

Inpatient Diabetes Care during the COVID-19 Pandemic

August 2020

Snapshot Summary

Why have we produced this report?

We know that [inpatient care for people with diabetes can and must be improved](#).

We know that the COVID-19 pandemic has impacted the way care is delivered across the UK. We needed to understand how inpatient care for people with diabetes has been affected and to identify opportunities, areas of concerns, and recommendations for the future.

How did we develop this report?

We interviewed 28 health care professionals and hospital teams from across the UK to find out about their experiences

of delivering inpatient diabetes care during the first peak of the COVID-19 pandemic.

What did we find?

We found that disruption to inpatient diabetes services created positive environments and opportunities for new ways of working, but in the minority, impacted on the quality of care clinicians felt they were able to deliver. Regardless of location, the way hospitals re-organised and prioritised inpatient services frequently determined whether clinicians reported a positive or negative experience.

Services who were already delivering care in line with the recommendations in our [‘Making Hospitals Safe’](#) report, by employing strong clinical leadership and with access to better systems and technology, described more positive experiences and felt they were able to provide a high standard of care.

What do we already know about delivering safe inpatient diabetes care?

[Since 2018 we have called for every stay in hospital for someone with diabetes to be safe.](#) For people with diabetes to be safe in hospital we need:

- Multidisciplinary diabetes inpatient teams in all hospitals
- Strong clinical leadership from diabetes inpatient teams
- Knowledgeable healthcare professionals who understand diabetes
- Better support in hospitals for people to take ownership of their diabetes
- Better access to systems and technology
- More support to help hospitals learn from mistakes

What needs to happen now?

In England, the NHS is moving to Phase 3 of their response to COVID-19. Priorities for phase 3 stress the need to take account of the lessons learned during the first COVID-19 peak and lock in beneficial changes. This report identifies those beneficial changes made in diabetes inpatient care and a refreshed sense of momentum and opportunity; which hospitals and local health systems must carry forward.

We believe the following recommendations are key to ensuring safe and effective inpatient diabetes care across the UK in the months ahead.

NHSE Phase 3 Priority	Our Recommendation
Accelerating the return to near-normal levels of non-Covid health services, making full use of the capacity available in the 'window of opportunity' between now and winter.	Making use of available capacity for planned, elective or emergency surgery should not come at the cost of safe and equally accessible care. Our position statement on inpatient surgical care recommends that during the COVID-19 pandemic local health systems ensure surgical care pathways for people with diabetes are in place at all sites where surgery is carried out. These pathways must be appropriately resourced and created in collaboration with local diabetes inpatient teams.
Preparation for winter demand pressures, alongside continuing vigilance in the light of	To prepare for the immediate months ahead, hospitals and local health systems must urgently ensure that:

further probable Covid-19 spikes locally and possibly nationally.

- Hospitals and local health systems involve diabetes specialist teams in recovery phase and winter planning.
- The NHSE Long-Term Plan commitments to ensure universal coverage of Diabetes Inpatient Specialist Nurse teams are urgently actioned.
- Diabetes inpatient teams are deployed effectively to maximise their value and provide safe, effective care for people with diabetes.
- Technology such as web-linked glucometers, ketone meters, electronic patient records, inpatient diabetes dashboards, and video call equipment is available in all hospitals.
- Hospitals and local health systems must ensure appropriate support and protection for staff physical and mental wellbeing.

Expert Opinion

Diabetes UK have found considerable variation in the quality of inpatient diabetes care across the UK during the first peak of the COVID-19 pandemic. In some trusts care was felt to have been compromised; particularly when inpatient teams were disbanded and all diabetes staff including community DSNs were redeployed to provide generalist ward care. In other trusts, teams were able to deliver inpatient care in ways not previously possible, including weekend working, as the inpatient diabetes team was bolstered by diabetes staff released from their outpatient or community duties. This resulted in a greater presence of diabetes specialist at ward level which was valued by other teams.

The worry is that as people get back to their usual jobs, diabetes services will no longer be able provide the level of safe care which was possible. The necessary moves to stand up outpatient services must not result in reverting to the large variations in inpatient diabetes care previously reported by Diabetes UK and GIRFT. We hope that this will not be the case and the benefits of appropriately staffed inpatient diabetes services seen during the 'COVID-19 diabetes experience' will be recognised and acted upon by hospital managers.

Professor Gerry Rayman, MD, FRCP, MBE

Clinical Lead, Improving Inpatient Care Programme, DUK

What We Found

Common Experiences

The following themes were common amongst clinicians' experiences:

Use of Technology

Technology such as web-linked glucometers, electronic patient records and prescribing, online referral systems, video conferencing tools, and the creation of inpatient diabetes dashboards were all deemed vital to providing care during the pandemic. This use of technology enabled teams to rapidly and remotely identify and consult on people with diabetes; thereby increasing the number of people who could be reviewed and improving patient flow from admission through to discharge. Importantly, this technology also enabled staff who were unable to attend at the bedside to continue to provide an inpatient service.

Service Structure

During the pandemic most teams re-organised their inpatient services; with many describing these structural changes as the key to providing safe and effective care. Key changes to service structure included:

- 6 or 7 day working.
- Running a proactive service; actively seeking people with diabetes for review.

- A greater number of junior and/or senior doctors available for diabetes review and management.
- Re-defining roles within the diabetes team.
- Maintaining flexibility to respond to emerging areas of concern.

Crucially, many of these positive changes to service structure were only possible due to a cessation or change in providing diabetes outpatient services. This increased the availability of staff to deliver these new ways of working. Those teams who were already well-resourced relied less on redeployed staff.

“Outpatient care is important to help with admission avoidance. COVID-19 has highlighted the fact that diabetes outpatient care needs to be optimised as much as possible. In particular, in the recovery phase with the potential for a second surge.

It’s important for us to provide the best outpatient support to prevent admissions and severe cases of COVID-19.”

Whilst the majority reported positive changes to service structure, some described negative changes. These negative changes were rooted in the disbanding or redeployment of the diabetes inpatient team. Diabetes specialist clinicians who were re-deployed felt under-utilised in their temporary roles

and were concerned that safe and quality care for people with diabetes could no longer be provided in their absence.

Case Study: Trust A

Trust A's diabetes inpatient service operates across four sites and became a 7-day service just prior to the pandemic.

Despite some staff being redeployed or shielding, the team were able to continue providing a 7-day service. Acting to stop people being admitted unnecessarily was key and steps to do this included:

- Proactively calling those deemed at high risk of admission.
- Increased follow up after discharge.
- Triage in emergency department and ambulatory care.
- Providing helpline for primary care colleagues and people with diabetes.

Using technology such as networked blood glucose monitors meant the team could do remote reviews. They also shifted to more proactive, responsive and individualised care. The team had good visibility in the hospital, were seen as responsive, helpful and able to provide the support others needed.

Relationship with Others

Different ways of working during the pandemic strengthened existing relationships and fostered new ones within diabetes teams and others across the hospital. These relationships were characterised by better communication, appreciation, and trust.

“The service was very visible. There was a lot more collaboration and early discussions about how to do things in the safest way.”

Recognition and Importance

As a result of improved relationships, a perceived prioritisation from hospital management, and greater visibility of diabetes teams, clinicians described a new or enhanced recognition of the importance of inpatient diabetes teams. Clinicians felt non-specialists better valued their skills and expertise; which often coincided with an increase in referrals. Clinicians also spoke positively of working closer with previously hard-to-access areas of the hospital such as accident and emergency and intensive care units.

Case Study: Trust B

Despite a business case for increased DISNs previously being approved, a freeze was put on recruitment and so the diabetes team were unable to provide a 7-day service. Due to capacity, the team had to focus only on insulin users, and not all people with diabetes. Previous systems of identifying people with diabetes and then triaging them to the diabetes team were stopped.

The diabetes team felt taken out of the equation by hospital management and were not prioritised. This was felt on the wards as well, with colleagues not asking for help or seeking their specialist advice. The team were concerned about the quality of care provided to people with diabetes, but also that

this experience has set their importance as a specialty back and that in the recovery period they will be starting again from scratch.

Momentum and Opportunity

Finally, almost all those interviewed spoke of a refreshed momentum and new opportunities to improve diabetes inpatient care. Those who had positive experiences were concerned with losing momentum, and those who reported negative experiences were concerned that diabetes inpatient care would slip further down the agenda and limit future opportunities for improvement.

Towards the Future

Short Term Preparedness

With the potential for a protracted pandemic before us, clinicians identified the following priorities for diabetes inpatient care in the short term:

- Maintaining or reinstating multi-disciplinary diabetes inpatient teams.
- Evidencing the impact of enhanced services employed during the first peak of the pandemic.
- Maintaining technological advances or putting new systems in place where they have previously been unable to.
- Putting in place better processes to tackle key challenges such as discharge and patient education.

- Prioritising the wellbeing of health care professionals to ensure there is time for rest and recovery.

“A lot of staff have been working beyond their means and exhausting themselves. I’m worried that we will have no time to repair and recover before either second wave or influx of postponed patients”

Immediate Recovery Phase

Priorities for the medium-term recovery phase included:

- Ensuring a holistic approach to care in hospitals. Including prioritising self-management and making use of opportunities to review a person’s diabetes management when in hospital.
“Patients have had more specialist input earlier in their journey. Educate, support, empower so that people don’t need to stay in hospital for any longer than they have to”
- Re-starting staff education; including mandatory insulin safety education and ward-based sessions.
- Re-commencing paused quality improvement projects and business cases.
- Reviewing inpatient team roles and skills.

One trust felt the pandemic meant there was less distinction between professions which encouraged everyone learning from each other. This has led to them developing a set of cross-profession core competencies for inpatient diabetes care.

A New Normal for Inpatient Care

Despite the challenges of providing care during the COVID-19 pandemic, those interviewed described a revelatory opportunity to deliver inpatient services in ways they had always wanted to. They stressed that the new normal for inpatient care should therefore not involve a move back to old ways of working. Clinicians described their hopes for a new normal in inpatient diabetes care consisting of:

- A continued prioritisation and recognition of diabetes inpatient care as an integral, governance and safety-led component of hospital care.

“We get involved with everything - the systems work so well. Inpatient diabetes is now suddenly more important and things run much smoother if they keep us involved.”

- Continued or enhanced resourcing to ensure appropriate workforce depth, technology, and scope for quality improvement analysis and activity.

- Support to capitalise on the momentum for positive change to the way diabetes inpatient care has been delivered, and to bring attention to the impact of negative experiences.

Final Thoughts

Acknowledgements

We acknowledge that inpatient diabetes services are a vital part of the larger journey of diabetes care. Each part of the journey requires planning and resourcing for the path ahead and moves to enhance inpatient care should not be at the cost of other services.

Our Commitments

Diabetes UK will continue to support people with diabetes and clinicians throughout and beyond the COVID-19 pandemic.

We would like to thank all the clinicians involved in this project. The richness of their experiences transcends the limits of this top-line review, and we look forward to building on this in the future.



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