

Specialty guides for patient management during the coronavirus pandemic

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

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“...and there are no more surgeons, urologists, orthopaedists, we are only doctors who suddenly become part of a single team to face this tsunami that has overwhelmed us...”
Dr Daniele Macchine, Bergamo, Italy. 9 March 2020

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-novel-coronavirus

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 diabetic patients 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 and the role involves co-ordination of the whole service from ED through to liaison with other specialties and managers.
- It can be very stressful during a crisis. Support each other and share the workload. Do not expect the clinical director to do all the co-ordination!
- 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:
 - support care of inpatients with diabetes and coronavirus
 - support other inpatients with diabetes to facilitate early discharge, maximising inpatient bed capacity
 - provide remote support if necessary for those discharged to prevent readmission.

Secondary care services

- Secondary care services that may need to continue at full capacity:
 - multidisciplinary diabetic foot services
 - pregnancy and diabetes services – although some contacts can be performed remotely
- 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)

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 sub-specialist 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.