

# Acute Diabetes Services

## BLANK TEMPLATE DOCUMENT

## SPECIMEN EXAMPLE

This template is based on the NHS 'Clinical guide for the management of acute diabetes during the coronavirus pandemic' ref 001559. The body of the document has been retained but space has been provided for you to populate to describe your local arrangements. In addition to the 'blank' template we have provided a specimen example which may be helpful. Clearly, arrangements will be different for different services and will depend on staff levels.

We hope you will find this useful in planning diabetes services in the light of the existing NHS guidance.

## Prepared by the National Diabetes Inpatient COVID Response Team

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Specialty guides for patient management during the coronavirus pandemic

Publications approval reference: 001559

## Clinical guide for the management of acute diabetes patients during the coronavirus pandemic

As doctors we all have general responsibilities in relation to CORONAVIRUS-19 and for these we should seek and act on national and local guidelines. We also have a specific responsibility to ensure that essential diabetes care continues with the minimum burden on the NHS. We must engage with those planning our local response. We may also need to work outside our specific areas of training and expertise, and the General Medical Council (GMC) has already indicated its support for this in the exceptional circumstances we may face: [www.gmc-uk.org/news/news-archive/how-we-will-continue-to-regulate-in-light-of-novelcoronavirus](http://www.gmc-uk.org/news/news-archive/how-we-will-continue-to-regulate-in-light-of-novelcoronavirus)

Diabetes may not seem to be in the frontline with coronavirus but we do have a key role to play and this must be planned. In response to pressures on the NHS, the elective component of our work may be curtailed. We should seek the best local solutions to continue the proper management of patients with diabetes while protecting resources for the response to coronavirus.

### Categories of diabetic patients to consider

- **Obligatory in-patients:** Continue to require admission and medical management, e.g. diabetic ketoacidosis (DKA). We must expedite treatment to avoid delay and expedite discharge to minimise length of stay.
- **Secondary care services:** Outpatient attendances should be kept to the safe minimum. Consider using virtual clinics and telephone updates.
- **Primary care delivered diabetes services:** Consideration of long term management.

When planning your local response, please consider the following:

## **Obligatory in-patients**

- A consultant must be designated as 'lead consultant; This duty can be for one day, a few days or even five days in small units. This is an essential role during crisis management. It cannot be performed by the consultant 'on-call'. They must be free of clinical duties as the role involves co-ordination of the whole service from ED through to liaison with other specialties and managers.

### **Local Trust Arrangements**

- 18% of hospital beds are occupied by someone with diabetes. People with diabetes are more likely to realise more severe manifestations of coronavirus infection, so this proportion is likely to increase beyond 18% over the next few weeks or months. Inpatient diabetes services will therefore need to continue (and potentially increase capacity) to:

1. support care of inpatients with diabetes and coronavirus

### **Local Trust Arrangements**

2. support other inpatients with diabetes to facilitate early discharge, maximising inpatient bed capacity

### **Local Trust Arrangements**

3. provide remote support if necessary for those discharged to prevent readmission.

### **Local Trust Arrangements**

## Secondary care services

- Secondary care services that may need to continue at full capacity:
  - multidisciplinary diabetic foot services

### Local Trust Arrangements

- pregnancy and diabetes services – although some contacts can be performed remotely

### Local Trust Arrangements

- Secondary care and community services where contacts can be performed remotely. Prior triaging of clinic lists will be required to assess which patients may still require face-to-face contact:
  - • routine type 1 diabetes clinics (secondary care or community based)
  - • routine type 2 diabetes clinics (secondary care or community based)

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## **Primary care delivered diabetes services**

Implications for management of diabetes should be considered within the context of broader long term condition management and prioritisation.

Consider the following factors:

- Diabetes services should look to maintain and optimise the health of individuals within their services over the course of the pandemic, and should not underestimate the importance of these contributions to the overall health service response.
- Some services should not be postponed/cancelled if at all possible, due to acuity and potential impacts, e.g. risk of amputation in the context of active diabetic foot disease.
- Some contacts can be performed remotely (telephone, email, video conferencing), although the reliance on biochemical parameters to inform clinical management decisions in diabetes means that associated need for, and access to, phlebotomy/blood testing must also be considered.
- Some patient contacts could be postponed, but there may not be sufficient capacity in the future to 'catch-up', so it should be acknowledged that postponement will equate to cancellation in a proportion of cases.
- Group-based face-to-face contacts should be avoided, and replaced with remote contacts, or if necessary, one-to-one face-to-face contacts.
- We should avoid unproductive attendances at hospital. Senior decision making at the first point of contact should reduce or even prevent the need for further attendances.

- Clinicians may need to work in unfamiliar environments or outside of their subspecialist areas. They will need to be supported.
- The possibility of a seven-day service may need to be considered.
- Imaging may be limited as it is the investigation of choice for coronavirus interstitial pneumonia.

These suggestions do not comprehensively cover all diabetes services that any particular provider may be delivering, but provide a framework for considerations and prioritisations.

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#### **Local Trust Arrangements**

- e.g. A weekly rota for the 'lead consultant' will be posted
- or Dr XX will be the 'lead consultant' for the duration working with a senior DSN (HJ) based in the diabetes centre. To be responsible for
  - Organisation of the service
  - Managing and supporting diabetes staff

Working with the senior DSN this team will be responsible for

- Seeing newly diagnosed type 1 and triaging urgent referrals
- Supporting the adolescent service
- Advising on urgent endocrine issues (consultant)
- Addressing GP, practice nurse and district nurse queries
- Identifying and video consulting all high risk patients to prevent them from falling ill i.e. the 15-30 age group, frequent flyers and type 1 patients who DNA'ed, patients with type 2 diabetes known to be at particular risk (consultant, senior DSN, and paediatric DSN)
- Contacting all type 1 patients on SGLT 2 to advise stopping and following up on subsequent control
- 'Trouble shooting' patients who are having difficulties with diabetes control and those vomiting with ketones

- Advising patients having problems with insulin pumps and other diabetes technologies
  - Holding virtual-meetings with the diabetes team to advise and iron out any problems
- 18% of hospital beds are occupied by someone with diabetes. People with diabetes are more likely to realise more severe manifestations of coronavirus infection, so this proportion is likely to increase beyond 18% over the next few weeks or months. Inpatient diabetes services will therefore need to continue (and potentially increase capacity) to:

#### 1. support care of inpatients with diabetes and coronavirus

##### **Local Trust Arrangements**

- 3.5 WTE Diabetes inpatient specialist nurses (LH, YM, SW, SS) to provide a weekday and partial weekend service to all wards except wards where there is a diabetes consultant
- 1 DSN (SC) to work in ED as general nurse but also available to review people with diabetes
- Referrals to be triaged using the electronic referral system
- Only urgent new referrals will be seen, these will require immediate review
- All patients on insulin pumps will be seen and managed in conjunction with advice from either the diabetes consultant or the lead pump nurse (band 7 in the diabetes centre)
- Out of range BG results will be identified from the ward's web-linked meter downloads and addressed by the diabetes inpatient nurses (DISN)
- DISNs will provide meter training and arrange bar code access for newly drafted in staff
- DISNs to provide basic diabetes training to all wards using CDEP 5 minute video on the safe use of insulin as well as face to face run through of the DICE chart. Guidance and support on managing glycaemia in COVID
- DISNs to review and follow up glycaemic control of complex patients
- DISNs to help with newly diagnosed

- Facilitate early but safe discharge – see below

2. support other inpatients with diabetes to facilitate early discharge, maximising inpatient bed capacity

#### **Local Trust Arrangements**

- DISNs to review discharge arrangements and identify those at risk of readmission for follow up in the community

3. provide remote support if necessary for those discharged to prevent readmission.

#### **Local Trust Arrangements**

- DISNs to inform Community DSN (LG) of the above patients who will then review their control in the community and liaise with district nurses/carers etc. supported by the consultant/lead nurse in the centre if there are issues with control

### **Secondary care services**

- Secondary care services that may need to continue at full capacity:

– **multidisciplinary diabetic foot services**

#### **Local Trust Arrangements**

All foot clinics will be podiatry led-

- Podiatrists- Ms VT supported by Mr LB
- Dr A and Dr B will share responsibility for consultant overview of the service and foot ward rounds (Tuesday am Friday pm). Formal MDTs ward rounds will be kept to the minimum with adhoc/virtual MDT decisions as a default
- Vascular consults as required

– **pregnancy and diabetes services (although some contacts can be performed remotely)**

## Local Trust Arrangements

Weekly Antenatal videoconference MDT-

Following attendance for the ultrasound scan, consultations will be remote using video consultation and access to CGM and meter downloads. Some patients may need face to face but this will be kept to a minimum

## Staffing

- Diabetes consultants (Dr A and Dr C alternate weeks)
  - DSN (BS)
  - Specialist midwife (FT)
  - Obstetrician (Miss JW)
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- Secondary care and community services where contacts can be performed remotely. Prior triaging of clinic lists will be required to assess which patients may still require face-to-face contact:
    - routine type 1 diabetes clinics (secondary care or community based)
      - Diabetes centre 'lead consultant' and band 7 DSN to triage and provide video consultation or face to face where necessary
    - routine type 2 diabetes clinics (secondary care or community based)
      - Community DSN (LG) to triage and provide video consultation or face to face where necessary

## Weekend services

**Inpatients-** as previously mentioned there will be a partial weekend service (1 DISN) - in addition BS will step in if one of the DISNs is unwell

**Admission avoidance and supporting rapid discharge-** 9am to 1.00 pm.  
HJ, BS, LG, supported by Dr X

## Remote workers/Isolating

MS, RA, KW- support the service by undertaking telephone consults for patient booked into consultant and nurse clinics

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