Northumberland Clinical Commissioning Group

North Tyneside Clinical Commissioning Group

Northumbria Healthcare NHS Foundation Trust

OVERSIGHT & COMMUNICATION

Management overseen by Primary Care

Queries about a management plan should be directed to the patient's primary care team.

If the primary care team require secondary care support, this can be accessed by:

- Diabetes specialist nurse (DSN) call back service available on 01670 529 368
- Advice & Guidance service
- Next Steps Assessments with diabetes specialist dietitians: for a non-urgent decision about starting therapies
- DSN via switchboard at Northumbria Specialist Emergency Care Hospital: for urgent referrals for possible diagnosis of new type 1 diabetes or admission avoidance
- Diabetologist of the Day (Monday-Friday 9am-5pm, accessible through Northumbria switchboard) for urgent diagnostic queries (e.g. is this new Type 1 diabetes?)

Referral to specialty diabetes service

Discharge from specialty diabetes service

Management overseen by Secondary Care

Queries about a management plan should be directed to the patient's secondary care team.

Primary care support can be achieved through:

- Clinic letter or miscellaneous letter communication
- SystmOne "tasks" (for medication changes or management plan changes in patients at a SystmOne practice)
- Telephone call to GP surgery for urgent issues, such as urgent changes needed to prescribed medications

In the event of acute admission to Northumbria hospitals

Diabetes management is overseen by the admitting inpatient team, supported if necessary by diabetes specialist nurses +/- diabetologist of the day.

Changes to diabetes management plan must be:

- Communicated clearly with the patient (or relatives / carers if reduced capacity)
- Detailed in the discharge letter
- Copied to the team with ongoing ownership of diabetes care (the patient, SingleView letters and / or SystmOne record can be used to establish the care team with oversight of a patient's diabetes care)

When day-to-day administration of the diabetes management plan after discharge lies with the community nursing team or care/nursing home staff, then the discharge date and any changes to the management plan must be communicated prior to discharge to ensure a smooth and safe transition of diabetes care. It is the responsibility of the hospital discharging team to contact the community nursing team or care/nursing home, ideally 24 hours prior to discharge.

Where there has been significant input from the specialist diabetes team, there will be supplemental communication detailing the ongoing management plan from the diabetes specialist team to the community teams involved via 1) SystmOne tasks, 2) an entry on the discharge letter or 3) a letter, and when required a telephone call.

Patients should be signposted back to the care team with ownership of their diabetes care for ongoing management of their diabetes after discharge

Diabetes Specialist Nurse review after discharge

After discharge, some patients with complex needs will be reviewed in the DSN discharge clinic. Depending on need, this may be a face to face or phone appointment and will be arranged with the patient prior to discharge.

Once the DSN's acute involvement is complete, a clear hand back of care is made to the team responsible for ongoing diabetes care (be that in primary or secondary care).