The Prince & Princess of Wales Hospice

Access, Referral and Admissions to Hospice Services

Policy and Procedures

Policy No: CL001-R1

Policy Leads	Dr Alistair McKeown, Consultant Dr. Laura Kelly, Lead Consultant
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Signature and Designation of Ratifier 2	Anne Hattie Director of Operations
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1. Policy

The Prince & Princess of Wales Hospice (PPWH) provides care by complementing existing health care services with an appropriate level of intervention for the needs of the individual and their carers.

The aims of this policy are to clarify the criteria for access and provide formal processes for the referring agents. It will also clarify the criteria for admission to the individual services and provide clear guidance for the acceptance and administration of referrals.

Service provision

- PPWH offers specialist palliative care for patients with advanced and progressive disease, irrespective of underlying diagnosis. The services at the Hospice are available to those individuals aged 18 years and over with complex problems associated with a life-limiting disease and where a progressive decline is evident. Referrals for patients aged 16 years and over will be considered on an individualised basis as part of the Hospice's development of a transitional care model.
- Complex problems are defined as those which are severe and intractable and have persisted after assessment and/or intervention by generalists. These complex problems can include physical, psychosocial, emotional or spiritual distress. Access to the services is for those who reside primarily in the given catchment areas of the south side of Glasgow and East Renfrewshire, although an out of area referral may be considered on an individual basis.
- A range of services are available including: multi-disciplinary in-patient care (14 beds); community based palliative care services which include the multi-disciplinary community team; a family support service; and out-patient services which include day services, out-patient clinics and specific programs of care.
- If deemed appropriate, a patient referred to any of our services will have the opportunity to be assessed by a range of palliative care specialists including medical and nursing staff, complementary therapists, pharmacist, physiotherapist, occupational therapist, social worker, counsellors and resident artists.
- The service offers specialist Palliative Care out of hours advice and support to local hospitals (Victoria Infirmary, Queen Elizabeth University Hospital and Leverndale Hospital) with input from a specialist Palliative Care medical Consultant.
- Access to Hospice services is not open ended. Patients who access Hospice services will be reviewed regularly by the multidisciplinary team and may be discharged if needs are met (in accordance with the Hospice's discharge policy). The Prince & Princess of Wales Hospice is unable to offer longer term continuing care for those without specialist palliative care needs.
- Specialist palliative care nursing and medical advice for health and social care professionals is available 24 hours a day, 7 days a week.
- Service provision is in accordance with the criteria within the National Care Standards (Hospice Care), the NHS QIS Standards for Specialist Palliative Care, Clinical Governance & Risk Management and Greater Glasgow and Clyde NHS Service Agreement for Hospice Services.

2. Responsibility/Accountability

Ultimate Responsibility:	Chief Executive
Line/Departmental Responsibility:	Lead Consultant/Director of Clinical Services
Individual Responsibility:	Clinical teams

3. Related Hospice Policies

1.	C002	Infection control policy and procedures
2.	C005	Protecting and Supporting Adults at Risk of Harm
3.	C009	Moving and positioning
4.	C015	Confidentiality
5.	C017	Complaints, comments and suggestions
6.	CL002	Consent to treatment
7.	CL005	Cardiopulmonary resuscitation
8.	CL006	Discharge from Hospice services
9.	CL019	Transfer of patients in the Hospice ambulance
10.	HR003	Lone working
11.	IG004	Management of patient information

4. Procedure(s)

4.1: Accessing the services

4.1(a) Criteria for access to Hospice services:

Essential:

- The referral has been discussed by the referrer with the patient (or appropriate guardian/Power of Attorney) who agrees for the referral to hospice services.
- A completed referral form is received – either electronic, SCI, or agreed structured referral letter with all appropriate information (appendix 1).
- Clear reasons for referral are identified by the referrer.
- Patient's GP or Consultant agrees with the referral.
- Patient has a progressive life-limiting disease.

Plus one or more of the following:

- Patient has complex physical, psychosocial, emotional and/or spiritual problems.
- Patient shows a progressive decline and increasing frailty.
- There is a need for specialist advice to other health care professionals (HCP) regarding continuing palliative care treatment plans.
- Patients referred to community or outpatient services should primarily reside in the given catchment areas of south side of Glasgow and East Renfrewshire.
- Patients with a non-malignant diagnosis referred to any service should have where possible a disease specific CNS to optimise the appropriate care requested.

Short term symptom management support may be available for some patients with potentially curative disease on a case by case basis, and should be discussed with a senior team member/Consultant.

Complex issues affecting access to Hospice services should be discussed with the Consultant or senior member of the medical/nursing team.

All patients who meet the criteria will be considered irrespective of disease, age, disability, marriage or civil partnership, pregnancy and maternity, gender reassignment, ethnic group, religious beliefs and sexual orientation (Equality Act 2010).

Access to Hospice services is in accordance with the QIS Standards for Specialist Palliative Care.

4.2 Referral pathway

4.2(a) Who can refer:

Referrals are accepted from Consultants or GPs. Referrals are also accepted from any health care professional with the consent of the patient's GP or Hospital Consultant. The referrals may originate from primary care, acute care, care homes or other tertiary sites (e.g. other hospices, private hospitals/homes).

Patients (or their guardian), may self-refer to Hospice services. Appropriate supporting information about a patient's condition will be required from relevant health care professionals.

4.2(b) How to refer:

- During office hours a hospice referral form (appendix 1) can be obtained by phoning 0141 429 9823 or downloaded from the hospice website **(www.ppwh.org.uk)**. Referral forms are available in all GP practices and hospital sites.
- Structured referral letters are accepted from the QEUH HSPCT
- Completed referral forms can be submitted in the following ways
    - SCI Gateway system.
    - Secure email from NHS/GGC email accounts.
    - Referrals should be sent from secure NHS or ggc.scot.nhs.uk email accounts: ggc.ppwhclinicaladmin@nhs.scot
    - As a last option, postal referrals are also accepted:
        - All referrals sent by post must be marked 'Private and Confidential' and be sent to a designated clinician.
- Only urgent referrals may be made by telephone by those referrers with immediate access to patient records. These calls will be referred to medical staff for a decision and must be followed up with a completed referral form.
- All referrals should be accompanied by relevant and recent clinical information on diagnosis, stage of illness, treatments and medication, current care and family issues. In the case of an incomplete referral form more information will be sought by a member of the multidisciplinary team before the referral is accepted.
- On occasion, there will be individuals who have palliative care needs but do not fit all the relevant criteria. In these situations, it is encouraged to discuss the patient directly with the Hospice team by phone and if appropriate, an assessment visit by a Palliative Care specialist will be offered.

4.2(c) Referral review/decision:

All new referrals are discussed at the daily multidisciplinary referral meetings (Monday to Friday). Initially patient's needs are assessed using the information on the referral form and acceptance to hospice services is prioritised accordingly.

Urgent requests for admission to the inpatient unit will be considered 24 hours a day, 7 days a week outwith the daily referral meeting. Such requests should be discussed with the Hospice duty doctor.

Inpatient bed admissions are prioritised based on need/urgency rather than length of time on a waiting list. This priority list is updated on a daily basis as per the agreed procedures (appendix 2).

On acceptance, referrals are assigned to the requested palliative care service, or may be redirected to another more appropriate service after discussion between the team and the referrer.

4.2(d) Contact with referrer/patient:
If a patient is referred to community or outpatient services, a letter is sent to the referrer within 2 working days to confirm receipt of the referral. The letter will inform the referrer of the outcome e.g. acceptance, waiting list, declined (appendix 3).

If the patient is referred to the inpatient unit, telephone or email contact is made with the referrer within 24 hours to confirm receipt of referral, confirming the outcome e.g. acceptance, waiting list, declined.

Where there is a delay in referrer contact the reason for the delay is recorded in accordance with NHS QIS standard 1.a.11.

4.2(e) Contact with the referred patient:
If a patient is accepted to community or outpatient services, the relevant Hospice service will make initial contact with the patient by telephone to arrange a first meeting. However, if the patient is required to go on a waiting list, the patient will be informed by letter which will provide named contact details of a hospice clinician whom they can contact should their circumstances change (appendix 4).

If a hospital patient is accepted to the in-patient unit (or put on a waiting list), the referrer, usually a hospital clinician/CNS, will inform the patient. If a patient is in the community, the hospice team will liaise with the referrer and often the patient directly to organise admission/inform them that they are on a waiting list.

4.2(f) Adherence with referral policy
Adherence to the referral policy is recorded using a combination of the Hospice referral management form (appendix 5) and the referral management template within the electronic patient record system (appendix 6).

4.3: Inpatient services
The inpatient unit seeks to meet the needs of patients with a life-limiting illness through a multidisciplinary team of specialists in palliative care. Inpatient care is most appropriate for patients with complex multidimensional needs which cannot be resolved in other care settings. All requests for beds are prioritised in relation to the individual level of need as assessed by the appropriate health care professionals (community team, hospital palliative care team, GP, district nurse).

4.3(a) Criteria for admission to inpatient unit
- Patient has distressing physical, psychosocial, emotional or spiritual symptoms which are difficult to manage in their current place of care.
- Patient has an acute decline secondary to non-malignant diseases and has either decided to discontinue active treatment, or is willing to accept the limitations of active management available in the Hospice setting.
- Patient requires a period of inpatient specialist assessment for effective symptom management or crisis intervention that cannot be given or delivered in their current place of care.
- Patient may benefit from a period of specialist assessment and rehabilitation to maximise active functional potential to return home (e.g. after an aggressive palliative chemotherapy regime or spinal cord compression).

- Patient is at the end of life (i.e. estimated prognosis of less than 2 weeks) and is either unable to be cared for appropriately elsewhere or their preferred place of care is in the hospice.

Admission to hospital should be considered for any patient who develops an acute or unexpected problem that would benefit from further investigation and treatment.

Patients in hospital should ideally be assessed by the hospital palliative care team before referral if possible, but if not, referrals can be made directly to the hospice and/or discussed with the on call doctor at the Hospice for individual consideration.

4.4 Community specialist palliative care team

The community team consists of specialist medical and nursing staff who are supported by the extended multidisciplinary team in the hospice. They provide a 7 day service between the hours of 9am-5pm which is delivered by home visits, virtual assessments, telephone advice and review in the hospice. This service has a capacity level and if this is reached a waiting list may be necessary and patients prioritised based on need.

The team also provides specialist palliative care information, advice and support to the primary health care team (particularly GPs and District Nurses) who are the key managers of the patients' medical and nursing care in the community. Where possible, joint home visits with relevant member(s) of the primary health care team should be arranged at key points in the patients care for advance care planning (e.g. place of care, end of life care).

4.4(a) Criteria for access to the community service

- Patient requires a period of specialist assessment for effective symptom management, complex advance care planning, psychosocial, emotional or spiritual support.
- Patient has an acute decline secondary to non-malignant diseases and has decided to discontinue active treatment and be cared for in their own home.
- Patient may benefit from a period of specialist assessment and rehabilitation to maximise active functional potential to maintain care at home.
- Patient is at the end of life (i.e. estimated prognosis of less than 2 weeks) and has indicated their preferred place of care is in the home.
- Patient's relatives and carers require advice and support.

4.5 Outpatient services

The hospice offers a wide range of outpatient services with the aim of promoting independent living and optimising quality of life for as long as possible. We recognise that one size does not fit all and our model of care provides an individualised and patient centered approach which can be tailored to patient choice and identified need. Regular assessment and collaboration with other health care professionals allows for the provision of a flexible service which can respond to changes in a patient's health or circumstances. When a referral is received for out-patients the patient will be contacted to discuss their individual needs and preferences. The referral will be triaged by members of multi-disciplinary team with the patient being offered an outpatient appointment (face to face or virtual) or for attendance at the Living Well Hub. All patients regardless of their attendance at an outpatient appointment or at the Living Well Hub sit under outpatient caseload.

The following outpatient services are available:

- Living Well Hub.
- Virtual Living Well Hub.
- Outpatient clinics.

Living Well Hub is a wellbeing service that is open to anyone with a life limiting condition from the age of 16. The design of the service remains flexible and is built around five pillars of well-being.

- **Connect**
- **Be Active**
- **Take Notice**
- **Learn**
- **Relax**

In addition, it offers specialist assessment and input from the Hospice multidisciplinary team as well as a variety of activities, companionship, and peer support.

Programmes may include:

- Fatigue management.
- Breathlessness management.
- Anxiety management.
- Exercise Group.
- Relaxation Group.
- Complementary Therapies.
- Art sessions.
- Creative Writing.
- The Living Well Hub operates two days a week and exists as a drop-in service from 10am to 4pm with no further referral required for patients known to the hospice. The service is also open to their carers. For access to the living well hub patients and/or carers require their own transport. In exceptional circumstances the hospice may be able to offer a hospice ambulance or volunteer car.

4.5(a) Criteria for access to Living Well hub

- Patient requires a period of specialist assessment for effective symptom management and/or psychosocial, emotional or spiritual support.
- Patient requires assistance to improve function/quality of life when there is a progressive decline and increasing frailty.
- Patient should primarily reside in the given catchment areas of south side of Glasgow or East Renfrewshire.
- Carers of patients attending the living well hub can access this service.

4.5 (b) Virtual Living Well Hub

All patients and carers referred to hospice services can access the Virtual Living Well Hub. This service utilises a social media platform by way of a closed Facebook page. It offers patients a new way to achieve their goals and connect with others. It offers advice, information and resources, and although this service was created during the COVID19 Pandemic to meet the needs of people in our communities, demand has encouraged us to continue to facilitate this and expand its role.

4.5(c) Outpatient clinics

- Symptom management clinic
  - Medical clinic runs weekly.
  - Nurse led clinic runs throughout the week.
- Therapeutic intervention clinic
  - Enables patients to undergo investigation e.g. abdominal ultrasound or to receive interventional treatments e.g. blood transfusions or bisphosphonate infusions.
  - Scheduled according to patient need.

4.5(d) Criteria for access to outpatient clinics

- Patient requires a period of specialist assessment for effective symptom management and/or psychosocial, emotional or spiritual support.
- Patient requires specialist assessment of complex symptomatology.
- Patient has potentially curative disease but requires short term symptom management.
- Patient requires assistance to improve function/quality of life when there is a progressive decline and increasing frailty.
- Patient requires therapeutic intervention (e.g. bisphosphonate infusion/paracentesis) to optimise symptom management.
- Patient is able to attend clinic by their own transport.

4.6 Declined Referrals

In the event that a referral is declined by the Hospice, the reason for this will be clearly communicated to the referrer ideally by phone, but followed up in writing as a formal clinical letter, created on Crosscare and which will be uploaded to Clinical Portal. (Appendix 7: Referral Declined Template)

In the event that a patient or relevant family member/guardian declines a referral that would be accepted by the hospice, this will be communicated to the referrer, again ideally by phone and with follow up documentation as above.

5. Compliance with Data Protection Legislation/GDPR

The General Data Protection Regulation (GDPR) (EU) 2016/679 [14] and Data Protection Act 2018 [15] came into force on 25 May 2018. All organisations that process personal data are required to comply with the requirements of this legislation.

This means that personal information will be:

- Processed lawfully, fairly, and in a transparent manner.
- Collected for specified, explicit and legitimate purposes.
- Only collected so far as required for our lawful purposes.
- As accurate and up to date as possible.
- Retained for a reasonable period of time, in accordance with retention policies.
- Processed in a manner which ensures an appropriate level of security.

Hospice incident forms, investigations and associated information are stored securely to comply with GDPR and record-keeping requirements. Incident forms contain personal data on a data subject. These are stored securely and accessed in line with hospice information governance and clinical records management policies. Incident reports for the purpose of managing risk and learning from events and incident trends do not contain personal data on a data subject. Likewise, electronic incident notifications that are submitted to HIS via a secure online portal in line with regulatory requirements do not contain identifiable information on the data subject. However, in rare circumstances there is a statutory requirement to share some personal data on a data subject such as:

- a RIDDOR reported to HSE [16, 17]
- a referral to the Procurator Fiscal [18, 19]
- formal incident notification (injury to a service user) to HIS [20]
- a regulatory investigation into any complaint reported to HIS [21]
- an investigation of professional practice by any practitioner's professional registration body.

In these instances, any information on related incidents would then be shared securely on a need to know basis via secure routes.

6. Compliance with Policy

Referral adherence will be audited bi-annually by clinical governance coordinator (or nominated other).

Reasons for referrals to hospice services will be monitored by the clinical admin team and clinical governance team on an annual basis.

Clinical activity will be monitored by the clinical leads, hospice clinical governance committee and the hospice board on an ongoing basis.

7. References

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2. Clinical Standards Board for Scotland (NHS QIS). June 2002*. Clinical Standards: Specialist Palliative Care.* Edinburgh:
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4. GGNHS. 2006 Service *Agreement for Hospice Providers.*
5. Gold Standards Framework Scotland website http://www.gsfs.scot.nhs.uk/
6. NHS QIS 2005 National Standards Clinical Governance and Risk Management, Edinburgh
7. Scottish Executive. Sept. 2005 *National Care Standards; Hospice Care*
8. Scottish Government. 2007 *Better Health Better Care*
9. *Scottish Government 2012 Living and Dying Well: Update on Progress*
10. Scottish Government. 2015 *Palliative and End of Life Care Strategic Framework for Action*
11. Scottish Parliament. *Adults with Incapacity (Scotland) Act 2000.* Edinburgh: HMSO
12. Scottish Partnership for Specialist Palliative Care (SPPC). 2008*. Living and Dying with Advanced Heart failure: a palliative approach.* Edinburgh
13. NHS MEL (1997) 45. *Guidance on the use of facsimile transmissions for the transfer of personal health information within the NHS in Scotland*
14. The General Data Protection Regulation (GDPR) (EU) 2016/679 https://publications.europa.eu/en/publication-detail/-/publication/3e485e15-11bd-11e6-ba9a-01aa75ed71a1/language-en (last accessed 21/1/2019)
15. Data Protection Act 2018 http://www.legislation.gov.uk/ukpga/2018/12/contents/scotland (last accessed 21/1/2019)
16. Statutory Instruments Health and Safety 2013 No. 1471. The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013. http://www.legislation.gov.uk/uksi/2013/1471/made (last accessed 21/1/2019)
17. Health & Safety Executive (HSE) website: RIDDOR guidance http://www.hse.gov.uk/riddor/ (Last accessed 23/1/2019)
18. Crown Office & Procurator Fiscal Service. Reporting Deaths to the Procurator Fiscal Information and Guidance for Medical Practitioners. February 2018

19. Scottish Government CMO (2015) 3. Electronic Reporting of Deaths to the Procurator Fiscal. February 2015.
20. Healthcare Regulation of Independent Healthcare Notifications Guidance version 2.8 (May 2020). http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/independent_healthcare/information_for_providers.aspx (last accessed PDF file via this link on 13/7/2020)
21. Healthcare Improvement Scotland. January 2019. IHC Complaints Procedure (for Providers and Complainants): How we deal with complaints about independent healthcare services (Draft).http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/independent_healthcare/complaints_consultation.aspx (last accessed 7/4/2019)

8. Appendices

Appendix 1: Hospice Referral Form
Appendix 2: PPWH Priority List Processes
Appendix 3: Referrer Contact Letter
Appendix 4: Patient Contact Letter
Appendix 5: Hospice Referral Management Form
Appendix 6: Crosscare Referral Management Template
Appendix 7: Referral declined template

Appendix 1

Hospice Referral Form

The Prince & Princess of Wales Hospice

Prince & Princess of Wales Hospice
20 Dumbreck Road, Glasgow G41 5BW
Tel: 0141 429 9823 Website: www.ppwh.org.uk
Secure email (from nhs accounts): ggc.ppwhclinicaladmin@nhs.scot

REFERRAL FOR							
Community Palliative Care:	Hospice Community Team	☐					
Outpatient Services:	Day Services	☐	Outpatient Medical Clinic	☐	Nurse-led Clinic	☐	
Inpatient Admission:	Symptom Control	☐	End of Life Care	☐	Assessment	☐	
For more information about what each service offers, please refer to our website							

REFERRED BY			
Name:		Contact number:	
Designation:		Date:	

PATIENT DETAILS			
Surname:		DoB:	
Forename:		CHI:	
Address:		Postcode:	
		Tel. No.:	
Religion:		Marital status:	Please select from menu
Ethnicity:	Please select from menu	Is patient aware that referral is being made?	◯ Yes ◉ No
Current location of patient:			

IF REFERRING FROM HOSPITAL			
Hospital:		Ward:	
Consultant:		Tel. No.:	

NEXT OF KIN DETAILS			
Surname:		Address:	
Forename:			
Relationship to patient:		Postcode:	
Tel. No.:		Aware of referral:	

IMPORTANT - Completed referral forms should be submitted via secure nhs email
ggc.ppwhclinicaladmin@nhs.scot

GP DETAILS			
Name:		Address:	
Tel No.:			
Postcode:			
Aware of referral:			

SOCIAL SUPPORT					
Lives with:				DN in attendance?	◯ Yes ◉ No
DN Name:				DN Tel No:	
Care Package?		Details:			

MEDICAL INFORMATION					
Diagnosis:				Date of Diagnosis:	
Metastatic Disease:					
Treatment to date (surgery, chemotherapy, radiotherapy etc.):					
Patient's understanding of disease & prognosis:					
Mobility:				Housebound?	◯ Yes ◉ No
Personal care:		Continence:			
Past medical history:					
Current medication:					
Allergies:				Pacemaker?	◯ Yes ◉ No

IMPORTANT - Completed referral forms should be submitted via secure nhs email to ggc.ppwhclinicaladmin@nhs.scot

CURRENT ISSUES					
Please choose the severity of the following from 0 to 4; 1 being none and 4 being overwhelming					
Agitation	⦿0 ◯1 ◯2 ◯3 ◯4		Spiritual/existential distress	⦿0 ◯1 ◯2 ◯3 ◯4	
Nausea/vomiting	⦿0 ◯1 ◯2 ◯3 ◯4		Patient distress/anxiety	⦿0 ◯1 ◯2 ◯3 ◯4	
Dyspnoea	⦿0 ◯1 ◯2 ◯3 ◯4		Family distress/anxiety	⦿0 ◯1 ◯2 ◯3 ◯4	
Constipation	⦿0 ◯1 ◯2 ◯3 ◯4		Confusion	⦿0 ◯1 ◯2 ◯3 ◯4	
Ascites	⦿0 ◯1 ◯2 ◯3 ◯4		Depression	⦿0 ◯1 ◯2 ◯3 ◯4	
Distress due to care environment	⦿0 ◯1 ◯2 ◯3 ◯4		End of life care (last 48 to 72 hours of life)	⦿0 ◯1 ◯2 ◯3 ◯4	
Other (please specify)					
Pain (please give numerical scale rating)	No pain	⦿1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10			Severe Pain

ADDITIONAL INFORMATION

IMPORTANT - Completed referral forms should be submitted via secure nhs email to ggc.ppwhclinicaladmin@nhs.scot

Appendix 2

PPWH Priority list processes

The Prince and Princess of Wales Hospice (PPWH) operates a priority list for admission to the IPU, based on a range of factors, including:

- Referral form information
- Symptom scores
- Information direct from referrers, relatives and patients
- Information from other Palliative Care specialists (HSPCT, CSPCT)

The list is updated on a twice daily basis

- During the bed meeting each weekday morning, with full MDT input
- Each afternoon with any additional information by the Bed Co-ordinator (BC)

When required, additional information on all patients on the Priority list will be sought by designated members of the MDT, with feedback given to the BC to allow prioritisation. The BC is responsible for ensuring all patients on Priority and Pending lists have had appropriate reviews and up to date information is available for the 9:15 am bed meetings.

QEUH HSPCT

As one of the main sources of referral to the PPWH IPU, there are specific processes to ensure most up to date information is available to allow appropriate allocation of IPU beds

- Each afternoon (approx. 4pm) an updated PPWH Priority List will be sent to the QEUH HSPCT team secretary via secure email, to allow review at the 9am patient allocation meeting the following morning Monday-Friday
- Before 2pm each day, the QEUH team will provide feedback (via secure email) to the PPWH Clinical Admin team to allow revision of the overall priority list by the BC
- Before 9am on a Monday, a member of PPWH staff will contact the wards of patients on the Priority List in QEUH/other Hospital settings to ascertain if they are still alive and fit for transfer should a bed be available
- Additional information for those patients on the “pending” list (see below) may also be requested via the above processes

PPWH CSPCT

As another main source of referrals to IPU, communication between the CSPCT and PPWH IPU team should be regular, with timely updates re: patient priorities, symptoms and rate of decline, both the allow timely access to PPWH beds, but also to consider alternative places of care (Hospices, Hospital) or means of supporting patients and families at home. It is the responsibility of the CSPCT involved to ensure this information is passed to the BC quickly and efficiently, ideally in advance of the 9:15am bed meeting.

Pending List

The PPWH "Pending List" runs alongside the priority list and should be kept updated on a regular basis by the bed co-ordinator, with input from the MDT.

Patients may be placed on the pending list for the following reasons:

1) Additional information required from referrer (Update required within 24 hours)

2) Patient condition unstable and currently unsuitable for admission e.g. on IV antibiotics (updates required at least every 48 hours)

3) Admission anticipated but further discussion required with team/patient/family/other (updates required at least every 48 hours)

Patients should not be placed on the pending list "just in case" – notes should be updated on Crosscare to reflect current situation for patients who may be approaching admission, and referrals made in a timely manner. Patients should not remain on the pending list indefinitely – there should be a clear plan re: review and patients should be removed in a timely manner.

Appendix 3

Referrer Contact Letter

Our Ref: JH/

Dr «GP_NAME»
«GP_ADDRESS1»

26 August 2014

Dear Dr

Re: «PATIENT_FIRSTFORENAME» «PATIENT_SURNAME»,
(«DATE_OF_BIRTH»), «PATIENT_ADDRESS»

The above patient has been referred to the Prince & Princess of Wales Hospice by «Referrer», «Referrer_source» and we would like to acknowledge that the referral has been accepted by «Care_Team» Palliative Care Team.

We would be grateful if you could include the Hospice in any future correspondence involving this patient's care, including any relevant investigation results.

Please do not hesitate to contact the hospice at any time regarding future care.

Yours sincerely

Jackie Husband
Director of Clinical Services

Appendix 4

Patient Contact Letter

Our Ref:

«Title» «First_Forename» «Surname»
«Patient_Address»

26 August 2014

Dear «Title» «Surname»

The Prince and Princess of Wales Hospice has received a referral by «Referrer», «Referrer_source», for the Laurieston Community Palliative Care Team to support you at home.

You have been placed on a waiting list and I will be in contact as soon as the team is able to arrange to visit you. Your GP and district nurse have been made aware of this referral and can be contacted if you have any immediate problems.

If you have any questions or concerns, please do not hesitate to contact the hospice at any time regarding your care on 0141 429 5599.

Yours sincerely

«Carer_Name»
Laurieston Palliative Care Nurse

Appendix 5

Referral Management Form

Patient Post Code: ☐

REFERRAL MANAGEMENT FORM

REFERRAL / BED REQUEST

Name: ☐ **CHI Number:** ☐

Hospice No: ☐ New ☐ Old ☐ Internal ☐ Re-Referral ☐

Referred by: _____ **Designation:** _____

Service Required:	**Community:** ☐	**DS:** ☐	**Med OP:** ☐	
	NLC: ☐	**FSS:** ☐		
	IPU: ☐	**Patient currently in: Hospital:** ☐ **Home:** ☐		
Urgency of Referral:	**Urgent:** ☐	**Routine:** ☐		

Date Referral Received by Hospice: _____

Date Referral Discussed at MDT/Triage: _____

Outcome of Discussion:

Further information Requested from	Date	Outcome

Does patient consent to hospice information being sent to them: **Yes:** ☐ **No:** ☐ **N/A:** ☐

If yes, by: Email ☐ Post ☐ (if email, CNS to input email address onto patient crosscare record)

Accepted Referral:	**Community:** ☐	**DS:** ☐	**Med OP:** ☐
	IPU: ☐	**NLC:** ☐	**FSS:** ☐

Accepted By: _____ **Caseload:** _____ **Date:** _____

CC first letter to referrer if not GP: **Yes:** ☐ **N/A:** ☐

Declined Referral: **Reason:** _____ **Declined by:** _____

Letter sent to the GP or/and the Referrer (if not GP)? **Yes:** ☐

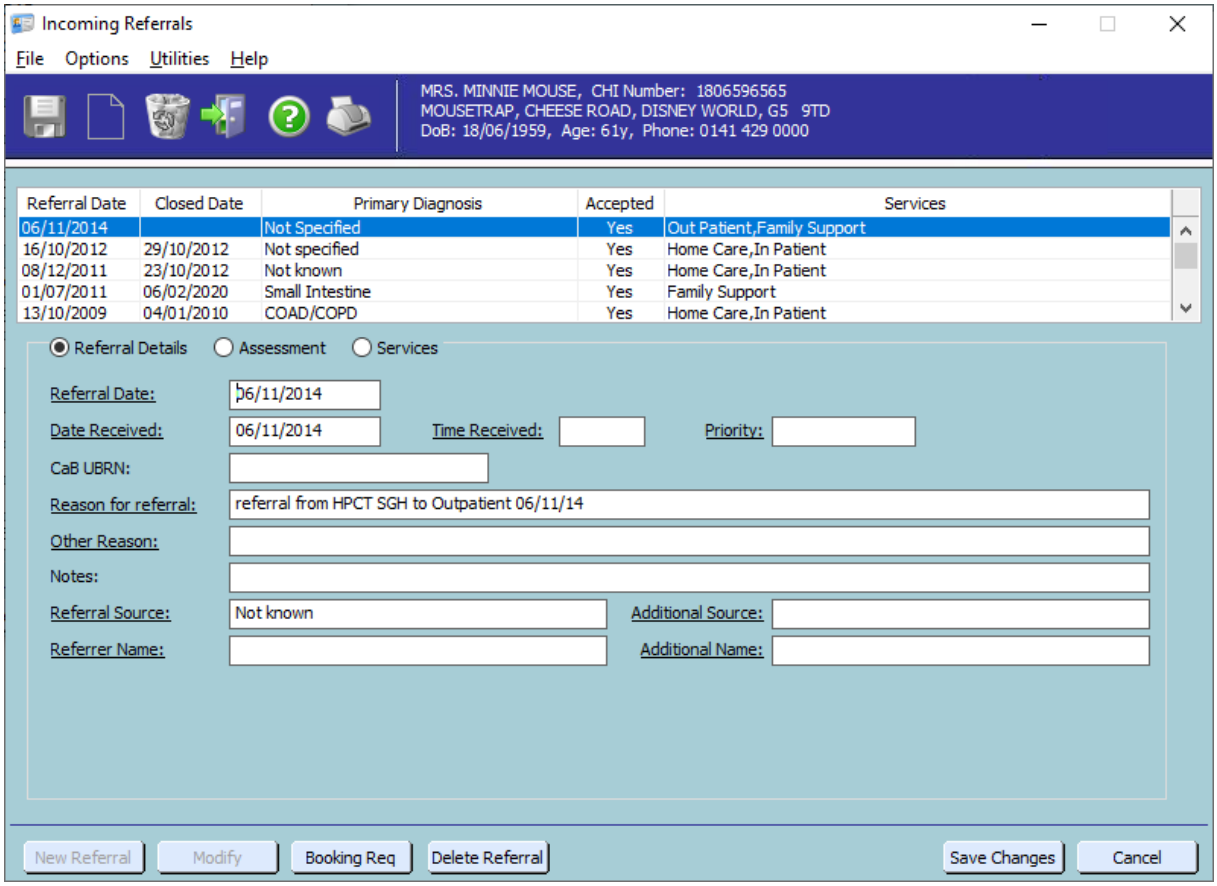
F:\CLINICAL\Clinical Admin\Referrals\Referral Management Sheet (Sept 2020).docx

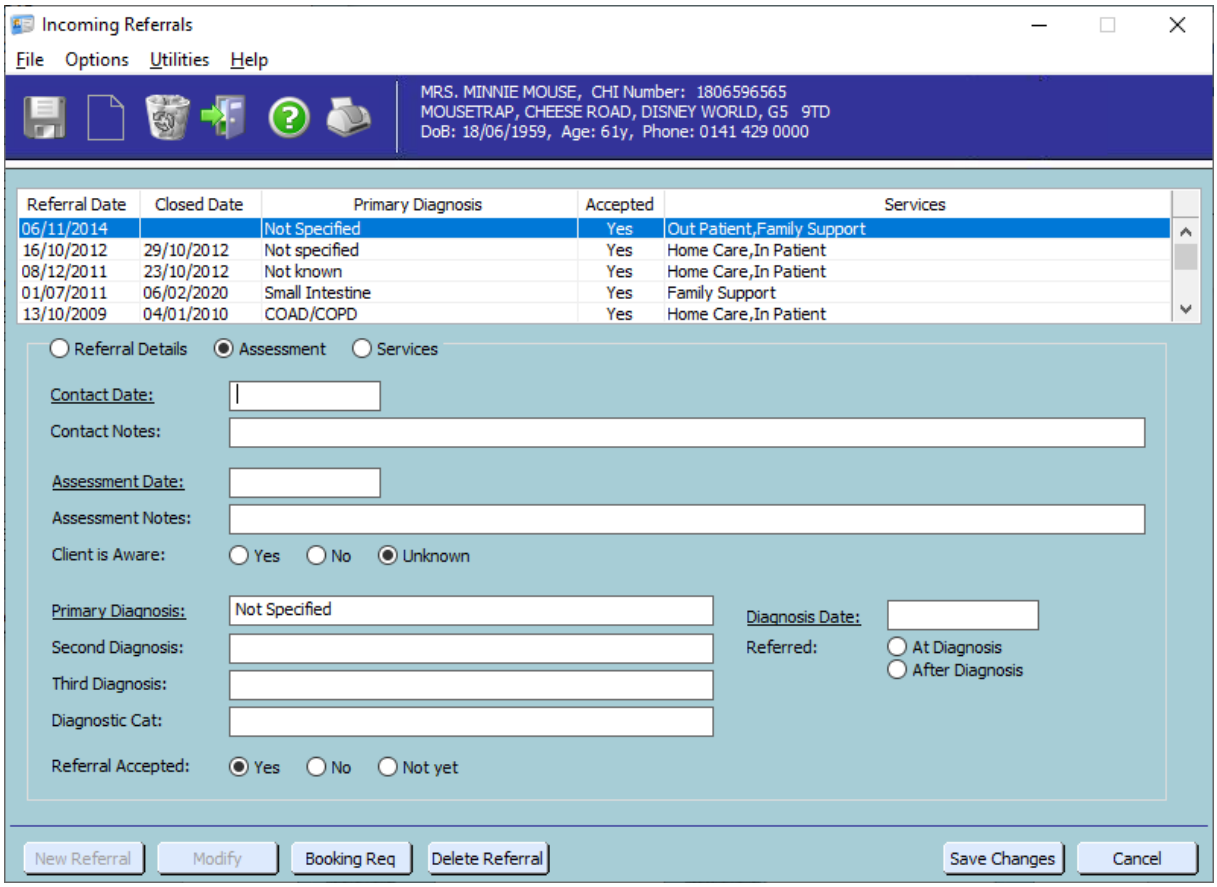
Outcome of Discussion:

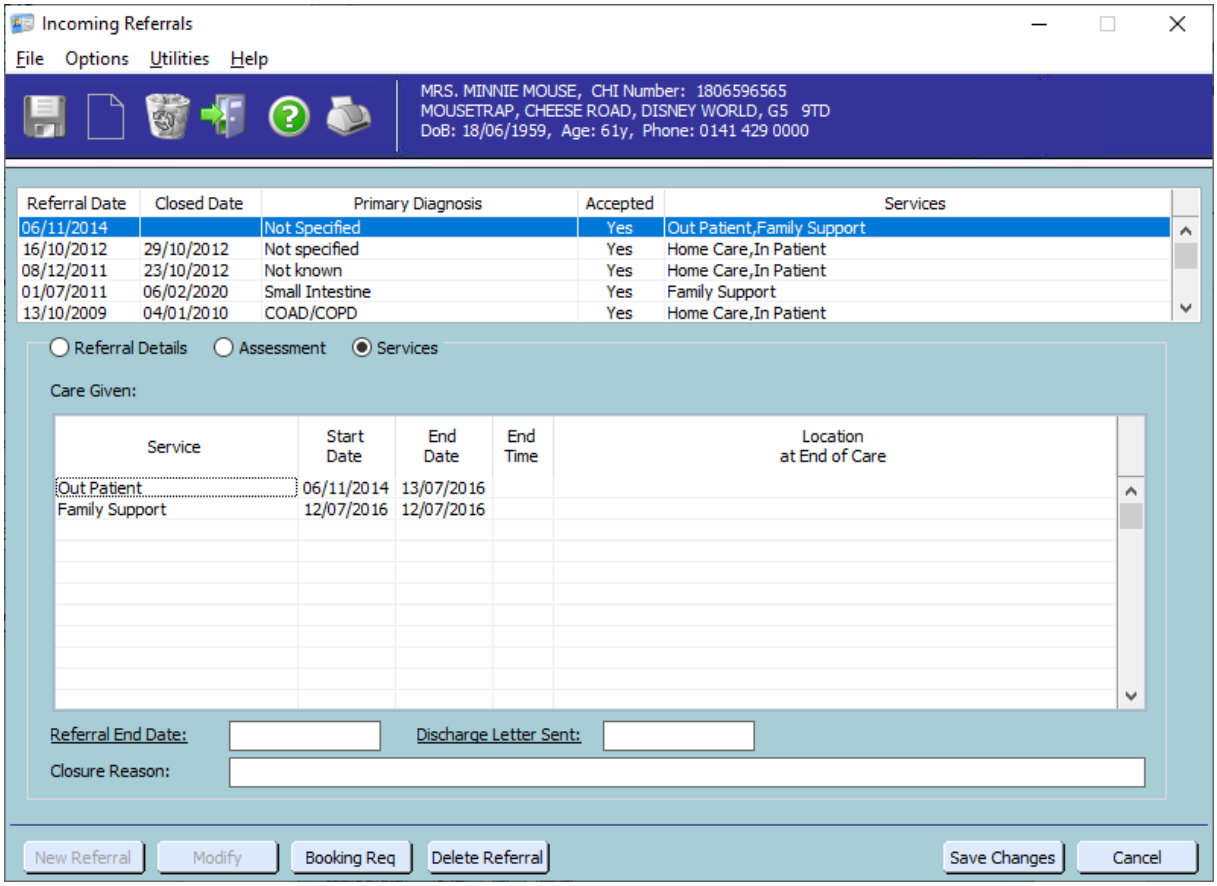
Further information Requested from	Date	Outcome

Appendix 6

Crosscare Referral Management Template




Incoming Referrals
File Options Utilities Help
MRS. MINNIE MOUSE, CHI Number: 1806596565
MOUSETRAP, CHEESE ROAD, DISNEY WORLD, G5 9TD
DoB: 18/06/1959, Age: 61y, Phone: 0141 429 0000
Referral Date | Closed Date | Primary Diagnosis | Accepted | Services
06/11/2014 | | Not Specified | Yes | Out Patient,Family Support
16/10/2012 | 29/10/2012 | Not specified | Yes | Home Care,In Patient
08/12/2011 | 23/10/2012 | Not known | Yes | Home Care,In Patient
01/07/2011 | 06/02/2020 | Small Intestine | Yes | Family Support
13/10/2009 | 04/01/2010 | COAD/COPD | Yes | Home Care,In Patient
Referral Details
Assessment
Services
Contact Date:
Contact Notes:
Assessment Date:
Assessment Notes:
Client is Aware: Yes No Unknown
Primary Diagnosis: Not Specified
Second Diagnosis:
Third Diagnosis:
Diagnostic Cat:
Diagnosis Date:
Referred: At Diagnosis After Diagnosis
Referral Accepted: Yes No Not yet
New Referral
Modify
Booking Req
Delete Referral
Save Changes
Cancel


Incoming Referrals
File Options Utilities Help
MRS. MINNIE MOUSE, CHI Number: 1806596565
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01/07/2011 | 06/02/2020 | Small Intestine | Yes | Family Support
13/10/2009 | 04/01/2010 | COAD/COPD | Yes | Home Care,In Patient
Referral Details
Assessment
Services
Care Given:
Service | Start Date | End Date | End Time | Location at End of Care
Out Patient | 06/11/2014 | 13/07/2016
Family Support | 12/07/2016 | 12/07/2016
Referral End Date:
Discharge Letter Sent:
Closure Reason:
New Referral
Modify
Booking Req
Delete Referral
Save Changes
Cancel

Appendix 7

Referral Declined Letter Crosscare Template

Our Ref: /

«DATE»

Dr «GP_NAME»
«GP_ADDRESS1»

Dear Dr

Re: «PATIENT_FIRSTFORENAME» «PATIENT_SURNAME», («DATE_OF_BIRTH»), «CHI», «PATIENT_ADDRESS»

We have received a referral from (**insert referrers name here**) for the above patient. As discussed, at this time they have (**declined/they are not felt to be suitable for**) (**delete as appropriate**) services at the Prince and Princess of Wales Hospice for the following reasons:

Patient/guardian declined review/patient does not meet service criteria/other (**delete as required and provide appropriate information**)

We would be more than happy to revisit this decision if the situation changes, and the patient/guardian is aware that if appropriate they can re-refer themselves to the service within six months without need for a further formal referral.

If you require any further information, please do not hesitate to contact us on 0141 429 9823.

Yours sincerely