CP2 Referral and Admission Policy

Summary	Policy outlining the referral and admission processes for all North Yorkshire Hospice Care services.
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Applies to	All of NYHC
Author	Kathy Newbould
Additional NYHC staff who have contributed	
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Document Control

Date	Version	Action	Amendments
July 2019	1.0		
April 2022	2.0	Reviewed	Updates to referral processes for all services.

1 Introduction

1.1 Policy scope

This policy covers all work and services carried out by North Yorkshire Hospice Care (NYHC), a registered charity in England and Wales (518905). All staff and volunteers (where appropriate) operating its family of services, including Herriot Hospice Homecare, Just 'B', Saint Michael's Hospice and Talking Spaces, must therefore comply with the contents below. Throughout this document North Yorkshire Hospice Care and its family of services are referred to as 'we' 'us' 'our' for clarity and consistency.

1.2 Purpose of organisation

The purpose of our services is wide ranging, from end of life services to bereavement support and counselling.

2. In-Patient Unit, Saint Michael's Hospice

2.1 Criteria for referrals

Patients are admitted to the Inpatient Unit, at Crimple House, for terminal care, symptom control, assessment and crisis care. Patients will be considered for admission to the in-patient unit who have a progressive terminal condition with specialist palliative care needs or are in the last week/s of life. Patients must be over the age of 18 and live in the Harrogate and Rural District catchment area; although discretion can be applied by the Head of or Deputy Head of the Inpatient Unit when the request for admission is from out of area. (Please see appendix A, map for the boundaries of the district).

Patients from out of area will be considered under the following circumstances:

1. Majority of treatment has been provided by Harrogate District Hospital
2. Crimple House Inpatient Unit is the patient/family's preferred place of care or death or their family is living within our catchment area and this allows easier visiting.
3. patient has Specialist Palliative Care needs whilst away from home.

The patient must always consent to referral and admission to the hospice. If they lack capacity this consent must fall to their nominated advocate.

Note: Referrals will be considered for patients from any place of care.

During Covid-19 pandemic the temporary clinical policy for admission, TCP 1, must be adhered to along with this policy.

2.2 Referral process

All admissions to the Inpatient Unit will be agreed by the on duty hospice Doctor and the In-patient Unit Co-ordinator Nurse. If required, advice should be sought from a Consultant or the Head/Deputy Head of the In-patient unit.

All patients must be referred for admission by the Specialist Palliative Care Team, their GP or a member of their treating team/Consultant who is in liaison with their specialist palliative care team.

Referrals should be made on the designated form, completed by the referrer and sent via SystmOne (preferred), or by secure encrypted email where SystmOne is not possible. Contact by letter or by telephone must always result in a written referral. However, urgent admission can be arranged prior to receiving the necessary admission request form so as not to cause unnecessary delay, with the hospice staff member arranging the admission responsible for ensuring that all the salient information has been provided verbally, including consent to admission and smoking arrangements. The timing of the admission should be agreed between the hospice, patient and referrer. Admissions can be planned for all hours of all days including weekends. Any number of admissions can be taken in the same day as driven by patient needs dependant on staffing with additional medical, nursing and other staff provided as appropriate. The ultimate decision for this rests with the Head/Deputy Head of Inpatient Services.

When a referral for admission is agreed but not possible as there is no bed available, that referral will be placed on the 'Waiting List' awaiting the next available bed.

It is important to liaise with the referrer regarding the outcome of the admission request. Any discussions regarding the referral should be clearly documented on the referral paperwork, to support decision making.

Patients referred from hospital should be assessed by a member of their specialist palliative care team. In some circumstances where the case of need is clear and this would cause unnecessary delay in admission this requirement can be waived by the hospice doctor.

2.3 Out of hours referrals and admissions

Admission requests may be made out of hours; i.e. weekend or overnight, by senior health care professionals after escalation to a level of seniority. A request for further assessment to inform the decision to admit may be made by the hospice doctor.

Initially the nurse in charge on the in-patient unit receiving the referral will establish if the admission is appropriate in the same way that a referral would be assessed during normal working hours.

The nurse in charge on the in-patient unit should then discuss with the on-call hospice doctor this request. Out of hours referrals from hospital should not be delayed due to an assumption that the patient is in a safe place. If the referral is accepted the doctor making the referral will then contact the patient.

2.4 Waiting List Guidelines

To prioritise admissions as much information needs to be obtained as possible from the referring source and it may be necessary to supplement this with a hospice domiciliary assessment.

Waiting lists and prioritisation of admissions will be reviewed every morning by the hospice doctor on duty and the co-ordinator nurse on the in-patient unit.

The safety and well-being of the patient is the overarching consideration in prioritising admission regardless of their place of care.

3. Well-being Network and Outpatients, Crimple House

3.1 Criteria for referrals

All referrals to the Well-being clinic appointments should be made through the appropriate specialist or, where applicable, by self-referral. The patient must be over the age of 18 years and live within the Harrogate District. Referrals may be accepted at the discretion of the Wellbeing network and Outpatient service Lead.

3.2 Referral Process

Referrals to the Wellbeing network and Outpatient clinics and sessions can be made from the following health care professionals:

- GP
- Consultant
- Specialist Palliative Care Team
- Disease specific CNS
- Community Matron
- District Nurse
- Internally via Inpatient Unit/MDT member/Head of HOME

Referral to this service is taken by the Well-Being Team through email, letter or phone call. Referrals will be taken for people aged 18 and over and who have a diagnosed terminal illness, or they are closely connected to someone with a terminal illness. This service offers social support, emotional support and help with practical issues. Each referral is reviewed individually to offer tailored support from our Well-Being Services.
Please note this is not a counselling service.

Contact by letter or by telephone to request admission to Wellbeing service must result in a referral via SystmOne (preferred) or where this is not possible by encrypted email to hospiceservices@saintmichaelshospice.org

4. Palliative Lymphoedema, Saint Michael's Hospice

Patients should be over 18 and be diagnosed with a progressive terminal condition and live within the Harrogate and Rural District catchment area, although some discretion can be applied by the lymphoedema team. A referral form via SystmOne should always be used.

The Lymphoedema team see all palliative lymphoedema patients within the catchment area and referrals can be made by the following:

- GPs
- Community or practice nurses
- Consultants
- Specialist palliative care team
- Disease specific CNS
- Allied health professionals

Crimple House Inpatient MDT
District Nurses

5. Volunteer Visitors,

5.1 Criteria for referrals

Patients must be aged 18 or over, diagnosed with a progressive terminal disease, and living within our catchment area. All referrals for this service will be agreed by the Saint Michael's Volunteer Visitor Lead.

5.2 Referral process

All patients can be referred by any Healthcare professional, by letter, email or telephone. A Team member will make an assessment visit if appropriate to clarify suitability.

This should be attached to 'Communications and Letters' on S1 and a referral sent electronically where possible. If this is not possible a referral form should be filled in and sent via Egress (secure email). This will be followed up within 2 days and contact made.

6. Neurological Conditions Community CNS, Saint Michael's

This service provides support and advice to individuals living with Motor Neuron Disease (MND), their families and significant others.

6.1 Criteria for referral:

Patients over the age of 18, registered with a GP in the Harrogate & Rural District catchment area living with Motor Neurone Disease can be referred

6.2 Who can refer?

Referrals can be made by consultants, GPs or other allied health professionals. Self-referral from patients or family members are accepted but a request for clinical information from their neurologist will be made. Once initially referred patients can self-refer back into the service if discharged.

6.3 How to refer?

By letter, phone, e-mail or via System1.

7. HOME/Homecare service, Saint Michael's and Herriot Hospice

7.1 Criteria for referral

All patients should meet the fast track criteria:

- Rapidly deteriorating
- Increasing care needs
- Likely to be in the last days to weeks of life
- Over the age of 18

7.2 Referral Process

All referrals into the HOME service come through the End of Life Coordination Service for each area; Harrogate and Rural District (HaRD) and Hambleton and Richmondshire (H&R) via S1. Referrals will be attached in 'Communications and Letters', and an electronic referral will be sent. Referrers need to be a

healthcare professional who has assessed the patient to meet the criteria above. Once received, the referral will be scrutinized by the Home Service Coordinator, and further clarification sought if needed before accepting the referral.
The service for both HaRD and H&R have an operational limit of 28.5 hrs a day each, however this is flexible and every attempt will be made to take every referral within 24 hrs.
Further details may be found in the contract for each service.

8. Non-Palliative Lymphoedema

This service is commissioned by HARD CCG and is for adults living with lymphoedema and who are registered with a Harrogate District GP.
Patients with non-palliative lymphoedema will have swelling due to primary (genetic) or secondary (any other cause including trauma, surgery, organ failure, cancer treatment, recurring cellulitis, venous disease, obesity) lymphoedema which has failed to respond to diuretics.

Criteria which excludes someone being referred for Non-Palliative Lymphoedema is as follows:

- Patients under 18

- Lymphoedema patients receiving palliative care (those patients with a progressive terminal condition with specialist palliative care needs). This service is provided via the palliative lymphoedema pathway

- Patients with suspected arterial insufficiency. These patients should be referred directly to Vascular Team

- Patients with a serious heart, lung, liver of kidney condition that had not been properly investigated to establish the cause of their oedema and required referral for an urgent medical assessment

- Patients with unilateral limb swelling where other diagnoses have not been excluded, such as deep vein thrombosis, arthritis, ruptured Bakers Cyst and lymphatic or vascular obstruction due to undiagnosed new or recurrent malignancy. These require direct referral onto an appropriate medical specialist to clarify the diagnosis

- Active leg ulceration where the primary problem is not lymphoedema

- Where there is evidence of non concordance with the prescribed treatment plan and following discussion with the patient and the referrer concordance cannot be agreed

• There are known risk management concerns that would compromise the safety and wellbeing of the patient and staff

9. Just B Bereavement Services

9.1 Criterion for referral

Any person in the Harrogate and Rural, Hambleton and Richmondshire CCG district who has had a bereavement and this is the main area of need for support. All referrals for this service will be agreed by the Service Manager.

9.2 Referral Process

Adults referring into the Bereavement service can be referred by a professional or they can self-refer. If they are referred by a professional the person must consent to the referral.

The Children and Young Peoples bereavement services are available to any Child or Young Person up to 18 years old in the Harrogate District and the Hambleton and Richmondshire District and Leeds District. The following guidelines are used for the referral process.

All children and young people under the age of 18 can be referred by a parent/carer or appropriate alternative agency included but not limited to:

- Children adolescence Mental Health Services
- Social Care Services
- GP surgeries
- Schools/childcare settings
- Other children's support services

9.3 Who can refer?

Any parent or carer (with Parental Responsibility) can refer a Child or Young Person (CYP)

- The CYP should have been consulted about accessing support before the parent/carer refers them.

Any professional can refer a Child or Young Person

- They must have gained the parent/carers consent to do this for ages 0-15. For 16 and 17 year olds, they must have directly gained consent from the young person. The service administrator will check with the family that consent has been given.

Any 13, 14 and 15 year old can refer themselves

- If they are aged 13, 14 or 15 a young person can refer themselves for support. These referrals must be taken by a Social Worker, or a member of the Just B management team, who will assess capacity to consent to support work. Parent/carer consent must also be gained as part of the referral process. Parent/carer involvement is not imperative.

Any 16 and 17 year old can refer themselves

- Any 16 and 17 year old can refer themselves for support. These referrals must be taken by a Social Worker, or a member of the Just B management team, who will assess capacity to consent to support work. Parent/carer consent or involvement is not required, although encouraged.

All bereavement referrals are completed via phone for self-referral and professional agencies complete all referrals on a word document and these are password protected before emailed to info@justb.org.uk

10. Schools Emotional Wellbeing Service

10.1 Criterion for referral

School Emotional Wellbeing Service
Any child or young person in the Harrogate and Rural, Hambleton and Richmondshire CCG district and Leeds District who has concerns around their emotional wellbeing needs and the school is contracted with Just B. All referrals for this service will be agreed by the school and the Service Manager.

10.2 Referral Process

The Children and Young Persons Emotional Wellbeing services are available to any Child or Young Person up to 18 years old in the Harrogate District and the Hambleton and Richmondshire District and Leeds District and the school is contracted with Just B. All Children and young people within these school settings can only be referred by a member of school staff.

10.3 Who can refer?

The School is responsible for the completion of all referrals. It is recommended by Just B that Student Referrals are completed by a staff member known to the student. All referrals are to be password protected before emailed to: schoolsservice@justb.org.uk

- The CYP should have been consulted about accessing support before school staff refer them.
- They must have gained the parent/carers consent to do this for ages 0-15.
- If they are aged 13, 14 or 15 a young person can themselves complete the referral with school for support. Parent/carer consent must still be gained as part of the referral process. Parent/carer involvement is not imperative.
- Any 16 and 17 year old can refer themselves without parental consent. They themselves can complete the referral with school for support. These referrals will then be passed to a Social Worker or member of management within the Just B team, who will assess capacity to consent to support work. Parent/carer consent or involvement is not required, although encouraged.
- Any 18 year old can refer through school without parental consent. Although parental consent is still encouraged.

Criteria to access this service are at the discretion of the school, with agreement from Just B. If the level of need is too high or needing a specialist approach, Just B will support school to refer and signpost on.

Terminology

Parent/carer consent means that they are aware that their CYP is accessing Just'B' or HHH and agree to it. They may or may not have any further involvement in the support process.

Parent/carer involvement means they are actively involved in their CYP's support work, such as attending the Family Assessment or planned reviews.

11. Talking Spaces

11.1 Criterion for referral

Talking Spaces is a counselling service available to any person in Harrogate and District

11.2 Referral Process

Talking Spaces accepts referrals from professional agencies. Anyone wishing to refer themselves to the service should therefore contact the health or social care agency involved in their care. Professionals who are able to refer to the service include GPs, health professionals, workers in social care, drug and alcohol services, services working with people who are victims of domestic abuse and charities working in the Harrogate and district area.

Waiting List Guidance

For all client services, the service administrators alert the services managers to pre bereavement, death through suicide referrals and cases that appear more complex. Client Services managers regularly monitor waiting list referrals and use their discretion to prioritise referrals according to the level and urgency of need alongside other agency involvement.

All client services referrals received out of hours will be responded to on the next working day during normal working hours.

All Children and Young People referrals are inputted onto the CPOMs data base.

12. Re-imagining Homecare in Reeth

12.1 Criteria for Referral

North Yorkshire Hospice Care has been commissioned by NYCC to provide a two-year pilot for social care in Reeth and the surrounding areas. All clients will have a social care need, these are variable and are identified by NYCC, who then assess the individual to see what kind of support they need in order to remain at home safely.

12.2 Referral process
Referrals will be sent securely by Egress to the Hospice Services Coordination Team who will log the referral. This care will be assessed and reviewed regularly by both the team and their case manager.

Appendix A: Map of Harrogate and District boundaries