A Guide for Referral of Patients to the Chronic Disease Ambulatory Care Hub Services

Version 1.0, December 2022

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Contents

Introduction

The Chronic Disease Ambulatory Care Hubs have been developed to support General Practitioners to provide ongoing care for their patients with selected chronic diseases (heart disease, diabetes type 2, asthma and COPD) in the community.

The Hub will provide self-management support services to which the General Practitioner can refer 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 Hub will also provide specialist team services for patients with heart disease, COPD, asthma and diabetes type 2. The specialist teams include; specialist nurses, physiotherapists, diabetes dietetic service, diabetes podiatry service and the Stop Smoking Advice service. They may also include consultant provided and led specialist clinical services.

The Hub model of care is referral of patient to the Specialist Hub Service required and return of the patient back to the General Practitioner when the service has been delivered. The clinical governance of the patient remains with the General Practitioner, except when the GP refers to the consultant-governed services which are; the consultant clinic services, pulmonary and cardiac rehabilitation services.
The following guide is for local Integrated Care Chronic Disease Governance Groups, Local Speciality Governance Groups and Teams to guide them in defining how referrals are managed. It details each of the services within the Ambulatory Care Hub, 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 clinician.

Local Chronic Disease Governance Groups may wish to adapt these guidelines depending on local circumstances. However, the underlying model of the Hub is to provide specific time limited specialist services to General Practitioners. Care must be taken to return patients to the care of their GPs and avoid generating an ongoing workload in the hubs, except in circumstances where ongoing case management is required. In addition, care must be taken that hospitals only refer patients appropriately to Hub services i.e. hospital consultants can refer to Integrated Care Consultants in the Hub (or existing Consultants who take on this role), to cardiac and pulmonary rehabilitation services and diabetes self-management education services in the Hub, but not directly to community specialist team members. In order for the patient to access specialist team services, hospitals must refer patients to the consultant in charge of the hub or discharge them back to the General Practitioner, as the clinical governance of the patient will be under the Hub's consultant or the GP.

A Healthlink Referral system is being set up to provide a single point of access for General Practitioners to refer patients to each Chronic Disease Ambulatory Care Hub

GUIDE TO ACCESSING CARDIOLOGY INTEGRATED CARE SERVICE

Version 1.0, December 2022

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GUIDE TO ACCESSING THE CARDIOLOGY INTEGRATED CARE TEAM

The following is intended for use as general guidance to help inform local care pathways, and should be considered in the context of the national models of care on which they are based. Local team discussions should take place, and decisions made regarding:

- Single point of access i.e. referral to hub speciality team or professional specific referral
- Inter-speciality and cross speciality referrals within the hub
- Circumstances arising where patients are being referred to hubs from an acute based service other than the hospital aligned to the specific hub.

LEVELS OF CARE

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Examples of types of cardiovascular clinics that may be considered for delivery in the hub:

- 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

Table 1: Referring to the community specialist cardiology services in the ambulatory care hub (Level 2 Care)

Specialist Service	Who can refer?	Referral guideline	Clinical Governance of the patient	Guideline for discharge/return to referrer
Cardiology nursing service (CNS Cardiology Integrated Care)	The CNS can accept direct referrals from: - GPs (Level 1 care) - Cardiology specialist team members including the Integrated Care Consultant (Level 2) - Other CD-CST members, subject to wider MDT 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. Referrals from other integrated care teams in the chronic disease hub.	Patients (16 years and older) living within the hub/ 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. This service would be under integrated care consultant governance. • Those with established heart failure who require medication titration (by Registered Nurse Prescriber). This service would be under Integrated care consultant governance or existing Consultants providing 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 CV disease • Patients with a diagnosis of Atrial Fibrillation	Clinical governance of patients referred directly to the CNS (Integrated Care) remains with the referring physician (GP or integrated care consultant)	• 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. • Avoid ongoing or unlimited review. • Return to referrer on resolution of presenting complaint or if no further input indicated and/or beneficial. • May also require referral to hospital (level 3/4) services if ongoing needs.

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) - A member of the Community Specialist Cardiology MDT (Level 2) - The patient's GP (Level 1)	Patients (16 years and older) resident in the Hub/CHN catchment area with appropriate indication for Cardiac Rehabilitation as per guidelines. Criteria will be outlined in detail in the Cardiac Rehabilitation Model of Care which will be published in 2023.	Clinical governance of patients referred to the Cardiac Rehab service is with the Consultant Cardiologist leading the service.	• Once CR course completed, patients should have an end of programme assessment to identify the patient's unmet needs. • 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 hub (level 2)

Specialist Service	Who can refer?	Referral guideline	Clinical Governance of the patient	Discharge guideline
Integrated Care Cardiology Consultant with CNS support at clinic	The Integrated Care Consultant can accept referrals from: - GPs (Level 1) - Members of the cardiology community specialist team (Level 2) - Integrated care consultants in respiratory and endocrinology in that hub (Level 2) - Acute hospital Cardiologists (Level 3 and Level 4)	Patients (16 years and older) resident in the Hub/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	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. • Avoid ongoing or unlimited review. • Discharge back to referrer on resolution of presenting complaint or if no further input indicated and/or beneficial. • May also require referral to hospital (level 3/ 4) services if ongoing needs)

		Atrial Fibrillation: • New onset stable atrial fibrillation in those who require specialist work up • Stable patients with anticoagulation or symptom issues 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		

Table 3: Referrals from the acute hospital consultant (level 3 /4) to the Integrated Care team in the hub (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 hub) can accept referrals from: - Consultant Cardiologists (Level 3 and Level 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
Cardiology Nursing Service (CNS Integrated Care)	The Cardiology Nursing Service can accept referrals from: - The Hub Consultant	Follow up post PCI (low risk, uncomplicated) for education following Consultant review	IC Care Cardiology Consultant	
Note: All of the above acute hospital team to hub 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 hub services).				

Table 4: 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 hub 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.	Hub 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 with a confirmed diagnosis of CVD, Diabetes type 2, COPD or Asthma living within the hub/CHN catchment area who are smokers.	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 5: Referring to GP direct access diagnostic service for chronic disease (level 2 / 3)		
Diagnostic Service	**Who can refer?**	**Referral guideline**
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 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. • A direct access 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. • One direct GP access 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.
	- Integrated Care Consultant - IC CNS according to agreed protocol	1. Suspected heart failure (ECG and NTproBNP required in advance, where available) 2. Investigation of heart murmur

GUIDE TO ACCESSING THE DIABETES INTEGRATED CARE SERVICES

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GUIDE TO ACCESSING THE DIABETES INTEGRATED CARE SERVICES

The following section is intended for use as general guidance to help inform local care pathways, and should be considered in the context of the national models of care on which they are based. Local team discussions should take place, and decisions made regarding:

- Single point of access i.e. referral to hub speciality team or professional specific referral
- Inter-speciality and cross speciality referrals within the hub
- Circumstances arising where patients are being referred to hubs from an acute based service other than the hospital aligned to the specific hub.

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Table 1: Referring to the community specialist diabetes services in the ambulatory care hub (level 2 care)

Specialist services	Who can refer?	Referral guideline	Clinical Governance of the patient	Guideline for discharge/return to referrer
Diabetes Nursing Service (CNS Diabetes Integrated Care)	The CNS Integrated Care can accept direct referrals from: – GPs including through their practice nurse(Level 1) – Community diabetes specialist team members, including the Integrated Care Consultant (Levels 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. Referral should clearly identify referring issue. Recent bloods and a copy of current medications should also be included.	Patients (16yrs & older) with a confirmed diagnosis of type 2 diabetes living within the hub/ CHN catchment areas with: • Suboptimal glycaemic control - HbA1c >58mmol/mol on two or more agents (oral or injectable) • Problematic hypoglycaemia e.g. recurrent or unaware • Unresolved issues with self-monitoring of glucose levels (this does not include routine establishment of monitoring) • Newly diagnosed type 2 with complex presentation only (uncomplicated diagnosis should be managed by GP) •Diabetes self-management education that is beyond the scope of the practice nurse Adult patients with type 1 diabetes who default from secondary care with a view to re-engaging them with services in secondary care	Clinical governance of patients referred directly to the CNS (Integrated Care) remains with the referring physician (GP or integrated care consultant)	• The CNS 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 CNS should return the patient back to the GP for ongoing management on resolution of presenting complaint or if no further input indicated and/or beneficial.

Diabetes Podiatry Service	The podiatrist can accept direct referrals from - GPs including through their practice nurse (Level 1) - Community diabetes specialist team members, including the Integrated Care Consultant (Level 2) - Other CD-CST members, subject to wider MDT discussion and agreement - Acute (hospital) diabetes podiatrist (Level 3 / 4). Referrals from all other health professions e.g. from Primary Care Teams etc. must be directed through the patients General Practitioner or Integrated Care Diabetes Consultant.	In line with the Model of Care for the Management of the Diabetic Foot, the podiatrist can accept referrals of patients with a diagnosis of diabetes living within the hub/ CHN catchment areas with: - Moderate risk diabetic foot disease - High risk diabetic foot disease - Diabetic foot disease in-remission (post diabetic foot ulcer) Patients may be seen with active foot disease if referred by the Integrated Care consultant or podiatrist on the MdFT and under an active management plan from the Acute Diabetic Foot Multidisciplinary Foot Team. Referral exclusion criteria: – Low risk diabetic – General footcare	Podiatrists work autonomously within teams and/or on an individual basis within their scope of practice. The overall clinical governance rests with the referring physician.	• 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) - Community diabetes specialist team members (Level 2) - Other CD-CST members, subject to wider MDT discussion and agreement Referrals from all other health professionals must be directed	Patient (16yrs & older) with a confirmed diagnosis of type 2 diabetes living within the hub/ CHN catchment areas requiring dietary support.	Dietitians 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 dietitian should avoid unlimited review.

	through the patients GP or Integrated Care Diabetes Consultant.			• 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) - Community diabetes specialist team members (Level 2) - Other CD-CST members, subject to wider MDT discussion and agreement - Acute hospital diabetes specialist team members (Level 3 / 4). - 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 1850 24 1850	Patients (16yrs & older) with a confirmed diagnosis of type 2 diabetes living within the hub/ CHN catchment areas requiring diabetes self-management education or support.		
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	Patients (16yrs & older) living within the hub/ 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.		

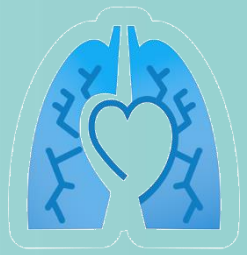
	Referrals from all other health professionals must be directed through the patients General Practitioner.			
Weight Management Service	The dietitian can accept direct referrals for the dietetic weight management service from: - GPs, including through their practice nurse (Level 1) - Other CD-CST members, subject to wider MDT discussion and agreement	Patients eligible for referral the Best Health Weight Management Programme should meet the following criteria: • Aged over 16 years • BMI ≥ 30kg/m2 with 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.		

Table 2: Referring to the Integrated Care Consultant Endocrinologist in the hub (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 endocrinology community specialist team (Level 2) - Integrated care consultants in respiratory and cardiology in that hub (Level 2)	The Integrated Care Consultant will work alongside the CNS and/or ANP in the hub 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 hub include (but are not limited to): •Patients (16yrs & older) with a confirmed diagnosis of type 2 diabetes living within the hub/ CHN catchment areas	The Integrated Care consultant holds the clinical governance of patients referred directly to them, and accepted by them.	• The Integrated Care Consultant in the Hub 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.

	- Acute hospital Consultant Endocrinologists (Level 3 / 4)	• Newly diagnosed type 2 with complex presentation only (uncomplicated diagnosis should be managed by GP) • Suboptimal glycaemic control - HbA1c >58mmol/mol on two or more agents (oral or injectable) • Problematic hypoglycaemia e.g. recurrent or unaware • Adult patients with type 1 diabetes who default from secondary care with a view to re-engaging them with services in secondary care		• Discharge the patient back to the GP for ongoing management on resolution of presenting complaint or if no further input indicated and/or beneficial.

Table 3: 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 hub 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.	Hub 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 with a confirmed diagnosis of CVD, Diabetes type 2, COPD or Asthma living within the hub/CHN catchment area who are smokers.	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.



GUIDE TO ACCESSING THE RESPIRATORY INTEGRATED CARE SERVICES

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GUIDE TO ACCESSING THE RESPIRATORY INTEGRATED CARE SERVICES

The following section is intended for use as general guidance to help inform local care pathways, and should be considered in the context of the national models of care on which they are based. Local team discussions should take place, and decisions made regarding:

- Single point of access i.e. referral to hub speciality team or professional specific referral
- Inter-speciality and cross speciality referrals within the hub
- Circumstances arising where patients are being referred to hubs from an acute based service other than the hospital aligned to the specific hub.

LEVELS OF SERVICE

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Table 1: Referring to the community specialist respiratory service in the ambulatory care hub (level 2 care)

Specialist Service	Who can refer?	Referral guideline	Clinical Governance of the patient	Guideline for discharge/return to referrer
Respiratory Nursing Service (CNS Respiratory Integrated Care)	Members of the Respiratory Integrated Care Team can accept direct referrals from: – GPs (Level 1) – Respiratory specialist team members including the Integrated Care Consultant (Level 2, 3-4 care) – Other CD-CST members, subject to wider MDT discussion and agreement 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	Patients aged >16 years resident within the Hub/CHN catchment area with: – Suspected or 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.	Clinical governance of patients referred directly to the CNS (Integrated Care) remains with the referring physician (GP or integrated care consultant)	– 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.
Respiratory Physiotherapy Service (Senior Physiotherapist Integrated Care)			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.	

Pulmonary Rehab Service	The pulmonary rehab service can accept direct referrals from: – The GP if patient has had full respiratory workup and is stable (Level 1) – Community Specialist Respiratory Team including IC Consultant (Level 2) – The acute hospital Respiratory Consultants (Level 3 / 4)	Patients resident within the Hub/CHN catchment area and: – Confirmed diagnosis of chronic lung disease by Spirometry and functionally limited by dyspnoea despite optimal management (mMRC>2). – Motivated to participate and change lifestyle. – Ability to exercise independently and safely. – Able to travel to venue or access to appropriate equipment if virtual VPR	Clinical governance of patients referred to the Pulmonary Rehab service is with the Respiratory Consultant leading the service.	• Patient discharged and letter sent to referrer with copy 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 hub (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 hub (Level 2) – Acute hospital Respiratory Consultants (Level 3 / 4)	Patients aged >16 years resident within the Hub/CHN catchment area with: – Suspected or confirmed **Asthma or COPD** with > 2 attendances in the preceding 12 months at GP practice (unscheduled) or attendance at GP out of hours service, attendance at emergency department	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.

Table 3: Referring to the pulmonary outreach team (level 3)

Specialist Service	Who can refer?	Referral guideline	Clinical Governance of the patient	Discharge guideline
Pulmonary outreach service (CNS and CSp. Physiotherapist)	Direct referral accepted from: - Respiratory Team and Consultants in ED - & AMAU - GP if patient know to service for admission avoidance.	**Early supported discharge** • Diagnosis of COPD • MMSE >7 • Systolic B/P >100mmHg • Room air ABG (or prescribed O_2ABG if being discharged on LTOT) • pH > 7.35 • PCO2 < 8kPa • PO2 >7.3kPa • WCC 4 20*10/L • New LTOT/Portable/NIV **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 home nursing (must have access to telephone) ✓ Appropriate degree of home support if living alone. ✓ Resides in catchment area	The Respiratory Consultant leading the pulmonary 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.

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 hub 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.	Hub 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 with a confirmed diagnosis of CVD, Diabetes type 2, COPD or Asthma living within the hub/CHN catchment area who are smokers.	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 5: 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: • One spirometry test may be done if an adult presents to the GP with new onset of symptoms or signs which require a diagnostic work up for COPD/asthma. • A spirometry test may be undertaken to investigate a deterioration in symptoms in an individual with an established diagnosis of COPD/asthma. • One spirometry test will be facilitated per Chronic Disease Management Programme GP registration visit for COPD and asthma, where clinically indicated	Clinical governance of the patient remains with referring clinician
	- Integrated Care Consultant - Respiratory Integrated Care Nurse 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 clinician