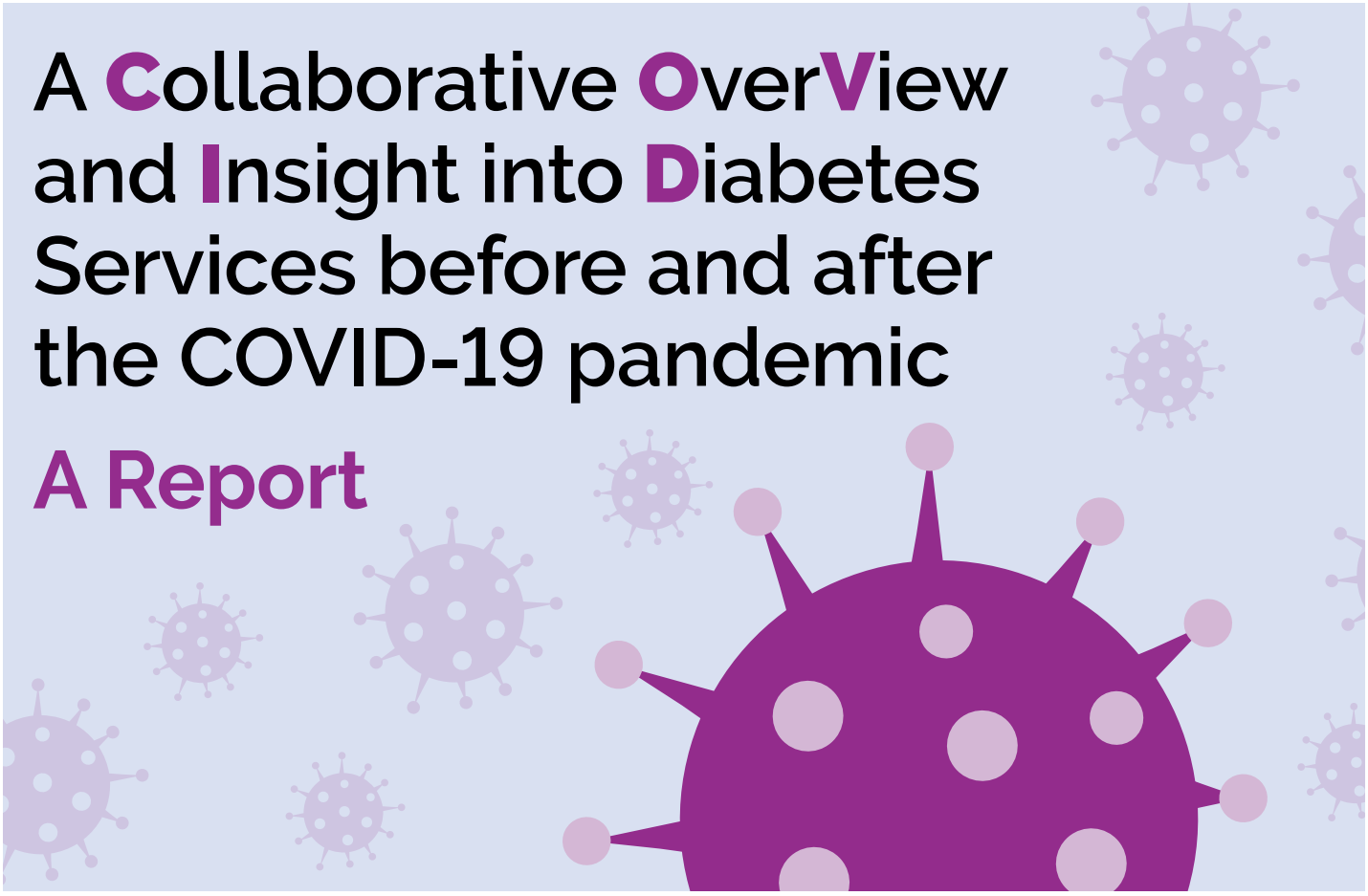
A Collaborative OverView and Insight into Diabetes Services before and after the COVID-19 pandemic

A Report



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Introduction

This report is part of an initiative led by Lesley Mills (Nurse Consultant); the group included Diabetes Specialist Nurses and Practitioners, Consultants, Registrars and Nurse Consultants. Diabetes specialist nurses (DSNs) work as part of multidisciplinary teams and can be based in a number of locations including, Primary Care, the Community setting and in Secondary Care. Some roles span more than one care setting. Diabetes teams are mixed medical and nursing teams who provide Inpatient and outpatient and community services for people with diabetes problems. The Registrar grade (ST) trainees straddle these lines as well, but provide more acute care, whilst receiving training in the diabetes and endocrine clinics. The information shown in this report has been collated from the writing group and demonstrates a before and after the COVID 19 pandemic view of diabetes services

Background and usual practice

Prior to the COVID-19 crisis many Diabetes Teams in England operated a number of face to face clinics, these included, outpatient, inpatient and intermediate care services.

Outpatient services

This work included teams of Consultants delivering a number of multidisciplinary diabetes clinics throughout the week. The number of people with diabetes scheduled to attend varied according to the type of clinic but are generally templated well in advance. Prior to the COVID-19 crisis the clinic systems often struggled to meet scheduled follow-up times with most Consultant waiting lists creeping up slowly. Some clinics are supported by a Diabetes ST grade who sees individuals independently with supervision as required. Nursing support is provided in many clinics and in some Trusts,

DSNs often practice independently running their own face to face clinics as well as providing telephone support to individuals with diabetes as a follow up appointment. Medicines management is a key element of this role with many DSNs having a non-medical prescribing qualification. The initiation of injectable therapies including insulin pump therapy, training on blood glucose meters, Continual glucose monitoring (CGMS) and Flash glucose monitoring is predominantly within the role of the DSN, with other members of the MDT including dietitians involved. Education for staff and people with diabetes is a vital element of every DSN's role

Inpatient diabetes services

The Diabetes Inpatient Specialist Nurse (DISN) role is well recognised and promoted; this role has been adopted in approximately 2/3rd of Hospital trusts in England and Wales (NHS Digital 2019) as it leads to reduced length of stay and safer care for in patients with diabetes. Within DSNs team some nurses predominantly deliver the inpatient review service on a daily basis. In some trusts this is a 5 days a week service and others a 24/7 service. Diabetes Inpatient Specialist Nurses receive support from Consultant colleagues with on-going / complex clinical issues.

Community based diabetes specialist nursing

Prior to COVID-19 Referrals were usually received by email, post or internal referrals and "loaded" on to the DSN caseload by the administration staff. Invitation letters were then sent to people with diabetes who have been referred once this referral had been triaged by the DSN. A two-four week time frame for individuals to call in and make an appointment was offered. If no contact was made in this time, the referral could be declined, and a letter sent back to referrer explaining no contact had been made.

Advantages:

- Letter could be sent by admin after review by DSN.
- Possibility of reduction in DNA

Disadvantages:

- There was sometimes no contact from a clinician to advise/discuss referral
- Clinical advice would not usually given on receipt of the referral except in some arrears a telephone call was made if the referrals was for made for individuals who had required 3rd party assistance for severe hypoglycaema
- Lack of engagement from the referred person meant no further appointment was offered

The impact of lockdown with COVID 19 on Diabetes Teams and people living with diabetes

When lockdown was announced on 23rd March 2020 it triggered a variety of measures. Hospital outpatient clinics were cancelled across the NHS, some DSNs were transferred to other non-diabetes departments including wards and others found themselves taking on the role of a DISN. For people requiring new or follow up outpatient appointments and those usually seen by a Community DSNS a new system of contact and consultation was required. To mitigate this, DSN teams working in a variety of settings undertook different ways of offering information and clinical support. This included:

- Telephone/video contacts with people with diabetes
- Safety-netting for young adults by using texts, video, and telephone consultation
- Insulin pump reviews and CGMS / Flash glucose monitoring using video consultation and internet training packages
- Different schedules for supporting pregnant women whilst minimising face to face contacts. Most women only attended the hospital when bloods required/scan or complications the rest was done remotely either via email/Clarity/Diasend /Libre view depending on device used
- People attending the diabetes foot service were triaged and those who still required a face to face appointment were seen.
- Insulin starts - in some teams these were undertaken remotely using a video consultation and internet tools. In other the person was seen in a face to face appointment , often this depended on the confidence of the DSN in using a virtual method of communication or it was felt that the face to face appointment was needed for that individual appointment

Community DSN services

In some teams, referrals were triaged by the Clinical Lead or a senior DSN with a telephone call to the person with diabetes– usually on the same day that the referral is received. Clinical advice was given as required, and a follow up telephone call (if needed) arranged whilst face to face clinics were put on hold or booked into a clinic that may be running in the future. The advantages of this were that it ensured:

- Contact with the person with diabetes to clarify referral
- Clinical advice could be given and recorded
- Improved waiting times (first contact can be 'countable')

The main disadvantage was reported to be that consultations could be time consuming. Time consuming – especially if a new referral or patient

Secondary and community care out patient services

In hospital and in some community-based teams a traffic light risk stratification system was added to triage referrals

Table 1 ABCD recommendations for triage of patients during COVID 19 Recovery (ABCD 2020)

	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	<4 mmol/mol (8.0%) >50% time in range BP < 140/80
Hypoglycaemia risk **Alternative measures**	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, cognitive impairmentor eGFR< 30ml/ min >20% time below 4 mmol/l	Normal awareness of hypoglycaemia

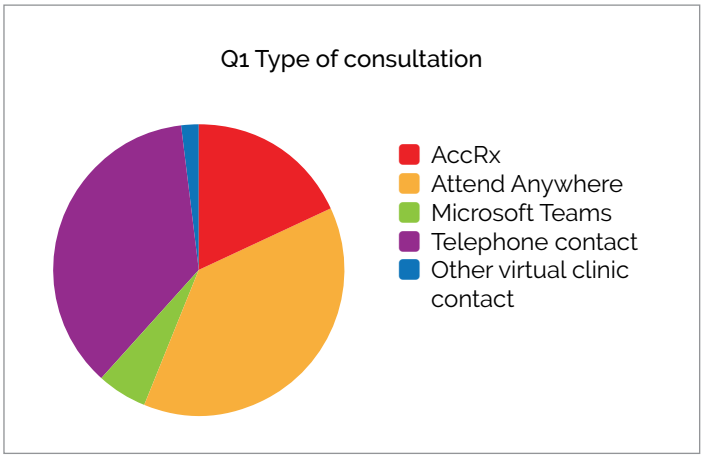
	RED	AMBER	GREEN
Renal Function	Known CKD level 4 or more (eGFR < 30 ml/min) Known to diabetes renal service (optimise care and avoid duplication Rapidly declining renal function (eGFR Reduction > 15 ml/min/year)	Known CKD 3b (eGFR < 45 ml/min) Or progressive albuminuria ACR >30	
Risk of admission	Admission 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	

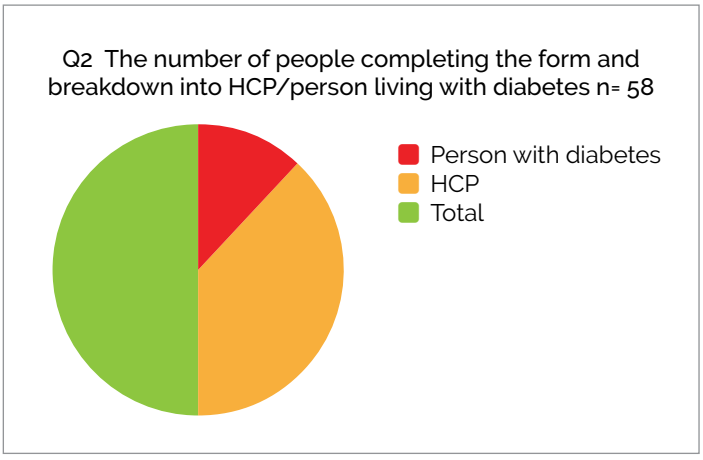
New ways of working: Virtual clinics

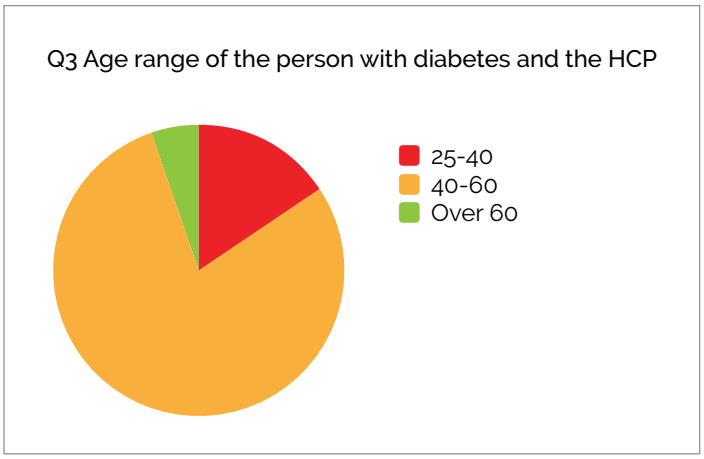
The COVID 19 pandemic prompted a number of new initiatives and these included virtual clinics. Some healthcare professionals embraced this new technology while other preferred to consult with their clinic population using the telephone.

A snapshot survey of staff and people living with diabetes was undertaken by the working group to identify their thoughts about these new ways of working. Fifty-eight people completed the online survey, 14 of these were people living with diabetes. Systems used for alternative consultations included:

- AccuRX
- Attend Anywhere
- Microsoft Teams
- The traditional telephone consultation





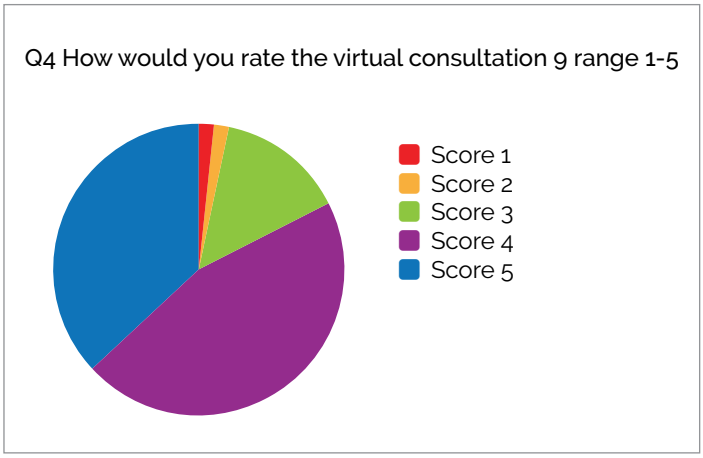


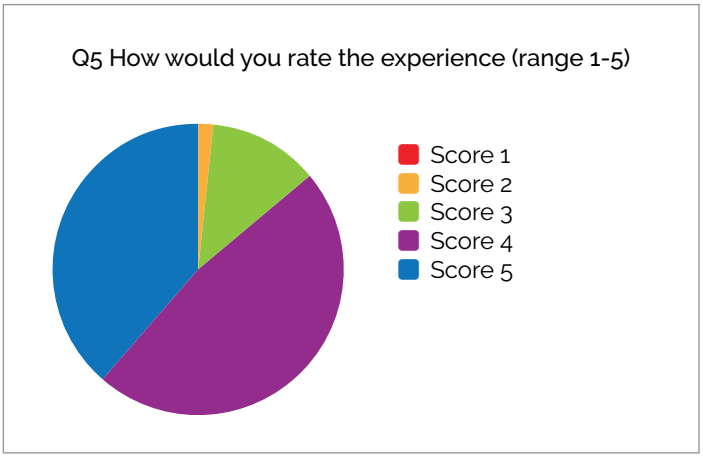
Comments are displayed in Table 2

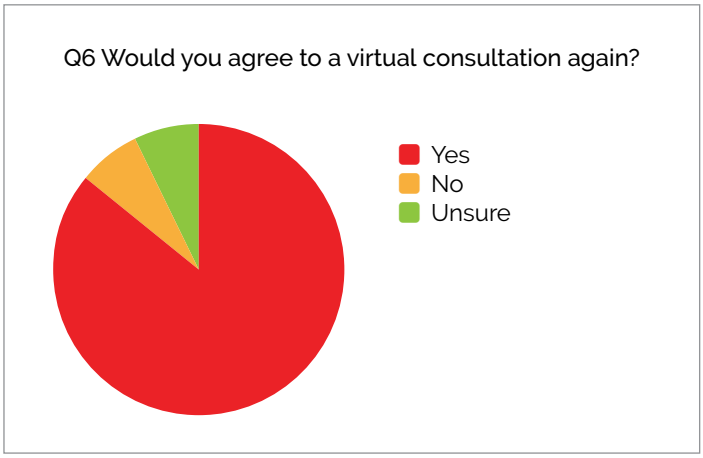
Table 2 Virtual clinic systems- general comments

Advantages	Challenges
• The various systems including AccuRX and Attend Anywhere can be built into GP EMIS systems, and for other Healthcare Trusts it can be used as a web-based virtual tool • No travel required for people with diabetes or staff • Short wait in the "waiting room" • Other members of the MDT can join the consultation if needed. • People with diabetes seem to enjoy this way of consulting this new way and not coming to clinic/parking issues etc • A significant reduction in the required physical infrastructure. • People with diabetes do not have to download any software or apps – they are sent an invitation to join the video consultation and they follow the link. They can this on their smartphone, tablet or computer (providing it has a camera and microphone • The individual is usually contacted by text on the day of the video call to remind them and the delivery receipt of the text can be attached to their community records. • Once individual accepts the link and joins the call verbal consent is obtained and this is recorded in the electronic notes. • Clinic letters can be sent out via the system • People with diabetes have fed back how easy it is and there have been lots of positives	• All HCPs need access to the same patient information • Administrative support to set up patient appointments, send out links, inform them of time delays in the virtual waiting room is needed • Suggest do not leave people with diabetes more than 30 minutes in a virtual waiting room • Staff confidence may be low when using these systems, so training is needed to be in place • DH Policy needed so that non prescribing nurses can titrate /initiate insulin. • Virtual clinics are not suitable for all individuals with diabetes, particularly with video consultations, due to the availability of appropriate technology, internet, or technical experience. Telephone alternatives would work for some. • Biophysical data and blood tests would require pre-organisation and the results be at hand. • Access to primary care data records is required • The utility of HbA1c in clinic is lost. There may be technical issues in uploading of data from meters etc. – potential mitigation could be arranged. • Initially, a reduction in clinic numbers would be required, whilst staff and patients adapt to a new way of working. Pre-clinic preparation would be required by current staff • The trainees would also need to be involved- potentially requiring separate defined clinic lists. • Separation of the current joint working experience of Doctors-DSN and dietitian, although this can be mitigated • Consultations such as insulin starts can take longer.

The survey questions asked revealed an overall positive response to the use of "virtual clinics" and most would use this system again







Comments from individuals with diabetes who were contacted using a visual system are shown in Table 3

Table 3 Comments from people living with diabetes

• No comment my diabetic nurse is excellent
• System sometimes lags and this makes conversations more difficult to have. Virtual appointments much more convenient in relation to less travel time and childcare issues.
• The phone number used to ring me was unknown to me so there is a chance I would have ignored it. Maybe letting you know the number beforehand.
• I think for a lot of appointments and certain people it suits because of the efficiency, however there are times when face to face is needed. A mix of approaches is definitely a way forward.
• Consultation did not work I was unable to hear our team due to poor sound which didn't help due to them having to wear masks. Reverted to a phone consultation which was very successful, and we were happy with
• The only downfall, understandably, is that the appointment was not on time so I felt slightly limited on what I could do whilst waiting for the phone to ring. My appointment was 2 hours late but I was only at home, so it didn't really matter however I was trying to work at the same time and didn't want to miss this call.
• I think the service could use a upgrade to work properly

The comments from healthcare professionals reflected many of those of people with diabetes

Table 4 Healthcare professional comments

• Always call person first to check they are ready and will be able to respond when you send the link to join otherwise you could waste a lot of time
• It was a useful exercise to review my data using the screenshare, as I could then see and mimic the same thing at home. Maybe a different approach in the future is to get the patient to lead some parts (such as Libre reporting) to sense check familiarisation and understanding, as it's different watching someone doing it when compared to doing it for real
• The only issues we have experience have been due to connectivity
• Improve internet connectivity
• Back to normality
• Had Skype/FaceTime facility
• Learn as you go, take time before the clinic /appointment to prepare and make sure it's clearly communicated to your patients that its a video call (many expected a phone call). Be patient, it's stressful to start with but it'll be worth it when it all works out!
• It depends on the patient's ability and some of our team struggle with the technology.
• The families must be able to download their meters and pumps and be linked up to Libre View/clarity if on CGM
• Offering video for some patients. We just doing telephone at moment and explore best video platform but also for group virtual video platform that can support Desmond. Was not sure what question 8 was about.
• Better equipment and private room to use it
• Helpful IT department and equipment on time rather than taking 8 weeks
• No comment, a positive experience to use.
• Offering video for some patients. We just doing telephone at moment and explore best video platform but also for group virtual video platform that can support Desmond.
• Ensure patients are well prepared for the virtual consultation beforehand. There are many resources out there on how to do this.
• We initially used telephone clinics now using attend anywhere successfully

Structured education programmes

Some structured education programmes were traditionally presented as face to face learning with the person with diabetes and a partner, Spouse or Carer attending These are held in a small group setting. Following the COVID 19 "lockdown: these sessions ceased. Some established structured educations however can be accessed oline and these include:

- DESMOND
- DAFNE
- Carbs and Cals
- My Path

However, it is acknowledged that some some individuals may prefer a face to face programme. Group sessions using a virtual system could be considered as a future development.

The way forward

It is unlikely that most teams or people will want to revert back wholly to the traditional ways of service delivery where:

- Waiting times would be long in outpatients as the clinics tended to be overbooked
- Frequently failure to attend episodes were recorded
- Travel for staff and people with diabetes along with parking costs were problematical for some.

There would still be instances where in the community setting where home visits may still be considered essential.

Diabetes teams may want to consider a mix of face to face and virtual consultations. This system blends aspects of the traditional service and the technology available to operate virtual clinics and may include:

- Face to face appointments to review people:
  - With a first appointment
  - Those declining a virtual appointment
  - Annual review in community clinics

  - People who are housebound
  - People with a significant co-morbidity e.g dementia, terminal illness, end of life.
  - Those with a diabetic foot ulcer when clinically necessary and telephone or virtual clinics for some follow up appointment
- The continuance of face to face appointments would be recommended when pregnant women attend for scans or their obstetric appointment and virtual appointments for the rest of the time
- The continuance of virtual clinics for young people with diabetes and one- two face to face appointments per year
- MDT review of people in a particular cohort, for example people with diabetes attending pre dialysis, dialysis departments or post-transplant

Diabetes and mental health

Diabetes and mental health and general well-being needs to be considered when undertaking virtual or face to face consultations. The Coronavirus pandemic has created an excess demand for mental health support and services including increase in rate of suicides amongst older/elderly populations, anxiety, depression and post traumatic stress disorder; this may continue over a medium to long term time frame .

Resources

When using alternative methods for consultations it is important that all staff are appropriately trained and that the person with diabetes gives consent. Record keeping and confidentiality is paramount. There are a number of resources available to help healthcare professions and people with diabetes when considering the use of telephone or virtual clinics. These are shown in the appendices and include

- Royal College of Physicians Guidance
- Getting the most out of virtual consultations
- Examples of literature for people with diabetes.

Summary

Proposed service changes may not return to the old ways of service delivery however they may change and return to a 'new normal'. It is presumed that there will NOT be a significant second phase of COVID-19 but likely that a small (manageable) number of cases will continue to occur over the next 12 months. This will require the NHS as a whole to address. It does mean however those hospitals will need to keep a COVID-19 "hot facility" functioning and isolated within its footprint, whilst the remainder of the "cold" service will continue to recover. There even remains the small possibility of single hospitals dealing with all COVID -19 cases functioning as a regional hub.

It may be that a second wave /re-emergence of the disease will occur in the Autumn/Winter period. Much of this depends on the progress made over the next 6 months with case identification and isolation, contact, test, and trace., and the availability of an effective vaccine. If a significant second wave does occur then it is imperative, that services continue to function rather than being completely shut down again. The ability to flex into a predominant 'virtual service' will build in a degree of flexibility to allow this to happen. This should be considered in the design of any new service.

Diabetes Teams have learnt how to adapt to new ways of working and it is important that these skills are not lost. In many ways they have helped health care professionals to streamline services and to ensure that those people who really need to be seen face to face can be seen in a timely manner. However, some individuals with diabetes may feel they have been "lost" in the system during the pandemic, so it is important the healthcare professions re-engage with them when introducing new ways of working.

Appendix 1: The Position of the Royal College Of Physicians

The RCP report on outpatient suggests a number of things to consider in OPD service delivery including:

- Generic referrals should be pooled to minimise waiting times for appointments. Local consultants should review an agreed mix of generic and sub-specialty referrals according to demand.
- All outpatient care pathways should aim to minimise disruption to patients' and carers' lives.
- Clinic templates should allow for timing flexibility depending on case complexity and the needs of the patient. They should allow a realistic timeframe to conclude business and avoid frequent unsatisfactory visits.
- Patients should be directly involved in selecting a date and time for an appointment. That can happen either in person, via telephone or electronically.
- Alternatives to face-to-face consultations should be made available to patients and included in reporting of clinical activity.
- Access to follow-up appointments should be flexible. Patient-initiated appointments should be offered, replacing the need for routine 'check in' appointments.
- Trusts should be remunerated on the basis of clinical value, not units of physical interaction or activity.

Regarding Video/telephone the RCP state this.

Telephone and video consultations

These appointments are not designed to totally replace face-to-face consultations, but are able to deliver some of their functions via video-link, eg Skype for Business, or the telephone. The benefit of these appointment styles is reduced disruption to patient lives and a reduced need for hospital infrastructure (eg clinic rooms, parking and support staff).

They can also increase the resilience of a service, particularly in response to travel disruption. During the 2018 snow storms the 'NHS near me' programme run in the Scottish Isles was able to deliver the majority, if not all, of its outpatient appointments using their established telemedicine clinics. This prevented cancellations and ensuing backlogs from rescheduling.

Patient selection and expectation management is crucial to ensure that satisfaction and care is not compromised. Patients are being reported to be 'embracing new technology and increasingly expect their care to be supported by it', including older patients.

Patients should have simple and reliable points of communication with secondary care services to trigger reviews or conversations if they have any problems or issues. This could be through an email service or telephone helpline with a guaranteed response time. The guaranteed response time allows a threshold of urgency to be set, so those using the advice service understand that if faster response is required they should use an emergency care pathway. Establishing this form of advice service could lead to the complete abolishment of standardised follow-up appointments as they currently exist, replacing them with patient initiated appointments according to patient need. These models have also been referred to as 'see on symptom' or 'patient-activated care'. This service could be extended to community teams, potentially removing the need for referral in the first place.

Full report - https://www.rcplondon.ac.uk/file/11479/download

Appendix 2. How to get the most out of a "virtual" clinic appointment

OCDEM Guidance for Telephone and Video Consultations during the Covid-19 pandemic

1. Confidentiality
    a. Ensure clinician is in a place where can speak to patient confidentially – and reassure patient that this is the case
    b. Ask patient specifically are they able to speak to you confidentially now – and if they are not – rearrange/ask them to move etc
    c. Ensure the electronic device used to record information is appropriately password protected etc
2. Positive Patient Identification
    a. Essential – ask them to confirm DOB and first line of address in the usual way
    b. They may ask you to positively identify – do this without giving away sensitive patient details
3. Patient Consent – essential to ask the patient whether they are happy to have a telephone/video consultation with you.
4. EPR power letter for every patient – this does not need reproducing in the hospital notes (HT communication with Caldicott guardian previously abut requirements).
5. Letter text should include – rationale for telephone rather than face to face appointment e.g. I reviewed Mr X by telephone with his consent, in view of the current Public Health Guidance in the context of the Covid 19-Pandemic.
6. Ensure you have all the information ready and prepared before the consultation – EPR – look at Power Note/Notes/OUH specials and investigations. GP information may also be accessed. Do not perform remote consultation if this is not available.
7. Highlight any specific problems to both the patient and the GP in the letter as unable to assess the patient clinically and therefore unable to ascertain
    - e.g. extent of visual fields, assess eye disease in Graves' disease
    - postural drop in Addison's etc, sensation in feet/retinopathy, limited ability to examine examination sites
    - Warn and document risk/advice if symptoms develop
8. Recognise what could be missed (potential cause for complaint/claim).
    a. New patients – see paragraph below
    b. safeguarding issues – flag if concerned - ? via GP phone call
    c. inability to examine patient (state in letter if an issue and organise clinical review)
    d. nuances of clinical condition – if concerned ensure GP informed and triage follow-up face-to face as soon as possible
    e. communication challenges including interpreters etc
9. Address and specific Covid-19 issues
    a. Shielding or stringent social distancing advice if required (NB Shielding list link below – active Cushing's, brittle Addison's, immunocompromised including rituximab, azathioprine, ciclosporin and interferon)
    b. Hydrocortisone replacement advice
    c. Diabetes advice
    d. ACEI – continue medication ..etc
    e. Patient anxiety – signpost to help (diabetes helpline/B and D/support societies with web pages)
    f. Key worker advice and long term conditions
    g. Reassure that while clinic appointment is at a distance there is always an OCDEM presence who can be contacted in an emergency via the Churchill.
10. Ensure follow-up is robust
    a. Let GP know in letter
    b. Inform patient during consultation

c. Ensure secretaries know – when and who with

d. Organise blood investigations as practical and necessary and let patient know how you will review and feedback. Currently, limited blood testing is available via the CSW team in OCDEM (mornings only and is dependent on staff availability).

e. Consider carefully imaging considering need to triage and back log – keep a personal record so none are forgotten and can be booked later.

11. New patients

a. Telephone/video assessment of new patients is not ideal as there is limited mechanism to examine the patient and no pre-existing relationship with OCDEM

b. From a practical OCDEM standpoint, all patients will be individually assessed by the doctor due to see them, regarding appropriateness of telephone consultation/delay till face to face OP

c. On-going new referrals will be assessed by consultants triaging the letters as to those who could be reviewed by phone but recognising that most new patients' appointments will be delayed until face to face consultation is possible.

https://www.themdu.com/guidance-and-advice/guides/conducting-remote-consultations

https://www.gmc-uk.org/ethical-guidance/ethical-hub/remote-consultations

Appendix 3: Video Clinic Confirmation letter

Appointment Telephone Number:

Dear XXXX

We are pleased to advise that the Trust has now commenced holding consultant appointments by video. This is to provide a significantly better patient experience as you will not need to leave your home/place of work to be seen by your consultant.

Your consultant has asked that we arrange your next appointment to be held using video. This means that you will not need to come to hospital but will instead attend on line using the web link and following the instructions shown below.

- The advantages of attending your consultation by video are:
- Ensures your and our staff safety by reducing exposure to infection
- You can see and talk to your consultant from the comfort of your own home or workplace
- Reduced clinic waiting times and disruption to your time
- You will still receive an appointment time as normal
- An improvement on telephone consultations as much of human communication is non-verbal and video allows your consultant to see you in person.

Your video consultation has been arranged as below, please allow for 10 minutes either side of this time as the clinic may not always be on schedule.

Clinician	Xxxx
Date	Xxxx
Time	Xxxxx
Location:	Home

How to attend by video:

1. Prior to your Video Consultation you will have a chance to test that your set up meets all of the above. If you encounter any problems when using the system please contact the Appointment Centre on <<<<<INSERT PHONE NUMBER HERE>>>>>>.
2. Copy or type this link <<<<<INSERT WEBLINK HERE>>>>>> into the web browser on any appropriate device such as mobile phone, tablet or desktop.
3. Please ensure that you log into the Video Consultation 10 minutes before your appointment time to ensure that you can connect to the hospital team.
4. Please have a list of your medication available.
5. If you have any technical issues or are unable to connect please contact our Contact Centre on 01925 662003.

To be able to use this service you will need the following:

- Device – Laptop / Desktop PC / Tablet (Ipad, Samsung Galaxy etc.) / Smart Phone (Iphone, Android etc)
- Web Browser – Safari (Iphone or other Apple Devices) / Google Chrome (Samsung Phones or Tablets, or downloaded engine on your PC/Laptop) OR Microsoft Edge (Latest version)
- Microphone (If you are not using a device with one built in)
- Web Camera (If you are not using a device with one built in)
- Internet Connection - Please note if you are not connected to the WiFi you will use your data allowance
- Battery – Please ensure you wireless device has sufficient battery for the appointment

Patient confidentiality

Please be aware that patient confidentiality still applies for video consultations. The video consultation would be for the patient or their legal guardian only. The doctor cannot legally talk to a patient's relatives about their health without written consent of the patient. The doctor will ensure that the video conversation is held in a room where the consultation cannot be over-heard. It is the patient's responsibility to ensure that they use a device in a suitably private area.

Confirmation of your appointment

You do not need to reconfirm your video appointment.

However, if the time is inconvenient for you or you do not wish to participate by video please let us know (by telephoning the number on the top of this letter) and we can reschedule your appointment/offer you a telephone or physical consultation.

You will receive text reminders before your appointment. If you wish to opt out of the text reminder service please email your request to <<<<<INSERT EMAIL HERE>>>>>>.

Please be aware that video consultation will require internet connection and charges may be incurred if you are not on an unlimited Wi-Fi tariff.

Appendix 4: Information for people with diabetes attending a "virtual clinic"

Attending your appointment by video instead of travelling to your appointment, you enter the clinic's online waiting area. The service is notified when you arrive, and your consultant will join you when ready. There is no need to create an account and no information you enter is stored.

What do I need to make a video call?

A good connection to the internet - If you can watch a video online (e.g. YouTube) you can make a video call

Use a private, well-lit area where you will not be disturbed during the consultation

One of these is needed:

- A Google Chrome web browser on a desktop or laptop, or on an Android tablet or smartphone
- Safari web browser on an Apple iMac,
- MacBook, iPad, or iPhone
- A web-camera, speakers and microphone already built into laptops or mobile devices

Is it secure?

Video calls are secure; your privacy is protected.

You have your own private video room that only authorised clinicians can enter.

How much internet data will I use?

You don't use any data while waiting for a consultant to join you. A video call uses a similar amount of data to Skype® or FaceTime®.

How much does a video call cost?

The video call is free (except for your internet usage

Patient Information

https://www.bartshealth.nhs.uk/video-consultations

https://www.diabetes.co.uk/news/2016/mar/virtual-clinics-launched-across-uk-to-improve-type-1-diabetes-care-94280693.html

http://www.rotherhamccg.nhs.uk/Downloads/Top%20Tips%20and%20Therapeutic%20Guidelines/Diabetes%20Specialist%20Advice%20Clinic.pd

Useful information and references

Association of British Clinical Diabetologists (2020) A Quick guidance to Risk Stratification and recovery of Diabetes Services In the post – Covid-19 Era https://abcd.care/sites/abcd.care/files/site_uploads/Resources/COVID-19/ABCD-Recovery-Guidance-2020-06-23.pdf accessed 16/7/20

Diabetes UK Care line: 0345123 2399

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