"Dear All,

The Community Respiratory Response Team was established in March 2020 as a result of the Covid Pandemic. The objective of the service was to provide a safe alternative to hospital admission for patients with Chronic Lung Disease and to support management of Covid Pneumonia in the community during the height of the Covid Pandemic. The service was set up rapidly by suspending other clinical activity and was never intended to be a long term plan.

Now that Covid infection numbers are significantly falling and that the majority of patients with Chronic Lung Disease have been vaccinated we aim to suspend the CRRT referral pathway on the 2nd of June, with no referral accepted on this pathway from the 3rd of June onwards. It there is a further surge in Covid Infection resulting in a further full "lock down" and suspension of routine clinical activity the service will be re established, although we all hope this will not be needed.

It is planned that the CRRT staff can return to their routine work supporting Chronic Lung Disease patients in the community and in secondary care settings.

I would like to take the opportunity to thank the Respiratory Nurse Specialist teams in GRI, QEUH, Inverclyde and RAH; the GG+C Pulmonary Rehab team, the Glasgow City Community Respiratory Team and the Renfrewshire Rehab team for all the hard work and dedication shown over the last 12 months.

The CRRT service activity over the last 12 months is being evaluated with a view to a potential long term service offering equity of service across GG+C.

I have asked each service to detail what pathways are available to support patients with Chronic Lung Disease after suspension of the CRRT service on the 2nd of June;-

**Greater Glasgow and Clyde Pulmonary Rehabilitation Service**

Patients with COPD, interstitial lung disease and bronchiectasis can be referred to the service when their MRC is 3, 4 or 5 and able to attend hospital appointments. When the impact of their lung conditions causes symptoms of breathlessness, decreased activity and changes to their quality of life, that is the time to refer.

The programme offer assessment of patients up to one hour and 8 weeks programme of 1.5 hours per class. **Referrals can be made by Gp’s or Practice Nurses via Sci Gateway.**Classes are held in hospitals and local sports centres.

**Glasgow City Community Respiratory Team**

We are a team of physiotherapists, occupational therapists, respiratory nurses, pharmacists, dieticians and rehabilitation support workers who provide specialist respiratory support to patients with COPD:

· During exacerbations

· On discharge from hospital

· To help improve their ability to manage their condition

Our team can help enhance the quality of patients’ lives through:

· Support through exacerbations to prevent unnecessary hospital admissions.

· Improving their understanding of COPD and self-management techniques such as chest clearance.

· Recognising exacerbations.

· Teaching breathing control and management of everyday activities.

· Providing support for emotional well being in relation to breathlessness/ COPD.

· Improving confidence and independence within the home environment, including equipment provision.

· Reviewing medication, including inhaled therapy, and improving compliance.

· Participation in home pulmonary rehabilitation programmes.

· Participation in achieving optimal nutritional health.

**Inclusion Criteria Note: all must be met for input to be agreed**

· Patient resides within the Glasgow City Health and Social Care Partnership area (i.e. council tax paid to Glasgow)

· Has a diagnosis of COPD and this is their primary health concern and reason for referral.

· COPD significantly impacts their quality of life and limits their function

· Requires a specialist respiratory service

· Requires support in the home setting, i.e. not suitable for outpatient/ pulmonary rehabilitation Note: majority of CRT patients score 4 (i.e. stops for breath after 100m or few minutes on level ground) or 5 (i.e. too breathless to leave the house or breathless when dressing or undressing) on the MRC Breathlessness Scale.

· Over 16

· Patient is agreeable to input

**Exclusion Criteria Note: any one of these would prevent input**

· Patient requires hospital admission due to severity of exacerbation e.g. unsatisfactory vital signs, acute confusion/ impaired conscious level, requires emergency oxygen or intravenous medication etc.

· Complicating co-morbidity requiring further hospital care/investigation – particularly cardiac

· Patient is more suitable for other community services e.g. post operative rehabilitation, conservative fracture management, hospice input etc.

· Patient refuses input

· Loneworker issues identified that would prevent home visits.

· Inability to cope at home and does not have the necessary support in place

**Referrals to the community respiratory team can be made via SCi gateway**

**GG+C GRI Resp Nurse Service-within North Sector Catchment**

**Acute:**

1 COPD Early supported Discharge support following an acute admission.

2.COPD Supported Discharge following an admission for patients newly commenced on Long term Oxygen Therapy.

**Domiciliary:**

1. Assessment, optimisation of COPD **chronic** disease management and support to house bound patients inclusive of Long Term Oxygen Therapy assessment and Nebulised Therapy assessment.

**Out Patient**

1. Nurse led COPD clinic; for optimising treatment, recurrent exacerbations, palliation of symptoms, for patients who can attend clinic

**Access for these services via SCI gateway to respiratory at GRI**

**GG+C QEUH Resp Nurse Service -within South Sector Catchment**

**Acute**:

1 COPD Early supported Discharge support following an acute admission.

2.COPD Supported Discharge following an admission for patients newly commenced on Long term Oxygen Therapy and Specialist Respiratory Therapies such as Home Ventilation

3. Recruitment, chronic disease management monitoring and self-management support to patients on the COPD Digital Platform.

**Domiciliary:**

1. Assessment, optimisation of COPD **chronic** disease management and support to house bound patients inclusive of Long Term Oxygen Therapy assessment and Nebulised Therapy assessment.

2. Recruitment, chronic disease management monitoring and self-management support to patients on the COPD Digital Platform.

3. Telephone help-line advice to both patients and health care providers.

**Patients can be referred via sci gateway or via the help lines on 0141 451 6073 and 0141 451 6074**

**GG+C Clyde Resp Nurse Service -within Clyde Sector Catchment**

**Acute**:

1. COPD Supported Discharge following an admission for patients newly commenced on Long term Oxygen Therapy

**Domiciliary**:

1. Assessment , optimisation of COPD **chronic** disease management and support to house bound patients inclusive of Long Term Oxygen Therapy assessment and Nebulised Therapy assessment.  
**Out Patient**

1. Nurse led COPD clinic ; for optimising treatment, recurrent exacerbations, palliation of symptoms, for patients who can attend clinic

**Access for both of these is via SCI gateway to respiratory at Clyde**

**Respiratory CNS Renfrewshire HSCP**

The RCNS offers a service for patients with a variety of respiratory conditions including patients with a diagnosis of COPD, ILD and Bronchiectasis who live within the Renfrew HSCP. We do not take referrals for asthmatic patients.

We offer advice/support to patients with persistent chest flare ups/chest infections and for patients with recurrent GP presentations for their chronic lung conditions.

Please ref via SCI gateway: Renfrewshire RES, GGC Rehab Services, NHS GG&C"