Tier 3 Diabetes Service - Information for Ebbisham Practices

The Tier 3 service for Surrey Downs is run by Kingston NHS Foundation Trust. It consists of a regular DSN visit to your practice to help you support your patients, a weekly hub MDT clinic together with provision of education for both patients & members of staff within each practice.

Q - How do I refer a patient into the Practice Clinics?
Your DSN is effectively your link to this service. The DSN's initial visit will comprise a needs assessment, involving looking at the specific needs of your practice (which may range from requiring support with caseloads through to education) and how support from the DSN can be tailored to align with your individual practice needs. The DSN will contact you to arrange the initial visit.

Click here for Criteria for Diabetes – Community Services

Q How do I refer a patient into the Hub MDT Clinic?
Patients who you feel require MDT input should be referred to your practice DSN who will review them with you and arrange for them to be booked to the appropriate hub clinics. Once their problem has been reviewed they will be triaged via your practice DSN back into practice with a detailed care plan. The patient may still continue to be seen in parallel by the Dietitian, Podiatrist or Psychologist until a defined course of treatment has been completed.

Q How will care for patients currently being reviewed at Epsom, Kingston or East Surrey Hospital be transferred to the new Tier 3 community service?
When you have received the discharge letter from the T4 service please notify your DSN and give them the discharge letter – the DSN will triage the patient to the appropriate clinic. Notifying your DSN can be carried out via email or alternatively the Tier 4 to Tier 3 discharge letter can be handed to the DSN when they are visiting your practice.

Q: Will GPs need to involve themselves in the transfer of care from T4 to T3 across sites? Patients will be triaged by the DSN or MDT. GPs won't have to be involved in this process unless the patient has been triaged to general practice care (otherwise the DSN will manage, once the patient has been highlighted to the DSN by the practice).
Q How do I contact my Diabetes Nurse Specialist (DSN)?

Mobile: 07595091983

Email: khn-tr.ebbishamdiabetes@nhs.net

Q How do I contact a Consultant Diabetologist

0208 934 2745 – Consultant Secretary, Deirdre Rendall (direct dial)

Q How do I contact the Dietician, Podiatrist or Psychologist

Email: khn-tr.ebbishamdiabetes@nhs.net

Q How do I book Patient Education

Please use the form embedded here: and email to: khn-tr.admindiabetes@nhs.net

Click here for the Desmond Referral Form

Q What is the Hub Clinic MDT?

All of the professionals listed above will hold weekly clinics at the same time to support patients with more complex needs than can be met at the practice. The DSN will book patients from your practice into this clinic once they have seen the patients in your practice. Hub clinic details and service criteria are provided via the file links below:

Click here for Epsom Diabetes Service Leaflet

Click here for Criteria for Diabetes Community Services
Q How do Patients Contact the DSN or the Administration team?

Phone: 0208 934 3520

Email: knh-tr.ebbishamdiabetes@nhs.net

Q Where can I find Patient Information on Diabetes?

Your DSN will provide certain types of information, however, the Diabetes UK website is also an extremely helpful resource: www.diabetes.org.uk

Q What happens when a patient is discharged back to me from Tier 3?

Patients will leave the Tier 3 hub clinic service with an updated care plan. The plan will be provided to the patient as a hand held record and sent to you electronically.

Q What is the basic set of diabetes bloods that are required?

You will be provided with a chart (see link below) listing the correct bloods and any tests that are required over and above this minimum set will be communicated to you. Patients will need to have these undertaken by the practice prior to their appointment to ensure availability of results on the day of appointment.

Click here for Regular Diabetes Blood Testing Guidance

Q How do we know if our patient has been seen at the MDT and if any action is required by us e.g. a change in medication?

Click here for GP Communication within EMIS
The process for notifying a GP of a patient seen following the MDT for EMIS practices is:

If an Action is required by the GP:

1. Clinician sees patient and identifies an action is required by the GP
2. Clinician sends a task to Kingston Patient Pathway Co-Ordinator asking her to action the request
   a. If the task is marked urgent and it is not actioned within 2 hours it is escalated
   b. The task will sit in Task Management as a notification and is completely auditable
3. The pathway co-ordinator will communicate with the practice in accordance with their wishes
   a. If the request is that a Task is sent to the practice, the KH task will be closed and forwarded to the Practice
   b. If the Practice want an email, this will be sent and the task closed with notes on who the email was sent to.

If the GP is just to be notified of an encounter:

1. The pathway co-ordinator will review the whole MDT clinic list and send appropriate communications to the GP either via an EMIS task or email depending on their request.

Prescribing Guidance:

Click here for Insulin initiation guidance

Key Contacts:

DSN: 07595091983
Admin Hub: 0208 934 3520
Service Email: khn-tr.ebbishamdiabetes@nhs.net
Websites:

www.kingstonhospital.nhs.uk
www.diabetes.org.uk