Healthlink Referral Guidelines for
Donegal – Errigal Chronic Disease Management (CDM) Hub (CHN 1, CHN 2, CHN 3 and CHN 4)

Version number	V2.3
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Service Name and Descriptor	Speciality	Service Criteria	Service currently provided (Y/N)	Referral accepted by Healthlink (Y/N)	Additional referral information required from GPs
DONEGAL RESPIRATORY INTEGRATED CARE SERVICES (RIC) Donegal RIC services within the Errigal Chronic Disease Management Hub is now operational with outreach clinics in each of community healthcare networks. The RIC service consists of; - Registered Advanced Nurse Practitioners - Senior Respiratory Physiotherapists - Respiratory Clinical Nurse Specialists - Clinical Specialist Physiotherapists The aim of the service is to identify and manage patients with COPD/Alpha 1 Antitrypsin, Asthma, Emphysema, and Bronchiectasis in the primary care setting. A comprehensive respiratory assessment will be carried out at the initial appointment, where care needs will be identified and the patient placed on the appropriate care pathway or referred back to your care with recommendations. **Interventions offered** - Assessment and Management (including spirometry) - Pulmonary Rehabilitation - Oxygen Assessment - Breathing and Airway Clearance - Advanced Lung Disease Management **Please optimise the pharmacological treatment of patients with the following conditions prior to referral:** - Uncontrolled Hypertension - Decompensated / Unstable Heart Failure - Unstable Angina - Insulin dependent diabetics	**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	In the 'Additional relevant Information' box within the HealthLink referral from the following information MUST be provided in order for the RIC team to progress the referral to triage 1. Is the patient currently on O2 therapy? 2. If so is it Long term O2 therapy (LTOT), Ambulatory O2 therapy (AOT), Nocturnal O2 therapy (NOT)? Include details of prescription (flow rate/settings) 3. Authorisation for reversibility testing with 400mcg Salbutamol if indicated 4. Is patient on lung transplant list/ referred to palliative care? Please advise If available, please attach the following; 1. PFTs / Spirometry 2. Blood results including FBC, ProBnp, RAST / IgE, CRP, U&E 3. Sputum results 4. Recent radiological investigations 5. Any infection control or patient safety alert 6. Up to date patient medication list. Due to the high volume of referrals to RIC, please ensure that the referral has enough clinical information to enable us to prioritise and support each case appropriately.

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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 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.	**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. 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.	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, 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.

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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. This Programme is currently delivered online with plans for delivery of face-to-face in future. **Referral pathway:** Referral can be submitted via Healthlink or alternatively by Email to cdmdonegal@hse.ie	**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 blood pressure on referral. 5. **Additional Needs** (e.g. literacy issues / language barriers) **Referrals received without this information will be returned to referrer**
DESMOND Desmond (Diabetes Education & Self - Management for Ongoing and Newly Diagnosed). A 6 hr session is delivered over 1-2 days, facilitated by a Diabetes Nurse and Diabetes Dietitian. Participants get 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 will be supported in gaining skills and confidence around managing their diabetes. This programme is offered in a number of locations throughout Donegal and can be offered virtually if demand is there. 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. Please consider a Dietitian referral for those who may find participation difficult e.g. poor literacy skills, language barrier **Please Note:** Referrals to the established Dietitian Type 2 Diabetes service should continue to be referred via Dietetics office. **Email:** communitydietitian.donegal@hse.ie **Address:** Community Nutrition & Dietetics Service, Level 1 Scally Place Justice Walsh Rd Letterkenny Co Donegal F92 P640	**Diabetes**	**Clinical Criteria:** • Diagnosis of Type 2 Diabetes (length of time since diagnosis does not matter) **Exclusion Criteria:** • Patients with Pre-Diabetes should not be referred to Desmond.	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 referrer**

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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 cdmdonegal@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 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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IC DIABETES NURSE SPECIALIST The CNS Diabetes IC: • work as part of the multidisciplinary diabetes team to provide a primary care based specialist diabetes nursing service to individual patients referred to them by General Practitioners (GPs) and General Practise Nurses (GPNs). • work 80% of the time in primary care and 20 % with Secondary Care or Integrated Consultant Endocrinologist providing a tangible link between primary and secondary care. • will provide education to the patient and enable them to monitor and manage their diabetes as well as possible. • assesses problems in glycaemic control and supports patients to improve it including pharmacological and non-pharmacological recommendations to the patient and GP. Patients with type 2 diabetes within the inclusion criteria are offered an assessment and review at a clinic venue close to their home. Once the episode of care has been completed, the patient is transferred back to General Practice Chronic Disease Management clinics. **REGISTERED ADVANCED NURSE PRACTITIONERS, DIABETES INTEGRATED CARE** Registered Advanced nursing practice is carried out by autonomous, experienced practitioners who are competent, accountable and responsible for their own practice. Referrals to RANP Diabetes, Integrated Care are accepted from Consultant Endocrinology and CNS Diabetes waiting lists and caseloads.	**Diabetes**	**Criteria for Referral to Diabetes Nurse Specialist, Integrated Care** • Patients with Type 2 Diabetes + HbA1c ≥ 58 -84mmol/mol despite maximum oral agents. • Patients with T2DM who require GLP1 initiation • Patients who require insulin initiation • Patients with T2 DM with poor glycaemic control on insulin therapy • Steroid induced hyperglycaemia (can be referred back once off steroids or blood glucose levels settle) • Patients with T2DM with recurrent hypoglycaemia or • Patients with loss of hypoglycaemia awareness **Exclusion Criteria - Refer to Hospital Consultant if:** • HbA1c >85mmols/mol • Type 1 Diabetes • Genetic diabetes • With paediatric or adolescent diabetes • With MODY or LADA • Cystic fibrosis related diabetes • Secondary causes of diabetes e.g. • Diabetes due to - endocrinopathies - Pancreatitis - Post- pancreatic surgery • Egfr <30 • Current foot ulcer • With Type 1 or Type 2 diabetes and are planning a pregnancy or who are pregnant	Y	Y	**1.Medical History** **2. Current medications** **3. Recent Biochemistry results: HBA1C, U&E Egfr** **4. Retinal screening result**

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DIABETES IC PODIATRY SERVICE **Who should attends this service?** • 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. **Who is not eligible for this service?** • Patient who have an active foot ulcer, suspect Charcot, critical limb ischemia or spreading infection. These patients should be referred to the multi-disciplinary foot protection team in Letterkenny University Hospital, in line with best practice. •Low risk patients. These patients will be managed under the care of the General Practitioner. • Those requiring nail care. Please note nail care is not provided routinely. **IMPORTANT NOTES:** **Due to 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.** **Referrals received without this information will be returned to the referrer** **If you are unsure of where to refer to, please review the 'Reason for Referral' list below**	**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:** • Patients < 18 years of age • Patient who have an active foot ulcer, suspect Charcot, critical limb ischemia or spreading infection. These patients should be referred to the multi-disciplinary foot protection team in Letterkenny University Hospital, in line with best practice. • Low risk patients. These patients will be managed under the care of the General Practitioner. • Those requiring nail care. Please note nail care is not provided routinely.	Y	Y	1. An up-do-date completed Diabetic Foot screening assessment - must be completed in order for referral to be accepted 2. Medical History 3. List of current medications 4. Photo (taken and provided with patient's consent) 5.Recent blood results 6. Any infection control or patient safety alert

REASON FOR REFERRAL	
Refer to Hospital Podiatry Dept if:	**Refer to Chronic Disease Hub, Podiatry Dept, if:**
All diabetic patients with:	**All diabetic patients with:**
Active Foot Ulcer	In Remission of foot ulcer /amputation
Suspected Charcot Neuroathropathy	High risk foot Disease
Suspected/Confirmed Osteomyelitis	Moderate risk foot disease
Red Hot swollen foot with/without pain	Diabetes with peripheral Neuropathy
Spreading infection	Diabetes with peripheral arterial disease
Critical Limb ischemia	Diabetes with foot pathology

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HEART FAILURE SERVICE **Donegal Integrated Service for Heart Failure** Donegal heart failure services within the Errigal Chronic Disease Management Hub is now operational with outreach clinics in each of community healthcare networks. The heart failure service consists of; - Registered Advanced Nurse Practitioner - Cardiovascular Clinical Nurse Specialists - Chief Cardiac Physiologist - Clerical support The aim of the service is to identify and manage patients with or suspected to have heart failure in the primary care setting, along with local follow up of those admitted to LUH with heart failure. A comprehensive cardiology assessment will be carried out at the initial appointment, where care needs will be identified and the patient management plan developed. If no further intervention identified they will be referred back to your care with recommendations. **Interventions offered** - Assessment and Management (including echo) - Patient education on self-management - Medication optimisation - Patient initiated review for decompensations **Please ensure proBNP blood test is measured prior to referral as this is used to triage urgency.**	**Cardiology**	**Inclusion Criteria:** • Signs and symptoms of heart failure & ProBNP >400pg/ml (if not known heart failure) • Previous diagnosis of heart failure with echo **Exclusion Criteria:** • Patients with new atrial fibrillation with heart failure • New Ejection Systolic Murmur • Active chest pain (these require referral to ED/ Consultant cardiologist)	Y	Y	1.Patients with no previous diagnosis will be seen by RANP & have cardiac echo for diagnosis and management plan 2. Patients known to service will be reviewed by CNS for ongoing education and titration 3.Once clinically stable and medication optimised will be discharged back to GP teams
CARDIAC REHAB SERVICE The Donegal Cardiac rehab Service will be available from January 2024. Once available, the service will accept referrals for individuals with heart support needs.		**Inclusion Criteria** Referrals are not accepted at this time	N	N	Referrals are not accepted at this time. Once the Cardiac Rehab service is available, referrers will be expected to include the following information in their referrals: • Cardiac symptoms • Relevant medical and MH history • Relevant bloods • Any infection control or patient safety alerts • An up-to-date medication list