East Galway Roscommon Integrated Care Hub (CHN 7, CHN 8 and CHN 9)

Service Name	Speciality	Service Descriptor	Service currently provided (Y/N)	Referral accepted by HealthLink (Y/N)	Additional referral information required from GPs
Cardiology Integrated Care Consultant-(Led Clinic) This is a consultant led service where the GP can access specialist Cardiology care advice in a timely manner in Hub catchment area. Service is supported by an Advanced Nurse Practitioner for Heart Failure, Cardiology Clinical Nurse Specialists and the Cardiac Rehab Team. Hub will act as point of care to patients who need specialist input. Care will be episodic care as required. Patient will not be kept in Hub, patient will either return to primary care or referred to secondary care in hospital depending on the need.	**Cardiology**	**Inclusion Criteria** In catchment area (CHN 7, 8, 9) Patients > 18years of age and over Newly diagnosed patients with heart failure who do not have an apparent underlying cause **NYHA** class III to IV refractory to alteration in therapy Post hospitalisation for **ADHF** Patients with severe **LV** dysfunction (**EF** <30%) especially if they have a background of **IHD** should be optimized on medical therapy **+/-** referral for device therapy **ICD** Those patients with ongoing symptoms despite optimal medical therapy and who have an **EF <35%** with **LBBB** on **ECG** for consideration of biventricular pacing **CRT** Patients with moderate-severe valvular disease requiring evaluation If needing specialist opinion re optimal treatment options in respect of **ACE/ARB/ARNI** intolerance, commencement of **MRA** for example Patients with end stage heart failure, NYHA class IV requiring long term specialist management Patients with heart failure and hyperkalaemia, K+ >5.5 Patients with heart failure and severe CKD eGFR < 25-30/mls min Patients with heart failure and severe asymptomatic hypotension systolic < 90mmHG Pregnant women with heart failure New Atrial Fibrillation (AF) diagnosis Atrial Fibrillation with uncontrolled HR Symptomatic Atrial Fibrillation. All patients should have recent bloods with at least renal function, electrolytes, and full blood count and ECG	Y	Y	GP must add the NTproBNP (in Heart Failure patients) Is the patient on an anticoagulant and when was it started Attach ECG Attach recent bloods : renal function, electrolytes, and full blood count

East Galway Roscommon Integrated Care Hub (CHN 7, CHN 8 and CHN 9)

		Patients with HF, also need an NTproBNP. All patients should have an ECG. This is not a complete list, as their will be variation in patient presentation. Each referral will be reviewed in weekly Hub Triage meeting and arrangement made for follow up on each case.			
Clinical Nurse Specialist (CNS) 1:1 (Cardiology) This is a CNS led clinic for patients diagnosed with Heart Failure and Atrial Fibrillation. They receive 1:1 individual assessment, support, and education including collaborative goal setting. **Services offered** Education provided on Heart Failure diagnosis, signs and symptoms, fluid management and weight monitoring. Atrial Fibrillation diagnosis, signs and symptoms. Medication reconciliation, benefits and potential side effects, sick day rules. Monitoring and managing of medication post titration. Self-management education and support. When to report any deterioration and signs and symptoms, with a contact number provided. Lifestyle factors.	**Cardiology**	**Inclusion Criteria** **Inclusion Criteria** Adult > 18 years of age with a confirmed diagnosis of Heart failure or Atrial Fibrillation. Patients home address within the catchment area (CHN 7,8,9) Patients consent for referral obtained. Stable patients for assessment and medication review. Poorly controlled heart failure patients who require education and review following on from Consultant /ANP assessment.	Y	Y	Recent ECG/Blood results. Up-to-date Medication list
Pulmonary Rehabilitation This is a comprehensive intervention based on a thorough patient assessment followed by patient-tailored therapies that include, but are not limited to, exercise training, education, and behaviour change, designed to improve the physical and psychological condition of people with chronic respiratory disease and to promote the long-term adherence to health enhancing behaviours.	**Respiratory**	**Inclusion Criteria** Confirmed diagnosis of COPD (via Spirometry) and on optimal medical treatment* as per the GOLD guidelines. **OR** Confirmed diagnosis of Asthma with the following: fixed airway obstruction deconditioning optimal medical treatment* as per the GINA guidelines *Optimal medical treatment is considered 2-3 ICPCD/GP reviews post commencement of inhaler therapy. Functionally limited by dyspnoea despite optimal management (mMRC ≥ 2) Motivated to participate and change lifestyle Ability to exercise independently and safely (with or without a walking aid)	Y	Y	

		If prescribed supplemental oxygen must have own portable supply and be independent in its use. Able to travel to venue			
Physiotherapy 1:1 (Respiratory) This is a physiotherapist led clinic for patients diagnosed with COPD/Asthma and COPD Asthma overlap syndrome. **Services offered include:** • Airway clearance management • Breathlessness management • Dysfunctional breathing management • Cough support • Individualised exercise prescription • Inspiratory muscle training • Review inhaler optimisation • Self-management support and action plans for COPD & Asthma • Advice on bone health • Referral onwards to Oxygen Clinics, Pulmonary Rehab, support groups and living well programs	**Respiratory**	**Inclusion Criteria** COPD & Asthma patients >16 years who have a confirmed diagnosis of Asthma or COPD or Asthma/COPD overlap syndrome having issues with airway clearance, sputum management, breathlessness, cough support, physical or functional activities , frequent exacerbations and self-management of chronic lung condition. **Exclusion:** Shortness of breath on exertion secondary to a cardiac or palliative condition.	Y	Y	Recent ECG/Echo/Blood results. Up-to-date Medication list

East Galway Roscommon Integrated Care Hub (CHN 7, CHN 8 and CHN 9)

Diabetes Integrated Care Consultant-(Led Clinic) This is a consultant led service where the GP can access specialist Diabetes care advice in a timely manner. The service is supported by CNS, Dietitian and Podiatry services. The Integrated hub will act as point of care for those who need specialist input. Care will be episodic in nature and as required.	**Diabetes**	**Inclusion Criteria** Adult >18years with confirmed T2DM with HBA1C >58mmol/mol on more than two oral hypoglycaemic agents. Steroid induced diabetes Initiation of GLP1/ Insulin Insulin Titration Albuminuria EFGR >30ml/min Recurrent hypoglycaemia Hypoglycaemic unawareness Defaulted T1DM for single visit in view of reengaging with secondary care. **Exclusion Criteria** **GP CARE** T2DM managed by lifestyle modification with HBA1C < 58 mmol/mol, Pre-diabetes **SECONDARY CARE** T1DM on pump MODY/GENETIC DIABETES Diabetes with complications Retinopathy/nephropathy/neuropathy with active foot disease as per national model of care Secondary Diabetes-Pancreatic diabetes Adolescent/paediatric diabetes<18yo. T1DM/T2DM planning pregnancy/pregnant ESRF on haemodialysis This is not a complete list, as their will be variation in patient presentation. Each referral will be reviewed in a weekly hub clinical triage meeting and arrangements made for follow up on a case by case basis.	Y	Y	Updates list of medication Most recent laboratory test-including HBA1C, LIPIDs, renal profile urine ACR. Medical history
DESMOND Diabetes Education and Self-Management for Ongoing and Newly Diagnosed (DESMOND) is a high quality structured patient education programme for people living with Type 2 diabetes.	**Diabetes**	**Inclusion Criteria:** ≥ 18 years of age Diabetes managed by lifestyle modifications only *or* with any type or combination of OHAs, SGLT2s, GLP1s and/or insulin Low, moderate, high risk/in-remission foot disease Up to and including stable CKD stage 3, if renal care is with GP (i.e. not under	Y	Y	1. Recent blood results (HbA1c/Renal)

East Galway Roscommon Integrated Care Hub (CHN 7, CHN 8 and CHN 9)

Education provided on: Diabetes and Glucose Monitoring Type II Diet / Glucose Control Long term Effects Physical Activity Food and Health Self-Management Plan		nephrologist) Recurrent hypoglycaemia or impaired awareness of hypoglycaemia **Exclusion Criteria:** Paediatric or adolescent diabetes (< 18 years) Pre-diabetes Type 1 Diabetes Gestational Diabetes Women who are actively planning a pregnancy or who are pregnant Continuous subcutaneous insulin infusion therapy Maturity onset diabetes of the young Cystic fibrosis related diabetes Secondary causes of diabetes e.g. Diabetes due to endocrinopathies, Pancreatitis, Post-pancreatic surgery, Post-transplant diabetes Genetic causes of diabetes e.g. Tumors, Klinefelters, Syndromes of insulin resistance etc. Residential Care Home residents who cannot travel into clinic CKD Stage 4 & stage 5 and unstable Stage 3 (i.e. renal care is with nephrology services) Active Foot Disease (as per National Model of Care for the Diabetic Foot) Diabetic eye disease with active proliferative retinopathy/maculopathy or recent laser therapy or intra-vitreal injections (within the past 24 months) Autonomic neuropathy (with exception of erectile dysfunction) Active eating disorders Active Crohn's/ ulcerative colitis Pre- or >2years post-bariatric surgery Receiving parenteral nutrition			

East Galway Roscommon Integrated Care Hub (CHN 7, CHN 8 and CHN 9)

Integrated Care Podiatry Service Providing standardised high-quality diabetes foot management for patients who are at **In-Remission, High and Moderate Risk** of developing diabetic foot complications, as defined per Model of Care for Diabetic Foot 2021.	**Diabetes**	**Inclusion Criteria:** Screened by GP and found to have Impaired sensation, Impaired circulation, Foot deformity End stage Renal Failure Stages 4 and 5 Previous foot ulcer Previous lower limb amputation Previous Charcot arthropathy **Exclusion Criteria:** Patient < 18 years of age Active Foot ulceration/ Charcot foot disease/ Infection to be referred to Acute MdFT or A&E Low risk diabetic Nail and general foot care	Y	Y	1.Medical History 2. Updated medication list 3.Recent blood results (HbA1c/Renal) 4.Non-invasive test results 5.Diabetic Foot screening must be completed in order for referral to be accepted
Clinical Nurse Specialist (CNS) 1:1 (Type 2 Diabetes) This is a CNS led clinic where patients can be offered 1:1 CNS interventions, receiving individually tailored assessment and interventions supported by collaborative goal setting and management techniques. **Education provided on:** Type 2 Diabetes Diabetes medication Blood glucose monitoring Blood glucose targets Hypoglycaemia Hyperglycaemia Insulin administration GLP1-RA Administration Glucagon administration SGLT2 – sick day rules Diabetes and driving Diabetes and Alcohol Diabetes and smoking Diabetes and travel Lifestyle factors Diabetes and foot care Diabetes self-management education and support Diabetes and retina screening	**Diabetes**	**Inclusion Criteria:** Adult > 18 years of age with a confirmed diagnosis of type 2 Diabetes with HbA1c > 58mmol/mol to include and/or one of the following: On 2 agents Steroid induced diabetes Recurrent hypoglycaemia Initiation of GLP-1 RA Initiation of insulin therapy Review of insulin regime Defaulted type 1 Diabetes (one visit) with the view or reengaging with secondary care **GP Care** Managed by lifestyle modification or HbA1c <58mmol/mol (<7.5%) Pre-Diabetes **Exclusion Criteria:** Type 1 Diabetes/ continuous subcutaneous insulin infusion Urine/Blood ketones Type 1/Type 2 Diabetes planning a pregnancy or who are pregnant Paediatric or adolescent diabetes < 18 years Maturity onset diabetes of the young (MODY) Cystic Fibrosis related diabetes Genetic causes of Diabetes e.g. tumours, klinefelters, Syndromes of Insulin resistance	Y	Y	1.Medical History including BMI 2.Medication History 3.Recent blood results (HbA1c/Renal/lipid profile/urine ACR) 4.Non-invasive test results 5. Diabetic Foot screening results (if available) 6. Last retina screening results (if available) 7. Diabetes Self - management education (DESMOND) been attended (Yes/No) 8. Has any physical activity programme been attended 9. Dietitian report (if available)

		Secondary causes of diabetes e.g endocrinopathies, Pancreatitis, Post Pancreatic Surgery, Post-transplant Diabetes, Diabetic eye disease with active proliferative retinopathy/maculopathy or recent laser therapy or intravitreal injections (within the last 24 months) ESRF or haemodialysis Active foot disease as per National Model of Care for the Diabetic Foot.			