

To Diabetes Teams,

In these unprecedented times, it is vital we ***maintain patient safety while accelerating patient flow through the system, including preventing avoidable admissions and readmissions.***

As a result of the COVID-19 pandemic all clinical services will be working differently for the foreseeable future. This document is intended for those involved in delivering and redesigning diabetes services in the light of this pandemic. It recognises the importance of maintaining certain elements of the diabetes service which will be essential in reducing the burden on hospitals and supporting inpatient teams.

These elements will:

- 1) **Prevent** people with diabetes in the community falling ill from diabetes related complications (hypoglycaemia, diabetic keto acidosis (DKA), hyperosmolar hyperglycaemic state (HHS), foot infections)
- 2) **Support** people with diabetes out of hospital when they become unwell to prevent admission for diabetes related complications – e.g. early DKA, mild foot infection, potentially serious hyperglycaemia
- 3) **Support inpatient teams** (especially those on COVID wards) to safely manage people in hospital with acute diabetes complications, including those on ITU requiring very high insulin doses to manage their hyperglycaemia
- 4) **Provide education for inpatient teams** called to the front line who are unfamiliar with diabetes management
- 5) **Facilitate early discharge** to the community with programmed daily follow up where necessary to support patients and carers in managing their diabetes to prevent readmission

***Initial reports from the London area suggest a significant influx of people with diabetes, often with atypical presentations; including a significant number of people with type 2 diabetes presenting with DKA, HHS or a combination of both. The glycaemic management of many COVID-19 positive patients with diabetes is proving extremely complex; with huge fluctuations in glucose control and the need for very high doses of insulin. Intravenous infusion pumps, also required for inotropes, are at a premium and there may be the need to consider the use of s.c or i.m. insulin protocols. There are also issues regarding the rate of fluid replacement in those with ARDS.***

It is therefore vitally important that we maintain a skeleton service for 1, 2 and 5 to keep people with diabetes out of hospital, and a more significant service for diabetes care in hospital. This should if at all possible include a limited weekend service to support inpatient teams, and people with diabetes in the community to prevent admissions and readmissions.

We have attached an easy to use template based on the NHS 'Clinical guide for the management of acute diabetes patients during the coronavirus pandemic' ref 001559, which you may find useful when planning your service. Teams can also find a more detailed document outlining how to maintain patient flow and patient safety across the community, and particularly in inpatient areas, [here](#).

Finally, with regards to the clinical issues arising from London, we hope to produce guidance based on shared experience. We would welcome you to provide any such experience via ABCD's [Info@diab.care](mailto:Info@diab.care).

Kind regards,

The National Diabetes Inpatient COVID Response Team

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