Referral Criteria for the Rapid Access to End of Life Care Service

Overview of Service

The Rapid Access to End of Life Care Service is for patients who have a 'primary health need' that has a rapidly deteriorating condition and/or are in the terminal phase of life, where their needs are more than ancillary to the provisions of accommodation by a local authority, i.e. the care they need is beyond the legal remit of Social Services.

- The Rapid Access to End of Life service replaced the Fast Track service across MSE in August 2023
- The new service is delivered by three hospices across Mid and South Essex. Havens Hospices, Farleigh Hospice and St Luke's Hospice. Known as the MSE HCP
- The referral pathways and service models have been aligned to ensure that there is continuity and equity across MSE
- Havens Hospices will manage referrals from Southend, Castle Point and Rochford
- Referrals from Chelmsford, Maldon and the Dengie, Braintree and the surrounding areas, including Finchingfield, Great Dunmow and Tiptree, will be managed by Farleigh Hospice
- Referrals from Basildon and Thurrock will be managed by St Luke's Hospice
- Any referrals received by a hospice outside of its geographical remit will be signposted appropriately.

Referral criteria

Eligibility for End of Life Personal Care, IPU or Nursing Home placement is based on an individual's assessed needs and is not disease-specific, nor is it determined by either the setting where the care is provided or who delivers the care. Access to consideration and assessment is non-discriminatory; it is not based on age, condition or type of health need diagnosed.

1.1. Referrals must be:

1. Those residents of Mid and South Essex Integrated Care Board who are over the age of 18 (or are registered with a GP within the Mid and South Essex Boundary)
2. And have been identified and assessed as having a primary health need, with a rapidly deteriorating condition, and/or the condition may be entering a terminal phase

1.2. Referrals will be considered from:

Rapid Access to End of Life Care applications is received by the hospices from:

1. GPs
2. Hospitals
3. RADS teams

4. Self-referrals
5. Clinicians in a range of other settings

1.3. Referrals will be considered for:

A patient, with a primary health need, whose condition is deteriorating rapidly and is thought to be entering the terminal phase, may be considered for an application.

1.4. SystmOne Referrals

The below referral form should be completed electronically and saved or scanned into the patient's SystmOne record. An electronic referral should then be sent to the appropriate hospice who will receive the referral as a 'Task'

1.5. Additional criteria information

A defined number of IPU beds will be allocated to support this service, however, a bed within the hospice cannot be guaranteed.

This service will assess and coordinate the delivery of personal care, IPU and nursing home placements for patients who fall within the criteria outlined above. Patients will be supported to remain in their preferred place of care by delivering an appropriate care package with the number and length of visits being dependent on individualised needs. If care at home cannot be sustained or sourced, the team will discuss transfer to a 24-hour care environment. This might include supporting the family with additional overnight care in the patient's home or the IPU in the hospice or a nursing home. A defined number of inpatient beds are allocated to support this service

Exclusion Criteria

- Patients under the age of 18 years
- Patients who are not a Mid and South Essex resident or registered with a GP within the Mid and South Essex Boundary
- Patients who do not meet the criteria of rapidly deteriorating, reaching the terminal phase of their illness and have a primary health need
- Core Hospice Service or partner service specification patients
- Individuals with long-term/chronic unless there is a step change in their condition which results in a rapid deterioration and Rapid Access to End of Life Care is required to enable the patient to achieve their preferred place of death

Referral Process

- Clinician to identify individual meets the eligibilty criteria for Rapid Access to End of Life Care.

- Clinician to make a referral to hospice using the Rapid Access to End of Life Personal Care referral form for personal care packages and CHC paperwork for Nursing Home Placement. Hospice is not commissioned to complete Fast Track Assessments/Paperwork for external organisations. It is the responsibility of the clinician who identifies the need to complete the relevant referrals and assessment documentation.

- Referrals will be acknowledged by email/SystmOne on the same day if before 4pm or within 24 hours of receipt if received overnight.

- When care is not already in place or is not meeting the currently identified needs, the referral will need to include immediate needs to be met, other agencies involved in the care, contingency arrangements whilst the care is sourced and the patient's preferences.

- Completed documentation must indicate implied or explicit patient consent. If the individual lacks the mental capacity either to refuse or to consent, a mental capacity assessment and best interest decision should be taken as to whether or not to proceed with assessment of eligibility for Rapid Access to End of Life Care A third party cannot give or refuse consent for an assessment on behalf of a person who lacks capacity, unless they have a valid and applicable Lasting Power of Attorney for Health or they have been appointed a Welfare Deputy by the Court of Protection.

  Where a "Best Interest" decision needs to be made, any relevant third party who has a genuine interest in the person's welfare must be consulted; this will include family friends and unpaid carers

- The referring clinician should await written confirmation of funding by the hospice team before informing the patient or relatives that a care package, IPU bed or nursing home placement would be funded.

- The referring clinician is responsible for discussing equity and choice, as well as any risks associated with the preferred decision. This means discussing what can realistically be offered and what families and friends/carers can do to work in partnership in the commissioning and delivery of care.

- The referring clinician must explain to the patient and relatives that the initial funding supports weeks of care, rather than months and years. Should the patient's condition stabilise or improve, the End of Life Personal Care funding will be withdrawn and alternative funding may be means tested.

- The referring clinician seeing the patient has a duty of care to consider contingencies and the level of care being prescribed, as well as completing the referral.

Rapid Access to End of Life Care Referral Form

Title, Forename(s) and Surname:	
NHS number:	Date of Birth:
Address:	
GP Surgery:	Religion:
Does patient live alone? Y / N	Preferred Language:

Nominated Person Name:
Nominated Person Contact Telephone:
Nominated Person Relationship to Patient:

Diagnosis:	Relevant Medical History:		
Phase of Illness (link to POI)	Dying	Deteriorating	Unstable

PPC			
PPD 1st choice		PPD 2nd choice	
DNACPR Location		PEACE document	
Would you expect your patient to die within 12 weeks? Yes / No Evidence of Rapid Deterioration:			

Additional Information (family circumstances, symptoms, emotional/psychological needs, any cognitive impairment, MCA):   Family/Friends/Neighbours support network: Known to District Nurse Y/N if no please refer immediately Any other services involved?   Contingency plan should support at home not be sustainable: Discussed and agreed with patient/family : Yes / No *(If discussions have not taken place the referral will be rejected)* Details of discussion:

Care frequency and number of carers per visit: Details of Current Care Package:

Equipment in Home:	Details of any Equipment Ordered: Delivery Date:
Manual Handling Risk Identified	Risks Identified in the Home

Pendant Alarm Y / N *If applicable*	Key Safe Y / N *If appliable* Number and Location
Community Medication Chart Y / N *If applicable*	Just in Case medications in home Y/ N

Signed _____ Date _____

Role _____ Department _____

Contact details_____

Please complete in full and email to:

Farleigh Hospice - contactteam.fh@nhs.net
St Luke's Hospice - Stlukes.oneresponse@nhs.net
Havens Hospices – havenshospices.rapidaccess@nhs.net