

Specialist Palliative Care (SPC) Referral Pathway

The referrer should be a clinical professional who has assessed the patient, and has knowledge of the patient's disease, symptoms, treatments and likely prognosis. Referrals must be made with the knowledge of the Senior Responsible Consultant; local policies may also apply. The Palliative Care Needs Assessment guidance is a helpful companion document.

Referral criteria to SPC:
 Patients with both:

- An advanced, progressive, life-limiting condition and
- Current or anticipated complexities relating to symptom control, end of life care-planning or other physical, psychosocial or spiritual needs that cannot reasonably be managed by the current care provider(s)

Assessment is conducted by the SPC team who are always available to advise or support other professionals in their delivery of palliative care.

Patient meets the above referral criteria

If patient is in **HOSPITAL**, then refer to Hospital SPC Team

If patient is at **HOME** (includes nursing or residential home, prison, hostel etc.), then refer to local community SPC service

Assessment by Specialist Palliative Care Team is undertaken

SPC needs identified

ACTION: SPC team develop care plan in collaboration with referring team, GP and Primary Care team. Care provided in patient's preferred place of residence whenever possible; admission may be sought to local SPC unit following discussion with patient and/or family should palliative care needs be too complex to be met in local care environment

No SPC needs at this time.

ACTION: Communicate outcome to patient and referrer. Recommend that needs are reassessed regularly using best practice as outlined in Palliative Care Needs Assessment guidance and re-refer if needs escalate.

Ongoing communication between SPC providers and other health and social care professionals with regular review and updating of care plan

Discharge from SPC may occur:

- When there is a change in disease status such that the patient no longer has any SPC needs e.g. following response to treatment; disease evident as only slowly progressive; investigations reveal less advanced disease than previously thought
- There is symptomatic improvement such that the patient no longer has SPC needs.
- Rehabilitation goals have been achieved
- Following initial SPC assessment it is determined that the patient does not have SPC needs and that ongoing needs are more appropriately met by other health care agencies.
- The patient, following informed discussion, requests discharge from SPC.
- The patient or family persistently prevent effective SPC input e.g. restricting access for assessment.