Referrals for our Neighbourhood Hubs

Aims of the service

To achieve the best quality of life possible for patients with a palliative or terminal illness or advanced progressive disease, centred on their goals, in a non-clinical environment nearer to people's communities, and to support their carers. To have physical, emotional and spiritual issues addressed, including discussing advance care planning where patients can detail how they want to be treated and cared for going forward.

The primary aim of the Neighbourhood Hubs is to provide rehabilitative, non-pharmacological and psychosocial intervention and support to empower patients and carers to:

- Understand their condition.
- Self-manage their symptoms using non-pharmacological strategies.
- Remain as independent as possible within the limitations of their illness.
- Maintain participation in meaningful activities and achieve realistic goals that add quality to life and improve function.
- Maintain and/or improve global quality of life and well-being.
- Remain at home or in their preferred place of care.

Service Structure

The service is managed by the Therapy and Community Services Manager and delivered by a team of allied health professionals, Community Engagement Nurse, Community Engagement Officer and volunteers supported by the Community Services Officer.

Services Offered

- **One-to-one outpatient therapy appointments** (face to face or telephone/video) for assessment and treatment by physiotherapy and occupational therapy. Foot care and lymphoedema treatment appointments are also offered but via internal referral only. In view of the general aims of the service focusing on rehabilitation, education and empowerment, patients/carers are offered a set number of 6 sessions per specialty. However, if patients/carers' needs change during this time or if needs are complex, additional sessions may be offered subject to approval by the therapy manager.

- **Home visits** may be conducted for environmental assessment purposes or in exceptional circumstances, but the Neighbourhood Hubs are not home-based services so housebound patients will be referred/signposted to other services in the community.

- **Living well workshops**, aimed at empowering patients and carers by providing information, education and practical tools for patients to manage their condition and symptoms. Topics covered include: Fatigue management, anxiety and stress management, breathlessness management, advance care planning, well-being.

- **Living well groups**, aimed at empowering patients and carers to maximise their day to day by engaging in new activities, learning new skills, sharing ideas with others. This is currently in development and we are hoping to offer the following soon: well-being group, gardening group, adapted tai-chi.

- Aside of the Neighbourhood Hubs, Cornwall Hospice Care Community Services offer post bereavement services including Walk Talk Kernow, Bereavement Help Points, Bereavement Support Groups and a telephone based Listening Ear Service. A Virtual Community Friendship Café is also offered on Facebook where useful information is posted daily.

Referral Criteria and Process

1 – General principles of referral

For the purpose of this document referral means a contract between any healthcare professional or patient directly, and Cornwall Hospice Care Neighbourhood Hubs.

Initial referrals will be accepted from Health and Social Care Professional as well as the patients or carers themselves.

For one-to-one therapy sessions only, information will be sought from the patient's GP and from recent hospital notes prior to any one-to-one treatment commencing to ensure it is safe and appropriate.

Professional referrers and GP will receive a copy of the referral acceptance letter sent to the patient so that they are aware of the Neighbourhood Hubs' involvement.

All referrals and contacts between Cornwall Hospice Care Neighbourhood Hubs and the referrer must be documented on the appropriate system or referral form. This forms a record of the service provided by Cornwall Hospice Care Neighbourhood Hubs for the purposes of governance, education and audits.

2 – Criteria for referral

- Patients/carers must be aware of and consent to the referral.
- Patients may be referred who have been diagnosed with a palliative or terminal illness or advanced progressive disease – meaning those whose disease has been determined to be for palliative management; who may be transitioning from active treatment to palliative care; who have severe or end stage disease; or who have an

advanced progressive condition. This includes diseases such as cancer, heart disease, neurological diseases and lung disease as well as other terminal- illnesses, from which a patient will not recover.

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- Issues with difficult symptoms for example breathlessness, fatigue, reduced mobility, pain, nausea, difficulty in participating in Activities of Daily Living (ADLs) or accessing and engaging in their 'community'.
- Psychological issues related to illness such as depression, anxiety, stress, low mood and loss of motivation.
- Spiritual issues such as adjusting to the meaning of diagnosis/prognosis and disease progression.
- Difficulties managing activities of daily living and accessing equipment to assist with the issues.
- Complex family issues and distress as a result of/or exacerbated by current illness.
- Social isolation due to illness.
- Rehabilitation needs following treatments and/or diagnosis.
- Difficult issues related to making decisions and planning for the future.
- Carers who need additional support as a direct result of the current illness.
- Inpatients discharged from one of our hospices who need further therapy.
- involvement to support their function at home or in support of imminent anticipated deterioration.

Carers may be referred who care for a patient meeting the above criteria. This does not include formal/paid carers.

Patients and carers must be 18 years of age or over and live in Cornwall in their own home.

3 – Inappropriate referrals

- Under 18 years of age.
- Referrals for patients out of county.
- Conditions not meeting the above criteria.
- Patients with chronic clinically stable disease or disability, or long-term conditions (i.e. a disease that persists over a long period and is neither decreasing nor increasing in extent or severity) with a life expectancy of several years.
- Patients with chronic pain problems not associated with progressive terminal disease.
- Competent patients who decline referral or who are unaware of their underlying disease.
- Those whose problems are principally psychological and need specialist psychiatric referral, whether or not they have declined such help.

4 – Response to referral

All referrals will be triaged by a Community Services allied health professional to ensure the person meets the criteria and that our services are suitable to meet the person's needs.

- Patients and carers will be sent a pack by post (or email if they prefer) including:
    - A letter confirming the referral has been received and accepted. Copy will be sent to professional referrers and to the GP.
    - "Your information – fair processing notice" leaflet
    - "Consent – information about your rights" leaflet
    - Information about community and Neighbourhood Hubs services.
    - Assessment of needs and priorities questionnaire. For the person to complete and bring to their first appointment (or send by post/email in the case of telephone appointments).

- Patients will be contacted by the allocated therapist or a therapy assistant within seven working days of receipt of the referral. This may be a telephone call, email or letter.
- Patients will be sent an assessment of needs and priorities questionnaire with the pack. Once returned, the questionnaire will be reviewed by a Community Services allied health professional to establish whether other therapies or services would benefit the person. For more urgent cases, the questionnaire can be completed over the phone.
- All patients and carers will discuss a "plan of care" with their therapists from the outset. This will include the number of sessions available, how to space them out and planning for discharge from the therapist's care once goals are achieved.
- All patients' and carers' needs and plan of care will be reviewed regularly. Not all sessions may be required. If additional sessions are needed (for example because the person's condition worsens, or significant events occur) this must be discussed with and agreed by the therapy manager.

Discharge Criteria and Process

Patients and their carers who meet the referral criteria for the Neighbourhood Hubs will generally remain patients of the Neighbourhood Hubs and retain the ability to access various aspects of the service as needs arise.

However, patients and carers will be discharged from the care of individual therapists/clinicians when the identified needs are met. This is generally seen as a positive process for patients who are well, whose disease is stable, those who have achieved their goals and who no longer need this particular therapy. The discharge will be tailored to fit the individual and may involve researching alternative arrangements for continued support.

In some situations, patients/carers will be discharged from the Neighbourhood Hubs service as a whole following a team decision. See below.

The "plan of care" discussed at the initial appointment will be reviewed with patients and carers on an ongoing basis to ensure the most appropriate and relevant care is provided.

This will ensure that patients and carers take an active role in their own care and will support them in developing self-management skills including awareness of other services available. At any point during the intervention or on discharge, the therapist and patient/carer may agree to referral(s) to other services such as elements of the Primary Care Team (with or without the support of the community specialist palliative care nursing team) as well as other community services and other Cornwall Hospice Care and Neighbourhood Hubs services. The decisions about discharge will be discussed with patients/carers and they will be informed that they may refer themselves again to the Therapy in question in the future if their needs change.

1 – Discharge criteria

Patients will be **discharged from the individual care of Neighbourhood Hubs clinicians** for the following reasons:

- The patient's current goals of the referral to the Hubs are met and further input from the team is not needed.
- Initial referral reason has been resolved and their needs met, and there is no further scope to impact on the symptoms or concerns.
- Patients and carers are more able to cope emotionally and/or physically having received appropriate care/treatment.
- Their condition has stabilised and they are now able to manage the symptoms/issues themselves, and Therapy input becomes neither desired nor beneficial.
- Patients and carers perceive they do not require intervention/support at the current time.

Patients will be **discharged from the Neighbourhood Hubs as a whole** for the following reasons:

- Severe confusion when this condition cannot be safely managed, or where, despite intervention undue distress is being caused to the patient/carers or others.
- The specialist therapists agree that the service is not appropriate to meet the patient or carer's needs.
- Due to deteriorating condition patients are not well enough to attend and become unable to travel.
- Patients/carers no longer meet referral criteria.
- Patients/carers fail to attend without cancelling on 2 occasions
- Patients/carers move out of county.

2 – Discharge Process

- A discharge date will be set by the specialist therapist with the patient/carer. This may incorporate a period of reduced attendance prior to final discharge.
- Where appropriate/needed and if not already covered during the treatment sessions, a plan will be made with the patient/carer for ongoing support with other

organisations in the community or with Cornwall Hospice Care services. This may include services aimed a preventing social isolation.

- Patients and carers will receive a letter from their therapist (copied to their GP and to their referrer if that is a healthcare professional). This letter will summarise the issues identified on assessment, the interventions carried out and outcomes.
- Patients/carers will be given relevant contact details and information should they in the future need to contact Cornwall Hospice Care to access services it offers as well as other relevant agencies/resources in the community.

Service Evaluation

In order to ensure the Neighbourhood Hub meets the needs of its service users and provides a high quality service, feedback is sought from patients and carers, during their involvement with the therapist and on discharge from their clinician's care, via a feedback questionnaire sent and returned by post. Patients and carers attending workshops and groups are also asked to complete a feedback questionnaire.

Feedback questionnaire answers are collated by the community services coordinator to be analysed. Results are incorporated in the dashboard for monitoring by senior management.

Statistics are collected from clinicians and progress chasing will monitor the responsiveness of the service.