At St Luke's we care for people aged 18 and above throughout Sheffield who have a terminal illness. We aim to improve their quality of life though holistic assessment and symptom control. Our services include the Patient and Family Support Service, the Integrated Community Team and the In-Patient Centre. To assist professionals in choosing when and who in the team to refer to we have updated our referral criteria.

Inclusion criteria

- Diagnosis of a life-limiting illness for which there is no cure and from which the person will die. This includes cancer diagnoses but also non cancer diagnoses such as heart, respiratory, renal and liver failure and neurological diagnoses like MND.
- Complex symptoms associated with that diagnosis; physical, emotional and/or psychosocial issues that cannot be managed by the team currently responsible for care (this may include disease specific team as well as primary care team).
- Patient is registered with a Sheffield GP Practice.
- Patient has given consent for referral.
- Patient is 18 years old or above.

Exclusion criteria

- Patients with chronic stable disease or disability with a life expectancy of several years
- Patients with chronic pain problems such as arthritis that are not associated with progressive terminal disease
- Patients who decline referral or are unaware of it, or their underlying disease
- Patients whose problems are principally psychological and need a referral for specialist psychiatric treatment

We are aware that patients may have specialist needs that do not fall into the categories below and would always welcome phone calls to discuss their needs and how we can best support them. Please call 0114 236 9911 and ask to speak to that day's senior clinician in the relevant area to discuss further.

Patient and Family Support Service.

The Patient and Family Support Service is often the first part of the St Luke's service patient and families have contact with. It is main based at our Ecclesall Road South site and allows people to access physio and occupational therapy, wellbeing and creative therapies, social work and chaplaincy or spiritual support for all faiths and none. This could include relaxation and wellbeing techniques, tips on nutrition, routine and sleep as well as fun activities for all interests.

Families and friends play a valuable role in a patient's care, so we also provide dedicated support for loved ones too through social, spiritual and bereavement support

Children and young people can access these services whilst accompanied by a responsible adult or pre-arranged at our specialist child and young person bereavement groups.

All classes and services are free, and lunch is available to purchase. We can arrange transport when needed as we are keen to allow as many people as possible to access our services. Our building is wheelchair accessible, and we encourage family and carers to attend with patients but regret we are not able to offer hands on care for patients at PAFFS as we do not always have clinical staff on site. If a patient may find it difficult to access our services, please give us a ring to see what adjustments can be made.

Please encourage patients to have a look at our website to check out our latest timetable and make a self-referral or just pop in on a Tuesday, Wednesday or Thursday 10-4 where we can talk them through the services on offer.

Once a referral is received a member of our triage team will call the person to talk through their needs and which of our services will best support this.

https://www.stlukeshospice.org.uk/what-we-do/for-patients/patient-family-support

The Integrated Community Team

St Luke's Integrated Community Team (ICT) is a multi-disciplinary team including Nurse Consultant, CNS, doctors, assistant practitioners, physiotherapist, social workers, wellbeing and chaplaincy. It provides specialist advice and support for patients with a life- limiting illness. This can be at home with our visiting team or at our Little Common Lane site in our outpatient services for patients who are more mobile. Our team visits 7 days a week and work closely with primary care services. The ECHO team, part of our ICT, support those people admitted to nursing homes, residential home and supported living accommodation across Sheffield.

Specialist Palliative Care manage complex palliative care problems that cannot be dealt with by generalist services, such as complex symptoms requiring assessment by an experienced palliative care professional, or overwhelming emotional or psychological issues that cannot be managed by their GP and community nursing teams.

St Luke's community team also see patients to give advice about their end-of-life care and management and support the community teams in allowing a patient to die at home.

Our team do not take over the care of patients at home but offer support and advice typically over several visits until that current problem or symptom is stable. We do not provide "hands on" nursing care. Once a patient is more stable, we would aim to step back and allow the patient to access support from our PAFFS services on a more ad hoc basis. This allows us to support a greater number of patients across the city. Once known to our community team a patient or family can get back in contact if the situation changes without a new formal referral.

Following referral to the service; all patients are triaged into either "urgent" or "routine". To enable referrals to be dealt with as efficiently as possible and triage appropriately please provide as much information on the form as possible.

- Have you had a ReSPECT conversation and is a plan in place?
- Have you had a discuss about CPR?
- Does the patient want escalation to hospital if they become unwell?
- Is a Pink Card and pre-emptive medication available in the home?
- Is the patient receiving cancer treatment, either with palliative or curative intent?
- Does anyone have lasting power of attorney, or other legal proxy for the patient?

Criteria for urgent referrals:

- Patient is actively dying or likely to die within the next 2 weeks.
- High risk of palliative care emergency such as catastrophic bleeding, seizures, bowel obstruction, spinal cord compression or airway obstruction.
- Complex psychosocial issues.
- Rapidly changing/escalating symptoms.

Our triage team aim to contact urgent referrals within 24-48 hours, but patients can be seen the same day if necessary. If you feel a patient needs a same day review, please call and speak to the community co ordinating nurse as well as sending a referral in.

If the patient you are referring is imminently dying, please ensure there is a ReSPECT plan in place, Pink Card and Pre-emptive medications available for use – these can all be put in place by their own GP.

Criteria for routine referrals:

- Patient has prognosis of several weeks/months.
- Symptoms more stable but require monitoring and support.

Our triage team aim to contact routine referrals with 3-5 days of receiving the referral and book the first assessment with 2-3 weeks.

To make a referral please complete the referral form, found on the ICB website and email. We process referrals 7 days a week.

Inpatient Centre

The inpatient centre accepts referrals both for patient who have specialist palliative care needs as documented above and require admission for symptom control, but also people who are actively dying and whose preferred place of death is St Luke's hospice. It is staffed by nurses, Consultants, trainee doctors, and specialist pharmacy, physiotherapist, occupational therapist, social workers, wellbeing and chaplaincy.

We hold a referral meeting every day to discuss patients referred to our service and those on the waiting list. Patients are triaged by need rather than length of time on waiting list. If a patient's situation changes it is therefore very important that the

referrer contacts us to update. Please do this by contacting the nurse in charge of the IPC available 7 days a week. We often have a waiting time before admission, and we may not be the right place for patients who have time critical medical need such as treatment for sepsis.

We are not a long-term care facility and are unfortunately unable to accept referrals for respite care or long term social care. Our average length of stay is around 2 weeks, but it varies as to an individuals need. Patients typically have more than one inpatient stay throughout their journey.

To make a referral please complete the referral form, found on the ICB website and email to the hospice. We process referrals and admit patients 7 days a week. If a patient needs an urgent same day admission, please call and speak to the nurse in charge of the IPC. Depending on availability it may be possible to admit them same day but cannot be guaranteed.