Meeting highlights: 16th National Conference of the PCDS

The 16th National Conference of the PCDS was held virtually on 5–6th November 2020. Over 2000 primary healthcare professionals attended live sessions covering a variety of topics including COVID-19 and diabetes, diet and lifestyle, medicines optimisation and mental health, and similar numbers have since accessed the on-demand sessions online. In this article we provide a brief overview of the key learning points from each of the sessions and masterclasses; however, we encourage readers to attend the on-demand sessions in their own time: click here to access.

The national picture

Jonathan Valabhji, National Clinical Director for Diabetes and Obesity

- Among people with all forms of diabetes, HbA_{1c} and raised BMI are modifiable risk factors for COVID-19-related mortality.
- Roll-out of online structured education to support self-management of diabetes has been accelerated in response to the pandemic:
  - For adults with type 1 diabetes: MyType1 Diabetes is now available without any referral requirement.
  - For children and young people with type 1 diabetes: the DigiBete App and web platform are now in place.
  - For adults with type 2 diabetes, Healthy Living for People with Type 2 Diabetes is available for direct patient registration.
- Evaluation of the first 2.5 years of activity of the NHS Diabetes Prevention Programme in England shows significant effects on weight loss and HbA_{1c} reduction in people with non-diabetic hyperglycaemia (NDH). Click here to read the study.
  - To adapt to the COVID-19 pandemic, eligibility for referral to the Programme has been extended to people with a blood test confirming NDH in the previous 24 months (formerly 12 months).
  - People have also been allowed to self-refer until March 2021, using the Know Your Risk tool.
- A new Quality and Outcomes Framework (QOF) Indicator for NDH (*The percentage of patients with non-diabetic hyperglycaemia who have had an HbA_{1c} or fasting blood glucose performed in the preceding 12 months*) is planned for introduction in financial year 2021/22.

What has COVID-19 taught us?

Kamlesh Khunti, Professor of primary care diabetes and vascular medicine, University of Leicester

- It is unclear if people with diabetes are more likely to contract COVID-19.
- Current data suggest that COVID-19 is associated with worse outcomes in people with diabetes.
  - People with type 2 diabetes were roughly twice as likely to die in hospital, while those with type 1 diabetes were three times more likely.
  - The increased risk is largely attenuated in those with good glycaemic control.
- The pandemic also risks contributing to worse diabetes outcomes due to the disruption it has caused, including stress and changes to routine care, diet, and physical activity.
- Outcomes are disproportionately worse in black, Asian and minority ethnic populations. See the evidence review and recommendations from the South Asian Health Foundation.

New ways of working post-COVID-19

Jane Diggle, Specialist Diabetes Nurse Practitioner, West Yorkshire

- Routine diabetes reviews are crucial but there is a large backlog due to the pandemic. Prioritising which patients to call in first should be based on diabetes, cardiovascular disease and COVID-19 risks, plus opportunistic identification. See: How to prioritise primary care diabetes services during and post COVID-19 pandemic.
- If deciding to defer a review, it is crucial to communicate the reasons to the person, signpost to support and set a date for future review.
- Remote consultations will generally be preferred. Asking patients to complete questionnaires prior to the review can allow the gathering of valuable information remotely (e.g. lifestyle information, weight, home blood pressure measurements, blood glucose diaries, the "Touch the toes" test).
  - See: At a glance factsheet: Sources of information and education for people with diabetes to support remote consulting
  - and: How to undertake a remote diabetes review
  - and: Video consulting in the NHS
- When face-to-face meetings are required, try to collect all clinical information in one visit.
  - Specific visits for blood testing should only be arranged if the results are felt likely to change management.

Masterclass: Prescribing fundamentals in type 2 diabetes

Sarah Davies, GPwSI in diabetes, Cardiff

- The ADA/EASD Consensus Statement is a good "living" guideline to keep us up to date with our prescribing according to recent evidence.

- Diet, lifestyle and education remain fundamental.
- Metformin remains first-line therapy.
- After metformin, establishing whether the patient has CVD, is at high risk of CVD, or has HF or CKD will guide the early use of SGLT2 inhibitors and GLP-1 RAs.
- Individualised prescribing to the patient sat in front of us is key.
- Safe prescribing and awareness of cautions and side effects is crucial.
- Sick day guidance needs reinforcing to patients wherever applicable.

Updates in lifestyle

Jason Gill, Professor of cardiometabolic health, University of Glasgow

- The amount of objectively measured physical activity needed for substantial health benefits may not be very large (only 5–10 minutes per day of moderate-to-vigorous physical activity).
- Muscle-strengthening (resistance) exercise is important for health; low strength is a significant risk factor for adverse health outcomes.
  - Early evidence suggests that one set per week of each major muscle group (equating to a few minutes per day) may be enough for health benefits.
- Sleep may be a third modifiable "lifestyle" risk factor to focus on (in addition to diet and physical activity) to optimise cardiometabolic health; however, research into this is in its infancy.

The opportunity that lies in every crisis

Stephen Lawrence, Associate Clinical Professor, University of Warwick

- COVID-19 has been an accelerant for the need to embrace digital technology into the care model approach.
- The digital technology model of care can transform how people with diabetes engage with services.
- Healthcare professionals have a focal role in upscaling public confidence in government programmes, including vaccination, and communicating good evidence in an unbiased fashion.
- Delivering large-scale digital transformation involves both risks and opportunities.
- To maximise uptake, the benefits of digitisation must be made clear, while reassuring about data security and use.
- Innovation and integration must be individualised.

Funny numbers

Clare Hambling, GP, Norfolk, and PCDS Chair; Patrick Wainwright, Consultant in Chemical Pathology and Metabolic Medicine, Betsi Cadwaladr University Health Board

- Always consider liver health in people with diabetes.
  - Non-alcoholic fatty liver disease, non-alcoholic steatohepatitis and cirrhosis are of increasing concern.
  - It is vital to assess the extent of fibrosis.
- Think about haematological factors which may affect interpretation of HbA_{1c}. If in doubt, call your local biochemistry lab for advice.
- People aged ≥60 years with new-onset diabetes and weight loss should be referred for abdominal CT or ultrasound to exlude pancreatic cancer (*NICE NG12 – Suspected cancer: Recognition and referral*).
  - Also consider in those with sudden worsening of existing diabetes (e.g. rapid progression to requiring insulin, unexplained weight loss).

Mental health

Mark Davies, Consultant Clinical Psychologist, Belfast

- Remember the three "core conditions" of a good relationship with a patient:
  - Empathy (a sense that their healthcare professional understands their point of view).
  - Congruence (authenticity; using the same voice when addressing patients as you would anyone else).
  - Unconditional positive regard (valuing the patient irrespective of their words or lifestyle).
- Primary care practitioner empathy has been associated with a lower risk of all-cause mortality in people with type 2 diabetes (Dambha-Miller et al, 2019).
- Many people may not see much value in looking after their own health, particularly if they have been brought up to have low self-worth or if they see this as secondary to looking after other people (e.g. parents, children). Discussion of good diabetes self-care should be framed around these perceptions.
- Autonomy is crucial to happiness and wellbeing. Diabetes education should be conducted with this in mind, aiming for autonomy and confidence rather than conformity with instructions from healthcare professionals.

Masterclass: Diabetic foot disease

Vanessa Goulding, Highly Specialist Podiatrist, Cardiff

- Examine and assess foot risk at least annually (see NICE NG19 guidance). Include subjective questioning, vascular, neurological, skin, musculoskeletal and footwear assessments.
- Know your patient: identify their level of activation, how important they consider their footcare and how confident they are to provide their own care and manage their own foot health. Remember: "their feet, their risk, their health" – making the patient an equal partner in decision-making leads to greater activation with self-care.
- Provide advice on management to reduce risk:
  - Information about how diabetes affects feet and the importance of blood glucose control.
  - Advise the person of their individual risk of developing a foot problem. Low risk does not mean no risk.
  - Provide basic foot care advice and promote the importance of foot care.
  - Advise on foot emergencies and who to contact.
- Know when and how to refer in more serious cases. Get to know your

local foot protection team (FPT) or multidisciplinary foot care team (MDFT). Know your local pathways.

- Rapid referral to FPT or MDFT within one working day, for triage within one further day, for:
  - Ulceration
  - Spreading infection
  - Suspicion of acute Charcot foot or unexplained hot red swollen foot with or without pain
  - Critical limb ischaemia
  - Gangrene.

Dietary advice in diabetes

Pamela Dyson, Research Dietitian, Oxford

- All people with diabetes should be referred to appropriate structured education programmes for ongoing lifestyle and dietary advice and support.
- Weight loss is a key feature for those with type 2 diabetes living with excess weight and obesity.
- Weight loss for those with type 2 diabetes is associated with remission, lower HbA_{1c}, lower cardiovascular risk and improved quality of life.
- There is no evidence supporting one specific dietary strategy for people with type 2 diabetes, and a variety of diets can be offered, including low-fat healthy eating, low-carbohydrate, low-energy (including total diet replacement), Mediterranean-style diets and intermittent fasting.
- Acknowledging personal preference and using behavioural strategies improves outcomes.

Masterclass: Insulin management

Su Down, Diabetes Nurse Consultant, Somerset

- Insulin should be considered, either as part of a combination regimen or temporarily to normalise acute hyperglycaemia, but it is frequently initiated much later than is optimal.
- There are many educational videos on starting insulin, correct injection technique, etc., that can reassure patients about starting the therapy as well as teaching them how to self-administer in their own time.
- Following inititation, the insulin dose will need to be titrated. However, consider other factors (e.g. insulin storage, meal/injection timing, lipohypertrophy) that may cause an otherwise optimised dose to be ineffective.
- Do not forget to consider de-escalation of therapy, particularly in older/frail people. See: How to manage diabetes in later life and: How to switch from twice-daily to once-daily basal insulin

Injectable support

- RCN: Starting injectable treatments
- TREND-UK: Basal insulin initiation
- FIT UK: Injection technique guideline
- Diabetes UK: Meds and Kit guide
- NHS: How to inject insulin video

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