Healthlink Referral Guidelines for
Benbulbin Chronic Disease Management (CDM) Hub
Sligo/South Donegal and Leitrim/West Cavan – (CHN 5 and CHN 6)

Service Name and Descriptor	Speciality	Service Criteria	Service currently provided (Y/N)	Healthlink Referral accepted (Y/N)	Additional referral information required from GPs
DIABETES TYPE 2 IC PODIATRY SERVICE **Podiatry Diabetes Type 1 and Type 2:** The Diabetes Community Podiatry service operates as the Foot Protection Team (FPT). All active foot disease i.e. open wounds, ulcers etc. must be referred to Sligo University Hospital to the following email address: **diabetespodiatryservicesuh@hse.ie** Currently the FPT operate clinics at: 1. The Benbulbin CDM Hub Sligo and 2. Primary Care centres in: o Ballyshannon o Ballymote o Enniscrone o Ballyshannon o Ballinamore	**Diabetes**	**Inclusion Criteria:** • Those patients with diabetes who are "in-remission", having previously suffered a diabetic foot ulcer or amputation. • Those deemed at moderate risk and high risk of developing foot complications associated with diabetes. **Exclusion Criteria:** - The team does not provide routine nail care. - The team does not manage active foot disease, open wounds, ulcers etc.	Y	Y	All Healthlink referrals to the service must be supported by: An up-to-date completed foot screening assessment Recent bloods Patient Safety alerts IPC alerts Medication and ideally a photograph (taken and provided with patients consent) Due to the high volume of referrals to this service - The FPT Podiatrist must have enough clinical information provided on the referral to be able to correctly prioritise and support each case.

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DIABETES PREVENTION PROGRAMME The National Diabetes Prevention Programme offers 12 months of support with diabetes risk reduction and lifestyle intervention for those with pre-diabetes. It is FREE to attend for all patients (GMS and non-GMS). Delivered by HSE community Dietitians. Participants are offered a 1:1 appointment with a Dietitian to determine an individual care plan. Participants are then offered 90 minute online group sessions for 6 weeks followed by 8 monthly sessions **Referral pathway: Referrals can be made via Healthlink**.	**Diabetes**	**Clinical criteria:** • Aged >16 years of age with a new diagnosis of Pre-diabetes. • All those with a pre-existing diagnosis of Pre-diabetes (provided they have had a recent blood test confirming that they are still in the Pre-Diabetes range). • Women with previous gestational diabetes who fall within the Pre-diabetes range. • Pre-diabetes is defined as HbA1c 42-47mmol/mol (6-6.4%) and Fasting Plasma Glucose (FPG) 6.1-6.9mmol/L, in the absence of symptoms results should be confirmed by repeat testing on a different day	y	y	**1.Medical History** **2. Recent Diagnosis** of pre-diabetes (confirmed by recent blood test) **3. Recent Biochemistry results:** HBA1C, Fasting Plasma Glucose (FPG) 4. Non-invasive test results weight, height BMI and Bp on referral. 5. Any additional needs (e.g. literacy/language barriers) Referrals received without this information will be returned to referrer.
Best Health Weight Management Programme The Best Health Weight Management Programme supports individuals with weight related behaviours (eating, activity, sleep and stress) to improve health and wellbeing. It is FREE to attend for all patients (GMS and non-GMS). Delivered by HSE community Dietitians. Participants are offered a 1:1 appointment with a Dietitian to determine an individual care plan. Participants are then offered 90 minute group sessions for 6 weeks followed by 8 monthly sessions. This programme is delivered online at present, with plans to deliver face to face in future. Referral pathway: Referral can be submitted via Healthlink or alternatively by Email to Benbulbin.cdmhub@hse.ie	**Diabetes**	**Clinical Criteria** Aged >16 years of age with BMI >**30kg/m2** (or **27.5kg/m2 for South Asian, Chinese, Black African or Caribbean individuals)** with 2 of the following obesity related co-morbidities. Note: obesity related co-morbidities are limited to type 2 diabetes, hypertension, hyperlipidaemia, obstructive sleep apnoea, polycystic ovarian syndrome, and osteoarthritis.	y	y	1. Medical History **2. Medication-history and list of current prescribed medication** 3. **Recent Biochemistry results:** Total Cholesterol, LDL, HDL, HBA1C 4. **Non-invasive test results:** weight, height, BMI and blood pressure on referral 5. **Additional Needs** (e.g. literacy issues/language barriers) **Referrals received without this information will be returned to the Referrer**

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DESMOND Education Diabetes Type 2 Virtual/ Face to Face DESMOND (Diabetes Education & Self-Management for Ongoing and Newly Diagnosed) is a 6 hour education programme delivered over 1 full day or 2 half-days. It is facilitated by a Diabetes Nurse and a Diabetes Dietitian. Participants are provided with up-to-date information on diabetes; learn practical skills on how to manage their diabetes; discuss food choices, monitoring, exercise, medication, and prevention of complications. They are supported in gaining skills and confidence around managing their diabetes. This programme is offered in a number of locations throughout Sligo, Leitrim and South Donegal and can be offered virtually if required. As part of the programme participants are provided with their own bloods and blood pressure results. Blood results are explained and recommended targets are discussed. Please consider a 1-1 appointment with Dietitian referral for those who may find group participation difficult e.g. poor literacy skills, language barrier.	**Diabetes**	**Inclusion Criteria:** • Diagnosis of Type 2 Diabetes (length of time since diagnosis does not matter) **Inclusion Criteria:** • Patients with Pre-Diabetes should not be referred to Desmond.	Y	Y	Bloods: recent Total Cholesterol, LDL, HDL, HBA1C and a recent blood pressure reading. Please indicate if participant has a preference for virtual or face-to-face programme and if they are bringing someone with them to support them. The booking system for this service requires unique patient identifier information therefore you must include a patient's Eircode or their mother's maiden name.

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ANP Diabetes Type 2 Nursing The Advanced Nurse Practitioner in Diabetes spends 50% of their working time in the community and 50% working in the acute hospital. Once glycaemic targets are achieved patients are transferred to GP care or in the case of complications/complex needs, diabetes care may be shared with GP services.	**Diabetes**	**<u>Inclusion criteria:</u>** • A diagnosis of Type 2 Diabetes Mellitus • Poor glycaemic control (i.e. HbA1C >58mmol/mol, 7.5%) on 2 or more glucose lowering agents • Steroid induced hyperglycaemia • Recurrent hypoglycaemia • Hypoglycaemia unawareness • Established Diabetes Mellitus related complications • Complex needs, defined as physical, social and psychological issues which may impact on a person's ability to self-manage their diabetes requiring more intense follow-up, support and management	Y	Y	All Healthlink referrals to the service must be supported by up-to-date referral information including: • Recent bloods • Relevant medical history inc MH • IPC alerts • Patient safety considerations • Medication • Update re diabetes dietician (and/or) podiatry referral status if relevant •Retinal screening result **Due to the high volume of referrals to this service the ANP must have enough clinical information provided on the referral, to be able to correctly prioritise each case.**

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CNS DIABETES TYPE 2 NURSING The Clinical Nurse Specialist in Diabetes spends 80% of their working time in the community and 20% working in the acute hospital. The medical team support nurses with a number of priority clinic appointments at SUH.	**Diabetes**	**<u>Type 2 diabetes patients (>16 years of age) with;</u>** • Increasing HbA1c (>58mmol/mol or 7.5%) • T2 patients requiring insulin/GLP1 initiation if additional support required by diabetes CNS IC • T2 patients on insulin not meeting individualised and appropriate HbA1c targets • Patients requiring diabetes education who are unable to attend the DESMOND structured education programme • Steroid induced hyperglycaemia with Type 2 diabetes patients • Recurrent hyperglycaemia/hypoglycaemia unawareness • Patients who default from secondary care including adults with type 1 diabetes with a view to re-engaging them with services in secondary care.	Y	Y	All Healthlink referrals to the service must be supported by up-to-date referral information including: • Recent bloods • IPC alerts • Patient Safety considerations • Medication • Update re diabetes dietitian • And/or podiatry referral status if relevant • Retinal screening result Due to high volume of referrals to this service the CNS must have enough clinical information provided on the referral to be able to correctly prioritise each case.

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TYPE 2 DIABETES DIETICIAN The Community Nutrition and Dietetics Service supports patients with a diagnosis of Type 2 Diabetes. Currently clinics are held at the Benbulbin CDM Hub Sligo and the following locations: Ballinamore, Coolaney Ballyshannon, Dromahair Bundoran, Drumcliffe Ballymote, Enniscrone Banada, Manorhamilton Carrigallen, Mohill Carrick-on-Shannon, Skreen Referrals will be triaged on receipt and patients at higher risk of developing complications are given higher priority. A Structured Patient Education (DESMOND) referral should be considered as initial treatment for those who consent and are suitable.	**Diabetes**	We do not accept referrals for Type 1 Diabetes, patients with Type 2 Diabetes under antenatal care or planning a pregnancy, Gestational Diabetes, Paediatric Diabetes and those with MODY/ LADA.			All referrals must contain the following clinical information: • Recent bloods (inc. HBA1C, Lipids, U&E) • List of medication • Medical history, including MH • Current weight • Weight history • Height and BMI • Social history • Any nutritional risk e.g. MUST score • Patient safety alerts If the referral does not provide us with adequate information to provide safe, effective care it will be returned to referrer.

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Overall Applicable Exclusion Criteria • Patients with chest pain/angina equivalents, unstable or needing urgent care (continuous monitoring, IV medications, urgent investigations). • Patients requiring acute care or long-term specialist management by hospital-based Cardiology Service. • Patients (except Heart Failure, new Atrial Fibrillation) who are already attending and have follow-up appointments with a Cardiology Consultant in SUH. • Pregnant patients • Patients residing outside the catchment area. • Patients under 16 years of age. The service also provides **Consultant led virtual online clinics for GPs**, if a patient is already attending a cardiac consultant they should not be referred for these clinics.					
Heart Failure Clinic (Hub & Enniscrone, Ballymote and Carrick On Shannon) **&** **Heart Failure Screening Clinic (Hub)** **Exclusion Criteria** Unstable patients. Acute CCF exacerbation. Suspected ACS.	**Cardiology**	Patients with suspected heart failure (signs, symptoms and raised NTProBNP =>400pg/mL) or with a new diagnosis of heart failure. Patients with stable heart failure who require medication review/titration. Medication optimisation for patients with poorly controlled chronic heart failure with worsening symptoms (development of Paroxysmal Nocturnal Dyspnea, failed first line management of worsening heart failure, recent decompensation [<1 month], associated with New Onset Atrial Fibrillation).	y	y	Recent blood results including FBC, U&Es, Iron Studies, NTProBNP, TFTs, LFTs and Lipid profile. Previous Cardiology correspondence letters, cardiac investigation reports if done outside SUH (Echocardiogram, Coronary angiogram, Cardiac MRI, Holter monitor, ABPM etc.). 12 lead ECG where applicable. Current medications with doses and specify if any known drug intolerance. Patients are seen without medical notes. All relevant medical information must be included in the referral letter
ARIAL FIBRILLATION CLINIC **Exclusion Criteria** Hemodynamically unstable Very symptomatic patient (EHRA Score >III) Resting heart rate > 120 bpm Active infection Acute heart failure (NYHA Score >II) Active bleeding issues Under 16 years of age Rheumatic mitral stenosis	**Cardiology**	Newly diagnosed Atrial Fibrillation. Stable patients with symptoms, anticoagulation issues. Persistent symptoms despite rate control.	y	y	Recent blood results including FBC, U&Es, Iron Studies, NTProBNP, TFTs, LFTs and Lipid profile. Previous Cardiology correspondence letters, cardiac investigation reports if done outside SUH (Echocardiogram, Coronary angiogram, Cardiac MRI, Holter monitor, ABPM etc.). 12 lead ECG where applicable. Current medications with doses and specify if any known drug intolerance. Patients are seen without medical notes. All relevant medical information must be included in the referral letter
PALPITATIONS/ARRHYTHMIA CLINIC **Exclusion Criteria** Unstable or very symptomatic patient.	**Cardiology**	Patients with palpitations or other irregular Heart Rhythms.	y	y	A 12 lead ECG must be attached with the referral Letter. Evidence from wearables with ECG tracing desirable

Resting heart rate > 120 bpm Active Infection. New onset heart failure. Recent syncopal episode.					
HEART MURMUR CLINIC **Exclusion Criteria** Unstable patients Suspected ACS	**Cardiology**	Patients with a suspected new Heart Murmur.	Y	Y	A Recent blood results including FBC, U&Es, Iron Studies, NTProBNP, TFTs, LFTs and Lipid profile. Previous Cardiology correspondence letters, cardiac investigation reports if done outside SUH (Echocardiogram, Coronary angiogram, Cardiac MRI, Holter monitor, ABPM etc.). 12 lead ECG where applicable. Current medications with doses and specify if any known drug intolerance. Patients are seen without medical notes. All relevant medical information must be included in the referral
HIGH RISK PREVENTION CLINIC	**Cardiology**	Patients with suspected genetic dyslipidaemias (e.g. Dutch criteria) Suboptimal risk factor control in those with established disease.	Y	Y	FBC, U&Es, Iron Studies, NTProBNP, TFTs, LFTs and Lipid profile. Patients are seen without medical notes. All relevant medical information must be included in the referral

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CDM Respiratory Integrated Care Service Currently the service is recruiting an integrated respiratory consultant. It is well supported by the medical team at SUH. Respiratory Pulmonary Rehabilitation Pulmonary Rehabilitation (PR) is a programme of exercise and education for people with respiratory disease. It is well-researched and has a good evidence base for its efficacy. The service is run by a specialist PR nurse and a PR physiotherapist. The programme is delivered over a 6-8 week period with 2 classes per week. All participants require a face-to-face pre-assessment and post assessment and patients that complete the programme are invited to a 6 month review and a 12 month review. The service targets patients with a confirmed respiratory diagnosis (COPD, Asthma (stable), Bronchiectasis, IPF) that fit the criteria for Pulmonary Rehab. Currently, the Pulmonary Rehabilitation courses are run at the Benbulbin CDM Hub Sligo, St Patrick's Hospital in Carrick-on-Shannon and virtually online but can be extended to other areas, where there is demand.	**Respiratory**	**<u>Inclusion Criteria -</u> Refer to Respiratory Integrated Care if:** - Patient >16 years old - Suspected Asthma or COPD - Chronic respiratory symptoms ongoing >3mths i.e chronic cough, sputum production, wheeze, breathlessness - History of 2 or more respiratory exacerbations in the previous 12 months - An attendance at A&E +/- admission to OOH GP in the previous 12 months - Symptoms despite optimisation of pharmacological treatment - Patients who are de-conditioned as a result of their chronic respiratory condition **<u>Exclusion Criteria -</u> Refer to Hospital Consultant if:** - Suspected malignancy - Haemoptysis - Unexplained weight loss - Night sweats - Hoarseness and/or swallow issues - Suspicion of progressive fibrotic interstitial disease - Suspected Sleep Apnoea	Y	Y	Al Healthlink referrals to the service should include the Following: • Cardiac symptoms • Relevant medical and MH history and confirmation that the patient meets the inclusion criteria • Recent PFTs • mMRC • Relevant bloods • Any infection control or patient safety alerts • An up-to-date medication list This service is in high demand. The PR team must have enough information to be able to correctly prioritise each individual for the service.
RESPIRATORY INTEGRATED CARE CNS/PHYSIO The Respiratory Integrated Care CNS/Physio service targets patients with suspected or confirmed COPD or Asthma, which is poorly managed. Please note the team only support patients over 16 yrs, with history of 2 or more x RTIs in past 12 months, attendance at GP, OOH GP or ED for same +/- in-patient stay. Currently it operates in Benbulbin CDM Hub Sligo, with outreach clinics in South Donegal, Sligo and Leitrim. The service is run by a Clinical Nurse Specialist Respiratory and a Senior Physiotherapist.	**Respiratory**				All Healthlink referrals to the service must be supported by: - relevant medical history including MH, an up-to-date chest X-ray report (in past 12 months) - Recent bloods - any infection control or patient safety alerts - an up-to-date medication list This service is in high demand. The RIC team must have enough information to be able to correctly prioritise each individual for the service
STOP SMOKING SERVICE The HSE Stop Smoking Service provides free, confidential support to anyone over 18 who wishes to quit tobacco or electronic cigarettes. If client is GMS, recommendation for NRT to be sent to GP for client to	**Respiratory**	This support can be provided face to face, on the phone or virtually on a weekly/fortnightly basis initially and continues for up to 1 year from the clients quit date.	Y	y	All referrals to the service should include the following: • Name • Address • Telephone Number • Consent to be referred and interested in quitting • Any Chronic Diseases – COPD/Asthma, Type 2 Diabetes,

receive on GMS system. If client is non GMS, recommendation is sent to chosen Pharmacy where client can access up to 12 weeks free combination NRT.		Our service focuses on the addiction, habit and emotional attachment that clients develop to nicotine. Behavioural support is provided along with client-centred combination NRT recommendations in line with Clinical Guidelines and Quality Assurance Guidelines developed in 2022. This increases chances of quitting successfully x 4 fold.			Cardiovascular Disease (including heart failure, heart attack (angina), stroke, irregular heartbeat (atrial fibrillation) and relevant MH history This service is in high demand. The team must have enough information to be able to correctly prioritise each individual for the service.