Association of British Clinical Diabetologists

Society for Endocrinology

Delivering Diabetes and Endocrine Services in Acute NHS Trusts during Covid 19 Pandemic reset – May 2020.

Dr Peter H Winocour, Professor Stephanie Baldeweg, Dr Dinesh Nagi, on behalf of The Association of British Clinical Diabetologists (ABCD) and the Society for Endocrinology (SfE) and Joint Specialist Committee (JSC) for Diabetes and Endocrinology at RCP London

Diabetes mellitus

At 25% of Capacity (a)

Disease Condition	Comments
In-Patient (1) Emergency in-patient: acute metabolic emergencies (2) Urgent in- patient diabetes care – on other wards Outpatient (3) Urgent and acute diabetes foot disease (in-patient and outpatient) (4) Ante natal clinic diabetes care	Smaller units may struggle to provide these services at 25% of capacity

At 50 % of Capacity (b)

Disease Condition	Comments
(a) and in addition Outpatient (5) New referrals - urgent new Type 1 diabetes, insulin initiation, urgent technology support, some face to face	Triage and consult by clinician according to risk stratification and patient need

At 75% of Capacity (c)

Disease Condition	Comments
(a)+(b) and In addition (6) In- patient support for less urgent diabetes patients on other wards (7) Complex type 2 diabetes (poor metabolic control and/or complex comorbid indications-renal , retinal)	Telehealth support option Virtual Consultations Many will need face to face

At 90-100 % of Capacity

Disease Condition	Comments
(a)+(b)+(c) and in Addition (1) Full clinical services depending upon local arrangements (2) Diabetes follow up review by current case mix	The support for primary care will vary due to local

(3) Primary care support including full integrated care (4) Joint clinics (5) Teaching and Training (incl patient education)	arrangements and may have to be virtual

Endocrinology

At 25% of Capacity (a)

Disease Condition	**Comments**
1. Pituitary tumours with visual loss -suspected apoplexy, Cushing's/ Acromegaly/Non-functioning immediate post-surgical follow-up 2. Active Phaeochromocytoma, Cushing's, suspected endocrine cancers 3. Thyrotoxicosis (new or high dose treatment), Worsening Thyroid eye disease, Solitary thyroid nodules to exclude cancer 4. Thyroid cancer with a change in status or new symptoms that require face2face examination 5. Hypothyroid coma and thyrotoxic crisis 6. Hypercalcaemia, severe 7. Adrenal insufficiency and urgent need for corticosteroids 8. Severe hyponatraemia 9. Denosumab treatment	Patients will need urgent review virtually but may require face2face in some cases. Some cases managed in tertiary care Triaging by clinician essential

At 50 % of Capacity (b)

Disease Condition	**Comments**
1. **(a) and in addition** 2. Dynamic testing and treatments (Lanreotide, tests for Adrenal Insufficiency) 3. Severe osteoporosis- recurrent fractures 4. Antenatal endocrine care	All new referrals to allow triage, possibly by phone Triaging by clinician essential

At 75% of Capacity (c)

Disease Condition	**Comments**
(a)+(b) and in addition 1. Less urgent dynamic testing (steroid weaning etc) 2. Long term thyroid cancer f/up with stable disease 3. Stable Thyrotoxicosis on treatment **4.** Phaeo's (nonsurgically treated), benign incidental adenomas- cortisol secretors, adrenal insufficiency, unstable CAH 5. Hypogonadal men, secondary amenorrhea not on treatment 6. Testosterone and gonadotrophin injections 7. Osteoporosis severe without fractures	Triaging by clinician essential , all New Patients to have at least phone consult

At 90-100 % of Capacity

Disease Condition	**Comments**
(a)+(b)+(c) and in addition	

1. Full clinical services depending upon local arrangements 2. Chronic pituitary adenomas, stable hypopituitarism 3. Dynamic test eg. growth hormone, water deprivation test 4. All cold adrenal, thyroid, reproductive, late effects cases 5. Osteoporosis and Bisphosphonate treatment	

Other important comments

1. MDT support will be required at all levels of services
2. The assumption that outpatient and urgent capacity at present is working at 90% is incorrect. This currently may be no more than 50% in many units.
3. Many current teleconsultations are often suboptimal without imaging, blood tests, physical examination and patient privacy. This is acceptable for the crisis but not suitable for a post pandemic new service

Constraints:

1. Staffing issues: Consultants, Trainees (ST3-7) and Specialist nurses, Health care assistants in team – size of unit and proportion seconded to acute general medical care. Members of team shielded from acute med work offer more opportunity for tele consulting.
2. Specialist training is severely compromised and length of training may need extension if < 90% service delivery
3. Staff physical and mental health, may need additional support
4. Current backlog of referrals for new and reviews – triage must be by clinician and requires effective IT systems and additional service provision
5. Dependency -primarily access to biochemistry , radiology and histopathology as well as MDT members (surgery, ophthalmology…)
6. IT systems – fully integrated with primary care for direct feedback currently in limited number of services
7. Very limited coding in trusts of specialist activity (especially endocrinology, diabetes foot outcomes, etc)
8. Social distancing of cohort with chronic disease will reduce access to clinics and investigations – wider access to phlebotomy required

Specific omissions and considerations

Endocrine related cancer and specialised commissioned services are being separately addressed

Diabetes service configurations vary – flexibility if integrated with community and primary care models

Next Stage developments

Effective commissioning and planning of complex specialist care with multi- morbidity (eg cardiorenal metabolic or obesity related pathology) attending several clinicians to enable 1-stop care working closely with primary care