Galway City Integrated Care Hub (CHN's 4, 5 and 6)

Service Name	Speciality	Service Descriptor	Service currently provided (Y/N)	Referral accepted by Health Link (Y/N)	Additional referral information required from GPs
Heart Virtual Clinic (HVC) service This is a consultant led clinic where the GP can access specialist cardiology advice in a timely manner for their patients. This service will be supported by direct GP access to diagnostics and follow up clinical contact with the patient from the Integrated Care Cardiology Specialist Team where required.	**Cardiology**	**Inclusion Criteria** • In catchment area (CHN 4, 5, 6) • Patients > 16years of age and over • The HVC service will be available to the full population in the area with heart failure and/or suspected heart failure (both GMS and Non-GMS patients). • The GP will be responsible for the identification of patients most suitable for the discussion at the HVC. Examples of typical cases include confirmation of diagnosis including assistance in interpreting investigations in context of symptoms, advice on management in stable cases where certain therapies have yet to be applied or in cases demonstrating unstable features where HVC intervention may avoid hospital referral.	Y	Y	
Respiratory Integrated Care Consultant-(Led Clinic) This is a consultant led service where the GP can access specialist Respiratory care advice in a timely manner. The service is supported by CNS, Physiotherapy and Physiologist 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.	**Respiratory**	**Inclusion Criteria** • In catchment area (CHN 4, 5, 6) • Adults > 16 years old • Suspected or uncontrolled asthma or COPD due to ANY of the following: Typical symptoms ○ ≥ 2 attendances to GP in past 12 months ○ Any ED or hospital admission in past 12 months **Exclusion Criteria** Any of the following: ○ Hemoptysis ○ ILD ○ Active or suspected malignancy ○ Pneumothorax ○ Other uncontrolled medical conditions ○ Long COVID	Y	Y	

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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) • If prescribed supplemental oxygen must have own portable supply and be independent in its use. • Able to travel to venue	Y	Y	
Clinical Nurse Specialist (CNS) 1:1 (Respiratory) This is a nurse led clinic for patients diagnosed with COPD/Asthma or Asthma/COPD overlap. **Services offered:** • Disease education • Symptom management • Medication use + inhaler technique/ change of device • Peak flows • Self-Management plans • Trigger factors and exposure avoidance • Health and well-being advice • Vaccination advice • Smoking cessation • Bone health • Specific phlebotomy where feasible if required.	**Respiratory**	**Inclusion Criteria** • Adults > 16 years who have a confirmed diagnosis of asthma and/or COPD via spirometry who have > 2 attendances to GP practice within 12 months (unscheduled), ED or admission to hospital within the previous 12 months • Are considered to be on optimal medical treatment as per GOLD/GINA guidelines: Optimal medical treatment is considered 2-3 ICPCD/GP reviews post commencement of inhaler therapy.	Y	Y	

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Physiotherapy 1:1 (Respiratory) This is a physiotherapist led clinic for patients diagnosed with COPD/Asthma.	**Respiratory**	**Inclusion Criteria** COPD & Asthma patients > 16 years with issues regarding: • airway clearance(sputum management)- (upper and lower airways) • breathlessness management • cough management • shortness of breath on exertion secondary to an underlying respiratory issue *(not cardiac or palliative)* • individualised exercise assessment & prescription • assessment and referral to pulmonary rehabilitation COPD education and Self-Management plans	Y	Y	
Direct Access GP Spirometry This is a direct access to Spirometry clinic where the patient will have Spirometry completed and this Spirometry will be reported on by a Respiratory Consultant and the report will be returned to the GP.	**Respiratory**	**Indications for Spirometry** • Clinical suspicion of COPD • Clinical suspicion of Asthma	Y	Y	• Is patient on inhalers? • Patient smoking status

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 >50years with confirmed T2DM with HBA1C >58mmol/mol on oral hypoglycaemic agents. • Steroid induced diabetes • Initiation of GLP1/ Insulin • Insulin Titration • 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	Y	Y	• Updates list of medication • Most recent laboratory test- including HBA1C, LIPIDs, renal profile urine ACR. • Medical history

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		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.			
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. **Education provided on**: • Diabetes and Glucose • Monitoring Type II • Diet / Glucose Control • Long term Effects • Physical Activity • Food and Health • Self-Management Plan	**Diabetes**	**Inclusion Criteria:** • ≥ 16 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 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 • Residential Care Home causes of diabetes e.g. Diabetes due to endocrinopathies, Pancreatitis, Post-pancreatic surgery, Post-transplant diabetes • Genetic causes of diabetes e.g.	Y	Y	1. Medical History 2. Medication History 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

		Tumors, Klinefelters, Syndromes of insulin resistance etc. 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 post-bariatric surgery • Receiving parenteral nutrition			
Diabetes Prevention Programme (Pre-Diabetes) Patient referrals accepted for Diabetes prevention will be offered an initial assessment with a dietitian and following this they may commence a Diabetes Prevention group programme (12 month block of care) or continue a 1:1 defined block of dietetic care as appropriate.		**Inclusion Criteria** • Patients 16yrs & older living within hub catchment areas with a clinical diagnosis of pre-diabetes. • 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 must include detailed medical background, recent biochemistry, current medications if any, weight history and any other relevant information. **Exclusion Criteria:** • Paediatric or adolescent diabetes (< 16 years) • Type 1 Diabetes • Gestational Diabetes • Maturity onset diabetes of the young • Cystic fibrosis related diabetes • CKD Stage 4 & stage 5 and unstable Stage 3 (i.e. renal care is with nephrology services) • 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 post-bariatric surgery • Receiving parenteral nutrition			

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cANP in Diabetes Integrated care	**Diabetes**	**Inclusion Criteria** • Adult >16 years and <50 years with confirmed T2DM • Within catchment area (Net 4,5 and 6) **Exclusion Criteria:** • Patients with Diabetes Mellitus <16years. • Pre-diabetes • GFR < 30 • uACR >100 • Patients with Type 1 Diabetes Mellitus. • Patients with active foot disease or osteomyelitis requiring admission/surgical intervention. • Cystic Fibrosis related Diabetes Mellitus. • Ketones <1.5moll/L • Patient planning pregnancy or pregnant patients with Diabetes Mellitus. • In the acute phase of Diabetes Ketoacidosis DKA defined as hyperglycaemia (blood glucose >11mmol/l), pH<7.3 or bicarbonate less than 15mmol/l and ketonaemia >3.0mmol/l and/or ketonuria >2+. • In the acute phase of Hyperosmolar Hyperglycaemic State HHS defined as marked hyperglycaemia (blood glucose>30mmol/l) without significant hyperketonaemia<3.0mmol/l or acidosis (pH>7.3, bicarbonate>15mmol/l) +Osmolality >320mOsmol/kg. • MODY(maturity onset diabetes of the young) • Genetic causes of diabetes e.g. tumours, kinefelters, Syndromes of insulin resistances • NYHA III-IV • The CANP Diabetes Integrated Care under the supervision of the diabetes integrated Consultant Endocrinologist may continue to provide Diabetes care to high risk patients as agreed with the Consultant Endocrinologist on a case per case basis.			

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Integrated Care Podiatry Service Providing standardised high-quality diabetes foot management for patients who are at **In-Remission Risk** of developing diabetic foot complications, as defined per Model of Care for Diabetic Foot 2021.	**Diabetes**	**Inclusion Criteria:** • Previous foot ulcer • Previous lower limb amputation • Previous Charcot arthropathy **Exclusion Criteria:** • Patient < 16 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. Recent blood results (HbA1c/Renal) 3. Non-invasive test results 4. 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	**Diabetes**	**Inclusion Criteria:** Adult > 16 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 **Exclusion Criteria:** **GP Care** • Managed by lifestyle modification or HbA1c <58mmol/mol (<7.5%) • Pre-Diabetes **Secondary Care** • Type 1 Diabetes/ continuous subcutaneous insulin infusion	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

education and support • Diabetes and retina screening		• Urine/Blood ketones • Type 1/Type 2 Diabetes planning a pregnancy or who are pregnant • Paediatric or adolescent diabetes < 16 years • GFR<30 • NYHA III-IV • uACR >30 • Maturity onset diabetes of the young (MODY) • Cystic Fibrosis related diabetes • Genetic causes of Diabetes e.g. tumours, klinefelters, Syndromes of Insulin resistance • 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. • Transplant			programme been attended 9. Dietitian report (if available)
Dietician 1:1 (Type 2 Diabetes) This is a dietitian led clinic where patients can be offered 1:1 dietetic interventions, receiving individually tailored assessment and interventions supported by collaborative goal setting and management techniques. **Education provided on:** • Diet • Weight management • Alcohol • Smoking • Physical activity • Medication • Lifestyle factors	**Diabetes**	**Inclusion Criteria:** • ≥ 16 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 nephrologist) • Recurrent hypoglycaemia or impaired awareness of hypoglycaemia **Exclusion Criteria:** • Paediatric or adolescent diabetes (< 16 years) • Pre-diabetes • Type 1 Diabetes • Gestational Diabetes • Women who are actively planning a pregnancy or who are pregnant • Continuous subcutaneous insulin infusion therapy	Y	Y	1. Medical History 2. Medication History 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

		• 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 post-bariatric surgery • Receiving parenteral nutrition			