Referral Criteria for St Wilfrid's Hospice Specialist Palliative Care Team (SPCT)

St Wilfrid's Hospice

The **Specialist Palliative Care Team (SPCT),** comprises of a group of health care professionals who **provide specialised care and support** to patients with life-limiting illness and their families in their own home, alternative care settings and the hospice Inpatient Unit. They work collaboratively to address the physical, emotional, social, and spiritual needs of the patients, aiming to improve their quality of life and provide comfort and dignity during the end of life stage. The team also works closely with primary care providers and other health care professionals to ensure a comprehensive and coordinated approach to care.

If the patient is in receipt of holistic care and support from the primary care team and symptoms are stable, it may **not** be appropriate for the SPCT to offer specialised support to those patients.

Australian Karnofsky Performance Status (AKPS) is a standard way of measuring a patient's functional status and ability to perform activities of daily living (ADLs). The scale ranges from 0-100%, with higher scores indicating better overall functioning and ability to carry out ADLs.

100%	Normal, no complaints, no evidence of disease
90%	Able to carry on normal activity, minor signs or symptoms of disease
80%	Normal activity with effort, some signs or symptoms of disease
70%	Cares for self, but unable to carry on normal activity
60%	Able to care for most needs, but requires occasional assistance
50%	Considerable assistance and frequent medical care required
40%	In bed more than 50% of the time
30%	Almost completely bedfast
20%	Totally bedfast and requiring extensive nursing care by professionals and/or family
10%	Comatose or barely rousable, unable to care for self, requires equivalent of institutional or hospital care, disease may be progressing rapidly
0%	Dead

***Acceptance to SPCT services contingent on service availability as well as patients' individual needs and circumstances**

Key:

Phase of illness	AKPS	Services	Professionals involved in intervention	Expected outcomes
Stable	100-60%	**Palliative rehabilitation:** • Living Well Programme • Living Well Drop-in Hub • Fatigue and Breathing (FAB) • Community links • Nurse Line support	**Therapy team:** • Occupational Therapy (OT) • Physiotherapy • Rehab Assistant • Community Nursing Team • Consultant OPA clinics in hospice and hospital	• Identified palliative rehabilitation goals and short intervention leading to **discharge once goals are met.** • Outpatient initial assessment and step down to telephone support via Nurse Line or **discharged once goals are met.**
Unstable/ Deteriorating	60-20%	**Palliative care:** • All the above, also • Out-patients (OPA) Clinics • Regular programmed home visits • Nurse Line support • Nursing home / care home telephone support **Complex symptom management:** • Virtual Hospice pilot • Community Team • Dr home visit on request • IPU admission	**Community Team:** • Specialty Doctors and Consultants • Clinical Nurse Specialist (CNS) • Registered Nurses (RN) • Health Care Assistants (HCA) **Wider MDT:** • OT • Physiotherapy • Social Work • Counselling and Complementary Therapy • Enhanced care (2 week maximum) • Community team and wider MDT (as above) **Inpatient Unit:** • Inpatient Unit Admission Team • Medical team • RN	• Holistic assessment to identify patient and carers' main problems and case management. • Symptom control and complex management. • Advance care planning. • Medication advice. • **Once stable, step down to Nurse Line or discharge.** • Symptom control and complex management at home • Complex symptom management in IPU • Holistic assessment to identify patient and carers' main problems

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			• HCA • Wider MDT (as above)	and case management. • Symptom control and complex management. • Advance care planning. • Medication advice. • **Once stable step down to community team or discharge to another care setting**
Unstable/ Deteriorating/ Dying	40%-10%	**Palliative care:** • Complex symptom management • End of life care • Nurse Line support	**Community Nursing Team:** • Specialty Doctors and Consultants • CNS • RN • HCA **Inpatient Unit** • Inpatient Unit Admission team • Medical team • RN • HCA **Wider MDT:** • OT • Physiotherapy • Social Work • Counselling and Complementary Therapy	• Complex symptom management at home. • End of life care and support at home. • Complex symptom management on Inpatient Unit and **plan for discharge to another care setting or community team once stable.** • End of life care and support on Inpatient Unit and **plan for discharge to another care setting or community team i**f phase of illness stabilises.

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SPCT Access Guide

Patient Profile	Service/Urgency		
Requires support in accessing community resources or palliative care services: The referral triage process may signpost to our Community Links coordinator who will help to identify local groups e.g., carers groups or social support groups for different conditions that are accessed in the local community. Or activities at the hospice, for example: a monthly craft group and our bereavement group (may not require an initial assessment).	**Routine (within a week)**		
Patients where the referrer has **identified specialist palliative care needs** express a desire for comprehensive, holistic approaches to their care.			
Requires **support managing the emotional and psychological aspects of their life-limiting illness** such as anxiety, depression, or grief. And who may require a structured and time limited pre- and post-bereavement counselling programme. **The referrer has identified the patient also has specialist palliative care needs.**		**Soon (within 24 to 48 hours)**	
Requires assistance with **decision making and advance care planning, including assistance with planning withdrawal of treatment** and making an end of life care plan.			
Young adults with life-limiting illness who are transitioning from children's hospice services to adult supportive hospice services, where it is important that there is a point of contact.			
Palliative patients who have complex physical, social or spiritual needs and require liaison and linked care with SPCT at the acute trust.			
Diagnosed with a life-limiting illness, such as advanced cancer, heart failure or chronic obstructive pulmonary disease (COPD). Urgency dependent on symptom burden and patient will be triaged and assessed by the most appropriate clinician.			**Urgent (within 24 hours)**
Palliative patient **with symptoms that are difficult to manage**, such as pain, nausea, or breathlessness, despite the best efforts of the primary care team.			
Has a life-limiting prognosis like Motor Neurone Disease, typically with a life expectancy of twenty-four to twelve months or less, dependent on symptom burden.			
Has complex medical history/comorbidities e.g., Parkinson's Disease or dementia requiring symptom management and care co-ordination, dependent on symptom burden.			

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