A Quick guidance to Risk Stratification and recovery of Diabetes Services
In the post – Covid-19 Era

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Introduction: The provision of Diabetes services need to restart, following the recent suspension during the Peak of Covid-19 Pandemic. As we are now entering the tail of the Pandemic with less pressure on acute services and GIM Rota's being de-escalated, there is a need to re-group and re-organise. Many of you would have likely to have started planning the recovery working with your Hospital services. ABCD will would like to provide members with some steer, recognising it is difficult to be didactic. We also recognise that you have worked extremely hard over the last 3 months, and many teams have worked stoically throughout the pandemic to try and cause as little disturbance to diabetes service delivery as possible, this should be acknowledged and celebrated.

ABCD Have already been working on the Roadmap to recovery of diabetes services (Phase A), which focussed on risk stratification and setting priorities during the recovery Phase. We have involved Colleagues form Primary Care, PCDS and Service users form DUK.

This work has been completed and is awaiting endorsement from our Partners and will be submitted for publication. The Phase B of the recovery with Focus on Innovation, new Models of care (i.e. virtual consultation)including integrated working with primary care colleagues and IT solutions, which are vital to the delivery of efficient and good quality care. We hope that this work will be completed over the next 2-3 months

In the mean-time, ABCD would like to offer some suggestions for how patients can be stratified into red (urgent), amber (priority) and green (routine). We suggest the follow –up of these patients should be driven by clinical need.

We understand that identification and risk stratification may be challenging for specialist services and therefore offer recommendation on how we can identify those at highest risk. ABCD is aware that during the Covid pandemic, we have seen service changes happen in a matter of days that used to take months or even years.

ABCD is keen that the restart of diabetes services offer a clear opportunity for more joined up and cohesive working between primary and specialist care and trigger the more widespread use of virtual consultations and data management systems. While we do our best to keep our patients and colleagues sage, this pandemic may be the catalyst for change, accelerating the appropriate use of technology in diabetes care.

ABCD proposes that specialist services our approach to recovery plan should start and focus on:

1. Risk stratification and triage
2. Appropriate Resource allocation
3. Communication Prioritisation of those most in need of clinical support
4. Following guidance on maintaining social distancing
5. Ensuring seamless communication and collaboration between primary and secondary care services

We suggest that this is a golden opportunity to learn from the crisis and have highlighted some of the benefits of the new ways of working, recognising that triage will be an additional activity for the team and this will need investment, whether it be additional staff, additional time of current staff IT support systems.

ABCD recommendations for triage of patients during Covid Recovery

Table 1: A suggested model for prioritisation of individual with Diabetes.

	RED	**AMBER**	**GREEN**
Recommended review date	Review all "RED" patients within 3 months	Review all "AMBER" patients before 31.12.2020	Inform patients in this category that they are unlikely to be seen before December. Provide clear advice on where and how to contact the team for emergency support if things change
Metabolic control **Alternative measures** **BP (mm of Hg)**	HbA1c 86 mmol/mol 10% < 30% time in range BP > 160/100	69-86 mmol/mol (8.5 -10%) 30-50% time in range BP 140-160/100 on suboptimal medication	<64 mmol/mol (8.0%) >50% time in range BP < 140/80
Hypoglycaemia risk	Complete loss of awareness (e.g. Gold score 6 -7) SH needing 3rd party assistance in last 12 months	Impaired awareness of hypoglycaemia e.g. Gold score 4 – 5) HbA1c < 48 mmol/l (6.5%) on insulin or sulphonylureas. with known frailty,	Normal awareness of hypoglycaemia

Alternative measures		cognitive impairment or eGFR< 30ml/min. >20% time below 4 mmol/l	
Renal Function	Known CKD level 4 or more (eGFR < 30 ml/min) Known to diabetes renal service (optimise care and avoid duplication Rapidly declining renal function (eGFR reduction > 15 ml/min/year)	Known CKD 3b (eGFR < 45 ml/min) Or progressive albuminuria ACR >30	
Risk of admission	Admission in the last 12 months with - Unstable glucose (DKA, HHS or hypoglycaemia) - Cardiovascular ds - Cerebrovascular ds	Those with frailty / cognitive impairment needing additional support from their diabetes teams.	
Diabetes Foot status	Known active diabetes foot disease	Known high risk foot disease not known to podiatry services	No known diabetes foot disease
Other factors	Planning pregnancy in the next 6 months	Young patient (age < 40 yrs) with T1D or T2D with known early complications Patients with no diabetes review in the last 18 months	

Special considerations: ABCD would like you to be aware that **t**here will be a subgroup of individuals with diabetes who will fall outside these recommendations and

who may be considered high risk (people with learning difficulties, social difficulties, mental health issues, frailty, autonomic neuropathy), or those with cystic fibrosis related diabetes, post – transplant diabetes or who have other co-morbidities that put them at high risk. It is important to recognise that often those in the high-risk group may be the least likely to engage with services. On the other hand, there may be some patients in the high-risk group whom the team know well and who are "stable" in the high-risk group and where previous attempts to engage and support have been unsuccessful. Teams will need to make individual case-based decisions on where to prioritise their own resources in these circumstances.

Other special need groups are individuals who have been discharged from hospital after a Covid or non-Covid related admission who may require monitoring and support due to unstable glucose levels or because they have been started on insulin, and those who need assessment and optimisation of their diabetes prior to elective surgery.

Optimising virtual consultations: There is invariably a lead-in phase as we all learn to use virtual technologies. Virtual consultations will not cover every possible scenario in clinical practice, and it is not for everyone, but when it works it can replicate the physical consultation processes in the virtual space. However, we need to be aware that some in the most high-risk groups are individuals who may be most likely to have a very limited or no access to online technology or possibly even a safe environment to conduct a remote clinical interaction. Some key principles for video consultations are available in some excellent guidance from primary care diabetes society is also available (1-3). Prior to virtual clinics, having appropriate access to data is key and the following tips may be valuable

Access to glucose data: Data management platforms that collect glucose and insulin data such as Diasend, Carelink, Libreview and Clarity are key for virtual consultations. Ensuring people are connected and have access to information to allow them to upload data becomes key. In the absence of this, we can still rely on skills we use in our face to face appointments, such as asking the patient to read through their meter as we jot down the results to try and see patterns in the data, or e-mail the results to HCPs.

Key Interim recommendations from ABCD

- Planning the recovery of lost diabetes activity should be an urgent priority for the Diabetes team working in hospital or in Primary Care.

- Risk stratification requires availability of data sets which is not universal and in these circumstances Diabetes teams will be further challenged.

- We will encourage that we work across the traditional boundaries to support each other will be key to ensure a joined up approach.

- maximise available all opportunities to ensure an "every contact counts" ethos, avoiding repeated appointments to ensure the basics of diabetes care are delivered

- Use a holistic and person centred approach, taking into account co-morbidities and personal preferences, rather than a biomedical model of care

- Communication within and across teams remains vital at times like this but timely and clear communication with the person with diabetes will ensure that we avoid confusion, duplication and chaos while recovering lost diabetes activity during COVID-19.

- The recovery of lost activity is likely to require significant extra admin support to risk stratify patients.

- We strongly support the use of virtual consultations in delivering diabetes care recognising that we cannot completely replace face-to face consultations which will be important in certain clinical situations.

- As outlined in the principles of recovery, it is crucial that the medical workforce is adequately supported as many colleagues will be mentally and physically exhausted from provision of front-line services during the COVID crisis.

- IT systems need to be available and accessible across the whole health care system to deliver seamless care.

The rules and guidance around lockdown are being relaxed gradually by the Government based on scientific advice. This brings with it the risk of Potential second wave. Our next challenge will be to work on preparedness for a potential second wave of Covid and winter pressure.

References

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