St Ann's Hospice

every day makes a difference

Referral Handbook

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

Inpatient Care

The Being You Centre

Community Support




St Ann's Hospice
St Ann's Road North,
Heald Green,
Cheadle,
Cheshire
SK8 3SZ
Tel: 0161 437 8136
Email: nehgm.admissions-hg@nhs.net

St Ann's Hospice
Meadowsweet Lane, off Peel Lane,
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Worsley,
Manchester
M28 0FE
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www.sah.org.uk
Registered charity number 258085

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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.

We serve a large proportion of Greater Manchester and Eastern Cheshire and work across 7 CCGs who commission our services. All people who are registered with a GP in Salford, Stockport, Manchester, Trafford are eligible to be referred. It should be recognised that the hospice also accept referrals from Wigan, Bolton and East Cheshire. The ethos of the hospice is to accept a patient if there is capacity. If the patient is registered with a GP outside of these areas then you will need to discuss this with a senior member of the MDT.

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 accepted 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
- Two outpatient units based at Heald Green and Little Hulton
- 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.

Specialist supportive and palliative care is available via The Being You Centre. Accessing the service provides an opportunity for specialist assessment, review and treatment of patients' needs enabling the provision of physical, psychological, social and spiritual interventions.

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 Therapists staff.

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

Smoking at St Ann's

Smoking legislation allows hospices to have designated rooms where patients are allowed to smoke within the hospice. At St Ann's Hospice there are smokers' conservatories that are open between 6am and midnight. Cigarettes, cigars, pipes and electronic cigarettes are all considered to be 'smoking' and the requirements are the same for each. Visitors are permitted to smoke only in the smoking shelter in the grounds. Illegal drugs are not permitted to be taken or used by patients or visitors whilst on site.

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

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.

Inpatient Care

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 at The Being You Centre 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.

There are single rooms available but these are on allocation of medical need. We will need advance warning if a patient needs a single room for medical reasons e.g. for barrier nursing.

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
- Specialist/complex seating or moving and handling needs eg. Bariatric
- There are current safeguarding concerns

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 should be submitted by email.

Referrals for admission are reviewed and accepted on a daily basis. Patients for whom admission is required as soon as possible will be admitted dependent on bed availability.

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

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

For out of hours or any urgent admissions, 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. The Mental Capacity Assessment Form and Best Interest Decision Form can be found on our website here: www.sah.org.uk/refer.

Referral response times

- Each referral received on Monday to Friday will be reviewed by the MDT.
- Referrals received out of hours will be reviewed by the Clinical Team.
- 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.

Transfer of patients to the hospice

Planned admissions will normally occur between 9am - 4pm, 7 days a week. 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. 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 end of life care, 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.

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.

Outpatient Services

The Being You Centre @ Little Hulton and Heald Green

The Being You Centre 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.
- 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)

The Being You Centre referral criteria

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

- Non-pharmacological and pharmacological symptom management
- Psychological, emotional, spiritual and complex social need
- Rehabilitation assessment following radiotherapy, chemotherapy, surgery and palliative care intervention

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.

On accepting a referral, all patients will be invited for triage. Following this we will discuss a plan of support based on the patients' individual needs and goals.

How to refer to The Being You Centre

- Referrals can be made by a GP, DN, hospital medical/surgical teams or by specialist teams in the community or hospital.
- People can also refer themselves directly to some of The Being You Centre services. They can contact The Being You Centre directly on the phone numbers on the back page. If needed, the team can then liaise directly with healthcare professionals.
- 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 or post.

Referral response times

- Verbal contact will be made with the referrer within 5 working days of receipt of referral if further information is required.
- Patients will be contacted by the Being You staff within 10 working days of receipt of referral, and invited to triage. Triage may be face to face or over the telephone.
- The GP will be notified within 10 working days of the patient's first attendance.
- We will aim to see patients within The Being You Centre within 20 working days of receipt of referral.
- If the patient is placed on a waiting list 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/

transport is available. The hospice can offer transport, but this is limited and may result in longer waiting times.

- We offer a drop-in service for people who'd like to find out more about The Being You Centre, have a look round and see what we do. Drop in sessions are run throughout the week, please call us first to book in.

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 The Being You Centre.
- The patient is not well enough to attend.
- Upon discharge a discharge letter will be sent to the GP.

Specialist Palliative Medical Outpatients @ Little Hulton and Heald Green

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.

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 or post.

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 Outpatient Service @ Little Hulton & Heald Green

Lymphoedema is a chronic condition which requires lifelong management. With active management, the swelling can improve and deterioration can be prevented.

The lymphoedema outpatient service provides:

- Assessment of individuals with mild to severe/complex lymphoedema, including mid-line oedema
- A management plan that is discussed and agreed with the individual
- Support and guidance for people to self-manage their condition
- Liaison with other health and social care professionals (in hospital or community settings)

How to make a referral

Healthcare professionals can refer to the lymphoedema service using the St Ann's Hospice referral form online. Visit www.sah.org.uk/refer for more details. Additional medical information can be attached to the referral, including a recent BMI.

If people have previously been discharged from the service, they can call or email the team with any concerns they may have in the future. If appropriate, they can then discuss self-referring back to the lymphoedema service.

Referral Criteria

Referrals can be made for people who have:

- Lymphoedema secondary to cancer or its treatment
- Primary Lymphoedema, preferably following an investigation by lymphoscintigraphy to confirm the diagnosis
- Lymphoedema for other causes, preferably following a vascular assessment
- Lipoedema
- People with a BMI over 40, following a screening and a willingness to access weight-management services

Individuals must be well enough to attend the outpatient clinic. Domiciliary visits can be provided for people toward the end of their lives who are unable to attend the clinic.

Response times

- Patients with a progressive disease will be seen urgently.
- Demand for this service often exceeds resources, so the service has a waiting list.
- Patients with a cancer diagnosis will be given priority over a non-cancer diagnosis.
- Patients will be informed by letter is they are on a waiting list with an approximate wait time. They will be provided information on the Lymphoedema Support Network who can offer advice whilst waiting to be seen.

Discharge criteria

People are discharged when any of the following criteria are met:

- The individual is free of swelling.
- The person is proficient in self-care and their condition is stable and maintained.
- The person declines the service, does not comply with treatment and consistently does not attend there appointments.
- The person has a chronic oedema which can be managed within primary care, following assessment and treatment from the specialist service.

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.

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

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)

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. Care management remains the responsibility of the GP and DN team.

Hospice at Home provide a six-week support service to assess, plan, implement and evaluate patients' specialist palliative care needs. Following the evaluation period, patients can be referred on to other appropriate services, discharged or we will continue to provide and evaluate support every six weeks.

Referral criteria for the Hospice at Home service

Referrals are accepted for the Hospice at Home service for patients who are assessed to be in the last year of life;

- 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 provide emotional and psychological support

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.
- 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

All patients will be made aware on the first visit that they will be reviewed on a regular basis and may be discharged from our service if they meet one or more of the following 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.
- Patient and family no longer want to receive the 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 in a clinic setting 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 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 by email.

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

Contact numbers:

Inpatient Units

Heald Green
Phone 0161 498 3608
Advice line 0800 970 7970

Little Hulton
Phone 0161 702 5408
Advice line 0808 144 2860

The Being You Centre

Heald Green
Phone 0161 498 3612

Little Hulton
Phone 0161 702 5416

St Ann's Hospice at Home

Salford and Trafford
Phone 0161 702 5405

Community Specialist Palliative Care Teams

Salford
Phone 0161 702 5406

Medical Outpatients

Heald Green
Phone 0161 498 3612

Little Hulton
Phone 0161 702 5416

Lymphoedema Service

Heald Green
Phone 0161 498 3612

Little Hulton
Phone 0161 702 5416