
Title:	CHRONIC HEART FAILURE – REFERRAL TO PALLIATIVE CARE SERVICES	Ref No: 1643 Version: 2
Directorate:	Palliative Care	Classification: Policy
Responsible for review:	Consultant in Palliative Care	Due for Review: 02/03/20 Document Control
Ratified by:	Care and Clinical Policies Group	
Applicability:	All patients as indicated in guideline	

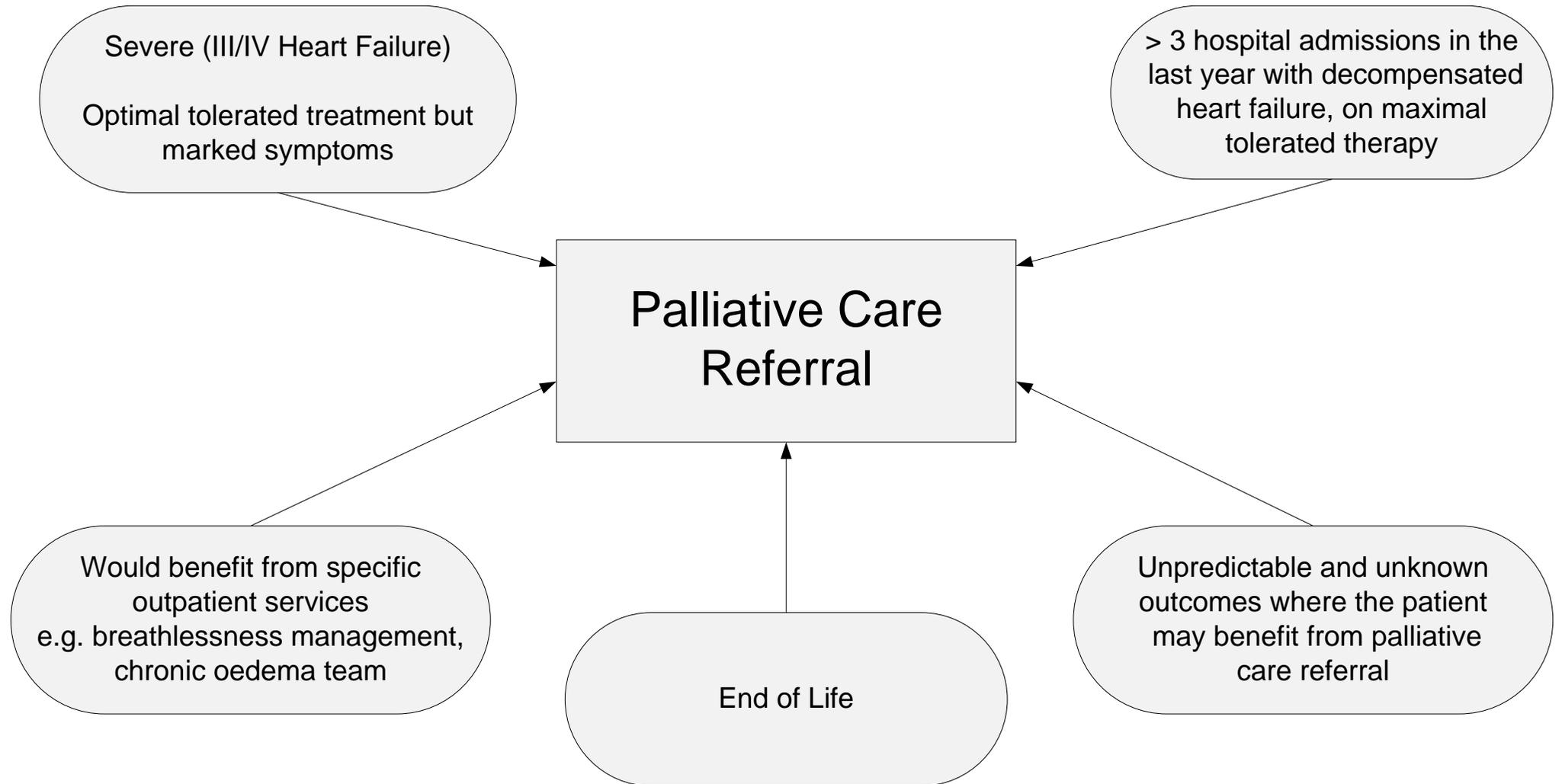
The National Service Framework for Coronary Heart Disease, published in March 2000, addressed the need for access to palliative care services and support for patients with severe and end-stage heart failure. This document is designed to aid referral of patients with severe heart failure to local palliative care services at the right time, and to the right team.

Figure 1 demonstrates which patients could be referred to palliative care. It is a guideline to aid decision making, but in grey areas and difficult or uncertain circumstances, cases can be discussed with the local palliative care physician or team.

Referral of patients to palliative care services remains at the discretion of the clinician involved in their care. These guidelines aim to facilitate a referral should palliative care input be required.

It is essential that patients are aware of, and in agreement with, their referral to palliative care.

Most patients will be class III/IV NYHA heart failure, but there will be some patients who on grounds of symptom control or complex psychosocial problems would warrant referral to palliative care services.



Palliative Care Services in Torbay consist of:

- Hospital Palliative Care Team (HPCT):

- Dr Jo Sykes, Consultant in Palliative Medicine Ext 55056
- Pippa Knight)
- Sarah Crisford) Clinical Nurse Specialists Ext 55042
- Kerenza Tucker)
- Zoe Bradley)

This may be for a ward referral or to be seen in an outpatient clinic.

- Rowcroft Hospice:

- Dr Georgina Walker (In patient unit) and Dr Sarah Human (Community Team),
 Consultants in Palliative Medicine

- Inpatient Unit Tel.: 01803 210810
- Outpatient clinic referrals Tel.: 01803 210810
- Multidisciplinary Community Palliative Care Team* Tel.: 01803 210811
- Hospice at home team Tel: 01803 217620

* Including occupational therapy, physiotherapy and specialist social work professionals

Referrals

The aim of referral is to offer guidance on the palliation of symptoms, both physical and psychological, to those with progressive, incurable, life-limiting conditions.

Referrals may fit into one of the following brackets:

1. Consultative

Short term involvement to deal with a particular problem.

E.g. Shortness of breath

Communication issues around prognosis, living with uncertainty.

May be seen whilst in hospital, at an outpatient appointment, or as a domiciliary visit.

2. Full Palliative Care Involvement

Cases where there is complex, on-going physical and/or psychological distress and/or complex social circumstances. Input may require involvement from the multidisciplinary community palliative care service, and where appropriate the hospital palliative care team too. This input may continue until the end of the patient's life.

3. End of Life Care

Control of overwhelming symptoms when death is imminent e.g. terminal agitation, dyspnoea, pain.

May be:

- a. In the **acute hospital**, supported by the **HPCT**. Providing advice on symptom control, support to families experiencing high levels of distress, and supporting ward staff to provide good end of life care (ext. 55056).

- b. In the **inpatient unit at Rowcroft Hospice** when patients require specialist symptom control at the end of life (tel:01803 210800).

- c. At **home**, supported by Rowcroft's **Hospice at Home** service specifically when it is suspected that patients are in their last two weeks of life. Hospice at Home offers hands on nursing care with the aim of supporting patients who wish to be at home in the final days of life. (Tel.: 01803 217620 – 24 hours).

Protocols & Guidelines – Document Control

This is a controlled document. It should not be altered in any way without the express permission of the author or their representative. On receipt of a new version, please destroy all previous versions.

Ref: 1643	Title: Referral to Palliative Care Services		
Date of Issue:	02 March 2017	Next Review Date:	02 March 2020
Version:	2		
Author:	Consultant in Palliative Care		
Classification:	Organisation-Wide		
Applicability:	All patients as indicated		
Equality Impact:	The guidance contained in this document is intended to be inclusive for all patients within the clinical group specified, regardless of age, disability, gender, gender identity, sexual orientation, race and ethnicity & religion or belief.		
Evidence based:	South Devon Formulary		
References:			
Produced following audit:	No		
Audited:	No		
Approval Route:	See ratification	Date Approved:	15 February 2017
Approved By:	Care and Clinical Policies Group		
Links or overlaps with other policies:			
All TSDFT Trust strategies, policies and procedure documents.			

PUBLICATION HISTORY:

Issue	Date	Status	Authorised
1	1 August 2014	New	Consultant and Clinical Director of Palliative Care
2	02 March 2017	Revised	Care and Clinical Policies Group
2	20 February 2018	Review Date Extended 2 Years to 3 Years	

The Mental Capacity Act 2005

The Mental Capacity Act provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from health and welfare decisions to finance and property decisions

Enshrined in the Mental Capacity Act is the principle that people must be assumed to have capacity unless it is established that they do not. This is an important aspect of law that all health and social care practitioners must implement when proposing to undertake any act in connection with care and treatment that requires consent. In circumstances where there is an element of doubt about a person's ability to make a decision due to 'an impairment of or disturbance in the functioning of the mind or brain' the practitioner must implement the Mental Capacity Act.

The legal framework provided by the Mental Capacity Act 2005 is supported by a Code of Practice, which provides guidance and information about how the Act works in practice. The Code of Practice has statutory force which means that health and social care practitioners have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.

“The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. It aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack the capacity to make decisions to protect themselves”. (3)

All Trust workers can access the Code of Practice, Mental Capacity Act 2005 Policy, Mental Capacity Act 2005 Practice Guidance, information booklets and all assessment, checklists and Independent Mental Capacity Advocate referral forms on iCare

http://icare/Operations/mental_capacity_act/Pages/default.aspx

Infection Control

All staff will have access to Infection Control Policies and comply with the standards within them in the work place. All staff will attend Infection Control Training annually as part of their mandatory training programme.

Quality Impact Assessment (QIA)

Who may be affected by this document?	Please select			
	Patient / Service Users	<input checked="" type="checkbox"/>	Visitors / Relatives	<input checked="" type="checkbox"/>
General Public	<input type="checkbox"/>	Voluntary / Community Groups	<input type="checkbox"/>	
Trade Unions	<input type="checkbox"/>	GPs	<input checked="" type="checkbox"/>	
NHS Organisations	<input type="checkbox"/>	Police	<input type="checkbox"/>	
Councils	<input type="checkbox"/>	Carers	<input checked="" type="checkbox"/>	
Staff	<input checked="" type="checkbox"/>	Other Statutory Agencies	<input type="checkbox"/>	
Others (please state):				

Does this document require a service redesign, or substantial amendments to an existing process?	<input type="checkbox"/>
<i>If you answer yes to this question, please complete a full Quality Impact Assessment.</i>	

Are there concerns that the document could adversely impact on people and aspects of the Trust under one of the nine strands of diversity?	Age	<input type="checkbox"/>	Disability	<input type="checkbox"/>
	Gender re-assignment	<input type="checkbox"/>	Marriage and Civil Partnership	<input type="checkbox"/>
	Pregnancy and maternity	<input type="checkbox"/>	Race, including nationality and ethnicity	<input type="checkbox"/>
	Religion or Belief	<input type="checkbox"/>	Sex	<input type="checkbox"/>
	Sexual orientation	<input type="checkbox"/>	No	

<i>If you answer yes to any of these strands, please complete a full Quality Impact Assessment.</i>	
If applicable, what action has been taken to mitigate any concerns?	N/A

Who have you consulted with in the creation of this document? <i>Note - It may not be sufficient to just speak to other health & social care professionals.</i>	Patients / Service Users	<input type="checkbox"/>	Visitors / Relatives	<input type="checkbox"/>
	General Public	<input type="checkbox"/>	Voluntary / Community Groups	<input type="checkbox"/>
	Trade Unions	<input type="checkbox"/>	GPs	<input type="checkbox"/>
	NHS Organisations	<input type="checkbox"/>	Police	<input type="checkbox"/>
	Councils	<input type="checkbox"/>	Carers	<input type="checkbox"/>
	Staff	<input checked="" type="checkbox"/>	Other Statutory Agencies	<input type="checkbox"/>
	Details (please state):	This is an updated policy with some name changes only.		

Rapid Equality Impact Assessment (for use when writing policies and procedures)

Policy Title (and number)		G1643 - Chronic heart failure - referral to Palliative Care Services		Version and Date	V2 January 2017
Policy Author		Consultant in Palliative Care			
An equality impact assessment (EIA) is a process designed to ensure that a policy, project or scheme does not discriminate or disadvantage people. EIAs also improve and promote equality. Consider the nature and extent of the impact, not the number of people affected.					
EQUALITY ANALYSIS: How well do people from protected groups fare in relation to the general population? <i>PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below</i>					
Is it likely that the policy/procedure could treat people from protected groups less favorably than the general population? (see below)					
Age	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Disability	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Sexual Orientation	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Race	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Gender	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Religion/Belief (non)	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Gender Reassignment	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Pregnancy/ Maternity	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Marriage/ Civil Partnership	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Is it likely that the policy/procedure could affect particular 'Inclusion Health' groups less favorably than the general population? (substance misuse; teenage mums; carers ¹ ; travellers ² ; homeless ³ ; convictions; social isolation ⁴ ; refugees)					Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Please provide details for each protected group where you have indicated 'Yes'.					
VISION AND VALUES: Policies must aim to remove unintentional barriers and promote inclusion					
Is inclusive language ⁵ used throughout?					Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Are the services outlined in the policy/procedure fully accessible ⁶ ?					Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Does the policy/procedure encourage individualised and person-centered care?					Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Could there be an adverse impact on an individual's independence or autonomy ⁷ ?					Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
If 'Yes', how will you mitigate this risk to ensure fair and equal access?					
EXTERNAL FACTORS					
Is the policy/procedure a result of national legislation which cannot be modified in any way?					Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?)					
Updated guideline to ensure equity of access to palliative care services for patients with HF					
Who was consulted when drafting this policy/procedure? What were the recommendations/suggestions?					
Cardiology and palliative care staff					
ACTION PLAN: Please list all actions identified to address any impacts					
Action	Person responsible		Completion date		
None required					
AUTHORISATION:					
By signing below, I confirm that the named person responsible above is aware of the actions assigned to them					
Name of person completing the form	Consultant in Palliative Care	Signature			
Validated by (line manager)	CD for Palliative Care	Signature			

Please contact the Equalities team for guidance:

For South Devon & Torbay CCG, please call 01803 652476 or email marisa.cockfield@nhs.net

For Torbay and South Devon NHS Trusts, please call 01803 656676 or email pfd.sdhct@nhs.net

This form should be published with the policy and a signed copy sent to your relevant organisation.

¹ Consider any additional needs of carers/ parents/ advocates etc, in addition to the service user

² Travelers may not be registered with a GP - consider how they may access/ be aware of services available to them

³ Consider any provisions for those with no fixed abode, particularly relating to impact on discharge

⁴ Consider how someone will be aware of (or access) a service if socially or geographically isolated

⁵ Language must be relevant and appropriate, for example referring to partners, not husbands or wives

⁶ Consider both physical access to services and how information/ communication is available in an accessible format

⁷ Example: a telephone-based service may discriminate against people who are d/Deaf. Whilst someone may be able to act on their behalf, this does not promote independence or autonomy