Referral Criteria

Referrals will be accepted for any patient:

1. Over the age of 18.
2. With any life limiting or progressive illness.
3. At any stage in his/her illness.
4. Experiencing severe, intractable, complex problems that are not responding to routine treatment and therapeutic intervention, and which have persisted after palliative care by a non-specialist.
5. Where his/her support network is/are having difficulties in adjusting to/coping with their disease physically, psychologically, spiritually or emotionally.
6. At key transition points in his/her illness where a specialist episode of support, including specific therapeutic interventions that cannot be provided by a non-specialist service, is indicated to optimise the patient or carer's wellbeing and prevent avoidable deterioration.
7. To assess their need for further hospice services or inpatient care.
8. Experiencing difficulties in bereavement, and who would benefit from specialist support/further psychological intervention.
9. Where complex information and explanation is required relating to the illness, treatment, care options and allied support services.

Referrals will be also be accepted where health care professionals require specialist advice and support with case management.

Reasons for Referral include:

• Specialist multidisciplinary assessment.

• Complex symptom management.

• Complex psychological/spiritual issues.

• Provision of supportive care including those delivered by day services.

• Provision of specific treatments where agreed with the multidisciplinary team and where appropriate arrangements can be confirmed, for example, day-case procedures.

• Specialist rehabilitation.

• Bereavement care.

• End of life inpatient care, where hospice is the patient's preferred place of care.

• Information and signposting.

Referrals will be accepted from:

1. Any health care professional, provided that the patient, carer and general practitioner/consultant are aware and in agreement with the referral to the service.

2. Self-referrals, provided they meet our criteria. Where appropriate, we will contact the relevant healthcare team to gain more information.

Discharges

All patients, carers and referrers will be made aware that they may be discharged from the team's care, if they no longer require specialist input. Individuals may be re-referred by any health care professional, themselves or their carers, according to the above guidance, if their needs or circumstances change at any stage in the future.

Their needs will be reassessed in line with the guidelines above.

Reasons for discharge may include:

• Acute needs stabilised, care to be continued by the primary health care team or acute trust or other provider.

• Patient/family/carer is more able to cope emotionally, or is receiving appropriate on-going support.

• Patient's wellbeing is optimised and they, in partnership with their support network, are enabled to self-manage his/her condition, health and wellbeing without specialist support.

• Patient/family/carer perceive that they do not require intervention/support at the current time.

• The specialist palliative care team agree that the service is not appropriate to meet the patient's needs (referral to another service).

• The non-specialist clinicians feel confident to deliver care using occasional specialist advice.

[END]