GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Diabetes Clinical Network

Supporting the restoration of diabetes services in primary care

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Supporting the restoration of diabetes services in primary care

1. Introduction

COVID-19 has inevitably interfered with the annual checks that are an integral part of the care of patients with diabetes. This disruption can lead to poorer control of HbA1c and a higher rate of complications. It is vital that we fully restore services for those most at risk. We need also to recognise the pressure on primary care by providing guidance about the patients for whom face-to-face contact can be postponed at minimal risk. This paper has been compiled by the Strategy Review Group (SRG) of the Greater Manchester (GM) Diabetes Clinical Network. It outlines some guiding principles with appendices giving national guidance on how, based on historical clinical information augmented by remote consultation, clinicians can decide who needs to be seen face-to-face. The SRG comprises primary and secondary care diabetes specialist clinicians, commissioners and Diabetes UK (Appendix A).

2. The impact of COVid-19

The National Diabetes Audit[1] (NDA) quarterly report for England (provisional by CCG) released in June 2020 reports 180,130 people living with Diabetes in GM (11,795 living with Type 1 and 168,335 living with Type 2). We know that diabetes on its own represents a significant additional risk factor for people contracting COVID-19 but a significant number of these people are also likely to be living with additional long-term conditions, not just diabetes. This makes it all the more important to identify those at highest risk during the COVID-19 pandemic. We know that:

- Evidence shows that diabetes is a significant risk factor, for worse outcomes including deaths. in people who contract COVID-19 infection[2][3][4].
- Uptake of the National Diabetes Prevention Programme – Healthier You (NDPP) in GM has been well below projections in GM and other areas during the COVID-19 pandemic.

It is also now being reported that:

- Compared to historical expected rates, significantly lower rates of diagnoses for type 2 diabetes are being recorded nationally during the COVID-19 pandemic.
- Less HbA1c testing is taking place in primary care during the pandemic.
- Hospital admissions in GM for acutely elevated glucose levels in people living with diabetes are being reported in increasing numbers.

Attendance rates dropping at primary care means there is a risk of hospital admissions increasing. This in turn can lead to worsening patient outcomes in diabetes and other long-term conditions and increased incidence of complications. We do not yet know if there will be additional impact of 'long covid' on people living with diabetes. There is guidance and advice available to support primary care which the SRG have reviewed, including:

[1] https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/national-diabetes-audit
[2] https://www.england.nhs.uk/publication/type-1-and-type-2-diabetes-and-covid-19-related-mortality-in-england/
[3] https://www.thelancet.com/journals/landia/article/PIIS2213-8587(20)30238-2/fulltext
[4] https://www.thelancet.com/journals/landia/article/PIIS2213-8587(20)30272-2/fulltext

- Clinical guidance and proposed recovery models available through the national diabetes clinical network and programme team.
- Guidance on risk stratification and remote diabetes consultations.
- Proposed diabetes care models in the new Primary Care Network (PCN) structure.

Some opportunities for improving patient care have also arisen during the pandemic from changed ways of working and accelerated/streamlined service improvements, particularly in the digital sphere (digital education, patient access to clinical data, cognitive support, nutrition/lifestyle support).

Notwithstanding the opportunities noted, the above adverse impacts of the COVID-19 pandemic present the risk of poorer patient outcomes and increased strain on primary and secondary healthcare services in GM.

3. Supporting restoration of services

Against the above backdrop, the GM Diabetes Clinical Network SRG has concluded that it is vital to act now to provide practical advice and guidance to primary care and support to people living with diabetes in order to capture the benefits of new ways of working and limit problems arising, escalation in the number of people affected and increased demand on GP practices and hospitals. The Clinical Network's immediate objectives are:

Objective 1: *Support implementation of prioritised clinical reviews based on patient clinical information and augmented by remote consultation to help ensure high risk patients are reviewed as early as possible.*

It is proposed that the Primary Care Diabetes Society (PCDS) advice on *How to Prioritise Primary Care Diabetes Services During and Post COVid-19 Pandemic* and *How to Undertake A Remote Diabetes Review* (which also contains advice on face-to-face follow-up) should be combined with some brief explanatory notes and promoted as a basis for primary care to prioritise patients, implement checks and follow-up, where required, with face-to-face care (Appendix B).

Objective 2: *Ensure as many patients as possible and people at risk of diabetes are supported to self-manage and avoid unnecessary admissions to hospital or the development of longer term complications.*

It is proposed that, wherever possible, patient communications and information should include information on:

- The importance of continuing to take prescribed medication.
- Home blood pressure testing and weight measurement where possible.
- How to access the NDPP (including self-referral through the DUK 'Know Your Risk'[5] portal.
- Use of the self-management support available through Diabetes My Way[6] and accredited digital educational resources[7] available to GM residents.
- Accessing remote and digital structured education where available.

[5] https://riskscore.diabetes.org.uk/start
[6] https://diabetesmyway.nhs.uk/
[7] https://diabetesmyway.nhs.uk/elearning/

- Following GP advice received and contacting the practice in the event of any problem(s).

4. Recommendation

The ***Primary Care Cell*** and the ***Community Co-ordination Cell*** are asked to endorse the guidance at Appendix B as good practice to support the restoration of services and make it available (directly or through the GM Diabetes Clinical Network) to primary care in Greater Manchester.

Appendices

A GM Diabetes Clinical Network Strategy Review Group membership
B Guidance for restoring primary care diabetes services

Additional Information

Further information on this document and resources are available through the GM Diabetes Clinical Network with details available from:

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GM Diabetes Clinical Network

Supporting Primary Care to Restore Diabetes Services

APPENDIX A

GM Diabetes Clinical Network – Strategy Review Group membership

Name	Designation	Organisation
Naresh Kanumill	Clinical Lead for Diabetes	GMEC SCN
Mark Owen	Diabetes Commissioning Lead	NHS Tameside & Glossop CCG
Alison Marsh	Directorate Manager Specialist Medicine	Tameside & Glossop Integrated Care NHS FT
Rachel Stott	Diabetic Specialist Nurse	Tameside & Glossop Integrated Care NHS FT
Steve Ball	Consultant Endocrinologist	Manchester University NHS Foundation Trust
Ingrid Small	Clinical Lead Dietitian	Greater Manchester Mental Health FT
Martin Rutter	Consultant Diabetologist	Manchester University NHS Foundation Trust
Yvonne Browne	Influencing Manager	Diabetes UK
Nicola Milne	Community Diabetes Specialist Nurse	Manchester Diabetes Centre
Nicole Alkemade	Diabetes Commissioning Lead	NHS Stockport CCG
Robert Green	Commissioning Manager	NHS Stockport CCG
Brooks Kenny	Head of Scheduled Care	NHS Trafford CCG
Clive Marchi	Clinical Lead	NHS Trafford CCG
Finn McCaul	Clinical Lead for Long Term Conditions	Bury CCG
Sam Howard	Diabetes Clinical Lead	Wigan CCG
Angela Paisley	Consultant	SRFT
Gemma Allen	Lead Diabetes Nurse	SRFT
Paul Keeling	Service Improvement Manager	Salford CCG
Jen Hopes	Commissioning Manager	HMR CCG
Sonal Sharma	GP	HMR CCG
Peter Elton	Clinical Director	GMEC SCN
Jenny Schofield	Project Support Officer	GMEC SCN
Krista Williams	Senior Quality Improvement Manager	GMEC SCN
Fatamah Shah	Senior Data Analyst	GMEC SCN
Ewan Jones	Programme Manager	GMEC SCN
Kamran Beg	Diabetes Lead	Health Innovation Manchester
Katie Merrick	Project Manager Food and Healthy Weight – Population Health	GMHSCP
Vannamalar Selvaraasan	GP	Salford
Nigel Burgess	Optometrist	Optometry Provider Board

GM Diabetes Clinical Network

Supporting Primary Care to Restore Diabetes Services

APPENDIX B

1. Prioritising primary care diabetes services, conducting remote reviews and managing face-to-face follow-up
2. Guidance for restoring primary diabetes services during and following the COVid-19 Pandemic

CONTENTS

The guidance offered in the following pages is reproduced with the kind permission of the authors and the Primary Care Diabetes Society.

How to prioritise primary care diabetes services during and post COVID-19 pandemic

by Pam Brown and Jane Diggle

Context

The COVID-19 pandemic forced practices (and community teams) to focus on delivering acute care, often at the expense of chronic disease management, including diabetes reviews. As the acute phase of the pandemic recedes, teams now face significant backlogs of diabetes reviews. It is likely to take at least 6–12 months for services to catch up. During this time, it is important that we prioritise care delivery to those who need more urgent reviews.

When identifying groups from our diabetes registers for early review, guidelines propose that we prioritise those most at risk of serious consequences from COVID-19, from CVD and from other diabetes complications. Fortunately, there is much overlap between these groups. Although some of the risk factors, such as age, are non-modifiable, we will want to prioritise review to optimise their modifiable risk factors, such as HbA_{1c}. Phase 3 of NHSE's response to COVID-19 also encourages focus on improving health and wider inequalities (see **Box D**, overleaf).

Here, we outline ways to identify these highest risk groups for COVID-19 and CVD, clarify the type of review and consultation required by individual people, and help teams assess their capacity for managing this catch-up workload.

By adapting these processes to our individual practice, cluster or CCG setting, it is hoped that those people who would benefit from more urgent reviews receive them in as timely a manner as possible.

Practices may want to incorporate a specific SNOMED COVID-19 restriction code or a statement that makes it clear that we have made prioritisation decisions based on review of individual patient circumstances in a restricted environment and with a backlog of reviews due to the effects of COVID-19. These prioritisation decisions are flexible and can be reviewed and revised, if required.

A COVID-19 risk score, similar to the QRISK score for CVD, is in late-stage development and this toolkit will help us to prioritise those on our diabetes registers who are most at risk from COVID-19.

Box A. Time frames for review[1]

Data from the National Diabetes Audit 2018/19 show the proportions of people with type 1 or type 2 diabetes in England with HbA_{1c} above different thresholds. However, many practices are finding many people's HbA_{1c} has risen significantly during lockdown, so numbers are likely to be higher.

HbA_{1c} threshold (mmol/mol)	Type 1 diabetes above threshold (%)	Type 2 diabetes above threshold (%)
97	7.9	3.4
86	15.5	6.6
75	29.5	12.3

Based on these data, the following time frame for review for each category has been proposed:

Category	Priority	Ideal time frame to be seen within	Likely % of total diabetes register
RED	Urgent	3 months	10
AMBER	Priority	6 months	30–35
GREEN	Routine	12 months	55–60

Box B. Risk factors for serious COVID-19 disease

Modifiable risk factors[3]

- Higher blood glucose levels (HbA_{1c} ≥86 vs 48–53 mmol/mol: mortality doubles in type 1 diabetes and increases ×1.6 in type 2 diabetes).
- Diabetes comorbidities and complications.
- Obesity (BMI ≥40 vs 25–29.9: mortality doubles in type 1 diabetes and ×1.46 in type 2 diabetes).
- Pre-existing kidney disease, heart failure and previous stroke.
- Absence of recorded care processes for smoking status, BMI or HbA_{1c} are associated with increased mortality.

Non-modifiable risk factors

- Advancing age (strongest mortality risk factor).
- Gender (greater risk in male versus female).
- People of black or Asian ethnicity.
- Deprivation.

Search strategy

No particular search strategy is superior to another and searches will vary according to administrative expertise, support and capacity within organisations. Primary Care Networks, federations and CCGs may be able to offer support by sharing tailored searches.

Higher HbA_{1c} increases risk of worse outcomes and mortality from COVID-19 and the risk of diabetes-related complications. Therefore, initial prioritisation by HbA_{1c} may be a good place to start.

RED, **AMBER** and **GREEN** categories based on risk factors correlate with need for urgent, priority or routine reviews (see **Box A**, left).

Absent data/overdue review:
No HbA_{1c} >18 months ▶**AMBER**
No HbA_{1c} >24 months ▶**RED**

Box C. People who might benefit from early review or opportunistic identification:

- Recent admission for any cause (particularly diabetes-related)
- Acute illness (incl. COVID-19)
- New blood results received
- New complication (e.g. foot problem, hypoglycaemia)
- New CVD/CKD diagnosis
- New therapy commenced.

REVIEW RECORDS to decide ▶RED or ▶AMBER category.

Initial search: last recorded HbA_{1c}

RED	AMBER I	AMBER II	GREEN
HbA_{1c} >86 mmol/mol	HbA_{1c} 65–86 mmol/mol	HbA_{1c} 59–64 mmol/mol	HbA_{1c} ≤58 mmol/mol

ADDITIONAL SEARCHES on amber/green groups to identify risk factors that may alter risk category and prioritisation (based on Risk factors [see Box B])[2]

Blood pressure:	≥160/100 mmHg ▶**RED**	141/81–159/99 mmHg ▶**AMBER**
Diabetes complication:	Retinopathy/high-risk foot ▶**RED**	
CKD:	eGFR <45 mL/min/1.73 m² ▶**RED**	eGFR 45–60 mL/min/1.73 m² ▶**AMBER**
CVD/HF/ stroke:	Assess CV risk factors to decide if ▶**RED** or ▶**AMBER** category. For example, may need additional therapy: ▶**RED** Not on statin but established CVD (excl. haemorrhagic stroke) ▶**AMBER** Not on statin despite ≥40 years and QRisk ≥10%	
BMI:	≥40 kg/m² ▶**RED**	≥30 kg/m² ▶**AMBER**

Those without any of the risk factors above that would place them in the red or amber group will remain in the GREEN category.
Short telephone call to:

- agree deferred review
- check no new diabetes-related concerns
- offer reassurance
- discuss safety-netting advice.

Although the key searches outlined above stratify by specific risk factors, clinical judgement will identify additional at-risk groups where early review is appropriate, including:

- vulnerable individuals
- those with significant mental health problems
- those with learning disabilities
- frail elderly, particularly if cognitive impairment
- those from BAME groups
- those with eating disorders.

Some of these can be identified via additional searches.

Abbreviations: BAME=black, Asian and minority ethnic; BMI=body mass index; BP=blood pressure; CKD=chronic kidney disease; CVD=cardiovascular disease; EASD=European Association for the Study of Diabetes; F2F=face-to-face; GP=general practitioner; HCA=healthcare assistant; HCP=healthcare professional; NHSE=NHS England; PPE=personal protective equipment; PTSD=post-traumatic stress disorder

Citation: Brown P, Diggle J (2020) How to prioritise primary care diabetes services during and post COVID-19 pandemic. *Diabetes & Primary Care* **22**: 97–8

What action is required?

NUMBERS

Having completed searches that stratify individuals according to risk and category (**RED**/**AMBER**/**GREEN**), consider:

- How many individuals have been identified within each category? Be aware you might have a large proportion in your **RED** or **AMBER** groups requiring Urgent or Priority review. Plan how you can work through them methodically within current constraints.

NEEDS

- Experienced clinician to review electronic records (**RED** category, then **AMBER**) to identify **NEEDS**:
  - Type of consultation – data gathering (remote or F2F), full annual review or targeted partial review.
  - Time slot needed.
  - Type of practitioner (HCA, experienced clinician).
  - Remote or F2F consultation.

  These details should be shared with administrative staff responsible for booking appointment slots.

  Depending on restrictions in place and delay in undertaking reviews in the **GREEN** category, these people will all need data gathering and full annual review (see How to undertake a remote diabetes review).

PLANNING

- Review ongoing challenges – impact of social distancing on throughput of patients and staffing/workforce concerns, whether lockdown has been lifted or is ongoing.
- To determine capacity, consider:
  - Number of clinics per week (nurse, HCA, GP, pharmacist).
  - Number of people who can be reviewed in each remote clinic.
  - Estimated capacity in next 3 months.
  - Estimated capacity in next 6 months.
  - Remember to factor in staff holidays and competing priorities, such as flu immunisation clinics, and to seek guidance from local laboratories on their capacity, which may restrict phlebotomy services.
- Practices may want to use an objective risk stratification tool (e.g. bit.ly/2ZXVqZ5) to facilitate COVID-19 risk assessment of team members not already identified as "vulnerable" and requiring to shield.
- Estimate your capacity for the different types of appointments and match this with priority appointments required (e.g. if only HCA doing data-gathering visits and has 3 diabetes clinics per week, each accommodating 8 people*, 24 slots will be available for F2F data gathering per week. Be realistic about what can be achieved safely and within the fluctuating restrictions faced.

  Once capacity has been calculated for each member of the team, review to ensure that there is no bottleneck in the system (e.g. full annual reviews being limited by number of data-gathering appointments available). Explore how to optimise use of each team member and each appointment type.

  *Amend this in relation to waiting-room capacity, social distancing and PPE use.
- Practices should work through **RED** to **AMBER** to **GREEN** categories without delay, as capacity allows. In addition, time will be needed to deal with opportunistic additions to the **RED**/**AMBER** categories (see **Box C**, overleaf).

Consider psychological risks[4]

When assessing suitability for delayed review, consider psychological as well as physical risks – people may need referral for additional support now or move from green to amber group for earlier review. Know your local referral pathways and current ways of working. Remember your own psychological health due to workload and infection concerns (see **Useful resources**).

- Direct psychological risks – anxiety, bereavement, trauma, PTSD (if serious COVID-19 admission), eating disorders.
- Indirect psychological risks – financial or employment problems, lack of activity, disrupted diabetes education and support.

Useful resources

- Looking after your mental health during COVID-19: Six tips for healthcare professionals. A quick reference guide from ***Diabetes & Primary Care***: bit.ly/2QcyrnA
- **Mind**, the UK charity for better mental health, provides advice and support to empower anyone experiencing a mental health problem: www.mind.org.uk
- **Diabetes UK**, professional resources on diabetes and psychological care: bit.ly/34gvJ8R

Practicalities

Use PPE as recommended for any F2F consultations and keep appointments as short as possible. Explain these are for data gathering only and that full remote consultation will follow once results are available. See How to undertake a remote diabetes review and Factsheet of patient resources for additional information and guidance.

- Avoid busy waiting rooms and risk of transmission.
- Ensure people know to reschedule if they have any symptoms of COVID-19, are feeling unwell or isolating after known contact tracing.
- Use COVID-19-free spaces for diabetes-related reviews.
- Encourage patient attendance by explaining what is being done to protect people.
- Agree how to document and manage those who choose not to attend but need data gathering.
- Provide careful safety-netting and resource links to those in the routine group, especially around foot inspection/care.
- Use home BP measurements where possible.
- Use Diabetes UK Touch the Toes Test to minimise risk of cross infection, instead of monofilament testing (bit.ly/2BS9LwJ).

Pitfalls to avoid

- Telephone triage to **GREEN**/routine review group by inexperienced clinician who may have difficulty identifying risk scenarios.
- Booking people with team member who does not have the skill set to carry out the required review.
- Duplication of effort/patient discussions.
- Timing issues – booking too short or long appointments for the consultation needed.
- Lack of clarity about whether F2F or remote consultation when notifying people of appointments.

Box D. Address inequalities[5]

- Protect the most vulnerable.
- Restore services inclusively, identifying those in greatest need and disadvantaged people (in particular, consider deprivation and ethnicity).
- Develop digitally enabled care pathways that increase inclusion.
- Accelerate prevention programmes, engaging those most at risk of poor outcomes.
- Particularly support those with mental ill health.
- Strengthen leadership and accountability, address inequalities, increase diversity.
- Ensure datasets are complete and timely to respond to inequalities.
- Collaborate locally in planning and delivering action to address health inequalities.

References

[1]East of England Diabetes Clinical Network (2020) *Delivering Diabetes Care during the COVID-19 Pandemic – the 'new normal'*. bit.ly/32uMKcZ

[2]ABCD (2020) *A Quick Guidance to Risk Stratification and Recovery of Diabetes Services in the post-Covid-19 Era*. bit.ly/2ECYvX7

[3]Holman N et al (2020) Risk factors for COVID-19-related mortality in people with type 1 and type 2 diabetes in England: a population-based cohort study. *Lancet Diabetes Endocrinol* **8**: 823–33

[4]Stewart R (2020) How do we recover from COVID-19? Helping diabetes teams foresee and prepare for the psychological harms. *Diabet Med* 6 Jul [Epub ahead of print]

[5]NHSE (2020) *Implementing phase 3 of the NHS response to the COVID-19 pandemic*. bit.ly/3m0DYwt

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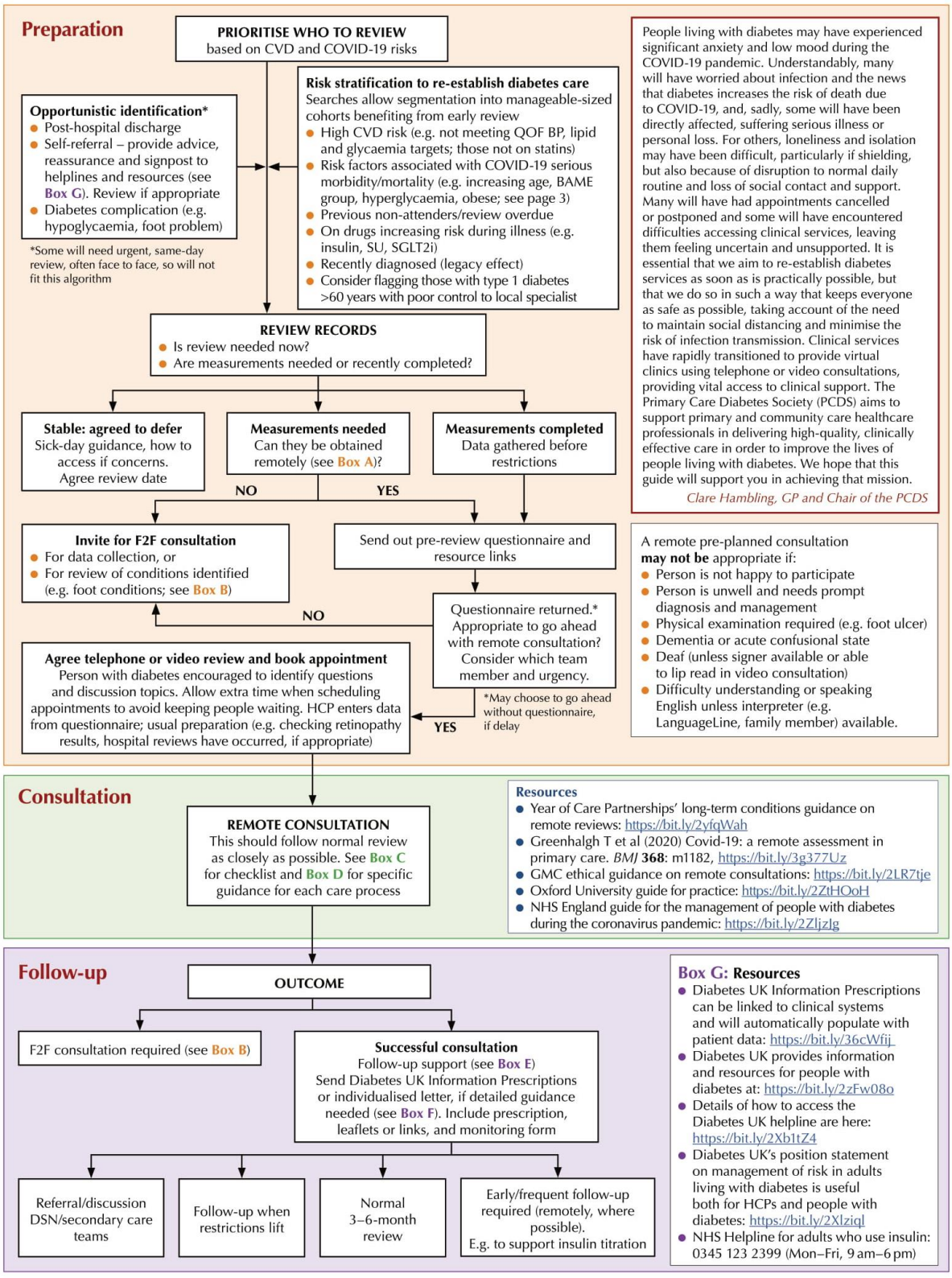
How to undertake a remote diabetes review – a PCDS quick guide

by Jane Diggle and Pam Brown



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Box A

Self-completed questionnaires allow us to gather valuable information prior to a face-to-face review and may be even more useful for remote consultations. Not everyone will be willing to complete one.

Pre-review care plans are embedded within some GP systems, populate with recent results, and can be sent to the person in advance of their review to share results and allow them to identify aspects of their diabetes they would like to discuss.

The Year of Care Partnerships' long-term conditions pre-review questionnaire and other resources, updated to include COVID-19-related topics, are available at: https://bit.ly/3bHNiPr

Data gathering

Consider whether the test or examination is needed:

- Are the results likely to change management? (If not, postpone.)
- Can the data be gathered by the person with diabetes?

If data can be gathered by the person at home, these can be included in the pre-review questionnaire, which can then be returned and reviewed to decide if a remote consultation is appropriate.

Links to online resources to help people with diabetes gather data and perform self-examinations at home include:

Home blood pressure monitoring (HBPM)

- HBPM explained: https://bit.ly/3g1xnPa
- HBPM diary: https://bit.ly/2XexWMS

Self-monitoring of blood glucose (SMBG)

For those with a clinical need, ensure test strips and lancets are available. If guidance needed on how to use monitor, provide link to online guidance, or talk through by telephone or video.

- SMBG diary: https://bit.ly/2ZjeyAX
- Video instructions on how to perform a finger-prick blood glucose test: https://youtu.be/eOsY84oYqKg

Measuring weight and waist circumference

Encourage people to weigh themselves. If waist circumference is appropriate, provide guidance on how to measure: https://bit.ly/2X7Ij5m

Remote foot assessment

Ask the person to document symptoms related to the feet and legs, visually check all parts of their feet themselves (using a mirror or with help from a household member), including identifying dry or cracked skin, changes in colour, ulcers, rashes or blisters. If changes or concerns are identified, try to arrange photos to be shared prior to the consultation.

The Diabetes UK "Touch the Toes" test uses the validated Ipswich Touch Test. Guidance and leaflet can be downloaded: https://bit.ly/36iRCDx

Box B

Face-to-face consultation may be required:

- To capture data (e.g. blood glucose or BP monitoring) or review foot problems.
- If unsuitable for remote consultation, but require review during COVID-19 restrictions.
- Following a remote consultation, if concerns are identified and cannot be resolved remotely.

Visits to the practice/clinic or home visits should only be arranged if urgent and likely to change management. Conduct a risk–benefit analysis for every face-to-face encounter. Practices that undertake Year of Care reviews requiring two consultations may choose to alter their care delivery during the pandemic (e.g. face-to-face data-gathering visit; then share results, and remote consultation to discuss results and plan care).

Decide in advance what needs to be achieved (measurements, phlebotomy) and keep face-to-face consultation time as short as possible. Reassure that remote consultation will provide opportunity for questions and discussion.

Use appropriate level of PPE depending on current recommendations. The patient should usually be asked to wear a mask.

PPE guidance: https://bit.ly/2yensES

Box C

Remote review checklist

You may wish to consult the free links (see **Resources**, p. 1) to upskill in remote consultations and learn more about what colleagues are doing during COVID-19 restrictions. As guidance is changing rapidly, check you are viewing the most up-to-date version. Ensure you have contact details for the person.

Template for undertaking remote consultation:

- ❑ Work through normal diabetes review template.
- ❑ Document as a remote consultation during COVID restrictions. There are various new SNOMED codes including Code 1321171000000106: *Provision of advice, assessment or treatment limited due to COVID-19 pandemic* – indicates that preferred best practice may not have been possible due to resource restrictions or COVID-19 circumstances.
- ❑ When documenting data, ensure it is clear who undertook the measurement.
- ❑ Discuss care processes: glycaemia, BP, lipids, kidneys, feet and retinopathy (see **Box D** for information and tips). Is pre-conception advice needed?
- ❑ Discuss smoking, alcohol, mental health and lifestyle changes that may be helpful.
- ❑ Discuss potential changes to drug therapy.
- ❑ Medication review using preferred method, code review and reauthorise until next review due.
- ❑ Discussion of hypoglycaemia and its management, if appropriate, and individualised sick-day guidance.
- ❑ Agree follow-up, including face-to-face review – if electronic diary used for recalls, ensure follow-up dates entered.
- ❑ Explain follow-up materials and how these will be provided, interim support available and safety net, including how/who to contact if concerns.
- ❑ Check email address and whether can receive, open and print attachments, or if prefers letter by post. Check if internet access and agree whether to send leaflets or links.

Box D

For each care process:

- Document self-monitoring data and face-to-face measurements, if available.
- Share previous readings and compare.
- Discuss possible management changes and whether to implement now or after COVID-19 restrictions lifted.

Weight and waist circumference

- If weight/waist circumference increased, discuss diet and physical activity.
- If significant weight loss, explore if intentional or how achieved.

BP

- Ask about headaches, blackouts, dizziness, faints, possible medication problems if on BP medication.
- If HBPM, discuss results, recommended changes to medication and follow-up required.
- Bring HBPM to next face-to-face review to validate accuracy, if not done previously.

Lipids

- Review most recent blood lipids.
- Assess cardiovascular risk. Is person already on a statin (if so, check tolerability and adherence; if not, explore reasons)?

Glycaemia

- Ask about hypoglycaemia if using insulin or SUs.
- Ask about osmotic symptoms including thirst, feeling tired, nocturia, polyuria.
- If recent HbA_{1c} or SMBG results available, discuss in relation to previously agreed glycaemic targets and COVID-19 risks.
- Discuss medication changes and whether they are happy to make changes at this time.
- If initiating GLP-1 RA, demonstrate device if using video consultation and/or refer to device-specific YouTube videos.
- If using insulin, check if any concerns regarding injection sites, discuss good injection technique. Provide link to Injection Technique Matters' YouTube patient videos: https://bit.ly/2zLeShj

Kidneys

- Share monitoring results, if available.
- Discuss medication changes such as dose reductions, initiating new medication such as ACE inhibitor (ideally after restrictions lift so that BP monitoring and renal function testing can occur).
- Agree follow-up monitoring recommended (e.g. time to next blood test or ACR measurement).

Eyes

- Ask about change in vision or eye problems.
- Share retinopathy screening results and any action required (e.g. referral to ophthalmologist, tighter control).
- If defaulted screening, remind of importance and encourage to attend.
- Request further appointment, if required (e.g. DNA and next appointment 1–2 years or apparently lost to follow-up).

Feet

- Ask about any change of foot colour or shape, burning, pain or itching, skin lesions (e.g. blisters, cuts, damage).
- Ask about Touch the Toes test, if able to do this; compare with previous foot examination.
- Reiterate importance of daily foot examination; discuss ways and times to do this (e.g. after shower, while dressing, with help from partner, with mirror on floor).
- Remind to report any changes.

Mental health

- Review mental health history and explore current concerns.
- Signpost to mental health charity resources (e.g. www.mind.org.uk or Diabetes UK Helpline; **Box G**).

How to undertake a remote diabetes review – a PCDS quick guide

Box E

These **follow-up steps** would usually be incorporated in the face-to-face review, so schedule time for them.

- Use Diabetes UK Information Prescription(s) to outline agreed follow-up or send individualised letter (see **Box F**, Topics to include).
- Update and issue amended medication, if agreed; send script to patient's pharmacy or include with follow-up resources.
- Send monitoring form, and when and where to undertake.
- Enclose leaflets or links to resources discussed and links to self-management education programmes (e.g. DESMOND – currently free access).
- Rearrange retinopathy screening or secondary care review, if defaulted or any new referrals needed.
- Use electronic system to prompt interim review and follow-up.

Box F

Topics to include in template for individualised follow-up letter

Prepare template letter on practice system that self-populates with patient details. Include multiple guidance paragraphs and individualise by deleting sections not required. Include a standard list of diabetes resource links on the reverse of the letter.

> "This is a summary of our discussion today and provides links to resources that you may find helpful. We are still available to support you throughout the pandemic. Do not hesitate to contact us or the 111 service if you become unwell or need urgent advice."

1. **Details of enclosures and what to do with them**
   - How to get blood tests organised urgently, after COVID-19 or when next review due.
2. **Changes to treatment**
   - Reminder to read patient leaflet and report side effects; how to use devices.
3. **Actions recommended**
   - BP – self-monitoring frequency; link to diary; when and how to share results.
   - SMBG – script for strips and lancets. Where to collect meter if new to SMBG. Link for how to use meter or encourage to read instruction leaflet.
   - Daily foot checks; leaflet or link to what to report; Touch your toes link or leaflet.
   - Retinopathy screening/hospital eye specialist appointment – new appointment requested; importance of attending.
4. **Seeking further advice/safety netting**
   - How to arrange a face-to-face consultation during restrictions or after they lift.
   - When to seek guidance re COVID-19 symptoms or diabetes concerns.

Familiarise yourself with local services and adaptations during COVID-19 restrictions. Consider preparing a local resources links sheet to send to people with diabetes.

Offer remote support and education at every contact – people may be more engaged and motivated to participate, and may have more time, currently.

Virtual/remote education may be more acceptable and accessible.

People with diabetes who wish to access myDESMOND structured diabetes education online (www.desmond-project.org.uk) should send their name, email address, post code, name of GP practice and NHS number to: myDESMOND@uhl-tr.nhs.uk

Abbreviations
ACE=angiotensin-converting enzyme; ACR=albumin-to-creatinine ratio; BAME=black, Asian and minority ethnic; BP=blood pressure; CKD=chronic kidney disease; CVD=cardiovascular disease; DNA=did not attend; DSN=diabetes specialist nurse; F2F=face-to-face; GLP-1 RA=glucagon-like peptide-1 receptor agonist; HCA=healthcare assistant; HCP=healthcare professional; PPE=personal protective equipment; QOF=quality and outcomes framework; SGLT2i=sodium–glucose cotransporter 2 inhibitor; SMBG=self-monitoring of blood glucose; SU=sulfonylurea

Diabetes and COVID-19 risk

Evidence confirms that people with diabetes are vulnerable to serious consequences from COVID-19 and are not currently included in the shielded group ("clinically extremely vulnerable"). Mortality is approximately double in people with type 2 diabetes and increased approximately 3-fold in people with type 1 diabetes, compared to those without diabetes (Barron et al, 2020). HbA_{1c} >86 mmol/mol compared to 48–53 mmol/mol is associated with a doubling of the mortality risk in those with type 1 diabetes and 1.6 times the risk in those with type 2 diabetes (Holman et al, 2020).

Other factors that have been associated with increased mortality include:

- Advancing age
- Gender (male>female)
- BAME groups
- Deprivation
- Comorbidity (CKD, cerebrovascular disease, heart failure)
- Obesity
- Absence of recorded care processes for smoking status, BMI or HbA_{1c}

Discussion and assessment of comorbidities and individual risks, together with use of clinical judgement, will be required to help people make individual decisions about isolation and shielding. This is an important role for primary and community care teams.

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Different teams work in different ways. A follow-up article exploring examples of good practice in remote diabetes reviews is planned for the journal.

The authors welcome your feedback and input, including additional resources that you have found useful when undertaking remote reviews: dpc@omniamed.com

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