

Collaborating and adapting: How diabetes services have changed during the pandemic

The pressures being borne by the NHS and health care over the past twelve months are unprecedented. Prior to the COVID-19 pandemic, diabetes services in the UK, whether in primary or secondary care, operated predominantly face to face. With the rapid spread of infections across the UK and the start of lockdown in March 2020, most face-to-face services were halted. Staff had to be redeployed and clinics needed to be restructured.

With the impact on the care of people with long-term conditions increasing, a working group was created consisting of an array of healthcare professionals from across the UK, including diabetes nurses, diabetologists and GPs. They began to discuss and consider the changes in working practices that were taking place in order to share experiences of how healthcare professionals and people with diabetes were adapting to virtual consultations, what barriers needed to be overcome and how those who felt lost within the system could be re-engaged. The result was the publication of a report called *A Collaborative Overview and Insight into Diabetes Services Before and After the COVID-19 Pandemic* (Mills et al, 2020).

Meanwhile, The Health Foundation surveyed a cohort of individuals with at least one pre-existing condition (Charlesworth et al, 2020). It found that, from the end of February to early May last year (during the first wave of infections), there was a 20% reduction in the number of times this group accessed health services to manage their conditions compared to the preceding two months. This trend continued to some extent in the subsequent wave and prompted healthcare services to adapt. This change has been no mean feat and has brought many challenges. Several groups of healthcare professionals quickly responded and together published guidance (Bakhai, 2020), risk stratification models (Brown and Diggle, 2020; Nagi et al, 2020) and collaborative

reports (Mills et al, 2020) to record and formalise new ways of working.

Despite more remote consultations being conducted, diabetes service teams had to decide who needed to continue to be seen face to face, such as those who were pregnant and individuals with active foot disease. Guidance from the Royal College of Obstetricians & Gynaecologists (2020) was published to help decide which of these women to prioritise. Some may say that this was too restrictive, and that all pregnant women need to be seen face to face. However, as we were all working with a very small COVID-19 evidence base, it was felt that choosing the safest option for the greatest number of people was the best approach. Individuals under the care of a specialist foot service also needed to continue to attend face-to-face appointments.

As noted, at the start of the pandemic, many professionals in primary care were redeployed to provide support for secondary care, which was dealing with increased numbers of patients and workload. This continued through the subsequent waves and now with the vaccination campaign. This, again, has impacted on the general follow-up care of all those with diabetes.

With the passing of what we all hoped was the peak of the pandemic and pressures on diabetes services subsequently reducing, thoughts turned to a recovery phase and addressing the backlogs of diabetes reviews. A risk stratification tool for triaging patients in primary, secondary or community care was developed by the Association of British Clinical Diabetologists (2020) and incorporated into *A Collaborative Overview and Insight into Diabetes Services Before and After the COVID-19 Pandemic*. This tool helped to identify individuals who needed to be reviewed as a priority and those who could afford to be left a while longer. An updated version has recently been published by Choudhary and colleagues (2020).



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Information published by NHS England (2020) can also help in prioritising those people most at risk and in need of review within a few months. Some of these individuals will be picked up by secondary care, but a larger proportion may remain in primary care, creating great pressures within the system.

The members of the working group that supported the writing of the COVID report were from across the UK and it quickly became apparent that some areas were impacted more than others and there were differences in care delivery. Diabetes services that were situated in dedicated buildings seemed to carry on as normal, whereas services that were attached to an acute hospital were halted very early in the pandemic. Community services also seemed to continue for some time before they too were paused. Service needs varied with moves to virtual consultations and as staff were re-deployed to support acute areas. This was seen more clearly when local lockdowns and tiers came into play. As quickly as guidance is written, the rules seem to change. Health seems to be driven by politicians at times.

A small snapshot survey of healthcare professionals and people with diabetes undertaken by the working group and summarised in the report strongly indicated that newer ways of working, such as video reviews and telephone support, can work but, again, some areas were able to set processes up faster than others. Despite frustrations, such as incorrect contact details and obstacles with computer systems, the overall experience of virtual consultations was rated as very good.

Structured diabetes self-management education, which has traditionally been conducted face to face, was halted during the pandemic. However, the free [My Type 1 Diabetes](#) digital platform was launched across England in June, providing self-management and education tools for people living with diabetes (MyWay Digital Health, 2020). Since then, other digital platforms have been developed and will continue to support access for people with diabetes and their families.

A Collaborative Overview and Insight into Diabetes Services before and after the COVID-19 pandemic

A Report

On behalf of the working group

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The way forward

It is unlikely that we will be able to get back to “the old ways” anytime soon, and nor should we. There are lessons to be learned from the experiences of the pandemic. The traditional ways that services have been delivered do need to be modernised. Digital support is paramount, and many would say that COVID-19 has forced our hand to work towards this sooner rather than later. A blend of virtual and face-to-face reviews must be considered as the new way of working. Teams have successfully started working like this and are unlikely to go back to the traditional way. Many service users like it too, freed as they are from the inconvenience of travelling, taking time off work and parking expenses.

In all of this, the mental health of people with diabetes needs to be considered when undertaking a consultation, whether it is face to face or virtual. The demand on primary care for this support during the pandemic has been unprecedented, may continue in the medium and long term and is something that we need to be mindful of. Anyone reviewing an individual with diabetes should enquire about their mental health and emotional wellbeing. If needed, they should be directed to relevant resources, such as those

provided online by Diabetes UK (www.diabetes.org.uk/guide-to-diabetes/emotions).

For a patient to get the most out of a virtual consultation, it is helpful if they understand why it is being conducted this way, what the benefits are and how to attend. A video clinic confirmation letter providing all of the necessary information can be prepared by the practice from a template contained in an appendix to the working group's report (Mills et al, 2020).

The report provides a clear account of how services were run before the pandemic and how they are being managed currently, with an aspiration that some sort of a new normal will become established in the near future. As so much uncertainty surrounds the current state of play, with tier systems changing fast and infection rates rising and falling, all healthcare professionals need to be aware that anything that is put in place may need to be changed subsequently. To help with the ongoing demands on our services, those individuals who would be reviewed more frequently in the past need to be empowered to self-manage their diabetes. By signposting them to suitable online resources, we can help them to achieve this. ■

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