily basis by the Hospice at Home nurse on duty.
- The nurse on duty will contact the referrer within 1 working day of receipt of referral to discuss requirements.
- Patient/family will be contacted within 1 working day of receipt of referral to arrange a visit.

Discharge criteria

- The patient's needs can be met by their primary/ social care providers, hospital or other hospice services.
- Outstanding needs do not fall within the referral criteria for the Hospice at Home Service.

Community Specialist Palliative Care Team

The Community Specialist Palliative Care Team (CSPCT, often referred to as The Macmillan Team) provides specialist assessment and support in a patient's place of residence including care homes or other long-term care facilities. The team will agree and implement a management plan with the patient. There is close liaison with other health and social care professionals (hospice/hospital/ community) involved in the patient's care. The management plan will be subject to ongoing review by the multi-disciplinary team. Access may be at the point of diagnosis, during treatment, following treatment, at times of disease recurrence or at any other key point in the patient's illness.

Referral criteria for the Community Specialist Palliative Care Team

Referrals are accepted for patients with a diagnosis of an advanced, progressive, life-limiting illness who have associated complex specialist palliative care needs.

To access this service, a patient must either be registered with a Salford GP.

How to refer to the Community Specialist Palliative Care Team

- Referrals can be made by any health or social care professional
- Referrals may also be initiated by the patient, family or carer, but this will be in consultation with relevant health and social care professionals
- Referrals can be discussed by telephone with a member of the Community Specialist Palliative Care Team (7 days a week)
- A hospice referral form should be fully completed by the assessing healthcare professional; for referrals from healthcare professionals other than the medical lead they must also sign to confirm that the patient's GP has been informed of the referral
- The referral form may be submitted either electronically, by post or by fax.

NB: Please ensure the referral form is fully completed. If we need to contact you for further information, there may be a delay in actioning the referral

Referral response times

- All referrals are triaged on a daily basis and the referrer/patient will be contacted within 24 hours in accordance with the need and urgency. The team aim to respond to all urgent referrals within 2 hours.

Discharge criteria

- When a patient's needs can be met by their primary and/or social care providers or by other hospice services.
- When a patient's symptoms or other concerns have been resolved
- When a patient declines further CSPCT intervention
- When a patient moves out of the catchment area