

Hospice of the Valleys

Referral Criteria and Process

1. Introduction:

Hospice of the Valleys is a Community Specialist Palliative Care Service based in Blaenau Gwent providing support, advice, care and comfort to patients and carers who are experiencing a progressive, life-limiting illness, compromised quality of life, loss and grief.

1.1. Philosophy of Care

Hospice of the Valleys believes:

In the affirmation of life and that everyone is unique, with individual cultural, spiritual, social beliefs and economic backgrounds and values.

In the value of respect, choice, empowerment, holistic care and compassion, in the care for the whole person to meet all needs – physical, psychological, spiritual emotional and social.

In the freedom and profound dignity of every man and woman.

That our patients should preside over their own care, and that we must respect their own priorities and serve their needs, enabling people to manage their illness with dignity and independence.

In the relief of physical, mental social and spiritual suffering using all the skills, techniques, kindness and wisdom available to us.”

1.2 Service Aims:

The overall aim of the service is to enable patients to be cared for in their own home if this is their choice and offer support to enable patients to die in their preferred place of care, by:

- providing a service that addresses individual patient need
- providing advice when required regarding pain control and symptom management
- providing physical, psychological, social and spiritual support
- being a resource for other health care professionals and generalist palliative care providers
- contributing to Palliative Care Education Programmes
- providing support for carers in bereavement; in general this would be on a short-term basis with appropriate sign-posting for those who need ongoing support

2. Policy Purpose:

The aim of this policy is to ensure:

- i. a consistent approach of access to the service
- ii. there is equity of access to the service
- iii. to ensure that staff working at Hospice of the Valleys have the appropriate information to assist with the process involved in the admission of patients to the service

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This document relates to the Hospice of the Valleys specialist palliative care service and Challenge Project. Further information and referral process for Hospice at Home is detailed in the *Hospice at Home operational policy*. Further information about referral for bereavement services is detailed in the *Bereavement Support Policy*.

3. Responsibility

Hospice of the Valleys Board of Trustees holds ultimate accountability for ensuring appropriate and equitable access to the service for patients and their families/carers within Blaenau Gwent.

The Chief Executive Officer retains overall responsibility for appropriate and equitable access to the service for patients and their families/carers within Blaenau Gwent.

The Head of Clinical Services (HoCS) is jointly responsible with the Palliative Care Consultant for the development of evidence-based guidelines and policies to support appropriate and equitable access to the service for patients and their families/carers within Blaenau Gwent; in addition the CSD is responsible for ensuring that the referral policy is effectively implemented at an operational level and that all referrals are considered in accordance with the referral policy and guidelines.

The Palliative Care Consultant is jointly responsible with the Head of Clinical Services for the development of evidence-based guidelines and policies to support appropriate and equitable access to the service for patients and their families/carers within Blaenau Gwent; in addition the Palliative Care Consultant is responsible for ensuring that the operational implementation of the referral policy and guidelines is supported by an appropriate clinical decision making process.

The Clinical Team is responsible for accepting/not accepting referrals in accordance with the referral policy and guidelines

The Administrative Staff are responsible for ensuring that referral information is collected in accordance with the referral policy and guidelines and that the required referral data is completed.

4. Related Policies:

- Access To Health Records
- Bereavement Support policy
- Challenge Project Operational Policy
- Complaints
- Confidentiality
- Data Protection
- Disclosure Of Information
- Discharge
- Hospice at Home operational policy
- Information Governance
- Lone Worker

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5. Definitions

5.1 Supportive Care

The National Council for Hospice and Specialist Care Services (NCHSPCS) suggest the following as a working definition:

“helps the patient and their family cope with cancer and treatment of it – from diagnosis, through to cure, continuing illness or death into bereavement. It helps the patient to maximise the benefits of treatment and to live as well as possible with the effects of the disease. It is given equal priority alongside diagnosis and treatment”

(NICE: Improving Supportive and Palliative Care for Adults with Cancer, 2004, p18)

5.2 Palliative Care

“the active holistic care of patients with advanced progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness in conjunction with other treatments.”

(NICE: Improving Supportive and Palliative Care for Adults with Cancer, 2004, p20)

5.3 Specialist Palliative Care:

Offers specialist expertise to support the active care of patients with progressive advanced disease of limited prognosis including interventions to:

- respond to unresolved symptoms and complex psychosocial issues
- respond to complex end-of-life issues
- respond to complex bereavement issues
- provide support and advice to their families, friends and carers
- provide support and advice to non-specialist health care staff

5.4 Urgent Referral:

Patients require specialist intervention within 24 – 48hours

5.5 Routine referral:

Patients require specialist intervention within 2 – 7 days

6. Eligibility Criteria

- a) Referrals are accepted on the basis of need for any patient with a life limiting diagnosis.
- b) The patient will be 18years or older
- c) The patient will have a progressive, life-limiting illness requiring complex symptom management

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- d) Complex problems are defined as those which are severe and intractable and have persisted after competent palliative care by generalists. The *All Wales tool for Identifying patients for supportive, palliative and advance care planning* is attached at Appendix 1 for reference.
- e) Complex problems can arise from multiple domains of need: physical symptoms, psychological symptoms or spiritual/emotional distress
- f) Referral for complex psycho-social/spiritual support for the carers and families of a patient with life limiting illness (where the patient has agreed to referral, or a best interest decision has been made for patients lacking mental capacity)
- g) Health Care Professionals caring for the patient/carer who require specialist advice and support
- h) Prior to referral, patients with capacity to consent to the involvement of the service are required to do so. . Referral for patients who do not have capacity to consent (e.g. those with advanced dementia) can be made on the basis of a best interest discussion between the health and/or social care professionals involved with the person's care, and their family or carer.
- i) The patient's General Practitioner or Hospital Consultant (for inpatients at Ysbyty Aneurin Bevan) must be informed of the referral; the Primary care Team remain as the core service provider for patient care.
- j) Hospice of the Valleys has a specific service, in partnership with the Alzheimer's Society, for people with dementia, the "Challenge Project". The same generic referral criteria apply but eligibility for the Challenge Project requires a confirmed diagnosis of dementia. Further information about the Challenge Project is detailed in the *Challenge Project Operational Policy*.

6.1 When not to refer:

- when patients are not in agreement with the referral or have not been informed of the referral
- when symptoms are well controlled
- when physical, psychological and spiritual needs are being met by present services and support networks
- when a discharge is well supported by others and meets current needs
- when patient needs are mainly social or financial, without a specialist palliative care need and alternative care is the responsibility of the statutory services

7. Standards

7.1 Routine referrals

Providing all relevant clinical information and data has been provided or is accessible, routine referrals will be contacted within 2 days of receipt of referral and (with the patient's agreement) a home visit arranged within 7 days for initial assessment

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7.2 Urgent referrals

Providing all relevant clinical information and data has been provided or is accessible urgent referrals will be contacted within 24 hours and seen within 48 hours.

8. Referral Process

- Any Health or Social Care Professional (with the patient's consent) can refer patients. Referral for patients who do not have capacity to consent (e.g. those with advanced dementia) can be made on the basis of a best interest discussion between the health and/or social care professionals involved with the person's care, and their family or carer.
- Patients may self-refer to the service but must be made aware that their General Practitioner will be informed of the referral
- Non-professionals may refer to the service providing the patient is aware of, and consents to, the referral; the patient's general practitioner will be informed of the referral (see first point in relation to patient's who are unable to consent to the involvement of the service).
- Decisions about appropriate intervention are based on comprehensive and detailed information about the patient and this must be provided at the time of referral either:
 - By fax or in writing on the Hospice of the Valleys referral form – a copy of the referral form is attached at Appendix 2. The referral form for the "Challenge project" is provided in appendix 3.
 - By telephone providing:
 - sufficient information is supplied to enable the person taking the call to fully complete the Hospice of the Valleys referral form
 - a completed referral form is provided by the referring agent within 24 hours of the telephone call
 - By Aneurin Bevan health Board Unified Assessment Documentation: Referral /Transfer Information for Complex Needs
- Known risks must be highlighted at referral and the service informed of risk mitigating strategies already in place
- Referrals will be triaged at the daily team meeting (Monday – Friday 9.10am) and once a patient has been accepted, a key worker will be assigned based on where the patient lives
- Following initial assessment all new patients will be discussed at the weekly multi-disciplinary team meeting held on Monday mornings and prioritisation of service provision will be made on the basis of clinical need using the palliative care phases system (Appendix 4).

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9. Discharge Policy

The length of time a patient stays with the service will vary according to the patient and carer's needs. Patients may be discharged from the service if:

- Following initial assessment they do not meet the criteria
- The patient refuses the service at the initial assessment or any time thereafter
- the patients condition becomes stable, or patient issues are improved or resolved
- the needs of the patient are more appropriately met by other services

All patient discharges will be in accordance with the discharge policy and process

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Appendix 1.

All Wales tool for Identifying patients for supportive, palliative and advance care planning

Identifying patients for supportive, palliative and advance care planning

1 ASK - Would it be a surprise if this patient died in the next 6 months?
IF NO go to section 4

2 If unsure consider the following: look for two or more general clinical indicators

- Performance status poor (limited self care; in bed or chair over 50% of the day) or deteriorating.
- Progressive weight loss (>10%) over the past 6 months.
- Two or more unplanned admissions in the past 6 months.
- A new diagnosis of a progressive, life limiting illness.
- Two or more advanced or complex conditions (multi-morbidity).
- Patient is in a nursing care home or NHS continuing care unit; or needs more care at home.

3 Now look for two or more disease related indicators - **IF YES go to section 4**

Heart Disease	Kidney Disease	Respiratory Disease	Liver Disease	Cancer	Neurological Disease	Dementia
NYHA Class III/IV heart failure, severe valve or coronary artery disease. Breathless or chest pain at rest or on minimal exertion. Persistent symptoms despite optimal tolerated therapy. Systolic blood pressure <100mmHg and /or pulse > 100. Renal impairment (eGFR < 30 ml/min). Cardiac cachexia. >1 acute episodes needing IV therapy in past 6 months.	Stage 4 or 5 chronic kidney disease (eGFR < 30ml/min). Conservative renal management due to multi-morbidity. Deteriorating on renal replacement therapy with persistent symptoms and/or increasing dependency. Not starting dialysis following failure of a renal transplant. New life limiting condition or kidney failure as a complication of another condition.	Severe airways obstruction (FEV1 < 30%) or restrictive deficit (vital capacity < 60%, transfer factor < 40%). Meets criteria for long term oxygen therapy (PaO2 < 7.3 kPa). Breathless at rest or on minimal exertion between exacerbations. Persistent severe symptoms despite optimal tolerated therapy. Symptomatic right heart failure. Low body mass index (< 21). > 3 emergency admissions for infective exacerbations or respiratory failure in past year.	Advanced cirrhosis with one or more complications: • intractable ascites • hepatic encephalopathy • hepatorenal syndrome • bacterial peritonitis • recurrent variceal bleeds Serum albumin < 25g/l and prothrombin time raised or INR prolonged (INR > 2). Hepatocellular carcinoma. Not fit for liver transplant.	Performance status deteriorating due to metastatic cancer and/or co-morbidities. Persistent symptoms despite optimal palliative oncology treatment or too frail for treatment.	Progressive deterioration in physical and/or cognitive function despite optimal therapy. Symptoms which are complex and difficult to control. Progressive speech problems difficulty communicating and/or progressive dysphagia. Recurrent aspiration pneumonia; breathless or respiratory failure.	Unable to dress, walk or eat without assistance; unable to communicate meaningfully. Worsening eating problems (dysphagia or dementia related) needing pureed/ soft diet or supplements. Recurrent febrile episodes or infections; aspiration pneumonia. Urinary and faecal incontinence.

4 If patient condition fits these criteria:

- Assess patient, family and dependents, including children, for supportive & palliative care needs.
- Review treatment and medication priorities.
- Consider patient for general practice palliative care register.
- Consider advance care plan discussions with patient and family.



Adapted from the Supportive and Palliative Care Indicators toolkit (SPICIT) – NHS Lothian

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Appendix 2. Hospice of the Valleys referral form

<S:\Clinical Documentation\Referral forms\Referral to HotV forms\Current version\NEW Referral form v4 13 06 2014.docx>

Appendix 3. Hospice of the Valleys Challenge Project referral form

<S:\CARIAD\CARIAD Services\Referral\REFERRAL FORM - Updated 3.5.18.docx>

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Appendix 4. Phases

(1) Stable Phase

All patients/clients not classified as unstable, deteriorating, or terminal. The person's symptoms are adequately controlled by established management. Further interventions to maintain symptom control and quality of life have been planned. The situation of the family/carers is relatively stable and no new issues are apparent. Any needs are met by the established plan of care.

(2) Unstable Phase

The person experiences the development of a new problem or a rapid increase in the severity of existing problems, either of which require an urgent change in management or emergency treatment. The family/carers experience a sudden change in their situation requiring urgent intervention by members of the multidisciplinary team.

(3) Deteriorating Phase

The person experiences a gradual worsening of existing symptoms or the development of new but expected problems. These require the application of specific plans of care and regular review but not urgent or emergency treatment. The family/carers experience gradually worsening distress and other difficulties, including social and practical difficulties, as a result of the illness of the person. This requires a planned support program and counselling as necessary.

(4) Terminal Care Phase

Death is likely in a matter of days and no acute intervention is planned or required. The typical features of a person in this phase may include the following:

- Profoundly weak
- Essentially bed bound
- Drowsy for extended periods
- Disoriented for time and has a severely limited attention span
- Increasingly disinterested in food and drink
- Finding it difficult to swallow medication.

This requires the use of frequent, usually daily, interventions aimed at physical, emotional and spiritual issues. The family/carers recognise that death is imminent and care is focussed on emotional and spiritual issues as a prelude to bereavement.

(5) Bereaved Phase

Death of the patient has occurred and the carers are grieving. A planned bereavement support program is available including counselling as necessary.

Reference: *Palliat Med* 2004 18: 217

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