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The following is intended to provide guidance to health professionals to enable appropriate patient referral to St David's Hospice Adult services. It is, of course, not exclusive, and the clinical team are happy to advise further in uncertain situations including patients with known infections e.g. C.Difficile and MRSA.

(NB: Throughout this document, where we refer to admission, this also includes attendance at Day Therapy)

Criteria for Determining the Most Appropriate Intervention, Including Face to Face Assessment
(Taken from the North East Yorkshire and Humber Clinical Alliance (NEYHCA) (Cancer) Referral, Admission and Discharge Criteria)

St David's Hospice provides interventions at different levels, according to the needs of the individual patient:
- Advice and support for generalist health and social care staff
- Single contact with patient for a specific problem
- Short term involvement for multiple problems
- On-going advice, support and involvement for complex issues

In some circumstances it may be appropriate for professionals referring a patient with a basic palliative care problem to receive advice only via a one off discussion between them and a specialist at the Hospice.

Referral Criteria
Referral for specialist palliative care can occur at any time in the pathway for patients with complex palliative care needs.

1. The service is available to people who have incurable, life limiting, malignant and/or non-malignant disease. Most patients will have an advanced progressive disease and the focus of treatment will have changed from curative to palliative. Some patients, who have complex specialist needs, may be referred at an earlier stage in their illness. Palliative care may be necessary during periods of prognostic uncertainty, including newly diagnosed people and when treatment fails.
2. General criteria for admission *(NB: see above)* are highlighted in the Referral Indicator Tool below, and it is essential on referral that the referrer identifies the reason for referral and the current problems requiring specialist palliative care input.

3. The patient, patient's GP and/or if appropriate their advocate should consent to the referral and admission to Hospice this includes patients from out of the area. Whilst attending day therapy the patient will remain under the care of their own GP.
4. Additional groups other than those highlighted in the Referral Indicator Tool may be referred and will be discussed individually by the multi-disciplinary team as to the appropriateness of admission e.g.
    - Patients who have progressive terminal disease with a longer prognosis than one year but who have complex needs
    - Patients that require specialist pain and symptom management at the time of diagnosis, yet are undergoing active treatments such as chemotherapy and radiotherapy.

The focus of specialist palliative care is on patients with a short prognosis. However, it is recognised that there are 'grey' areas and members of the clinical team will be happy to discuss such patients:

Inappropriate Referrals include:

- Patients with chronic stable disease or disability with a life expectancy of several years
- Patients with chronic pain problems not associated with progressive terminal disease
- Competent patients who decline referral or who are unaware of their underlying disease
- Competent patients who decline referral and where referral is made for family member support only
- Patients with diagnosed primary lymphoedema

Patients Who Lack Capacity

If a patient lacks the capacity to make a decision about referral and admission to Hospice services and there is no relevant Lasting Power of Attorney or Court Appointed Deputy, the decision to admit the patient to Hospice services must be made in their best interests in accordance with the Mental Capacity Act 2005 and the accompanying Code of Practice. This may necessitate a Best Interests meeting and may require the involvement of an Independent Mental Capacity Advisor (IMCA). These reports must be made available on referral of the patient for specialist palliative/Hospice care.

Patients referred for Hospice care will be admitted according to the urgency of their need and subject to capacity to admit. Where patients are placed on a waiting list for admission, and urgent care/support is required from the Hospice, for example symptom management advice or psychological support, a discussion will be held with the referrer to assess the level of need and to agree the interventions. There will be regular contact with the referrer, during this period, and they will be asked to provide updates to the clinical team in relation to the patient's condition and need for admission.

Process for Referral – In Patient Unit

The following Referral Indicator Tool will assist in establishing the level of need the patient has for admission and can be used to identify a timescale enabling the health professional making the referral to have a target date.

a. Written referrals to the hospice should be made to the adult services inpatient unit via fax on **01492 870564**
b. Referrals can be made at any time. Relevant and up-to-date information will be collected by a staff member, who will also offer guidance on additional support/advice as required.
c. Referrals will be received from any healthcare professional/patient/carer with the patient's knowledge and consent.
d. Telephone referrals are not accepted.
e. The referral will be reviewed by the hospice clinical team to assess whether it meets the criteria.
f. Admissions are accepted dependant on available capacity.
g. Members of the clinical team determine the appropriate waiting list category. Occasionally capacity problems mean that patients wait longer than the ideal and every effort is made to ensure that, if appropriate, the patient and their family/carer are supported by alternative clinical services, who will initiate, for example, symptom management, until such time as an admission can be arranged.

Respite Care within the Inpatient Unit

1. Respite care can be offered to patients over the age of eighteen who meet the criteria for palliative care respite.
2. Palliative care respite admissions will be discussed with the patient and/or primary carer and wherever possible, planned in advance.
3. The patient will have been referred to the hospice and assessed by the Hospice Nurse.
4. Every patient receiving palliative care respite is reassessed during their stay prior to further respite being offered.

Process for Referral – Day Therapy

St David's Hospice adult services day therapy offers a range of services for patients with a diagnosis of an advanced, progressive, life-limiting illness that have associated complex palliative care needs. All patients who meet the Hospice criteria have access to the day therapy service. Sessions are held in the Hospice building Monday to Friday of every week.

How to refer to Day Therapy Services

- Referrals can be made by General Practitioners (GP), District Nurses (DN), hospital medical/surgical teams or by Macmillan/Specialist teams in the community or hospital. Referrals may also be initiated by the patient, but this will be in consultation with their GP and key worker.
- Patients referred for day therapy will be contacted within 48 hours of referral and assessed following consent from the GP.
- Macmillan Specialist Nurse referrals are normally accepted without the need for initial nurse assessment.
- Once the patient is accepted for day therapy, they are placed on the waiting list until the next session is available.
- Once the patient has been assessed and it is found that they meet the Hospice criteria contact will be made by the outpatient service(s) identified by the assessment to arrange an appointment.
- Regular liaison with the patient will be maintained during this time.

St David's Hospice Adult Services In-Patient Unit Referral Indicator Tool			
Reason for Referral	**Indicators**	**Prompt**	**Response Time** Supported by NEYHCA (Cancer) 2012
Pain & Symptom Management	• Complex, unpredictable and rapidly changing pain and symptoms that cannot be managed in another care environment • Unstable condition with sudden exacerbation/deterioration that requires 24/7 specialist assessment • Symptoms that cannot be alleviated by treating the underlying disease • Severe progression of illness over a few months/weeks	Physical symptoms such as intractable vomiting Spiritual distress and/or psychological disturbances, severe anxiety or depression Pain crisis Rapidly progressive disease Complex medication review and monitoring	**Urgent :** Whenever possible, admission to happen within 24 to 48 hours Prioritised by need and subject to bed availability
Care in Dying	• Dying patient with specialist palliative care needs	Deterioration in condition on a daily basis When it is clear the patient is actively dying	**Urgent:** Whenever possible, admission to happen within 24 to 48 hours Prioritised by need and subject to bed availability
Respite	• Temporary physical, emotional or social care of a dependent person in order to provide relief from caring to the primary care provider	Patients requiring palliative care respite should have specialist palliative care needs.	**Routine:** Pre booked dates by arrangement with patient, family/carer
Emergency Respite	• Respite as above, where there are critical circumstances to respond immediately		**Urgent :** Whenever possible, admission to happen within 24 to 48 hours Prioritised by need and subject to bed availability

Admission:
St David's Hospice adult services in-patient unit is open 24 hours a day throughout the year. Admissions are accepted dependant on the availability of medical support for the admission and morning admissions of the patient is encouraged to permit timely completion of the process.
The service is not able to offer an emergency out-of-hours service for the direct admission of patients.
When a patient is admitted to the in-patient unit, a nursing and medical assessment will take place on the day of admission. Any previously expressed preferences for care and/or treatment will be discussed as appropriate.

Discharge Criteria and Planning:
The Hospice is unable to accept patients for indefinite care and this should be made clear by the referrer to the patient and their family/carers when admission to the unit is being discussed. Patients are likely to be discharged as soon as they can be suitably cared for by a non-specialist team with the appropriate specialist support. This may be at the end of a pre-set duration of attendance, (NEYHCA (Cancer) 2012).

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 in the last days/hours of life (unless this is the patients wish and can be supported), discharge planning commences on admission.

Discharge should only be made:

- Following discussions between the patient and appropriate family members, carers and relevant professionals
- If the patient's condition stabilises or improves such that they or the Hospice team feel that input from the specialist palliative care service is no longer required
- If the patient is no longer able to benefit from Specialist Palliative Care

The Hospice clinical team acknowledges the importance of Advance Care Planning (ACP) and recognises that patients may have preferences with regard to their preferred priority of care/death. The in-patient unit is required to prioritise access to its service according to the complexity of need and will always take preferences into account but there may be times when this may not be possible, due to the stage of the patient's illness or the capacity of the unit.