

# DIABETES CARE DURING THE COVID-19 PANDEMIC

## Position statement (December 2020)

### Key points

- Diabetes services should communicate with people living with or at risk of diabetes to let them know what level of care they can expect to receive in the coming months
- The Association of British Consultant Diabetologists' and the Primary Care Diabetes Society's guidance to identify patients who should be prioritised for review<sup>1,2</sup> should be used to ensure those most in need are able to access care
- HbA1c tests should be offered to patients who have not had one in 2020 and to those identified as being at high risk of developing type 2 diabetes. This will help identify individuals who need to be prioritised for review
- If a person living with diabetes has specific concerns about their diabetes, they should initiate a consultation directly with their healthcare professional

## Why have we produced this position?

The Covid-19 pandemic resulted in routine diabetes services, in primary, community and secondary care settings, being severely disrupted. Where care has taken place, much of it has moved to a remote format, mostly telephone or video.

During the summer of 2020, planning was stepped up across the UK for the re-start of NHS services, as acute Covid-19 related pressures reduced<sup>3,4,5</sup>. However, it is increasingly clear that much of the routine care people living with diabetes once expected to receive in a face-to-face setting will continue to be reduced and where it is available much of it will be delivered remotely for the foreseeable future.

There has been a real focus on adapting and driving innovation across many diabetes care teams, which has the long-term potential to deliver more flexible and personalised care to all people with diabetes. It is important, however, to recognise the impact these changes have had on people living with diabetes. In some cases, they have made accessing care, support and advice more difficult, although it is recognised that for others it has made care more accessible.

It has also been difficult for some healthcare professionals to make innovative changes happen. A lack of support, infrastructure and connectivity problems have resulted in greater variation in what and how diabetes care is delivered at present. Training for healthcare professionals to use technologies that can facilitate remote care has been patchy, with some lacking the skills and confidence to take advantage of the innovative models of care available.

The Covid-19 pandemic has highlighted the extent of the problem surrounding health inequalities in terms of clinical outcomes and access to good care – something diabetes care is not exempt from. Ethnicity, socioeconomic status and geography all impact on the care a person living with diabetes can expect to receive and the Covid-19 pandemic has demonstrated how these factors can also impact on a person's risk of becoming seriously ill with the virus<sup>6</sup>.

The purpose of this position is to describe what good routine diabetes care, based on individual clinical need, can and should look like. This position focuses on care for adults living with type 1 and type 2 diabetes and makes recommendations about care during the pandemic for both conditions, many of which overlap. We have made clear where recommendations apply to a specific patient group. This position also makes reference to inpatient and urgent diabetes care.

This position takes account of the different and difficult circumstances the Covid-19 pandemic has placed us in, where the ability to conduct face-to-face care is

significantly restricted and many routine diabetes appointments have been cancelled since March 2020, without having been rescheduled.

The recommendations in this position statement are designed to support the delivery of the best possible diabetes care during the Covid-19 pandemic to ensure people with diabetes are getting the care they need.

## How did we develop this position?

Work has been published in recent months with extensive advice for healthcare professionals about how to successfully deliver diabetes care remotely. Extensive research has been published detailing patient views on remote consultations and numerous reports have been written for our health systems advising them on how to deliver care at scale in this new way. We have used this work to inform the development of this position.

Diabetes UK has also conducted insight work with people living with diabetes and healthcare professionals about their experiences during this time. There is also an existing body of research about the effectiveness of telemedicine in diabetes care which pre-dates the pandemic.

We have also sought the views of healthcare professionals and people living with and affected by diabetes through our Council of Healthcare Professionals and our Council of People Living with Diabetes.

## Recommendations

### For people living with diabetes:

1. At this time diabetes healthcare professionals (like GPs or diabetes specialist nurses) are being advised to use a triage model<sup>7</sup> designed to assess who needs to be prioritised for appointments. For example, it is recommended that those with a higher HbA1c, those planning pregnancy or those with complete loss of hypo awareness should be offered appointments first
  - Diabetes UK supports this approach during the pandemic, as we recognise the need to ensure those most in need can access care while capacity to deliver diabetes care is substantially reduced

2. If a person living with diabetes has specific concerns about their diabetes, they should initiate a consultation directly with their healthcare professional. We particularly recommend doing this where they:
  - notice changes with their feet, such as a cut or blister they are concerned about
  - are worried about changes with their vision
  - are planning pregnancy in the next 6 months
  - are experiencing regular episodes of hypoglycaemia, especially during the night
  - have lost their hypo-awareness
  - are experiencing new or worsening psychological distress
  - are experiencing new hyperglycaemia, which is not normal for them
3. If someone living with diabetes has not had any contact with their diabetes healthcare team for 12 months, or for 6 months since they were last expecting to be seen, and they are worried about their diabetes management we recommend they contact their diabetes team to ask for advice
4. People living with diabetes are likely to be contacted by phone, email, video for appointments initially
5. If a person living with or at high risk of developing type 2 diabetes has a remote appointment scheduled, they should access [our advice on how to prepare for a remote consultation](#)
6. If a face to face appointment is scheduled it will normally be because it is important that the individual attends (for example retinal screening appointments may be targeted at those who already have background retinopathy or pregnant women, who are at highest risk of developing retinopathy) . However, if the person living with diabetes is concerned about attending, we recommend they speak to their healthcare team to discuss their concerns. If they have not attended an appointment but then decide that they should attend, they should contact their healthcare team to reschedule.
7. People living with diabetes should consider using online diabetes education programmes to support self-management at this time, like Diabetes UK's [Learning Zone](#)
  - Some local areas have commissioned online diabetes education programmes. People living with diabetes should speak to their healthcare professionals about what is available
  - Other online education programmes to access or ask for referral to include:
    - [My Type 1 Diabetes](#) (for type 1 diabetes)
    - [DigiBete app](#) (for younger adults with type 1 diabetes and their families)

- [DAFNE](#) (for people living with type 1 diabetes)
- [DESMOND](#) (for people living with type 2 diabetes)

### For people at risk of developing type 2 diabetes:

1. If an individual is concerned that they may be at risk of developing type 2 diabetes, we recommend using our [Know Your Risk](#) tool to assess their risk and understand what steps they can take
2. Look out for the symptoms of type 2 diabetes, which are detailed on our [website](#)
3. Access our [advice](#) on how to reduce their risk of developing type 2 diabetes

### For healthcare professionals:

1. Communicate with your patients living with or at high risk of type 2 diabetes to let them know what level of care they can expect to receive in the coming months
2. Use the Association of British Consultant Diabetologists' and the Primary Care Diabetes Society's guidance to identify patients who should be prioritised for review<sup>8,9</sup>
3. Identify patients who have not had an annual review or any contact for 12 months or more, or who have had no contact for 6 months since a cancelled appointment, and consider offering them an appointment
  - There is evidence that non-attendance at diabetes appointments increases an individual's risk of adverse health outcomes<sup>10</sup>
4. Offer an HbA1c test to patients who have not had one in 2020 and to those who have been identified as being at high risk of developing type 2 diabetes (this may be via an NHS health check, for example, although we recognise capacity to conduct these checks is limited at present).
  - HbA1c is a key indicator for identifying patients who need to be prioritised for a diabetes review<sup>11</sup>.
  - Where a normal, blood HbA1c test (face-to-face, drive-thru<sup>12</sup> or at-home<sup>13</sup>, for example) is not an option, consider giving patients, particularly those using insulin intensive therapy with type 1 or type 2 diabetes, technologies like Flash and Continuous glucose monitors – these devices can offer a picture of Time in Range and a predicted HbA1c
5. Where possible, someone newly diagnosed with diabetes should be offered a face-to-face appointment

- Note that some patients may be concerned about the potential risks surrounding face-to-face appointments at this time
  - Identify individual Covid-19 related risk when offering a face-to-face appointment. This will help establish whether it is appropriate<sup>14</sup>.
  - For some people newly diagnosed with type 2 diabetes a telephone or video appointments may be acceptable at present
6. Signpost patients to online diabetes education programmes and other diabetes support services that may be available locally
  7. The following appointments should not be cancelled, although some can be done remotely:
    - Antenatal appointments
    - Urgent footcare appointments
    - Retinopathy treatment
    - Appointments for people experiencing regular, severe hypoglycaemia or very fluctuating blood glucose levels
    - Urgent advice for people experiencing hypo- and hyper-glycaemia
    - Initiation on to technologies like Flash, CGM and insulin pumps, which can be done remotely

**For healthcare professionals delivering remote consultations:**

1. Where possible, give patients a fixed time and a choice in *how* a remote consultation is conducted (e.g. video or telephone)
  - Research has shown that patients prefer a fixed time for their appointment, as this reduces anxiety and allows them to prepare<sup>15</sup>
  - Where appointments are delayed, try to let patients know in advance. Consider building buffer time into your clinics and tell patients that there may be delays
2. Where a video consultation is planned, ensure you have another means of contact in case of technical problems
3. Ensure you are in a safe and confidential space for the consultation. Likewise, ask your patient if they are in a comfortable space for the consultation
4. Consider bringing other members of your multi-disciplinary team into remote consultations where appropriate
  - This may help to promote efficiencies within your service, saving time for patients and clinicians
5. Consider using translation or interpreting services, like Language Line, to help facilitate your remote consultations with patients who require this additional support



6. Where possible, offer your patients access to blood testing ahead of the appointment
7. Recognise that for some patients, video consultations may not be accessible due to the digital exclusion they face. Digital exclusion may present as, but is not limited to:
  - People who do not have access to a device or the necessary connectivity (e.g. mobile phone/laptop/broadband)
  - People who have access to a device but do not have the confidence or skills to use it
  - People who are only able to access a device in a public place (e.g. a library)
  - People who have neither access to a device, nor the skills to use it
8. Where you are using video consultations, offer alternative options to people who are digitally excluded, like a telephone consultation
  - Where you are aware of them, sign-post to local services that are supporting digitally excluded people (e.g. the local authority or community-based projects)
9. Consider using email, letters or, if appropriate, text messaging to engage with patients you cannot have telephone or video consultations with
10. Where possible, encourage patients to upload data they may have from remote monitoring technologies to a relevant data management platform (i.e. Diasend<sup>16</sup>, My Diabetes My Way<sup>17</sup> or LibreView<sup>18</sup>) so you can review and discuss it. Do this ahead of the appointment where possible
11. Recognise the potential limitations of remote consultations<sup>19</sup> and seek ways to mitigate them. Limitations include but are not restricted to:
  - Potential to miss non-verbal cues, thus restricting ability to identify distress
  - Inability to conduct a physical examination (e.g. foot check)
  - Potential difficulties developing a rapport with patients you have not worked closely with before
12. Where patients are asked to conduct health checks at home, the necessary devices used to do this should be provided at no cost to them
13. Ask patients about their mental health and wellbeing, recognising that this can be a very worrying time for people living with diabetes and refer to local or online sources of support, such as peer support groups
14. Access [resources designed to support remote consultation delivery](#), including the Diabetes UK website

## For those planning and designing services:

1. Support diabetes healthcare professionals to communicate with their patients about the routine care they can expect to receive during the pandemic
2. Refer to our [report on inpatient diabetes care during the pandemic](#) which details a number of recommendations, including but not limited to:
  - Hospitals and local health systems should involve diabetes specialist teams in the recovery phase and winter planning
  - Diabetes inpatient teams should be 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 should be available in all hospitals
3. Ensure that diabetes antenatal services remain open and able to provide effective continuity of care
4. Ensure diabetes foot services are open, and support diabetes teams to do this, including not redeploying their staff
  - This is particularly important for urgent new and ongoing chronic foot care
5. Ensure that those at higher risk of developing retinopathy are invited to a retinal screening appointment
6. Ensure that mental health support services for people living with diabetes are reinstated to at least pre-pandemic levels
7. Invest in innovative service re-design and learn from best practice in other areas. For example:
  - A number of areas have developed virtual foot care services during this time<sup>20</sup>
  - Some areas have introduced the use of at-home HbA1c tests<sup>21</sup>
  - Other areas have made use of drive-through<sup>22</sup> phlebotomy clinics
  - In Scotland, the *House of Care* model<sup>23</sup> is being used in a number of areas to support integrated, patient-centred care delivery
8. Provide the additional administrative support and resource required for remote consultations
  - There may be a need for an additional staff member in the virtual 'waiting-room', for example
  - Clinicians may require a 'work phone' or laptop to allow them to conduct telephone consultations from home
  - Invest in translation and interpreting services to ensure remote diabetes care is accessible to all those for whom it is appropriate
9. Ensure space is provided for staff conducting remote consultations to do this in a confidential environment
  - Consider providing headsets for staff, especially where they are not conducting the remote consultation in private and confidential space



10. Invest in and maintain an IT infrastructure that ensures staff can conduct video consultations in a seamless manner
  - There is likely to be an increased need for IT services and support at present, for example, for clinicians who are not confident using online consultation platforms or where computers or operating systems being used are old
  - Healthcare professionals will need reliable internet, whether they are working in primary or secondary care settings, or from their homes where applicable
11. Actively promote and support the interoperability of software to promote efficiency and seamlessness between diabetes services
12. Require diabetes teams to collect patient feedback about their experiences of remote consultation and, where appropriate, offer them the tools to do this
13. Offer training for and up-skill healthcare professionals who are not confident with remote consultation and the associated technology
14. Work to identify areas of high deprivation and health needs in order to ensure the appropriate level of investment and support is being offered to those delivering diabetes care

### For researchers:

1. Further research is needed to establish the effectiveness of remote diabetes care (sometimes referred to as telemedicine) where there is no regular face to face contact
2. A greater understanding of health inequalities in these new models of diabetes care is needed
  - Who is being excluded from this care? What can be done to mitigate this?
  - Who is being newly included in this new model of care?

### For government:

1. Recognise the impact the Covid-19 pandemic has had on people living with diabetes, who have been disproportionately affected by it
2. Commit to investing in greater care and support for people living with diabetes
  - For example, invest in technologies that will allow people living with diabetes to more confidently and effectively manage their condition at home

## Evidence and analysis

### What the research tells us about the effectiveness of remote consultations

There are a number of studies and research papers (largely systematic reviews) discussing the effectiveness of telemedicine specifically in diabetes care. Most of these papers pre-date the Covid-19 pandemic.

In 2017 a systematic review by [Farruque et al.](#) found that compared to usual care, the addition of telemedicine to normal care appeared to improve HbA1c significantly in people with type 1 or type 2 diabetes but no significant reduction in hypoglycaemia was found.

A more recent review published at the start of this year by [Timpel et al.](#) looked at telemedicine in diabetes, dyslipidaemia and hypertension, and found that these interventions, in addition to face-to-face care, again delivered clinically relevant reductions in HbA1c: >0.5%/5.5 mmol/mol on average.

[Timpel et al.](#) found, however, there were insufficient quality of life measurements to assess the effectiveness of these interventions. There is a need to assess on a larger scale how a shift to telemedicine will affect quality of life and mental health, although some smaller individual studies have looked specifically at these issues.

Concerns have been expressed in some studies about the risk of excluding people who, for example, lack internet access or face other forms of digital exclusion.

A paper published in summer 2020 by [Wake et al.](#) also looked at how diabetes services could and should adapt to Covid-19, including remote outpatient care delivery. The paper highlighted that whilst glucose monitoring, structured education and care more generally may be provided and evidence for their effectiveness exists, remote complications screening is not currently readily available.

It is noted that two of these papers refer to telemedicine *in addition to* face to face consultations.

### Our survey of people living with diabetes

We conducted a survey in September 2020 asking people with diabetes about their experiences accessing care during the Covid-19 pandemic. Over 4000 people living with type 1 and type 2 diabetes responded.

We also surveyed healthcare professionals working in a range of settings about their experiences of delivering remote diabetes care during the pandemic. We spoke to 140 people working across primary and secondary care.

Below we summarise the responses we received.

### **Where people did have access to care:**

51% of survey respondents have had contact with their healthcare team during the pandemic and of this group, 81% had a consultation (58% telephone, 17% face-to-face, 6% video). 76% of respondents who had a remote consultation during the pandemic told us the experience was positive and 73% of people told us they felt the consultation was useful.

Key things people living with diabetes told us they felt were important for a remote consultation were:

- Knowing exactly what time the appointment will take place (65%)
- Covering everything they want/need to in the appointment (64%)
- Speaking to the person they want to during the consultation (60%)
- Using their preferred method of communication for the appointment (e.g. face-to-face, telephone, video) (49%)

Where people had remote consultations, 36% received none of the main diabetes healthcare checks. 46% had an HbA1c, 26% had a cholesterol check, 25% were asked about their emotional wellbeing, 23% had a kidney blood test, 20% had a urine kidney test, 18% had a blood pressure check, 14% had their BMI measured and 7% had their feet checked.

10% of this group of respondents told us they were asked to buy equipment to conduct some of these tests at home. The majority (73%) of this 10% were asked to buy a blood pressure monitor. 30% were asked to weigh themselves and 18% were asked to provide their own blood glucose monitor.

### **Where people did not have access to care:**

49% of survey respondents had no contact with their healthcare teams during the Covid-19 pandemic and 45% of this group have had consultations cancelled. Where consultations have been cancelled, 77% of respondents told us these appointments had not been rescheduled. 36% of survey respondents who had no remote consultation during the pandemic told us they would have wanted one.

Where respondents had no contact with their healthcare team during the pandemic, 55% of survey respondents told us they feel they wanted or needed contact. 38% of survey respondents in this group told us they have had difficulties managing their diabetes during the pandemic and 56% cited lack of access to healthcare professionals as a key reason for this. 37% also told us their diabetes management had been negatively affected by anxiety and stress caused by the pandemic.

## **Our survey of diabetes healthcare professionals**

We asked healthcare professionals (HCPs) if anything worked particularly well in remote consultations during the Covid-19 pandemic. The main themes were:

- For some, remote consultations were as good as face to face, feeling like they were able to address most issues remotely, particularly when they used new ways of working for key health checks
- We were told some healthcare professionals have been able to make better use of IT, such as screen sharing or data sharing
- It was accepted that remote consultations may not always work for everyone, including those who face digital exclusion
- Remote consultations can be more convenient and efficient by saving time from travel and they give the ability to have more availability to see patients
- There is greater engagement with patients, with fewer people not attending, or patients that would not normally engage with care starting to attend consultations
- Remote consultations have been a particularly useful tool during lockdown, enabling some consultations to keep running while keeping people safe from Covid-19 exposure

Most healthcare professionals told us they had contact with patients during the pandemic and over 90% (91%) of them said that they typically initiated the contact between them and their diabetes patients and for most (81%) telephone was the most common method. Almost two thirds (64%) have held video consultations. Almost three quarters have reported that they have held some face to face consultations during lockdown.

Under a third (30%) of healthcare professionals said that some of their patients have been asked to buy or provide equipment to perform healthcare checks at home.

Healthcare professionals were also asked about what specifically hasn't worked well with remote consultations. The main themes were:

- Issues with access or quality of technology - some were lacking IT equipment that was good enough for remote consultations and some did not have the ability to conduct video consultations
- There is inequitable access to remote consultations due to issues surrounding digital exclusion
- Remote consultations can't cover everything as some key health checks are difficult to do remotely
- Nurturing the clinician-patient relationship can be a challenge
- Remote consultations can produce more administrative work and less time with patients - there is a lack of additional support.

When we asked how healthcare professionals have managed to provide healthcare checks for remote consultations during the pandemic, we were told:

- They were able to ask questions about smoking status and emotional wellbeing and have a discussion with patients about these issues
- Some patients were able to get tests face to face at a hospital or practice with a nurse or HCA in advance of a remote consultation
- New, dedicated spaces have been set up to perform healthcare checks safely during the pandemic (sometimes referred to as Covid-free sites)
- Patients can self-report or self-assess some of their healthcare checks, although some require patients to have the necessary equipment
- Patients have also been able to do some checks at home, either via home visits or by diabetes services providing a way for patients to drop off samples themselves

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<sup>1</sup> [https://abcd.care/sites/abcd.care/files/site\\_uploads/Resources/COVID-19/ABCD-Recovery-Guidance-2020-06-23.pdf](https://abcd.care/sites/abcd.care/files/site_uploads/Resources/COVID-19/ABCD-Recovery-Guidance-2020-06-23.pdf)

<sup>2</sup> <https://www.diabetesonthenet.com/journals/issue/612/article-details/how-undertake-remote-diabetes-review>

<sup>3</sup> <https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/07/20200731-Phase-3-letter-final-1.pdf>

<sup>4</sup> <https://www.gov.scot/publications/re-mobilise-recover-re-design-framework-nhs-scotland/pages/9/>

<sup>5</sup> <https://www.health-ni.gov.uk/publications/rebuilding-hsc-services>

<sup>6</sup> <https://www.diabetes.org.uk/resources-s3/public/2020-07/COVID-19%20position%20statement%20V3%2030.6.20.pdf>

<sup>7</sup> [https://abcd.care/sites/abcd.care/files/site\\_uploads/Resources/COVID-19/ABCD-Recovery-Guidance-2020-06-23.pdf](https://abcd.care/sites/abcd.care/files/site_uploads/Resources/COVID-19/ABCD-Recovery-Guidance-2020-06-23.pdf)

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- <sup>8</sup> [https://abcd.care/sites/abcd.care/files/site\\_uploads/Resources/COVID-19/ABCD-Recovery-Guidance-2020-06-23.pdf](https://abcd.care/sites/abcd.care/files/site_uploads/Resources/COVID-19/ABCD-Recovery-Guidance-2020-06-23.pdf)
- <sup>9</sup> <https://www.diabetesonthenet.com/journals/issue/612/article-details/how-undertake-remote-diabetes-review>
- <sup>10</sup> <https://onlinelibrary.wiley.com/doi/full/10.1111/dme.14241>
- <sup>11</sup> <file:///C:/Users/lizp/Downloads/Delivering-Diabetes-Care-during-the-COVID19-Pandemic-120620.pdf>
- <sup>12</sup> <https://www.sheffieldchildrens.nhs.uk/services/diabetes/resources-for-children-and-young-people-with-diabetes/>
- <sup>13</sup> <http://pathology.imperial.nhs.uk/index.php?page=home-testing>
- <sup>14</sup> <https://www.diabetes.org.uk/resources-s3/public/2020-07/COVID-19%20position%20statement%20V3%2030.6.20.pdf>
- <sup>15</sup> [https://traverse.ltd/application/files/3315/8823/6199/knock\\_on\\_effects\\_of\\_coronavirus\\_on\\_healthcare.pdf](https://traverse.ltd/application/files/3315/8823/6199/knock_on_effects_of_coronavirus_on_healthcare.pdf)
- <sup>16</sup> <https://www.diasend.com/>
- <sup>17</sup> <https://www.mydiabetesmyway.scot.nhs.uk/#gsc.tab=0>
- <sup>18</sup> <https://www.libreview.com/>
- <sup>19</sup> <https://wileymicrositebuilder.com/practicaldiabetes/wp-content/uploads/sites/29/2020/08/PP-Kilvert.pdf>
- <sup>20</sup> [https://www.diabetesonthenet.com/journals/issue/625/article-details/covid-19-catalyst-change-virtual-foot-protection?mc\\_cid=2ff3dae6bc&mc\\_eid=610b31c02b](https://www.diabetesonthenet.com/journals/issue/625/article-details/covid-19-catalyst-change-virtual-foot-protection?mc_cid=2ff3dae6bc&mc_eid=610b31c02b)
- <sup>21</sup> <http://pathology.imperial.nhs.uk/index.php?page=home-testing>
- <sup>22</sup> <https://www.sheffieldchildrens.nhs.uk/services/diabetes/resources-for-children-and-young-people-with-diabetes/>
- <sup>23</sup> <https://www.alliance-scotland.org.uk/health-and-social-care-integration/house-of-care/house-of-care-model/#expanded>