

A roadmap to recovery: Diabetes in the post Covid-19 Era

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Five general principles as laid out by the Academy of Royal Colleges

Principle 1 – Patients should be offered virtual or remote care where safe and possible

Principle 2 – Patients should be offered alternative management options which are temporary or permanent using shared decision making

Principle 3 – Patients should feel safe and protected when they need to access direct healthcare in all settings

Principle 4 – Staff should feel enabled, safe and protected to deliver care

Principle 5 – Staff should be supported and provided with training and education that will ensure adequate preparation of current and future staff

The path to recovery plan should start and focus on:

1. **Risk stratification and triage**
2. **Resource allocation**
3. **Transfer of care to specialist centres when required**
4. **Communication Prioritisation** of those most in need of clinical support
5. Maintaining **social distancing**
6. Ensuring ongoing access to **evidence-based interventions**
7. **Ensuring seamless communication and collaboration between primary and secondary care services**

RISK STRATIFICATION AND TRIAGE:

URGENT “Red”: These people with diabetes should be reviewed as soon as possible (within 3 months) by their team and require a detailed individualised care plan to address their risk factors and minimise their risk of admission. We estimate this may make up 10-20% of those in specialist services. These should include those with newly diagnosed, or possible type 1 diabetes.

- HbA1c > 86 mmol/mol
- Uncontrolled BP (> 160/100)
- Known CKD level 4 or more (eGFR < 30 ml/min)
- High risk of hypoglycaemia: severe hypoglycaemia in the last year or complete loss of hypoglycaemia awareness
- High risk of admission: Recent admission with DKA / HHS or a diabetes related comorbidity such as ischaemic heart disease, heart failure– or cerebro-vascular disease
- Active diabetes foot disease
- Planning pregnancy in the next 6 months

PRIORITY “Amber”: These people should be reviewed within the next 6 months by their team

- People with HbA1c between 64-86 mmol/mol
- Elevated hypoglycaemia risk such as those with impaired hypoglycaemia awareness or those with HbA1c < 48 mmol/l on insulin or sulphonylureas with known frailty.
- Those with known CKD stage 3B (eGFR < 45ml/min or current albuminuria) or rapidly declining e GFR (> 15 ml/year) or progressive albuminuria ACR >30
- Known “high-risk” feet not known to podiatry service

- Those with no diabetes review in the last 15 months

Where capacity allows, these further groups can also be considered in the priority "amber" group:

- BMI > 40 kg/m² (or BMI >35 kg/m² associated with co-morbidities)
- Those aged <40 years with known early onset complications (type 1 or type 2 diabetes)
- Those not meeting their 3 treatment targets (HbA1c, BP, lipids) at last visit

ROUTINE "Green": Given the challenges mentioned, it is possible that these patients may not be seen before 2021. Health care providers should contact these people explaining the situation and providing them with information and resources, with guidance on what to do if any of their parameters change. For example, if they become unwell, or their blood glucose readings are much higher or much lower than usual. They should be advised to monitor their glucose where appropriate (insulin treated patients) and monitor their weight and blood pressure where appropriate. Signpost individuals to educational resources commissioned by CCGs and the new NHSE educational websites¹⁰.

- HbA1c < 64 mmol/mol with no risk factors for hypoglycaemia
- Stable renal function (eGFR > 60 ml/min; no current microalbuminuria or proteinuria)
- People with T2D who were meeting all 3 treatment targets in the last 12 months (i.e. BP<140/80, total cholesterol <5mmol, HbA1c <58 mmol/mol, had low risk feet)

Special considerations: There are of course some people with diabetes who will fall outside these recommendations who may be considered high risk (people with learning difficulties, social difficulties, mental health issues, frailty, autonomic neuropathy), or those with cystic fibrosis related diabetes, post – transplant diabetes or who have other co-morbidities that put them at high risk. In particular, identifying people with frailty and de-escalating therapies when appropriate will be important. It is important to recognise that often those in the high-risk group with associated mental health, learning, social or personality conditions may be the least likely to engage with services in this time¹¹. There may be some patients in the high-risk group whom the team know well and who are "stable" in the high-risk group and where previous attempts to engage and support have been unsuccessful. Teams will need to make individual case-based decisions on where to prioritise their own resources in these circumstances.

Other special need groups are individuals who have been discharged from hospital after a Covid or non Covid related admission who may require monitoring and support due to unstable glucose levels or because they have been started on insulin, and those who need assessment and optimisation of their diabetes prior to elective surgery.