A Guide for Referral of Patients to the Chronic Disease Specialist Integrated Services

Version 2.0, April 2024

HSE

Clinical Design & Innovation

Person-centred, co-ordinated care

Contents

Introduction

The Chronic Disease Specialist Integrated services have been developed to support General Practitioners to provide specialist multidisciplinary care in the community for their patients, aged 16 years or over, with selected chronic diseases (Heart Disease, Type 2 Diabetes, Asthma and COPD). These services are available to the full population (i.e. private patients and all GMS patients) upon appropriate medical referral.

The Chronic disease Community Specialist team (CD-CST) will provide **self-management support** services to which the General Practitioner can refer their patients e.g.: an integrated pulmonary rehabilitation service, an integrated cardiac rehabilitation service, diabetes self-management education service, diabetes prevention service and a weight management service.

The Chronic disease Community Specialist team (CD-CST) will also provide **specialist team services** for patients with complex Heart Disease, COPD, Asthma and Type 2 Diabetes. Members of the CD-CST includes; advanced nurse practitioners, clinical nurses specialists, physiotherapists, cardiology psychology, diabetes dietetic service, diabetes podiatry service, senior cardiac and respiratory physiologists and the Stop Smoking Advice service. They will also include Consultant-led specialist clinical services.

The CD-CST model supports the GP in managing patients with more complex chronic disease and multimorbidity in the community and ultimately, supporting hospital avoidance where possible and improved patient outcomes, through providing early access to specialist multidisciplinary care in the community. The CD-CST facilitates referral of patients by the GP to the CD-CST in accordance with clinical need, for a discrete episode of care, and the subsequent discharge of the patient back to the General Practitioner when the episode of care has been delivered.

The following guide is for local Integrated Care Chronic Disease Governance Groups, Local Speciality Governance Groups, CD-CSTs, GPs and hospital-based healthcare professionals to inform on referral criteria and to support regions in referral management. It details each of the services within the Chronic Disease Specialist Integrated service, advising on who should refer to the service, what the clinical criteria for referral should be, what the clinical governance of the patient is during that episode of care and guidelines for return of the patient to the referring physician. The following is intended for use as general guidance to help inform the development and implementation of local care pathways, and should be considered in the context of the national models of care upon which they are based. Local team discussions should take place, and decisions made regarding inter-team speciality patient referral and intra-team speciality patient referral as per the guidance outlined under “Clinical Governance” below:

- Inter-team speciality referral - i.e. between HCPs on the specialty-specific team to support multidisciplinary approach to care as required
- Intra-team speciality referral - i.e. between specialities within a CD-CST, to support multidisciplinary integrated care for patients with multimorbidity

Local Chronic Disease Governance Groups may wish to adapt these guidelines depending on local circumstances. However, the underlying model of the CD-CST is to provide discrete episodes of care for individuals to support General Practitioners in accessing early diagnostic, specialist and multidisciplinary care for their patients living with complex chronic disease and multimorbidity in the community, to optimise their patients' conditions and to support the delivery of GP-led care in the community.

Clinical Governance

The clinical governance of the patient remains with the General Practitioner (GP) except:

- When the GP refers to the consultant-governed services which are; the consultant clinic services, pulmonary and cardiac rehabilitation services.

- In circumstances where the GP initiated referral to the nursing service but the patient's treatment options requires further specialist Consultant input, the nurse will discuss with the Integrated Care (I.C.) Consultant who will then assume clinical governance for the patient for that episode of care.

- Inter-Team Speciality Referrals: If a patient is referred to one speciality (e.g. Respiratory) and is seen and assessed by the relevant Respiratory community specialist team (CST) member e.g. Physiotherapist, and a clinical decision is made where the patient requires further review by another Respiratory CST member in the CD-CST e.g. Nurse; the referral is forwarded to the relevant CST member for review, and if appropriate, accepted. Clinical governance of the patient remains with the referring GP. If the patient has been referred by the I.C. Consultant, the I.C. Consultant holds the clinical governance of the patient. The referring GP or referring Consultant will be issued with communication to update them of the additional specialist referral with the clinical rationale for same. Communications to the referring GP or referring Consultant will be managed through a locally agreed protocol.

- Intra-Team Speciality Referrals: If a patient is referred to one speciality (e.g. Respiratory) and is seen and assessed by the relevant respiratory CST member, and a clinical decision is made where the patient requires further review by another chronic disease speciality (e.g. Diabetes) in the CD-CST; the referral is forwarded to the relevant Integrated Care Consultant for discussion at Consultant-led multidisciplinary team (MDT) meeting, and if appropriate assigned to the relevant member of the team. Clinical governance is then transferred to the Integrated Care Consultant who has accepted the referral to the speciality. The referring GP or referring Consultant will be issued with communication to update them of the additional specialist referral with the clinical rationale for same. Communications to the referring GP or referring Consultant will be managed through a locally agreed protocol.

Consultant Led Modernised Care Pathways for Chronic Disease

The Integrated Model of Care for the Prevention & Management of Chronic Disease (ICPCD) aims to deliver an end-to-end care pathway that focuses on the prevention, early diagnosis and proactive management of chronic disease and its associated complications. An important enabler of this is timely access to specialist opinion when required. Implementation of the modernised care pathways across the Chronic disease Specialist Integrated services will support the delivery of timely specialist opinion in a more flexible, efficient and patient-centred manner.

<u>The 7 Modernised Care Pathways are as follows:</u>

1. Deteriorating/Worsening heart failure
2. First presentation Atrial Fibrillation
3. Heart Murmur
4. Undifferentiated Dyspnoea
5. Asthma (Stable/Chronic)
6. COPD (Stable/Chronic)
7. Type 2 Diabetes Mellitus.

The Integrated Care Consultant, supported by the CD-CST, will implement the relevant specialist Modernised Care Pathway(s) across their hospital and affiliated CD-CST(s). This will involve the triaging and review of patients across a number of streams including:

- Clinical GP queries (via Healthlink) that can be responded to remotely - Consultant writes, phones or emails GP with advice
- Virtual Clinic – Consultant to GP group virtual case review
- Specialist Nurse/HSCP clinic with Consultant supervision
- Face-to-face patient clinics
- Consultant to patient virtual appointment
- Urgent access face-to-face hospital outpatient clinic

Healthlink

The Healthlink Referral Process enables GPs to refer patients directly to a member of a CD-CST. The referral is triaged upon receipt in the CD-CST. The process has been developed to support optimal use of the resources available in the CD-CST, and at the same time, meet the needs of GPs and support GP-led primary care. Once accepted by a CD-CST member, case discussion at specialist Multidisciplinary Team (MDT) meetings and interdisciplinary referrals within the specialist team may ensue according to clinical need.

The ICPCD Healthlink Referral process is designed so that GPs will be presented with a bespoke dropdown menu of referral options for each CD-CST, based only on the services that are available in a CD-CST at a given time. Once a referral option has been selected, the GP will be presented with the National Generic Referral Form for completion with the relevant details required for triage, which is then submitted to the relevant CD-CST.

GUIDE TO ACCESSING CARDIOLOGY INTEGRATED CARE SERVICE

Version 2.0, April 2024

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Integrated Care Programme for the Prevention and Management of Chronic Disease

GUIDE TO ACCESSING THE CARDIOLOGY INTEGRATED CARE TEAM

LEVELS OF SERVICES

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Examples of types of cardiovascular clinics that may be considered for delivery in the CD-CST:

- Email advice
- Virtual consult (GP to Specialist Service)
- Cardiac Rehabilitation
- Echocardiography
- Integrated Care Specialist Clinics
- Patient Education Services
    - Heart Failure
    - Atrial Fibrillation
    - Coronary Artery Disease
    - High Risk Prevention Education
    - Structural/Valvular Heart Disease
    - Ischaemic Heart Disease
    - Arrhythmias

Table 1: Referring to the community specialist cardiology services in the Chronic Disease Community Specialist Team (Level 2)

Specialist Service	Who can refer?	Referral guideline	Clinical Governance of the patient	Guideline for discharge/return to referrer
Cardiology Nursing Service i.e. CNS/ANP Cardiology Integrated Care	The Cardiology Nursing Service can accept direct referrals from: - GPs including through their practice nurse (Level 1) - Members of the Cardiology CD-CST including the Integrated Care Consultant (Level 2) - Other CD-CST members, subject to wider MDT	Patients (16 years and older) living within the CD-CST / CHN catchment area with any of the following: **Heart Failure:** • Review service - patients with stable heart failure who require medication review (GP governance) • Patients with a new diagnosis of heart failure for self-management education (GP Governance) • Medication optimisation or patients with poorly controlled heart failure who require a multidisciplinary care plan (Integrated Care	Clinical governance of patients referred directly to the Cardiology Nursing Service (Integrated Care) remains with the referring physician (GP or Integrated Care Consultant) If the GP initiated referral requires further specialist input, the nurse will discuss with the Integrated Care Consultant who will then assume clinical governance	• The Specialist Community Team interventions are intended to be focused, time-limited interventions to support the GP to care for the patient in the community. The aim is to optimise patient condition with discharge back to the GP as soon as possible. • Avoid ongoing or unlimited review.

	discussion and agreement (Level 2) Referral should clearly identify referring issue. Recent bloods, ECG and a copy of current medications should also be included. Referrals from all other health professions e.g. from Primary Care Teams etc. must be directed through the patients GP.	Consultant governance). Those with established heart failure who require medication titration by Registered Nurse Prescriber (Integrated Care Consultant or existing Consultants governance). **Provide education following Consultant first review and agreed MDT care plan established:** • Patients at high risk of developing cardiovascular disease - examples: genetic hyperlipidaemias, resistant hypertension, suboptimal risk factor control in those with established disease, evaluation of those with family history of premature Cardiovascular (CV) disease • Follow up post PCI (low risk, uncomplicated) • Patients with a diagnosis of Atrial Fibrillation • Patients with a diagnosis of significant valvular/structural disease • Patients with diagnosis of Ischaemic Heart Disease • Patients with a diagnosis of an arrhythmia	for the patient for that episode of care. In the case of intra-speciality patient referrals; following the specialist MDT meeting discussion and subsequent acceptance of an intra-speciality referral, the clinical governance of the patient is then transferred to the relevant I.C. Consultant. Advance Nurse Practitioner(s) work autonomously within teams and / or on an individual basis within their scope of practice and as outlined in the local service MOU (Memorandum of Understanding) with their supervising Consultant. Clinical Nurse Specialist(s) work within teams, supporting the I.C. Consultant and within their scope of practice.	• May also require referral to hospital (Level 3/4) services if ongoing needs for specialist input.
Cardiac Rehab Service	The cardiac rehab service can accept direct referrals from: - A member of the Acute (hospital) Cardiology Team (Level 3 and Level 4)	Patients (16 years and older) resident in the CD-CST/CHN catchment area with appropriate clinical indication for Cardiac Rehabilitation (CR) as per the Model of Care for Integrated Cardiac Rehabilitation.	Clinical governance of patients referred to the Cardiac Rehab service is with the Consultant Cardiologist leading the service.	• Once CR course completed, prior to discharge from the CD-CST service, all CR patients should have an end of programme assessment to identify the patient's unmet needs.

	- A member of the Cardiology CD-CST (Level 2) - The patient's GP (Level 1)			• A care plan will be developed to support the patient's needs going forward. • This care plan will be shared with the patient and their GP at end of programme.

Table 2: Referring to the Integrated Care Consultant in the Chronic Disease Community Specialist Team (Level 2)

Specialist Service	Who can refer?	Referral guideline	Clinical Governance of the patient	Discharge guideline
Integrated Care Cardiology Consultant	The Integrated Care Consultant can accept referrals from: - GPs (Level 1) - Members of the Cardiology CD-CST (Level 2) - Integrated Care Consultants in respiratory and endocrinology in that CD-CST (Level 2) - Acute hospital Cardiologists (Level 3 / 4) - ICPOP Integrated Care Consultants (Level 2) - (Acute) Medical Assessment Unit (A) MAU Consultant Physicians (Level 3 / 4)	Patients (16 years and older) resident in the CD-CST/CHN catchment area with: **Heart Failure:** • Patients with new diagnosis of heart failure or possible heart failure for further evaluation • Medication titration – those with established heart failure who require medication titration • Review service - patients with stable heart failure who require medication review/medication optimisation or patients with poorly controlled heart failure who require a multidisciplinary care plan. GP referrals: The following indications are for immediate referral to either the CD-CST/ED/MAU, with the referral route based on GP assessment of patient stability, clinical judgement and availability of required local services in the CD-CST: • Development of Paroxysmal Nocturnal Dyspnoea • Failed first line management of worsening Heart Failure	The Integrated Care Cardiology Consultant holds the clinical governance of patients referred directly to them, and accepted by them.	• The Specialist Community Team interventions are intended to be focused, time-limited interventions to support the GP to care for the patient in the community. The aim is to optimise patient condition with discharge back to the GP as soon as possible. • Avoid ongoing or unlimited review. • May also require referral to hospital (Level 3/4) services if ongoing need for specialist input

	- Private Hospital Cardiology Consultants (Level 3 / 4)	• Recent Decompensation (<1 month) • Associated with New Onset Atrial Fibrillation **Atrial Fibrillation:** • New onset stable Atrial Fibrillation (AF) in those who require specialist work up • Stable patients with anticoagulation or symptom issues In addition to above, consider direct GP referral to the CD-CST Consultant for consideration of rhythm control in: o Younger patients (<65 years) o Persistent symptoms despite rate control o Reversible causes o Symptomatic paroxysmal AF o Heart failure caused or exacerbated by AF The following patients are not appropriate for referral to the CD-CST (Refer to ED/MAU) o Unstable or very symptomatic patient o HR > 120 bpm o Active Infection o New onset Heart Failure o Under 16 years of age **High Risk Prevention Clinic:** • Patients at high risk of developing cardiovascular disease - examples: genetic hyperlipidaemias, resistant hypertension, suboptimal risk factor control in those with established disease, evaluation of those with family history of premature CV disease **Significant Valvular/Structural Disease:** • Patients with evidence of significant valvular/structural disease following echo		

		Heart Murmur: • New Heart Murmur with presyncope or syncope (advise urgent Integrated Care Cardiology Consultant referral to the CD-CST) **Arrhythmia:** • Predominately Atrial Fibrillation (as outlined above) • Other irregular Heart Rhythms to be assessed in the CD-CST		

Table 3: Referrals from the acute hospital Consultant (Level 3 / 4) to the Integrated Care Consultant Cardiologist in the Chronic Disease Community Specialist Team (Level 2)

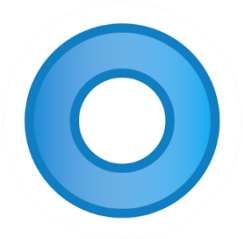
Specialist Service	Who can refer?	Referral guideline	Clinical Governance of the patient	Guideline for discharge /return to referrer
Integrated Care Consultant Cardiologist	The Consultant (in the CD-CST) can accept referrals from: - Consultant Cardiologists (Level 3 / 4)) - (A)MAU Consultant Physicians (Level 3 / 4)	• Follow up post PCI (low risk, uncomplicated) • Follow up post discharge of ACS presentation deemed low risk (where no ANP available) • Follow up post discharge for heart failure	The Integrated Care Cardiology Consultant holds the clinical governance of patients referred directly to them, and accepted by them.	• Discharge back to GP
Note: All of the above acute hospital team to CD-CST service examples will have added needs, in particular risk factor management. These additional factors should be assessed case by case with the GP to determine where they should be managed (e.g. post PCI check, all is good from procedure viewpoint but cholesterol management needs attention, therefore refer to CD-CST services).				

Table 4: Referral to the Integrated Care Consultant Cardiology GP Email Advisory Service (Level 2)				
Specialist services	**Who can refer?**	**Referral guideline**	**Clinical Governance of the patient**	**Guideline for discharge/return to referrer**
Integrated Care Consultant Cardiologist - GP Email Advisory Service (An email-based advisory service for GPs via Healthlink seeking advice on clinical queries) Service adapted as per locally agreed Standard Operating Procedure (SOP)	The Integrated Care Consultant can accept referrals from: • GPs (Level 1)	Patients (16yrs & older) living within the CD-CST / CHN catchment areas with a diagnosis of Heart Failure, Atrial Fibrillation, High Risk Cardiovascular Disease, Significant Valvular/Structural Disease, Arrhythmia and Heart Murmur. **Appropriate queries/inclusion criteria for this service include:** • Clinical questions about disease processes or specific patient scenarios. **Inappropriate queries/exclusion criteria for this service are:** ○ Urgent clinical queries and/or clinical queries relating to acutely unwell patients. ○ Clinical queries unrelated to the above cohorts listed above. ○ Clinical queries relating to patients under the age of 16. ○ Referrals to the service (although it is understood a certain number of email. discussions may lead to a subsequent referral). *The Integrated Care Consultant will reply to emails as per the locally agreed Standard Operating Procedure (SOP) for the service.*	The GP submitting the clinical query has clinical governance for the patient who is being discussed until the query is resolved, and makes the final decision on clinical care alongside the patient themselves.	• The email advisory service may entail prolonged email conversations depending on the nature of the clinical query, but will ultimately conclude with the clinical query answered and/or a recommendation for referral to the Integrated Care Cardiology services via Healthlink.

Table 5: Referring to the Stop Smoking service for chronic disease (Level 2)				
CD Support Service	**Who can refer?**	**Referral guideline**	**Clinical Governance of the patient**	**Discharge guideline**
Stop Smoking Advisor – They deliver intensive behavioural support in person in the CD-CST and area available on site when other clinicians are seeing patients to receive referrals. The service will operate as per HSE Stop Smoking Services Standard Treatment Programme, and administers/arranges stop smoking medications to support a successful quit attempt.	CD-CST Smoking cessation service can accept referrals from: – GP – All Integrated Care Consultants – All members of the CD CST integrated team	Patients 16 years and older who are tobacco smokers with a confirmed diagnosis of Heart Disease, Type 2 Diabetes, COPD or Asthma living within the CD-CST/CHN catchment and/or are attending one of the CD- CST services should be referred.	Clinical governance remains with the referring Physician	Patient is discharged after a minimum of 9 sessions (i.e. HSE Stop Smoking Services Standard Treatment Programme) over a period of up to 12 months post quitting.

Table 6: Referring to GP direct access diagnostic service for chronic disease (Level 2 / 3)			
Diagnostic Service	**Who can refer?**	**Referral guideline**	**Clinical Governance of the patient**
Echocardiogram	The Echo service can accept referrals from: - GP	The national referral criteria below for the GP direct access Echocardiography service are as follows: • One **routine** echocardiogram will be facilitated per Chronic Disease Management Programme GP registration visit for heart failure, where clinically indicated, and if they have not had an echocardiogram done in previous 12 months. • One **routine** echocardiogram may be ordered in the non-acute setting for an individual who presents with symptoms and signs suggestive of heart failure and who has a NTproBNP result >400pg/ml.	Clinical governance of the patient remains with referring physician

		OR • One **urgent** echocardiogram may be ordered in a non-acute episode for an individual who presents with symptoms and signs suggestive of heart failure and who has a NTproBNP result >2000pg/ml • One **routine** echocardiogram will be facilitated per Chronic Disease Management Programme GP registration visit for a new diagnosis of atrial fibrillation, where an echo has not been done in the previous 12 months. • One **routine** direct GP access echocardiogram will be facilitated per Chronic Disease Management Programme GP registration visit for an individual with a suspected heart murmur, or if an individual presents with a suspected heart murmur, and where they have not had an echocardiogram performed in the previous 12 months. **(Patients not suitable for referral within this cohort)** ○ Unstable patients, such as suspected ACS ○ New Heart Murmur with presyncope or syncope (advise urgent Integrated Care Cardiology Consultant referral to the CD-CST) • One **routine** direct GP access echocardiogram may be ordered in the non-acute setting for an individual who presents with undifferentiated Chronic/Subacute Dyspnoea and signs and symptoms suggestive of a potential cardiac cause i.e. Arrhythmia, Valvular, IHD or HF if elevated NTproBNP (see above), and where they have not had an echocardiogram done in previous 12 months. **(Patients not suitable for referral within this cohort)** ○ Not for patients with established causes of Dyspnoea ○ Not for unstable patients ○ Urgent Presentations → ED/ MAU ○ Infectious causes ○ Under 16 years of age	
	- Integrated Care Consultant - Cardiology Integrated Care Nursing Service, according to agreed protocol	1. Suspected heart failure (ECG and NTproBNP required in advance, where available) 2. Investigation of heart murmur	Clinical governance of the patient remains with referring physician



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LEVELS OF SERVICES

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Table 1: Referring to the community specialist diabetes services in the Chronic Disease Community Specialist team (Level 2)				
Specialist services	**Who can refer?**	**Referral guideline**	**Clinical Governance of the patient**	**Guideline for discharge/return to referrer**
Diabetes Nursing Service i.e. CNS/ANP Diabetes Integrated Care	The Diabetes Specialist Nursing Service can accept direct referrals from: – GPs including through their practice nurse (Level 1) – Members of Diabetes CD-CST, including the Integrated Care Consultant (Level 2) – Other CD-CST members, subject to wider MDT discussion and agreement Referrals from all other health professions e.g. from Primary Care Teams, nursing homes etc. must be directed through the patients GP.	Patients (16yrs & older) with a confirmed diagnosis of Type 2 Diabetes living within the CD-CST / CHN catchment areas with/for: • Suboptimal glycaemia • Recurrent hypoglycaemia or impaired hypoglycaemic awareness • Unresolved issues with self-monitoring of glucose levels (this does not include routine establishment of monitoring) • Newly diagnosed Type 2 Diabetes • Diabetes self-management education that is beyond the scope of the practice nurse • Pre-pregnancy planning (Patients will attend acute services for duration of pregnancy) • Patients who default from secondary care with a view to re-engaging them with services Patient who has developed complications e.g.: • Declining renal function (unless eGFR <30 in which case refer to Level 3) or persistent microalbuminuria (>30mg/mmol) • Pre-proliferative or proliferative retinopathy • Steroid induced hyperglycaemia • New atherosclerotic cardiovascular disease, or uncontrolled CV risk factors	Clinical governance of patients referred directly to the Diabetes Nursing Service (Integrated Care) remains with the referring physician (GP or Integrated Care Consultant). If the GP initiated referral requires further specialist input, the nurse will discuss with the Integrated Care Consultant who will then assume clinical governance for the patient for that episode of care. In the case of intra-speciality patient referrals; following the specialist MDT meeting discussion and subsequent acceptance of an intra-speciality referral, the clinical governance of the patient is then transferred to the relevant I.C. Consultant. Advance Nurse Practitioner(s) work autonomously within teams and / or on an individual basis within their	• The nursing service should avoid ongoing or unlimited review. • The Specialist Community Team interventions are intended to be focused, time-limited interventions to support the GP to care for the patient in the community. The aim is to optimise patient condition with discharge back to the GP as soon as possible. • May also require referral to hospital (Level 3/4) services if ongoing need for specialist input

			scope of practice and as outlined in the local service MOU (Memorandum of Understanding) with their supervising Consultant. Clinical Nurse Specialist(s) work within teams, supporting the I.C. Consultant and within their scope of practice.	
Diabetes Podiatry Service	The podiatrist can accept direct referrals from - GPs including through their practice nurse (Level 1) - Members of the Diabetes CD-CST (Level 2) - Other CD-CST members, subject to wider MDT discussion and agreement - Acute Diabetes Podiatrist in the Level 3 and 4 service Referrals from all other health professions e.g. from Primary Care Teams etc. must be directed through the patients General Practitioner	In line with the Model of Care for the Management of the Diabetic Foot (2021), the podiatrist can accept referrals of patients with a diagnosis of diabetes living within the CD-CST/ CHN catchment areas with: • Moderate risk diabetic foot disease • High risk diabetic foot disease • Diabetic foot disease in-remission (post diabetic foot ulcer) • Painful peripheral neuropathy without the presence of active foot disease Patients may be seen with active foot disease if under an active management plan from the Acute Diabetic Foot Multidisciplinary Foot Team. Referral exclusion criteria: ○ Low risk diabetic ○ General foot care	Podiatrists work autonomously within their teams and/or scope of practice and speciality. The overall clinical governance rests with the referring GP or Integrated Care Consultant for the patient's diabetes.	• Avoid ongoing or unlimited review. • Once the initial episode of care has been completed, patients will remain on the register and offered review in-line with the surveillance plan as per the Diabetic Foot MOC.

Dietetic-led services				
Diabetes Dietetic Service (Senior Dietitian Integrated Care)	The dietitian can accept direct referrals from: - GPs, including through their practice nurse (Level 1) - Members of the Diabetes CD-CST (Level 2) - Other CD-CST members, subject to wider MDT discussion and agreement Referrals from all other health professionals must be directed through the patients GP or Integrated Care Diabetes Consultant.	Patient (16yrs & older) with a confirmed diagnosis of Type 2 Diabetes living within the CD-CST / CHN catchment areas requiring dietary support for: • Suboptimal glycaemia • Unresolved issues with self-monitoring of glucose levels (this does not include routine establishment of monitoring) • Newly diagnosed Type 2 Diabetes • One-to-one medical nutrition therapy consultation • Patients who default from secondary care with a view to re-engaging them with services • Pre-pregnancy planning (Patients will attend acute services for duration of pregnancy) Patient who has developed complications e.g.: • Declining renal function (unless eGFR <30 in which case refer to Level 3) or persistent microalbuminuria (>30mg/mmol) • New atherosclerotic cardiovascular disease, or uncontrolled CV risk factors • Steroid induced hyperglycaemia • Recurrent hypoglycaemia or impaired hypoglycaemic awareness It is essential that the dietetic services provide an equal balance of group and one-to-one, Self-Management Education and Support (SMES) and clinical care, in line with the model of care. Each dietitian in post can provide up to 50% of their patient-facing time offering one-to-one consultations, with the other 50% of their patient-facing time to be dedicated to the delivery of group SMES.	Dietitians work autonomously within their teams and/or scope of practice and speciality. The overall clinical governance rests with the referring GP or Integrated Care Consultant for the patient's diabetes.	• The Specialist Community Team interventions are intended to be focused, time-limited interventions to support the GP to care for the patient in the community. • The dietitian should avoid unlimited review. • Once the package of care has been completed discharge back to referrer. • Offer review as required

Diabetes Self-Management Education Service	The dietitian can accept direct referrals for group-based structure DSME from: - GPs, including through their practice nurse (Level 1) - Members of Diabetes CD-CST (Level 2) - Other CD-CST members, subject to wider MDT discussion and agreement - Acute Diabetes team in the Level 3 and 4 service - Members of the Primary Care Team Patients can also self-refer (Level 0) by booking a place on the DSME webpage (www.hse.ie/diabetescourses) or calling HSE Live on 1800 700 700	Patients (16yrs & older) with a confirmed / new diagnosis of Type 2 Diabetes / sub-optimal glycaemia living within the CD-CST / CHN catchment areas requiring diabetes self-management education or support. It is essential that the dietetic services provide an equal balance of group and one-to-one, Self-Management Education and Support (SMES) and clinical care, in line with the model of care. Each dietitian in post can provide up to 50% of their patient-facing time offering one-to-one consultations, with the other 50% of their patient-facing time to be dedicated to the delivery of group SMES.		
Diabetes Prevention Service	The dietitian can accept direct referrals for the diabetes prevention service from: - GPs, including through their practice nurse (Level 1) - Other CD-CST members, subject to wider MDT discussion and agreement Referrals from all other health professionals must be directed	Patients (16yrs & older) living within the CD-CST / CHN catchment areas with a clinical diagnosis of pre-diabetes. Diagnosis is based on the following criteria: • HbA1c 42 – 47mmol/mol or FPG 6.1-6.9mmol/L. In the absence of symptoms the FPG should be confirmed on repeat testing on a different day. • Or a history of Gestational Diabetes It is essential that the dietetic services provide an equal balance of group and one-to-one, Self-		

	through the patients General Practitioner.	Management Education and Support (SMES) and clinical care, in line with the model of care. Each dietitian in post can provide up to 50% of their patient-facing time offering one-to-one consultations, with the other 50% of their patient-facing time to be dedicated to the delivery of group SMES.		
Best Health Weight Management Service	The dietitian can accept direct referrals for the Best Health weight management service from: - GPs, including through their practice nurse (Level 1) - Other CD-CST members, subject to wider MDT discussion and agreement Referrals from all other health professionals must be directed through the patients General Practitioner.	Patients eligible for referral to the Best Health Weight Management Programme should meet the following criteria: • Aged over 16 years • BMI ≥ 30kg/m2 with at least 2 obesity related co-morbidities Note 1: BMI 27.5kg/m2 for South Asian, Chinese, Black African, or Caribbean individuals Note 2: obesity related co-morbidities include Type 2 Diabetes, hypertension, hyperlipidaemia, obstructive sleep apnoea, polycystic ovarian syndrome, and osteoarthritis. It is essential that the dietetic services provide an equal balance of group and one-to-one, Self-Management Education and Support (SMES) and clinical care, in line with the model of care. Each dietitian in post can provide up to 50% of their patient-facing time offering one-to-one consultations, with the other 50% of their patient-facing time to be dedicated to the delivery of group SMES.	The overall clinical governance of the patient rests with the referring physician. Dietitians work autonomously within teams and/or on an individual basis within their scope of practice.	

Table 2: Referring to the Integrated Care Consultant Endocrinologist in the Chronic Disease Community Specialist team (Level 2)				
Diabetes Service	**Who can refer?**	**Referral guideline**	**Clinical Governance of the patient**	**Discharge guideline**
Integrated Care Consultant Endocrinologist	The Integrated Care Consultant can accept referrals from: • GPs (Level 1) • Members of the Diabetes CD-CST (Level 2) • Acute Diabetes team (Level 3 and 4) • Integrated Care Consultants in respiratory and cardiology in that CD-CST (Level 2) • ICPOP Integrated Care Consultants (Level 2) • (A)MAU Consultant Physicians (Level 3 / 4) • Acute hospital Consultant Endocrinologists (Level 3 / 4) • Private Hospital Endocrinology Consultants (Level 3 / 4)	The Integrated Care Consultant will work alongside the Diabetes Specialist team in the CD-CST to deliver a high quality service and to support colleagues in General Practice to improve their management of patients with complex diabetes. Specific criteria for referral to the Integrated Care consultant clinics in the CD-CST include: • Patients (16yrs & older) with a confirmed diagnosis of Type 2 Diabetes living within the CD-CST/CHN catchment areas • Suboptimal glycaemic control for advice/review for optimisation of glycaemic control • Recurrent hypoglycaemia or impaired hypoglycaemic awareness • Patients who default from secondary care with a view to re-engaging them with services • Pre-pregnancy planning (Patients will attend acute services for duration of pregnancy) Newly Diagnosed Patient with Type 2 Diabetes referral to Integrated Care Consultant in setting of complex presentation e.g. • Clinical uncertainty as to type of diabetes (unless ketotic or acutely unwell) • Patients under age 40 years • Patients with established cardiovascular or renal disease • Patients with established complications at diagnosis (uncomplicated diagnosis should be managed by GP)	The Integrated Care Consultant holds the clinical governance of patients referred directly to them, and accepted by them.	• The Integrated Care Consultant in the CD-CST should avoid ongoing or unlimited review. • The Specialist Community Team interventions are intended to be focused, time-limited interventions to support the GP to care for the patient in the community. The aim is to optimise patient condition with discharge back to the GP as soon as possible. • Discharge to Level 3 / Level 4 if requires ongoing Diabetes management e.g. MDI.

		Patient who has developed complications e.g.: • Declining renal function (unless eGFR <30 in which case refer to Level 3) or persistent microalbuminuria (>30mg/mmol) • New atherosclerotic cardiovascular disease, or uncontrolled CV risk factors • Painful peripheral neuropathy without the presence of active foot disease • Pre-proliferative or proliferative retinopathy • Steroid induced hyperglycaemia		

Table 3: Referral to the Integrated Care Consultant Diabetes GP Email Advisory Service (Level 2)

Specialist services	Who can refer?	Referral guideline	Clinical Governance of the patient	Guideline for discharge/return to referrer
Integrated Care Consultant Endocrinologist - GP Email Advisory Service (An email-based advisory service for GPs seeking advice regarding Type 2 Diabetes) Service adapted as per locally agreed	The Integrated Care Consultant can accept referrals from: • GPs (Level 1)	Patients (16yrs & older) living within the CD-CST / CHN catchment areas with a diagnosis of Type 2 Diabetes: **Appropriate queries/inclusion criteria for this service are:** • Clinical questions related to the Type 2 Diabetes care (including complications and cardiovascular risk factor modification) **Inappropriate queries/exclusion criteria for this service are:** ○ Urgent clinical queries and/or clinical queries relating to acutely unwell patients.	The GP submitting the clinical query has clinical governance for the patient who is being discussed until the query is resolved, and makes the final decision on clinical care alongside the patient themselves.	• The email advisory service may entail prolonged email conversations depending on the nature of the clinical query, but will ultimately conclude with the clinical query answered and/or a recommendation for referral to the Integrated Care Diabetes services via Healthlink.

Standard Operating Procedure (SOP)		○ Clinical queries unrelated to Type 2 Diabetes or its complications. ○ Clinical queries relating to diabetes in pregnancy. ○ Clinical queries relating to patients under the age of 16. ○ Referrals to the service (although it is understood a certain number of email. discussions may lead to a subsequent referral). *The Integrated Care Consultant will reply to emails as per the locally agreed Standard Operating Procedure (SOP) for the service.*		

Table 4: Referring to the Stop Smoking Service for chronic disease (Level 2)				
CD Support Services	Who can refer?	**Referral guideline**	**Clinical Governance of the patient**	**Discharge guideline**
Stop Smoking Advisor – They deliver intensive behavioural support in person in the CD-CST and area available on site when other clinicians are seeing patients to receive referrals. The service will operate as per HSE Stop Smoking Services Standard Treatment Programme, and administers/arranges stop smoking medications to support a successful quit attempt.	CD-CST Smoking cessation service can accept referrals from: • GPs • All Integrated Care Consultants • All member of the CD CST integrated team.	Patients 16 years and older who are tobacco smokers with a confirmed diagnosis of Heart Disease, Type 2 Diabetes, COPD or Asthma living within the CD-CST/CHN catchment and/or are attending one of the CD-CST services should be referred.	Clinical governance remains with the referring Physician	Patient is discharged after a minimum of 9 sessions (i.e. HSE Stop Smoking Services Standard Treatment Programme) over a period of up to 12 months post quitting.

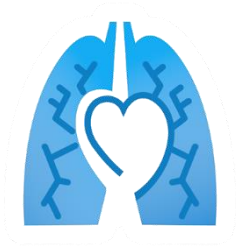
LEVEL 3 ACUTE SPECIALIST AMBULATORY CARE DIABETES INTEGRATED CARE SERVICES

The purpose of the CD-CST and the underlying Integrated Model of Care for the Prevention & Management of Chronic Disease is to provide discrete episodes of specialist care for General Practitioners.

The following patients would most appropriately have their diabetes related care managed by the acute specialist ambulatory multidisciplinary diabetes care team in the secondary care setting, as they will likely require ongoing specialist input and at a level of complexity not delivered in the CD-CST.

Patients with Type 2 Diabetes who:

- Need insulin
- Have progressive diabetic nephropathy
- Require dialysis
- Have significantly impaired renal function (<30mg/mmol)
    - (CKD ≥ Stage 4 / eGFR ≤30/min/1.73m^2)
- Are pregnant
- Are on active cancer treatment
- Have active diabetic foot disease
- Have an active eating disorder
- Have gastroparesis
- Had Bariatric / metabolic surgery in the last 2 years and in conjunction with the obesity care team
- Have early onset (< 40 years old)



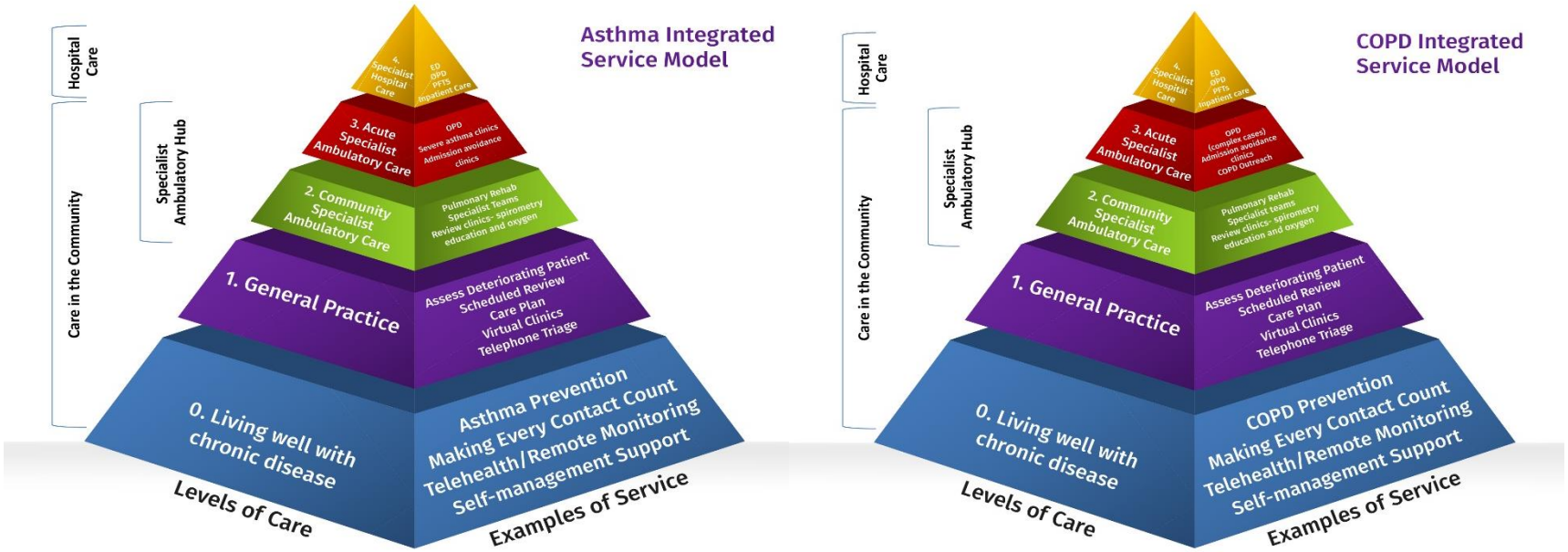
GUIDE TO ACCESSING THE RESPIRATORY INTEGRATED CARE SERVICES

Version 2.0, April 2024

Clinical Design & Innovation
Person-centred, co-ordinated care

Integrated Care Programme for the Prevention and Management of Chronic Disease

GUIDE TO ACCESSING THE RESPIRATORY INTEGRATED CARE SERVICES



LEVELS OF SERVICES

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Table 1: Referring to the community specialist respiratory service in the Chronic Disease Community Specialist Team (Level 2)				
Specialist Service	**Who can refer?**	**Referral guideline**	**Clinical Governance of the patient**	**Guideline for discharge/return to referrer**
Respiratory Nursing Service i.e. CNS/ANP Respiratory Integrated Care	Members of the Nursing Service Respiratory Integrated Care Team can accept direct referrals from: – GPs (Level 1) – Members of the Respiratory community specialist team members (Level 2) including *COPD Outreach team and the Integrated Care Consultant (Level 3 - 4 care) – Other CD CST members, subject to wider MDT discussion and agreement, if appropriate Referrals from all other health professions e.g. from Primary Care Teams etc. must be directed through the patients GP. Referrals should include a recent CXR and Bloods if available. (*The majority of COPD Outreach patients can be managed within their episode of care with the COPD Outreach team, but there may be patients who need ongoing specialist follow–up).	Patients aged >16 years resident within the CD-CST/CHN catchment area with: • Clinically confirmed **Asthma or COPD** *# with > 2 attendances in the preceding 12 months at GP practice (unscheduled) or attendance at GP out of hours service or attendance at emergency department. *** In areas where GP Direct Access Spirometry (Table 5 below) *is* available**: Spirometry must be performed to confirm any *new* diagnosis of COPD or Asthma prior to patient referral to this CD-CST service. A historical diagnosis of COPD or Asthma in GP patient records should be honoured. **# In areas where GP Direct Access Spirometry *is not* available**: Clinical diagnosis may be based on either historical diagnosis of COPD or Asthma in the GP patient records OR a new diagnosis of COPD or Asthma using the combination of identification of risk factors, symptoms and GP assessment.	Clinical governance of patients referred directly to the Respiratory Nursing Service (Integrated Care) remains with the referring physician (GP or Integrated Care Consultant). If the GP initiated referral requires further specialist input, the nurse will discuss with the Integrated Care Consultant who will then assume clinical governance for the patient for that episode of care. In the case of intra-speciality patient referrals; following the specialist MDT meeting discussion and subsequent acceptance of an intra-speciality referral, the clinical governance of the patient is then taken over by the relevant I.C. Consultant. Advance Nurse Practitioner(s) work autonomously within teams and / or on an individual basis within their scope of practice and as outlined in the local service MOU (Memorandum of Understanding) with their supervising Consultant. Clinical Nurse Specialist(s) work within teams, supporting the I.C.	• The Specialist Community Team interventions are intended to be focused, time-limited interventions to support the GP to care for the patient in the community. The aim is to optimise patient condition with discharge back to the GP as soon as possible. • Avoid ongoing or unlimited review. • Once patient appears stable and/or confident to self-manage their respiratory condition, they are discharged back to the care of their GP.

			Consultant and within their scope of practice.	
Respiratory Physiotherapy Service (Senior Physiotherapist Integrated Care)	Members of the Physiotherapy Service Respiratory Integrated Care Team can accept direct referrals from: – GPs (Level 1) – Members of the Respiratory community specialist team members (Level 2) including *COPD Outreach team and the Integrated Care Consultant (Level 3 - 4 care) – Other CD CST members, subject to wider MDT discussion and agreement, if appropriate Referrals from all other health professions e.g. from Primary Care Teams etc. must be directed through the patients GP. Referrals should include a recent CXR and Bloods if available. (*The majority of COPD Outreach patients can be managed within their episode of care with the COPD Outreach team, but there may be patients who need ongoing specialist follow–up).	Patients aged >16 years resident within the CD-CST/CHN catchment area with: • Clinically confirmed **Asthma or COPD** *# with > 2 attendances in the preceding 12 months at GP practice (unscheduled) or attendance at GP out of hours service or attendance at emergency department. *** In areas where GP Direct Access Spirometry (Table 5 below) *is* available**: Spirometry must be performed to confirm any *new* diagnosis of COPD or Asthma prior to patient referral to this CD-CST service. A historical diagnosis of COPD or Asthma in GP patient records should be honoured. **# In areas where GP Direct Access Spirometry *is not* available**: Clinical diagnosis may be based on EITHER historical diagnosis of COPD or Asthma in the GP patient records OR a new diagnosis of COPD or Asthma using the combination of identification of risk factors, symptoms and GP assessment.	Clinical governance of patients referred directly to the Respiratory Physiotherapy Service (Integrated Care) remains with the referring physician (GP or Integrated Care Consultant). If the GP initiated referral requires further specialist input, the physiotherapist will discuss with the Integrated Care Consultant who will then assume clinical governance for the patient for that episode of care. In the case of intra-speciality patient referrals; following the specialist MDT meeting discussion and subsequent acceptance of an intra-speciality referral, the clinical governance of the patient is then taken over by the relevant I.C. Consultant. Physiotherapists work autonomously within teams and/or on an individual basis within their scope of practice. The overall clinical governance rests with the referring physician.	• The Specialist Community Team interventions are intended to be focused, time-limited interventions to support the GP to care for the patient in the community. The aim is to optimise patient condition with discharge back to the GP as soon as possible. • Avoid ongoing or unlimited review. • Once patient appears stable and/or confident to self-manage their respiratory condition, they are discharged back to the care of their GP.

Integrated Pulmonary Rehabilitation Service • **CSp Pulmonary Rehabilitation Coordinator** • **CNS** • **Staff grade physiotherapist**	The Pulmonary Rehabilitation service can accept direct referrals from: – The GP if patient has had full respiratory workup and is stable (Level 1) – Members of the Respiratory community specialist team including the I.C. Consultant (Level 2) – The COPD Outreach team (Level 3) – The acute hospital Respiratory Consultants (Level 3 / 4)	Patients resident within the CD-CST/CHN catchment area and: • Stable medically optimised COPD and Asthma • Motivated to participate and change lifestyle • Ability to exercise independently and safely • Able to travel to venue or access to appropriate equipment if virtual Pulmonary Rehabilitation.	Clinical governance of patients referred to the Pulmonary Rehab service is with the Respiratory Consultant leading the service. In the absence of a supervising Respiratory Consultant, clinical governance is with the referrer.	• Patient discharged and letter sent to referrer and filed in the Healthcare Record. • The Specialist Community Team interventions are intended to be focused, time-limited interventions to support the GP to care for the patient in the community.

Table 2: Referring to the Integrated Care Respiratory Consultant in the Chronic Disease Community Specialist Team (Level 2)

Specialist Service	Who can refer?	Referral guideline	Clinical Governance of the patient	Discharge guideline
Integrated Care Respiratory Consultant	– GPs (Level 1) – Members of the Respiratory community specialist team (Level 2) – Integrated Care Consultants in cardiology and endocrinology in that CD-CST (Level 2) – ICPOP Integrated Care Consultants (Level 2) – (A)MAU Consultant Physicians (Level 3 / 4) – Acute hospital Respiratory Consultants (Level 3 / 4)	Patients aged >16 years resident within the CD-CST/CHN catchment area with: • Clinically confirmed **Asthma or COPD** *# with > 2 attendances in the preceding 12 months at GP practice (unscheduled) or attendance at GP out of hours service or attendance at emergency department. *** In areas where GP Direct Access Spirometry (Table 5 below) *is* available**: Spirometry must be performed to confirm any *new* diagnosis of COPD or Asthma prior to patient referral to this CD-CST service. A historical diagnosis of	The Integrated Care Consultant holds the clinical governance of patients referred directly to them, and accepted by them.	• The Specialist Community Team interventions are intended to be focused, time-limited interventions to support the GP to care for the patient in the community. • Once patient appears stable and/or confident to self-manage their respiratory condition, they are discharged back to the care of their GP.

		COPD or Asthma in GP patient records should be honoured. # **In areas where GP Direct Access Spirometry *is not* available**: Clinical diagnosis may be based on either historical diagnosis of COPD or Asthma in the GP patient records OR a new diagnosis of COPD or Asthma using the combination of identification of risk factors, symptoms and GP assessment.		

Table 3: Referral to Integrated Care Consultant Respiratory GP Email Advisory Service (Level 2)

Specialist services	Who can refer?	Referral guideline	Clinical Governance of the patient	Guideline for discharge/return to referrer
Respiratory Integrated Care Consultant - GP Email Advisory Service (An email-based advisory service for GPs seeking advice regarding COPD/Asthma patients) Service adapted as per locally agreed Standard Operating Procedure (SOP)	The Integrated Care Consultant can accept referrals from: • GPs (Level 1) via Healthlink	Patients (16yrs & older) living within the CD-CST / CHN catchment areas with a clinical diagnosis of COPD/Asthma: **Appropriate queries/inclusion criteria for this service are:** • Discrete clinical queries related to patients with COPD/Asthma **Inappropriate queries/exclusion criteria for this service are:** o Urgent clinical queries and/or clinical queries relating to acutely unwell patients. o Clinical queries unrelated to COPD/Asthma o Clinical queries relating to patients under the age of 16. o Referrals to the service (although it is understood a certain number of email discussions may lead to a	The GP submitting the clinical query has clinical governance for the patient who is being discussed until the query is resolved, and makes the final decision on clinical care alongside the patient themselves.	• The email advisory service may entail prolonged email conversations depending on the nature of the clinical query, but will ultimately conclude with the clinical query answered and/or a recommendation for referral to the Integrated Care Respiratory services via Healthlink.

		subsequent referral). *The Integrated Care Consultant will reply to emails as per the locally agreed SOP for the service.*		

Table 4: Referring to the COPD Outreach team (Level 3)				
Specialist Service	**Who can refer?**	**Referral guideline**	**Clinical Governance of the patient**	**Discharge guideline**
COPD outreach service (CNS and CSp. Physiotherapist)	Direct referral accepted from: - Respiratory Team and Consultants in ED & (A)MAU (Level 3 / 4) - GP if patient know to service for admission avoidance (Level 1)	**Admission avoidance** Patients are suitable for admission avoidance home visits if the meet all of the following Inclusion Criteria: ✓ Confirmed diagnosis of COPD and patient known to the service ✓ Agreement by patient and carer / family to home visits ✓ Suitable social circumstances for management at home (must have access to telephone) ✓ Appropriate degree of home support if living alone. ✓ Resides in catchment area **Early supported discharge** Patients are suitable for early supported discharge if they meet the following Inclusion Criteria: ✓ Diagnosis of COPD ✓ Inpatient <72 hours ✓ MMSE >7 ✓ Systolic B/P >100mmHg ✓ Room air ABG (or prescribed O_2ABG if being discharged on LTOT)	The Respiratory Consultant leading the COPD outreach service holds the clinical governance of patients attending the service	Patient should be discharged after 14 days and letter sent to referrer with copy filed in the patients' healthcare record.

		✓ pH > 7.35 ✓ PCO2 < 8kPa ✓ PO2 >7.3kPa ✓ WCC 4 20*10/L ✓ New LTOT/Portable/NIV **Assisted Discharge** This service can be offered to patients who initially did not meet the inclusion criteria for an Early Discharge programme. These patients will have been in patients for over 72 hours, however are now clinically suitable for discharge with support.		

Table 5: Referring to the Stop Smoking Service for chronic disease (Level 2)

CD Support Services	Who can refer?	Referral guideline	Clinical Governance of the patient	Discharge guideline
Stop Smoking Advisor – They deliver intensive behavioural support in person in the CD-CST and area available on site when other clinicians are seeing patients to receive referrals. The service will operate as per HSE Stop Smoking Services Standard Treatment Programme, and administers/arranges stop smoking medications to support a successful quit attempt.	CD-CST Smoking cessation service can accept referrals from: • GP • All Integrated Care Consultants • All member of the CD CST integrated team	Patients 16 years and older who are tobacco smokers with a confirmed diagnosis of Heart Disease, Type 2 Diabetes, COPD or Asthma living within the CD-CST/CHN catchment and/or are attending one of the CD-CST services should be referred.	Clinical governance remains with the referring Physician	Patient is discharged after a minimum of 9 sessions (i.e. HSE Stop Smoking Services Standard Treatment Programme) over a period of up to 12 months post quitting.

Table 6: Referring to GP direct access diagnostic services for chronic disease (Level 2 / 3)

Diagnostic Service	Who can refer?	Referral guideline	Clinical Governance of the patient
Spirometry	The Spirometry service can accept referrals from: - GP	The national referral criteria below for the GP direct access Spirometry service are as follows: **Diagnosis** • One appointment to include spirometry +/- reversibility testing may be arranged to confirm diagnosis if adult patient presents to GP practice with new onset symptoms suggestive of COPD or Asthma **Confirmatory Spirometry** • One appointment to include spirometry +/- reversibility testing will be facilitated per CDM Programme GP registration visit for COPD or Asthma, but only if specifically clinically indicated to: A) confirm previous clinical diagnosis where spirometry not previously performed *or* B) to clarify previous uncertain original spirometry-based diagnosis	Clinical governance of the patient remains with referring physician
	- Integrated Care Consultant - Respiratory Integrated Care Nursing Service or Physiotherapist as per agreed protocol	• Investigation of breathlessness • To assess therapeutic intervention • To investigate a deterioration in symptoms in an individual with a diagnosis of COPD or Asthma	Clinical governance of the patient remains with referring physician