# http://staffnetcomms/nhsggc/logos/logo_NHSGG&C_%202_colour.jpgMANAGED CLINICAL NETWORK

# FOR DIABETES

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**Prioritisation of Diabetes care during the COVID-19 pandemic**

The COVID-19 pandemic has required healthcare services to adapt their approaches to care delivery, with remote consultations becoming the default where applicable. It has brought a number of challenges regarding clinical capacity and the management of ongoing care needs alongside the risks associated with face-to-face contact.

We recommend reviews should follow a two-stage process; the first part is focused on any necessary elements requiring face-to-face contact (such as venous blood testing and complete foot checks) and may be omitted on a case-by-case basis after discussion of risks and benefits; the second part is essential for all reviews and is a consultation, performed

remotely unless face-to-face contact is specifically required, covering information

gathering, issues, concerns, results, actions and next steps.

**People with evidence of hypoglycaemia, or extreme hyperglycaemia (new significant polyuria and polydipsia or HbA1c >86 mmol/mol), active foot disease, new pregnancy or new insulin initiation have urgent clinical needs and should be reviewed by appropriate teams without delay.** Primary care colleagues can obtain advice from acute service teams on:

South Sector (NVH, QEUH, Gartnavel General catchment areas)

These dedicated consultant mobile numbers will be operational during working hours:

**Vic Hub Consultant: 07943 585877**

**GGH Hub Consultant: 07943 585890**

**QEUH Inpatient Consultant: 07943 585924**

North Sector **(Stobhill/GRI catchment areas) Please call 0141 355 1078**, leave a message if there is no answer and someone will call you back.

Clyde Sector (IRH, RAH and VOL catchment areas)

**RAH/Vol: 0141 314 7009 (Consultant Connect available Mon-Fri 12.00-13.30 and 16.00-17.00 RAH area only)**

**IRH: 01475 504868**

Contact numbers for patients attending acute service clinics and latest diabetes guidelines can be found on the NHS GGC Diabetes MCN webpage:

<https://www.nhsggc.org.uk/about-us/professional-support-sites/heart-stroke-diabetes-rheumatology-and-chronic-pain-mcns/diabetes-mcn/covid-19-and-diabetes/>

**Education and Self-Management**

“My Diabetes My Way” should be encouraged and can provide access to self-management and online educational material.

<https://www.mydiabetesmyway.scot.nhs.uk>

Glasgow Weight Management Services are still accepting referrals and can provide access to remote weight management treatments. Patients with Type 2 diabetes can self refer:

* NHS GGC Weight Management Service : 0141-211 -3379 [www.nhsggc.org.uk/weightmanagement](http://www.nhsggc.org.uk/weightmanagement)

**Prioritising T2DM recall and reviews**

With capacity for routine reviews being limited and prioritisation being necessary, various possible approaches could be used. These may take into account both risk of mortality with COVID19 and the risks of diabetes-related complications. There is no single ‘correct approach’ for prioritisation and the following is a suggested pathway.

We would recommend utilising the SCI-Diabetes Dashboard search function via

<https://www.sci-diabetes.scot.nhs.uk/> and/or existing search tools on EMIS/VISION. One approach for prioritisation is stratifying into RED, AMBER and GREEN on the basis of

last recorded HbA1c, blood pressure and lipid management status, while taking into

account significant co-morbidities (such as CKD and CVD) or significant complications of

diabetes as well as missed reviews (Diagram 1) and risk factors for serious COVID-19 disease (BOX A).

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| **Box A: Risk factors for serious COVID-19 disease** |
| **Modifiable risk factors3**   * Higher blood glucose levels (HbA1c ≥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 HbA1c 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. |

**Suggested timeframe of reviews**

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| **Box B: Timeframes for Review** |

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| --- | --- | --- | --- |
| **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** |

**Diagram 1. Stratifying prioritisation groups (Adapted from the ABCD recommendations for triage of patients during Covid Recovery1)**

**Initial search: last recorded HbA1c**

**Absent data/overdue review:**

**No HbA1c >18 months**

**AMBER**

**No HbA1c >24 months**

**RED**

|  |  |  |  |
| --- | --- | --- | --- |
| **RED** | **AMBER I** | **AMBER II** | **GREEN** |
| **HbA1c**  **>86 mmol/mol** | **HbA1c**  **65–86 mmol/mol** | **HbA1c**  **59–64 mmol/mol** | **HbA1c**  **≤58**  **mmol/mol** |

|  |  |  |
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| **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:** | **Not on statin but established CVD (excl. haemorrhagic stroke)**  **RED** | **Not on statin despite ≥40 years**  **AMBER** |
| **BMI:** | **≥40 kg/m2**  **RED** | **≥30 kg/m2**  **AMBER** |
| **Other Risk Factors:** | **Planning Pregnancy**  **Recent admission in last 12 months (Diabetes or acute CV event)**  **HbA1c <48mmol/mol in Frailty and on sulphonylurea or insulin**  **RED** | **Frailty /Cognitive Impairment**  **Requiring additional support e.g Significant mental health illness**  **Learning disability**  **BAME Groups**  **AMBER** |

**References**

1. A Quick guidance to Risk Stratification and recovery of Diabetes Services In the post– Covid-19 Era. <https://abcd.care/resource/abcd-recovery-guidance> 24th June 2020.
2. Brown P, Diggle J (2020) How to prioritise primary care diabetes services during and post COVID-19 pandemic. Diabetes & Primary Care 22: 97–8
3. Multivariable analysis of mortality data from England, linked to the National Diabetes Audit (NDA), has revealed significant associations in people with diabetes between mortality with COVID-19 and age, sex, deprivation, ethnicity, comorbidities (kidney disease, heart failure, previous stroke), BMI and HbA1c (Holman et al, 2020; see https://www.england.nhs.uk/wpcontent/

uploads/2020/05/Valabhji-COVID-19-and-Diabetes-Paper-2-Full-Manuscript.pdf).

1. Delivering Diabetes Care during the COVID-19 Pandemic – the ‘new normal’ Guidance for General Practice 12th June 2020. NHS England and NHS Improvement.

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