Pan Birmingham NHS
Cancer Network

Guideline for the Referral, Admission and Discharge of Patients to (specialist) Palliative Care Services
Formerly the Guideline for the Referral to Specialist Palliative Care

Date Approved by Network Governance	**September 2012**

Date for Review	**September 2015**

ENDORSED BY THE GOVERNANCE COMMITTEE

1 Scope of the Guideline

This guideline relates to peer review measures 12-1E-103r and 12-1E-104r and has been produced to support the referral, admission and discharge of patients to (and from) the following services:

- specialist palliative care multidisciplinary teams (MDT), including community cased services
- inpatient specialist palliative care services
- specialist palliative care day services
- specialist palliative care outpatient clinics

2 Guideline Background

2.1 The configuration of palliative care services in PBCN is shown in table 1 below. The specialist palliative care teams care for patients on a need rather than diagnosis basis.

Table 1

Provider specialist palliative care teams forming the Combined Specialist Palliative Care MDTs*	Named hospital/hospice inpatient facilities covered	Associated outpatient / community / day care services
UHBFT/BSMH	UHBFT and BSMH Support to BWFT and the ROHFT	BSMH community team BSMH day care BSMH outpatient
SWBH/SaCT	SWBH	Sandwell community team Sandwell day care services Bradbury Day Hospice
HEFT (Good Hope Hospital site)/JTH/SGH	HEFT, JTH and SGH	SGH community team SGH day care SGH outpatient John Taylor community team John Taylor day care services John Taylor outpatient
WHT / SGWH	WHT and SGWH	Walsall Community Palliative Care teams Walsall – Fair Oaks Day Hospice day care
HEFT (Heartlands Hospital site and Solihull Hospice) MCHS and SCS	HEFT (Heartlands and Solihull hospitals) and MCHS	SCS team MCHS community team MCHS day care MCHS outpatient

*Access to the combined SPC MDT is via the local SPC MDT – see appendix 2 for contact details.

BDH	Bradbury Day Hospice
BSMH	Birmingham St. Mary's Hospice
BWFT	Birmingham Women's NHS Foundation Trust
HEFT	Heart of England NHS Foundation Trust
JTH	John Taylor Hospice
MCHS	Marie Curie Hospice Solihull
ROHFT	Royal Orthopaedic Hospital Foundation Trust
SaCT	Sandwell Community Team
SCS	Heart of England NHS Foundation Trust Solihull Community Services
SGH	St. Giles Hospice
SGWH	St. Giles Walsall Hospice (inpatient unit)
SWBH	Sandwell and West Birmingham hospitals NHS Trust
UHBFT	University Hospitals Birmingham NHS Foundation Trust
WHT	Walsall Healthcare NHS Trust

Guideline Statements

3 Referral, admission and discharge criteria

The criteria shown in table 2 below should be used as a guide to the referral, admission and discharge to palliative care services. Further details are listed in section 4, and the referral form can be found in appendix 1.

Table 2

	Referral Criteria (see section 4 for more details of the term 'complex')	Admission Criteria	Discharge Criteria
Provider SPC MDT* outpatient clinic or ward visit	• complex problems: physical or psychological symptoms, or spiritual/emotional distress • patients who have complex social needs resulting from their illness or whose families show exceptional emotional distress.	Not Applicable	• Patient is stable for approximately 3 months • Patient has not been seen by a member of the team for 3 months • Patient asks to be discharged from the palliative care team.
Combined SPC MDT (see table 1)	• Patients known to the provider SPC MDT, and judged by them to be highly complex (for example: clinically, psychologically, spiritually, socially, and geographically) • Patients likely to require or be receiving input from many disciplines • Patients likely to require / have required prolonged or multiple multi professional discussions	Not Applicable	• When needs are met by provider MDT and there is no on-going need to discuss the patient in forum of combined providers.
Inpatient Hospice SPC service	• Complex problems requiring symptom control: physical or psychological symptoms, or spiritual/emotional distress. • Respite care where needs are too complex for general respite but patient is stable and respite bed is booked for an agreed length of time • Terminal care where patient has very short prognosis and is requesting to die in the hospice • Patients who have complex social needs resulting from	Where a SPC professional has assessed the patient /liaised with a generalist and agrees that an admission is appropriate	• patient has symptom control optimised • patient /family requesting discharge • agreed respite term completed • ongoing care has been reviewed and planned • medication available to take home or at home and primary care team

	Referral Criteria (see section 4 for more details of the term 'complex')	Admission Criteria	Discharge Criteria
	their illness or whose families show exceptional emotional distress.		informed of discharge and aware of all relevant information • DNAR paperwork prepared for transfer with patient where appropriate
Inpatient Hospital SPC service	• Complex problems requiring symptom control: physical or psychological symptoms, or spiritual/emotional distress. • Patients who have complex social needs resulting from their illness or whose families show exceptional emotional distress.	NA	**This refers to discharge from the service not the bed** • patient has symptom control optimised • patient /family requesting discharge from hospital SPC • on-going care has been reviewed and planned and patient handed over to more appropriate clinical team or professional
Day Care Services	• Complex problems: physical or psychological symptoms, or spiritual/emotional distress. • Patients who have complex social needs resulting from their illness or whose families show exceptional emotional distress.	Not Applicable	• Patient is stable for approximately 3 months • Patient has not been seen by a member of the team for 3 months • Patient asks to be discharged from the palliative care team.
SPC Community Services	• Complex problems: physical or psychological symptoms, or spiritual/emotional distress. • Patients who have complex social needs resulting from their illness or whose families show exceptional emotional distress.	Not Applicable	• Patient is stable for approximately 3 months • Patient has not been seen by a member of the team for 3 months • Patient asks to be discharged from the palliative care team.

SPC MDT = Specialist Palliative Care Multidisciplinary Team
* Provider SPC MDT: Trust / Hospice / community SPC outpatient clinic or ward visit.

4 Who to refer

4.1 Patients with complex problems (further explained below), beyond the scope of current clinical team in hospital or primary care regardless of diagnosis, should be referred to specialist palliative care services.

4.2 Patient's complex problems can arise from multiple domains of need: physical or psychological symptoms, or spiritual/emotional distress.

4.3 Patients who have complex social needs resulting from their illness or whose families show exceptional emotional distress may also be referred.

4.5 Prior to referral patients with capacity must consent. Referral must be judged to be in the best interests of patients who do not have capacity.

4.6 In Summary, the patient has a diagnosis of advanced, or complex, life limiting illness and: has symptom control problems, which are escalating and are felt to be unmanageable within the generalist palliative care experience of their current clinical team. These symptoms may be physical, psychological, spiritual, social, or family and carer orientated issues.

5 How to refer to SPC services

5.1 Specialist palliative care services include: the SPC MDT; hospital SPC teams; inpatient hospice care; day hospice; outpatient clinics and community based services.

5.2 The referral form in appendix 1, or correspondence containing the equivalent content, should be completed. It should be accompanied by relevant clinic letters and discharge summaries and medication lists.

5.3 Referral forms should be faxed (via 'safe haven' numbers) or emailed to a secure email address to the specialist teams: see appendix 2 for a list of specialist palliative care teams.

5.4 Referrals are accepted from all health or social care professionals directly involved in the patient's management. In exceptional circumstances patient self-referral may be accepted, but this should be supported by a named health or social care professional.

5.5 Referring district nurses or case managers should ensure the patient's GP is aware of the referral, and vice versa (community nursing staff should be informed when a GP makes a referral).

5.6 Referrals made by hospital staff e.g. site specific CNSs or ward managers; should ensure the patient's consultant team is aware of the referral. The patient's GP and district nurse should also be informed of the referral.

6 Levels of intervention:

i. Telephone support / advice from specialist palliative care service to other care professionals. This level of intervention does not require a referral form to the service. Patient and care professional details will usually be required for record-keeping purposes and if the situation is complex and requires follow up a referral may be requested by the specialist team.

ii. A 'one-off' specialist assessment, with or without attendance by managing clinical team.

iii. Short term contact with specialist palliative care service to stabilise a situation, in partnership with usual clinical team / key worker.
iv. On-going contact with specialist palliative care service in partnership with usual clinical team / key worker.
v. Discussion at the **combined** SPC MDT (see table 1 for further details)

7 Standards for response

There should be capacity for the team to carry out a face to face assessment within 1 day of referral where this is deemed necessary. Other, less urgent referrals, will be triaged and visited or telephoned as appropriate. Only in exceptional circumstances would it be expected that a patient will wait for more than 2 weeks.

Monitoring of the Guideline
Adherence to the Network guidelines may from time to time be formally monitored.

Author of version 1
Updated by Dr Steve Plenderleith

Author of Version 2
Lara Barnish and John Speakman

Approval Date of Network Site Specific Group Date: September 2012

Approval Date of the Governance Committee Date: September 2012

Approval Signatures

Pan Birmingham Cancer Network Governance Committee Chair
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Signature: Date: September 2012

Pan Birmingham Cancer Network Manager

Name: Karen Metcalf

Signature:

Date: September 2012

Network Site Specific Group Clinical Chair
Name: John Speakman

Signature: Date: September 2012

Pan-Birmingham NHS Cancer Network

Appendix 1 Adult Specialist Palliative Care Referral Form –Version 3

All sections of this form must be completed. If a section is not relevant put 'Not Applicable'.

All referral forms must be sent to the specialist teams, who will assess what level of input is appropriate.
Please send copies of recent clinical correspondence with the form

Providers can be located via the Palliative Care Directory – www.birminghamcancer.nhs.uk

Criteria for Referral:
The patient has a diagnosis of advanced life limiting illness and:

- complex problems, which are escalating or are unable to be managed by the current clinical team. These symptoms may be physical, psychological, spiritual, social, or family and carer orientated issues
- complex social needs resulting from their illness or whose families show exceptional emotional distress

Prior to referral patients with capacity must consent. Referral must be judged to be in the best interests of patients who lack capacity.

Patient details			
NHS Number:	Patient consents to Specialist Palliative Care involvement: Yes ☐ No ☐ Unable ☐ *If No please give details on next page.*		Office use
Surname: Male / Female		**DoB** / Age:	
First Name:		Marital Status:	
Address:		Ethnicity:	
		Religion:	
Post Code:	Telephone:	Mobile:	

Referrer's signature:	Name (please print):	
Job title:	Contact number:	Bleep No:
Surgery or Hospital:	Date:	

Next of kin/patient representatives	**District Nurse:** Involved Yes☐ No☐	**General Practitioner:** Informed Yes☐ No☐
Name:	Name:	Name:
Address:	Based at:	Address:
	Telephone:	
	Fax:	Post code:
Telephone:	**Social Services:** Involved Yes☐ No☐	Telephone:
Mobile:	Name:	Fax:
Relationship to patient:	Based at:	Email:
Main Carer (if different from above)	Telephone:	On practice GSF Register: Yes☐ No☐ Unknown☐
Name:	Fax:	Continuing health care assess. completed: Yes☐ No☐ Funding Agreed☐
Telephone:	**Other professionals involved:**	
Mobile:		
Relationship to patient:	On supportive care or end of life pathway: Yes☐ No☐ Unknown☐	

Communication First language if not English:	Communication in English (please tick)
Would an interpreter be helpful to patient or palliative care staff? Yes ☐ No ☐	Good ☐ Fair ☐ Poor ☐
Other barriers to communication, e.g. hearing loss, confusion.	

Patient Name: ……

Inpatient details (if appropriate)		
Hospital:	Ward:	Hospital Number:
Telephone:	Direct Ward Ext:	Date of discharge (if known):
Consultant (1):		Consultant (2):
Hospital Palliative Care team involved: Yes☐ No☐ Key Team CNS/Contact:	MRSA Status: Positive☐ Negative☐ Unknown☐	C Diff. Status: Positive☐ Negative☐ Unknown☐

Main Diagnosis(es):
Other Significant Medical & Mental Health Problems:

Brief history of diagnosis(es) and key treatments		
Date	Progression of disease and investigations/treatment	Consultant and hospital

Referrer's expectation of current treatment if relevant: Symptom control ☐ Life prolonging ☐ Curative ☐

Estimated prognosis: Days ☐ Weeks ☐ Months ☐ Years ☐

Service Required ☐Home assessment and support ☐Day Hospice ☐Admission - *please circle reason below* symptom control / terminal care / respite care *(respite is often pre-booked & limited to patients with SPC needs)*	**The patient is currently** ☐At home ☐In hospital ☐Elsewhere (e.g. NH, with family) …… Does the patient live alone? Yes☐ No☐ Add details below
Preferred place of care:	Preferred place of death if different:

Indicators for Referral ☐Pain / symptom control ☐Patient Emotional / psychosocial / spiritual support ☐Carer support
☐Other reason. e.g. lymphoedema. Please detail….

Please outline the **issues** & specify what **treatments or strategies** have already been tried:

Urgency of referral:	**Within 1 day** ☐ - **MUST** be accompanied by a telephone call from the referrer for immediate advice
	Within 5 working days ☐ **Within 10 working days** ☐ **1st contact by SPC team may be by phone.** ☐

Allergies/ sensitivities	**MEDICATION (ATTACH a list of current & recent prescriptions)**

Insight					
	Has patient been told diagnosis?	Yes ☐	No ☐	Is the carer aware of patient's prognosis?	Yes ☐ No ☐
	Is patient aware of prognosis?	Yes ☐	No ☐	Is the carer aware of patient's referral?	Yes ☐ No ☐
	Does patient discuss the illness freely?	Yes ☐	No ☐	*Please provide details in **Issues** section if any "No" responses*	

Please ensure patients are aware information will be held on computer according to the Data Protection Act

Appendix 2 Contact Details for Adult Specialist Palliative Care Services

Birmingham St Mary's Hospice 176 Raddlebarn Road, Selly Park, Birmingham B29 7DA	Telephone: 0121 472 1191	
	Fax: 0121 472 4159	
	e-mail: info@bsmh.org.uk **(not secure for referrals)**	
Heart of England NHS Foundation Trust **Specialist Palliative Care Team** 3rd Floor Tower Block Birmingham Heartlands Hospital Bordesley Green East, Birmingham B9 5SS	Telephone: 0121 424 2442	
	Fax: 0121 424 1139	
	e-mail: alison.harrison@heartofengland.nhs.uk	
John Taylor Hospice 76 Grange Rd, Erdington. B24 0DF	Telephone: 0121465 2000 (24/7)	Hospice at Home Mobile: 07791727242 (7 days)
	Fax: 0121 465 2010	
	Bed Manager for admission/transfer enquiries Mobile: 07971321242	
Marie Curie Hospice 911 – 913 Warwick Road, Solihull. B91 3ER	Telephone: 0121 254 7800	
	Fax: 0121 254 7840	
	e-mail: Solihull.hospice@mariecurie.org.uk **(not secure for referrals)**	
Queen Elizabeth Hospital Birmingham **Specialist Palliative Care Team** Room 22E, 3rd Floor Nuffield House Edgbaston, Birmingham B15 2TH	Telephone: 0121 627 2439	
	Fax: 0121 697 8493	
Sandwell and West Birmingham NHS Trust Specialist Palliative Care Team Covers - Sandwell and Rowley Regis Hospital	Telephone: 0121 507 2511	
	Fax: 0121 507 3711	
Covers - City Hospital	Telephone: 0121 507 5296	
	Fax: 0121 507 4009	
Sandwell Community Specialist Palliative Care Team Bradbury Day Hospice 494 Wolverhampton Road, Oldbury. B68 8DG	Tel: 0121 612 2928 8am – 6pm Monday - Friday 0845 0020 136 8am – 6 pm Weekends & Bank Holidays	
	Fax: 0121 612 2934	
Sandwell Community Specialist Palliative Care Team SGS Building Penthouse St John's Lane, Tividale. B69 3HX	Tel: 0121 612 2930 8am – 6pm Monday - Friday 0845 0020 136 8.30am - 4.30pm Weekends & Bank Holidays	
	Fax: 0121 612 2934	
Solihull Care Trust (Community) Macmillan Specialist Palliative Care Team 20 Union Road, Solihull. B913EF	Telephone: 0121 712 8474	
	Fax: 0121 712 7299	
	e-mail: macmillan@solihull-ct.nhs.uk **(not secure for referrals)**	
St Giles Hospice Fisherwick Road Whittington, Lichfield. WS14 9LH	Telephone: 01543 434528	
	Fax: 01543 434560	
	e-mail: community@st-giles-hospice.org.uk **(not secure for referrals)**	
	Fax: 01922 656253	
Walsall Healthcare NHS Trust Community Specialist Palliative Care Nursing Service Walsall Palliative Care Centre Goscote Lane, Goscote, Walsall, WS3 1SJ	Telephone: 01922 602620 Monday to Sunday 09.00hrs- 16.30hrs Walsall Manor Hospital Switchboard 01922 721172 from 17.00-21.00hrs every day inc. weekends & bank holidays	
	Fax: 01922 602510	
Walsall Healthcare NHS Trust **Walsall Manor Hospital** **Macmillan CNS Team** Route 121, New Build, Moat Rd, Walsall. WS2 9PS	Telephone: 01922 656253 Fax: 01922 656253	