COPD / Respiratory Referral Guide Nov 2016

COPD /Respiratory Services -Barnsley

Referral forms available on Respiratory referral section forms of BEST website
If not found on Emis web/ System One

Please note that as the Respiratory MCP Pathways develop new services and changes to referral pathways are likely. Practices will be notified and the referral guide updated as the new pathways come on board.

1. **Respiratory Hub**
2. **Rapid Response Nurses**
3. **Community Nursing Services/Community Matrons**
4. **Community COPD Specialist Nurses**
5. **Pulmonary Rehabilitation**
6. **Stop Smoking Service- Yorkshire Smoke Free**
7. **Be Well Barnsley**
8. **Long Term Oxygen Therapy Assessment**
9. **Care Navigation/Health Coaching**
10. **Telehealth Vital Signs Monitoring**

Respiratory Hub

Monday – Friday (09.00-17.00). **The cut off point for referral is 15.00hrs.**

The respiratory hub is based upon Ward 18 the respiratory ward.

Who to refer: Patients with a moderate COPD exacerbation, who would benefit from Consultant advice but who probably do not need admission

Inclusion criteria:

1, Oxygenation levels <88% ORA

2, History of presenting complaint

3, Patient required diagnostics (ABG, CXR,etc)

4, Patient failing to improve on ARAS pathway

5, Need for rapid secondary care input

6, Respiratory rate <26bpm

7, Patient able and willing to attend the hub

Exclusion criteria:

1, Patient in respiratory distress –go to ED

2, Diagnostic uncertainty

3, Alternative respiratory diagnosis

4, Drowsiness or reduced GCS

5, Patient too unwell to sit in unsupervised area

What support is available: Specialist nurse assessment, diagnostics plus consultant review

How to refer: Via RightCare Barnsley direct line 01226 434344/ Mobile 07792587635

Referral form: No

Telephone contact number: 07792 587635 / 01226 73 00 00 ex 4344

Rapid Response Nurses

Who to refer: Patients with a moderate COPD exacerbation, who would benefit from advice.

Inclusion criteria: Hospital avoidance.

Exclusion criteria; Referral is made via a phone call to either RightCare Barnsley or directly to Rapid Response. Irrespective of who takes the referral call a triage process is undertaken. If following telephone triage the service user is identified as being suitable to have input from the Rapid Response Nursing Team the service user is accepted onto the service. The triage may indicate other more appropriate services e. g ED COPD HUB ETC.

What support is available: Input from nurses who will assess, monitor and manage services for users with COPD. They are also able to prescribe if required to do so.

How to refer: Between 8am and 8pm the referral is made via RightCare. Out of hours contact is via Mobile one and is answered by a Rapid Nursing Sister. Please note that the Rapid Response nursing sisters are part of RightCare Barnsley.

Referral form: No - Referrals are made during a telephone conversation and the information provided is documented during the telephone referral process.

Telephone contact numbers:

RightCare: 01226 644560 between 8am and 8pm

Mobile One: 07747 794698 – 8pm to 8 am

Community Nursing Services

Community Matrons

Who to refer: Patients 18 years of age or older who have a long term conditions whose needs are complex or unstable

Inclusion criteria:

- Patients with a long term condition whose needs are unstable or of high complexity
- Exacerbation intervention/episode of deterioration
- Worsening family distress
- Patients at risk of hospital admission
- Step up and step down support including discharge planning

Exclusion criteria:

- Those who do not meet the referral criteria (the referral may be signposted to a service which is better able to meet the patient's needs)
- Those who have not consented to treatment/referral

What support is available: The service will provide high quality nursing, prevention and treatment to include, care pathway planning, medication management, promotion of health and self-care, disease prevention and the management of acute or chronic long term conditions

The service will work in an integrated way with primary care and any other health and social care teams to ensure multidisciplinary team working and continuity of care

In partnership with the patient and where appropriate, the carers and family, the service will undertake a comprehensive and holistic assessment of those accepted by the service including the agreement of personal goals and the creation of an individual care plan using a single assessment process.

How to refer: Communications department 08.45 until 17.00 hours seven days per week including bank holidays.

Referral form: Community Nursing Referral forms can be completed and faxed to communications department on 01226 785690 however telephone referrals will be accepted.

Telephone contact number: 01226 644575

Community COPD Specialist Nurses

Who to refer:
Patients with COPD who require specialist respiratory input in the community. All patients started on Long term oxygen therapy.

Inclusion criteria

- Patients who have a confirmed diagnosis of COPD
- Patients assessed as requiring Long Term Oxygen Therapy

Exclusion criteria
Those who do not meet the referral criteria

What support is available:
In partnership with the patient and where appropriate, the carers and family, the service will undertake a comprehensive and holistic assessment within the home environment of those accepted by the service including the agreement of personal goals, facilitating self-management and the creation of an individual care plan using a single assessment process.

How to refer:
SystmOne: E referrals

Referral form: Yes

Telephone contact number: 01226 209889
Fax Number: 01226 209888

Pulmonary Rehabilitation

Who to refer: Patients who are functionally disabled from their respiratory disease

Inclusion criteria:

- All patients who consider themselves functionally disabled by COPD (usually ≥ MRC grade 3)
- Patients who have had a recent hospitalisation for acute COPD exacerbation (start within 1 month, repeat if > 12 month since last had pulmonary rehab)
- Patients with other chronic respiratory illnesses leading to functional disability due to SOB (eg fibrosis, awaiting transplant)

Optimise respiratory treatment prior to referral

Exclusion criteria

- Not asthma (except in exceptional cases)
- Not suitable for patients:
- Unable to walk
- Unstable angina, recent MI, Severe Aortic Valve Stenosis
- Other co morbidity disease with prognosis less than 6 months
- Significant cognitive impairment
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What support is available: Comprehensive assessment by Multidisciplinary team – Respiratory Specialist Nurse, Physiotherapist and Exercise Instructors. Pre and post programme outcome measures

6 weeks, 2 x week programme with 1 hour education, 1 hour individualised exercise plan .

Transport

Car Park at Dorothy Hyman Sports Centre - Large free car park with disabled spaces

Bus - from Barnsley Bus station No:32 Stops outside Dorothy Hyman Sports Centre.

Dial–a–Ride 01226 732096 Door to Door

- Patient needs to complete registration form and return to Dial–a–Ride
- Cost involved but less than taxis.
- Bookings should be made 48 hours in advance.

NHS Travel Refund 0300 3301343 - Travel expenses refunded for patients on low income.

- Patient to complete form HC1 to register
- Once registered complete form HC5 to claim
- GP/Doctor details are needed on claim form (part 3), if referred by other health professional Ie Physiotherapist, then their details should also be included.

Patient Transport Service (PTS) 0333 1300514

- Patient has to meet set criteria, operator will ask for information and make suitability decision **Need to hand –** NHS number, address and postcode, possible property details Information **–** They will ask personal, mobility and medical condition questions, can block book before 2pm for following day.

Look out for new satellite venues in Spring 2017 at Hoyland Sport Centre and Recovery College, Gawber Rd, Barnsley

How to refer:

Team e-mail: Swy-tr.CardiacRehab@nhs.net **SystmOne:** E referrals

FAX: Referral form to 01226 719789 for the attention of Pulmonary Rehabilitation Team or post to Pulmonary Rehabilitation, Dorothy Hyman Sports Centre, Snydale Road, Cudworth, Barnsley, S72 8LH

Referral form: Yes - on BEST website and clinical systems (see link at top of document)

Telephone contact number: 01226 719781

Stop Smoking Service – Yorkshire Smoke Free

Who to refer: Smokers wishing to quit

What support is available: Telephone support, face to face sessions, live chat and an online quit program.

How to refer: Patients care self-refer: 0800 612 0011 (free from landlines) or 0330 6601 166 (free from mobiles) or using live chat.

Refer via BeWell Barnsley

Referral form: BeWell Barnsley referral form from BEST website or http://www.bewell-barnsley.com/referral-form

Telephone contact number: 0800 612 0011 (free from landlines) or 0330 6601 166 (free from mobiles)

http://barnsley.yorkshiresmokefree.nhs.uk/

Fax No. 01226 737078

Be Well Barnsley

Who to refer: Patient wishing to make a lifestyle change: giving up smoking, eating a healthier diet or losing weight, becoming more active, reducing stress, improving mood and drinking more sensibly.

Inclusion criteria

Free service supporting anyone across the lifespan who has a Barnsley GP or postcode.

What support is available:

- One to one support in the community and GP practices.
- 8 week rolling programme for Weight Loss called 'Choose 2 Lose'.
- Tailored healthy lifestyle courses e.g. Fit Reds men only, Fit Mums pre and post-natal.
- Physical Activity Timetable e.g. Tai chi, chair based exercise, football.
- One to one and group based support for Children and Families

How to refer: Professionals making referral e-mail referral form to refer@bewell-barnsley.com or phone on 0800 0169 133.

Patients can self-refer: 0800 016 9133 or EMAIL: hello@bewell-barnsley.com

Referral form: Yes - http://best.barnsleyccg.nhs.uk/clinical-support/referral-and-investigation-forms/ or bewell-barnsley.com

Telephone contact number: 0800 0169 133

Long Term Oxygen Therapy Assessment

Who to refer: Patients for consideration of long term oxygen therapy and/or Ambulatory oxygen assessment who have:

- COPD
- Asthma
- Interstitial lung disease
- Bronchiectasis
- Pulmonary hypertension
- Pulmonary malignancy
- Congestive heart failure
- Other (specify)

Inclusion criteria: Refer the patient if when stable:

- oxygen saturation on room air ≤ 92%
- oxygen saturation on room air ≤94% if they have secondary Polycythemia or Cor pulmonale
- if oxygen saturation on room air ≤94% for ambulatory oxygen assessment

NB:- Patients should undergo formal assessment for LTOT after a period of stability of at least 8 weeks from their last exacerbation

Exclusion criteria

Patients who are at end of life requiring oxygen for palliation – clinician completes a HOOF A for for short term O2.

If patient is end of life but has been prescribed O2 for more than four weeks using an Hoof A form then the patient should be referred to the Chest Clinic as per the LTOT pathway so that on-going O2 monitoring of the patient can be undertaken. I.e. if patient is palliative but not in last stages of life then the on-going O2 monitoring for the patient would be picked up by the Community based COPD Nurses once the patient had been initially seen via the hospital based COPD nurses.

What support is available: Assessment for suitability for LTOT; risk assessment; prescription of LTOT +/- ambulatory therapy; ongoing review/fu

How to refer: New patients who require LTOT for a respiratory condition via Respiratory Consultant referral via e-referrals

Referral form: No

Telephone contact number: 01226 434971 (BHNFT COPD Specialist Nurses)

Care Navigation / Health Coaching

Anybody who has an on-going illness / condition i.e. COPD, Diabetes, Heart Failure, Asthma, hypertension who would benefit from on-going telephonic support to promote enhanced self-management / independence.

Inclusion criteria:

- Over 18 years
- Registered with a GP within the CCG region

Exclusion criteria:-

- Dementia unless newly diagnosed
- Must have a telephone / mobile

What support is available:

- Personalised information and advice about their condition
- Help to access and provide more information about local services, self- help programmes, financial services, social services etc to meet the individual needs.
- Help / support in accessing services (advocacy)
- Providing regular telephonic support to comply with advice/treatment
- Help with motivation and confidence.
- Help to change behaviour and promote self- management

How to refer:
Referral form: Yes e-referral via TPP SystmOne.

Email: carenavigators@nhs.net

Telephone contact number: 0800 612 1976

Telehealth Vital Signs Monitoring

Who to refer:
Patients with COPD, Heart Failure, Hypertension, Asthma who have increase exacerbations / infections / hospital admissions / GP appointments or visits due to their long term condition(s).

Inclusion criteria
Known to a Matron and/or Heart Failure Specialist Nurse

What support is available:
Vital Sign monitoring BP, Oxygen Saturations and Weight Management (Heart Failure) with personalised questions related to their condition which generate alerts and then the data is reviewed 24 hours after by Long Term Condition Staff Nurses. With encouragement and help form the LTC Staff Nurse the patient is able to recognise changes in their condition which helps them to make the decision of when they will need take appropriate action i.e take rescue medication or seek medical help from their GP / Specialist Nurse / Matron. This will help to prevent /reduce emergency services involvement / hospital admissions. Thus encourage the patient to manage their own condition.

Referral form: Yes e-referral via TPP SystmOne.
Telephone contact number: 0800 612 1976
Email: carenavigators@nhs.net