Guidance for referral of people with progressive life limiting illness to the Poole Specialist Palliative Care Service

Who might benefit from specialist palliative care input?
Anyone with a progressive life limiting illness may need the input of specialist palliative care (SPC) at one or more stages of their illness, for assessment, advice and support when COMPLEX physical and/or psychosocial needs arise for the patient or their family.

What are complex needs?
Complex needs may be physical and/or psychosocial:

- physical or psychological symptoms that are not improving despite intervention
- multiple symptoms which may interact with each other and are therefore complex to manage
- complex psychosocial circumstances
- where it is anticipated that grief may be complex, for instance young families, past history of complicated grief etc.

When should I refer?
Dependent on the patient and family's needs – this could be from diagnosis or at any stage thereafter, when an initial plan of care has been tried, but the patient is not improving, coping or maintaining as good a quality of life as possible. If the patient is already known to SPC or has been known to SPC services in the past, this can be checked by accessing the Palliative Care Record on EPR (note they may have been discharged from specialist palliative care follow up).

How do I make a referral?
Referrals can be made face to face, by phone or by email (forest.holme@poole.nhs.uk). The referral form is available on the intranet http://nww.intranet.poole.nhs.uk/departments__directorates/medical_clinical_care_group/palliative_care/referral_to_palliative_care.aspx.

When making a referral please outline the reason(s) for referral. If unsure of this, it may be helpful to discuss with the hospital palliative care team (bleep 0028 or 0830) for inpatients or the community duty SPC nurse (01202 448115 option 1) for community patients. To avoid delay, we recommend that we are notified of referrals by phone or email. Clinic letters can take a long time to reach us, causing unnecessary delay for the patient.

Most patients will be contacted initially by a SPC CNS, who develops an initial plan and liaises with other members of the team as appropriate. If needed, consultants will see patients on the wards, in outpatient clinic at Forest Holme (for community patients who are able to travel) or occasionally at home. Referrals will be allocated to the appropriate service – Hospital Palliative Care Team (HPCT), Community SPC Nurse or OPA with SPC Consultant.

What about patients who have palliative care needs which are not complex?
Patients who are deteriorating or symptomatic but do not have complex physical symptoms/psychological needs should be discussed with their Primary Care Team for generalist palliative care support. Community Specialist Palliative Care Nurses meet regularly with GPs and DNs at GP surgery palliative care meetings (often known as Gold Standard Framework meetings). At these meetings, patients on their palliative care registers are reviewed. GPs or DNs will refer to SPC at any time patients' needs become more complex and patients are also welcome to self-refer at any stage.

What should I say to the patient and their family?
We recommend that you check with the patient that they are happy for you to get in touch with their GP and the palliative care team to make sure they have the right level of support to meet their needs.

If in doubt, give us a ring or discuss with us at an MDT – we will be happy to talk through the most appropriate plan of action with you.