Delivering diabetes care in a

NEIGHBOURHOOD HEALTH SERVICE

DIABETES UK

KNOW DIABETES. FIGHT DIABETES.

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PCDO Society | Primary Care Diabetes & Obesity Society

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Key steps for

DIABETES CARE IN NEIGHBOURHOOD HEALTH

- recommendations for local systems

1. Integrate diabetes care and prevention across neighbourhood health teams, including voluntary sector, local authorities and specialist diabetes teams.

2. Ensure, through commissioning, that neighbourhood teams are focused on identifying and addressing diabetes related health inequalities.

3. Fund diabetes clinical leadership and networks. These drive innovation, facilitate integration, and help share specialist diabetes knowledge with new and current staff across local systems.

4. Assign data leads responsible to use and share datasets across neighbourhood health teams, such as the National Diabetes Audit, to guide commissioning, identify vulnerable populations, and track targets.

5. Fund diabetes care professional roles including diabetes specialist nurses, healthcare assistants, mental health practitioners, dietitians, pharmacists, technologists, admin support and other health care professionals with specialist expertise.

6. Share diabetes models and provide support to adapt and implement them. The National Neighbourhood Health Implementation Programme could have a role in supporting this.


Kingston Hospital
NHS Foundation Trust
hello my name is

The opportunity for diabetes care in NEIGHBOURHOOD HEALTH

Published in July 2025, 'Fit for the Future: The 10 Year Health Plan for England' highlights that more than a quarter of the population are now living with a long term condition, accounting for 65% of NHS spending. To address this the plan sets out steps to provide more preventative care via a neighbourhood health service.

Diabetes is a relentless long-term condition that requires constant self-management, supported by regular routine healthcare, to stay well. It is a gateway to many other conditions. One in five adults in the UK are now living with diabetes or prediabetes, and numbers are still rising.

The development of neighbourhood health provides exciting new opportunities to improve both diabetes care and the prevention of type 2 diabetes, building on and further rolling out local and national examples of innovation.

This paper sets out what could be achieved by fully integrating diabetes into neighbourhood health services and sets out some of the key next steps for those developing neighbourhood health across England.

Why care for people with diabetes needs to improve?

There are now over 12 million people living with diabetes or prediabetes in the UK. The risk of death from cardiovascular disease (CVD) is 4.2 times higher in people with diabetes compared to those without. Almost a third of people needing kidney dialysis or a transplant have diabetes. Every week in the UK, diabetes leads to more than 3,230 cases of heart failure, 980 strokes, 680 heart attacks, and 184 amputations. The cost of diabetes complications makes up 60 per cent of the total cost to the NHS of managing and treating diabetes. But with the right care, treatment, and support, diabetes complications can be prevented.

Almost 168,000 people under 40 in the UK are now registered as having a type 2 diabetes diagnosis, an increase of more than 47,000 since 2016-17. Being diagnosed with type 2 diabetes at an earlier age carries with it a higher risk of developing complications earlier, driving a widening gap in healthy life expectancy.

Despite this higher risk, people under 40 are currently less likely to access even basic levels of diabetes care. Diabetes also has one of the largest gaps in prevalence between people from high and low areas of deprivation of any condition, with type 2 diabetes in the under 40s 3.8 times higher in the most deprived areas compared to the least deprived.[2]

£8,987,000,000

Diabetes costs the NHS in England almost £9 billion a year[1]

Estimated cost for key component of diabetes care:

- Diagnosis..... **£62,261,065**
- Management..... **£3,682,923,871**
- Complications..... **£5,241,733,281**

Diabetes UK website includes a breakdown of cost of diabetes by ICB - **diabetes.org.uk/investing-in-care/uk/england**

1 Estimation of the direct health and indirect societal costs of diabetes in the UK using a cost of illness model - https://onlinelibrary.wiley.com/doi/epdf/10.1111/dme.15326

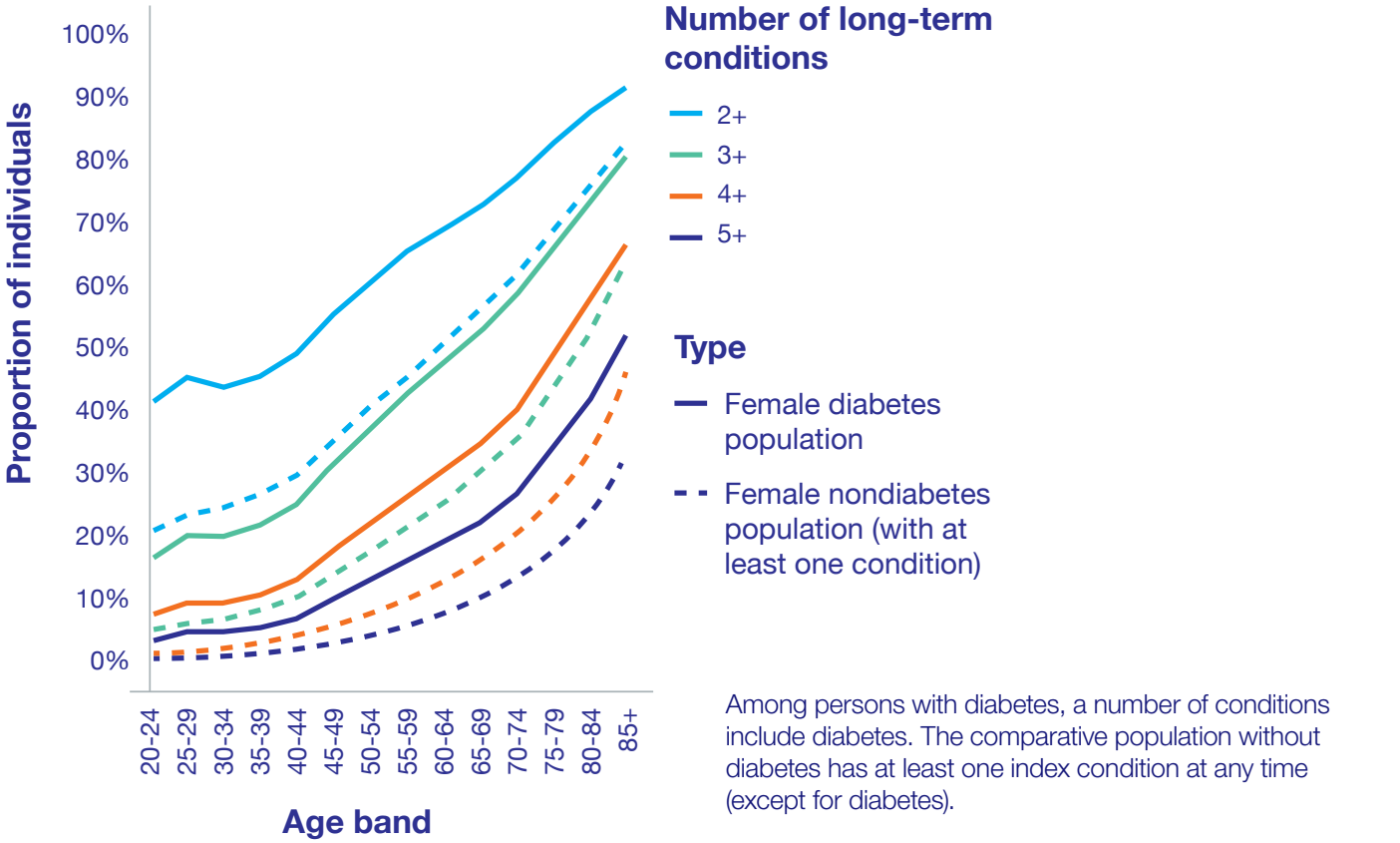
2 NHS England (2024) National Diabetes Audit: Young People with Type 2 Diabetes, 2022-23

People with diabetes are more likely than those without to be living with multimorbidity. By the age of 50, a third of people with diabetes have at least three comorbidities, will spend 20 years living with them, and die 11 years earlier than the general population.[3] The figure below shows how the diabetes population compares to people living with another long term condition without diabetes.

Both type 2 diabetes and diabetes complications can be prevented for many with access to good routine healthcare and support. People with type 2 diabetes, who make up approximately 90% of all diabetes diagnoses, experience most of their routine care within primary and community services and many of their interactions are with practice nurses and healthcare assistants as well as GPs. NICE guidance recommends nine routine care processes (which include blood tests, blood pressure, urine test, foot check, Body Mass Index (BMI) check, diabetic eye checks and smoking status) to optimise care and treatment and reduce the risk of complications for people with diabetes. Because of their importance in helping people with diabetes to live well, many of the health checks are linked to financial incentives for general practice (the Quality and Outcomes Framework (QOF). Yet, despite their importance in reducing complications, there is currently significant variation in completion rates of these care processes across England.

The latest data from 2023/24, shows 61.3% of people in England diagnosed with diabetes received all of their care processes - eye checks are not included in these statistics, but the difference in these completion rates seen between Integrated Care Boards (ICB) and Primary Care Networks (PCN) was vast. Only 43.8% of people received all of their care processes in the lowest performing ICB (NHS Coventry and Warwickshire), compared to 75.3% in the highest performing ICB (NHS North West London ICB). Data broken down

How the female diabetes population compares to people living with another long term condition without diabetes



Among persons with diabetes, a number of conditions include diabetes. The comparative population without diabetes has at least one index condition at any time (except for diabetes).

3 The burden of diabetes-associated multiple long-term conditions on years of life spent and lost | Nature Medicine - https://www.nature.com/articles/s41591-024-03123-2

at PCN level reveals an even starker degree of variation. The percentage of people with diabetes who received all their care processes varied from 15.7% in the lowest performing PCN to 89.4% in the highest. Within one ICB, the completion rates between its PCNs ranged from 21.8% at the lowest to 84.2% at the highest.

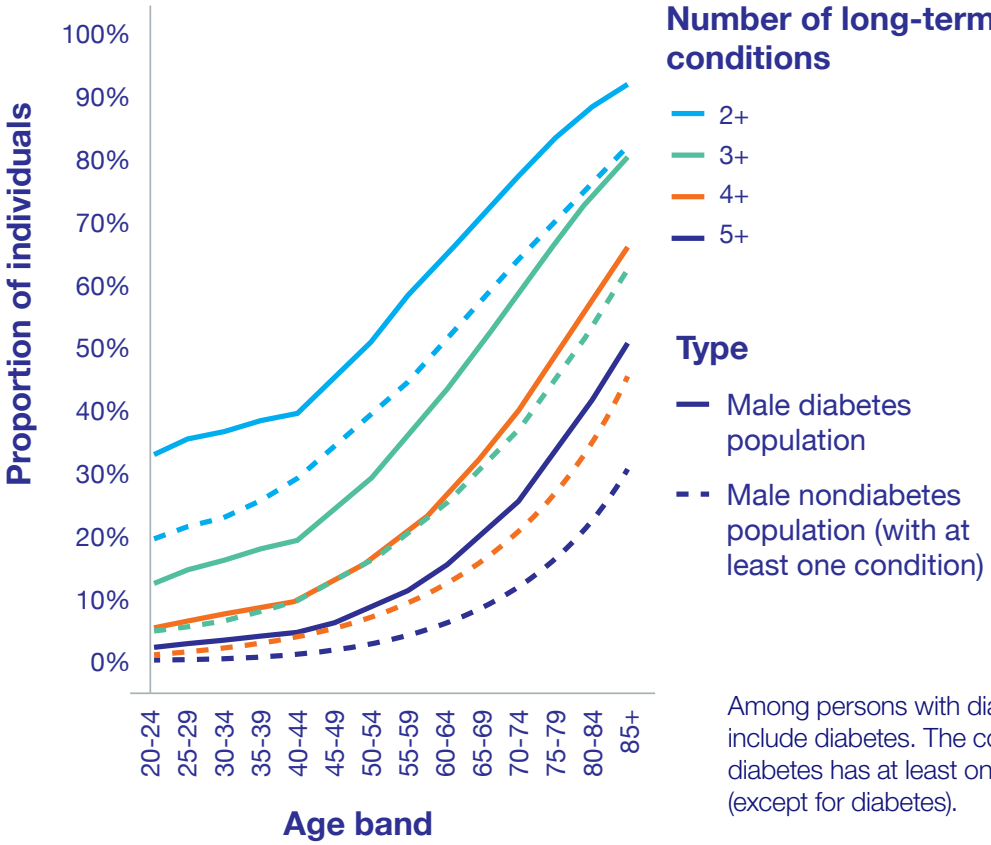
Annual reviews enable healthcare professionals to discuss the outcome of care process checks and treatment targets with people with diabetes. They are a vital opportunity to identify any emerging concerns, optimise treatments, discuss new medications and technologies and make referrals for specialist input.

In the recent National Diabetes Patient Experience Survey (NDPES), 14% of people with type 2 diabetes said they had not had a review in the last year and 7% reported never having had an annual review. 16% of people had not discussed the results of their annual review checks with a health care professional and three in ten (31%) had not had a conversation with a healthcare professional about what would happen next with their diabetes care at their last annual review.

Reducing inequities in diabetes care is widely recognised as a key issue to tackle. A recent independent report on patient safety across the health and care landscape, led by Penny Dash, now Chair of NHS England highlighted that addressing the variation in diabetes care processes is key to improving primary care.[4]

The NHS England Performance Assessment Framework for 2025/26 includes diabetes care processes as a metric of ICB success on effectiveness of care.[5]

How the male diabetes population compares to people living with another long term condition without diabetes



Among persons with diabetes, a number of conditions include diabetes. The comparative population without diabetes has at least one index condition at any time (except for diabetes).

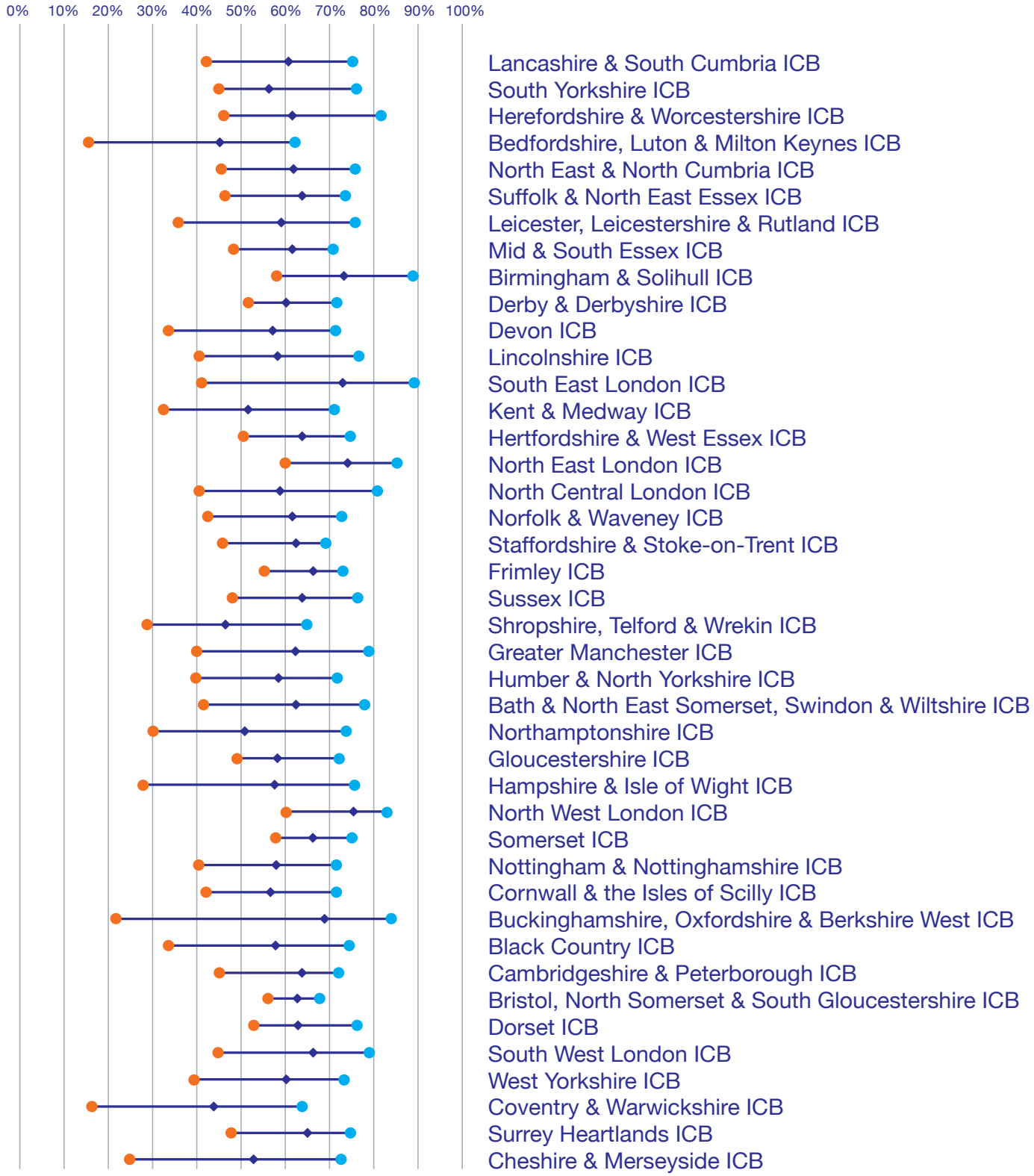
4 Review of patient safety across the health and care landscape - GOV.UK - https://www.gov.uk/government/publications/review-of-patient-safety-across-the-health-and-care-landscape/review-of-patient-safety-across-the-health-and-care-landscape

5 NHS England - The NHS Performance Assessment Framework for 2025/26 - https://www.england.nhs.uk/long-read/the-nhs-performance-assessment-framework-for-2025-26

I would love to see my care more joined up. I currently sit on sixteen different NHS waiting lists, five of which are dealing with issues around my diabetes (not including routine care). It is not just the workload for the NHS, it is the burden on my professional carers and husband trying to get me to and from all of these appointments on time.

Sarah
Living with type 2 diabetes

The highest and lowest percentage of people who received all 8 care processes by PCN within each ICB, 2023-24



- PCN with lowest % of all eight care processes
- PCN with highest % of all eight care processes
- ICB Average % all eight care processes

SHIFTING CARE CLOSER TO HOME

The Darzi review (2024) identified that "as the disease burden has shifted towards long-term conditions, multidisciplinary-team working has become more important. Yet NHS structures have not kept pace".

While ICBs and local health systems have the potential to deliver some of this fundamental change and improve diabetes services, without national planning guidance there is too often a lack of prioritisation of diabetes amongst many local systems. Of the 42 ICB Joint Forward Plans published in 2023, only 16 had a section dedicated to improving diabetes care. This is reflected within diabetes services where attempts to innovate and provide more care in the community, have often found themselves hindered.

Diabetes UK has carried out a series of interviews with a range of healthcare professionals working to improve diabetes care in England to establish what are the key steps for neighbourhood health services to deliver for people with diabetes. These included speaking to GPs, secondary care doctors, nurses, project managers, and dietitians involved in innovative models of care which are, or were, delivering high standards of care for people with diabetes in the community with joined up, multi-disciplinary support.

Recurring themes surfaced in these interviews, identifying key barriers to innovation within the primary and community care system. Even those who had been successful in setting up neighbourhood health services to improve diabetes and health inequalities, felt they were too often working against the system rather than being supported by it.

The barriers included:

- A lack of people with diabetes expertise in leadership roles (and a lack of opportunities for those who aspired to lead) meant that improvements to care were not happening.
- A poor understanding of the diabetes population and related health inequalities from local care systems.
- Financial incentives for local health systems that don't support the needs of the diabetes population.
- Short term, unprotected funding for improvements in diabetes care – meaning that funding can end up being used elsewhere.
- Siloed data systems preventing different care providers from supporting one another.
- Not enough integration and collaboration between services including primary, community, and secondary care providers.

Key principles for creating a neighbourhood health service which delivers for people with and at high risk of diabetes

Diabetes UK interviews with people delivering and receiving diabetes care identified six key areas for improvement for delivering neighbourhood health care. As the vision in the 10 Year Health Plan starts to be implemented, these principles will be important in ensuring that neighbourhood health can deliver needed improvements in diabetes care.

1 Embed diabetes clinical leadership to drive innovation

- Delivering good care for people with diabetes starts with having strong diabetes clinical leadership working together across different levels of care.
- In areas where diabetes leaders have the resources, flexibility and trust to provide solutions that work for their populations, there have been significant improvements in care for people with diabetes. This includes use of risk stratification algorithms and data health segmentation of the population (such as the UCL proactive care framework*) to identify and support proactive care for high-risk people with diabetes/at risk of type 2 diabetes.

* https://uclpartners.com/proactive-care-frameworks-version-2

The Leicester Model of Diabetes Care

Leicester has some of the highest prevalence of diabetes in the country, with up to 13% of the inner city population affected. Ten years ago, primary and secondary clinicians and managers came together to design an enhanced diabetes service. The Leicester Model of Diabetes Care is a primary care-centred approach shown to be safe, effective, and cost-saving, supported by the local ICS, council, public health, universities, and acute trusts. The model works by moving key services from secondary care to primary and community care and they are supported by an enhanced service. Alongside this, the Effective Diabetes Education Now (EDEN) program was developed to train healthcare professionals to deliver high-quality diabetes care, reduce hospital admissions, and ensure appropriate specialist referrals. If this were to be nationally adopted across the UK, the model has potential to save £83 per patient annually, with potential NHS savings of over £276 million per year if implemented in all primary care practices, without compromising patient outcomes.


NHS
Kingston and Richmond
NHS Foundation Trust

2 Invest in financial incentives which support diabetes care and reduce inequalities in health

- Financial incentives (such as the Quality and Outcomes Framework (QOF)) are an effective way of driving improvements in diabetes care in primary and community settings. Recent changes, as part of the strategy to reduce CVD risk are welcome, and similar uplifts in thresholds for diabetes checks not currently included should also be introduced for 2027/28. Financial incentives at a local and national level can also be used to target the reduction of health inequalities.
- Data on care, treatment, and outcomes which is consistently monitored and updated can ensure investment in diabetes care is delivered equitably and supports improvement in delivery and outcomes. And a commitment to ongoing funding for the National Diabetes Audit is crucial to enable this.
- Nationwide diabetes programmes have proven to be an effective way of delivering care and should continue to be funded.
- Enhanced financial support can reduce inequalities in health outcomes for targeted demographics. For example, the 'T2Day: Type 2 Diabetes in the Young' initiative, backed by NHS England Diabetes Programme funding has which provided an additional payment to local systems roll our extra support for people diagnosed with type 2 diabetes under 40 to help minimise the risk of this high risk group developing health complications and severe illness and to support a reduction in health inequalities.

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Type 2 Diabetes in the Young (T2Day)

In August 2023 the NHSE Diabetes Programme launched T2Day, a new initiative supported by £14.5m, to provide additional tailored health checks for people with type 2 diabetes aged 18 to 39 years old. Early onset type 2 diabetes is associated with higher risks of complications and is also more likely to affect people from deprived areas and ethnic minority backgrounds. The programme, taken up by 40 ICSs in England, supports primary care in providing additional support including care processes, optimisation of glycaemia, blood pressure, cardiovascular risk, weight management, psychosocial support as well as providing women with advice for planning for pregnancies. The programme includes nationally led guidance but it is up to local systems on how it is delivered so that it best meets the needs of different populations. Early evaluation suggests T2Day is having a positive impact, however, transformation funding is not ringfenced and is subject to ICB cost pressures and clinical teams having to make the case to secure it locally. The intervention needs to be supported by formal national or local contracting/ incentives such as DES to ensure consistent uptake and outcomes improvement.


MY BODY
What's going on?
50%
X2

3 Ensure neighbourhood health teams provide optimum routine diabetes care, including:

- Identifying more people with high risk of type 2 diabetes using NHS health checks and other initiatives. This should include outreach to communities with a higher risk of type 2 diabetes. Due to the steep increase in people developing type 2 diabetes under 40, consideration should be given to testing approaches to roll NHS health checks or similar approaches to individuals from the age of 25 to high risk groups.
- Implementing care coordination which provides person-centred support based on a detailed understanding of the different health challenges and needs of the diabetes population.
- Increasing the number of people with diabetes offered opportunities to attend 'one stop shop' services in their neighbourhoods particularly focusing on areas with significant inequalities or low uptake in care processes, rather than having to attend multiple appointments. This should include more extended hours appointments in community settings to allow more people to get their checks.
- Providing multi-disciplinary support in neighbourhood care settings, including expertise in physical and mental health conditions, dietitians, pharmacists, and social prescribing opportunities.
- Referrals to other support services (both NHS and VCSE) for people with diabetes and at high risk of type 2 diabetes should be fully embedded into neighbourhood health teams.

This would include

1. everyone with prediabetes and individuals who have had gestational diabetes being encouraged to join the NHS Diabetes Prevention Programme
2. everyone newly diagnosed with diabetes being encouraged to take part in a structured education programme
3. all those newly diagnosed with Type 2 be considered for referral to the NHS Type 2 Diabetes Path to Remission Programme
4. automatic referrals to VCSE sector organisations at diagnosis for peer support and information adopted as part of the "Diagnosis Connect" commitment.

- For the person with diabetes or at high risk of type 2 diabetes, much of their access to the above should be supported by the NHS app, providing people with digital access to NHS health checks, care coordination and links to other services and support.

Cornwall One Stop Shop Clinics

Cornwall and Isles of Scilly Integrated Care Board have been improving numbers of people with type 2 diabetes receiving routine care processes via diabetes one stop shop clinics. The clinics held in local practices across Cornwall have been selected to support a reduction in health inequalities. They have been delivered in collaboration with the Integrated Care Board (ICB), Primary Care, Kernow Health CIC, Cornwall Diabetic Eye Screening programme, Diabetes UK, Volunteer Cornwall, and Cornwall Council. The clinics have saved significant amounts of surgery appointment time and enabled people with type 2 diabetes to avoid having to attend numerous separate appointments. They have identified dozens of referrals (some urgent) that would otherwise have been missed and supported people in deprived areas with community support via social prescribers.

4 Invest in a healthcare professional workforce with the expertise to both prevent type 2 diabetes and treat

- Develop a range of roles within neighbourhood health teams that can provide diabetes care and treatment, including diabetes specialist nurses, healthcare assistants, mental health practitioners, dietitians, pharmacists, technologists, admin support and other health care professionals with specialist expertise. This might be done through the Additional Role Reimbursement Scheme (ARRS).
- Embed training opportunities into the system to support upskilling and career progression for community and primary care professionals.
- Share examples of innovative practices and models in staff mix and utilisation of technology from neighbourhood care.
- Learn from existing examples of innovation in providing enhanced community-based specialist support, support with medical optimisation, and obesity management.

Diabetes Support Teams (DiaST)

The Brooklands and Northenden Primary Care Network funded a Diabetes Support Team (DiaST) model to improve integrated, holistic care for people with diabetes. Led by a primary care Diabetes Specialist Nurse funded with 'Covid-Recovery' monies to work 24 hours a week in delivering diabetes education, guidance, support and some 'hands-on clinics' across the PCN. The DiaST team particularly provided support for underserved communities, people newly diagnosed, women of childbearing potential and complex cases not able to be managed in routine general practice care.

Despite some difficulties in delivering the service, which included limited estates availability, the results were very positive, with year 2 data showing that 202 referrals to secondary care were prevented, there was effective optimisation of glycaemia and cardio-metabolic risk factors and care processes uptake especially for the under 50 years cohort, improved greatly. However, when the initial funding completed, the DSN who had led on this innovative work was not able to be funded by the Additional Role Reimbursement Scheme (ARRS) and the service ended.

People with complex diabetes needs now need to be referred to secondary care with longer waiting times for review.

https://diabetesonthenet.com/wp-content/uploads/Diabetes-in-the-Primary-Care-Network-Structure-April-2021.pdf

5 Assign clear accountability for recording data and delivering improvements. Use integrated data across community, primary, and secondary care providers to identify where and in which populations treatment and support needs to be enhanced.

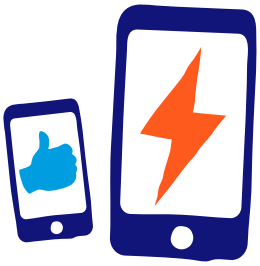
- All of the preceeding principles can only be delivered by effective data management to understand the diabetes challenges within neighbourhood health and track progress in diabetes management.
- Data segmentation of the population should be used to identify people who have the greatest need for engagement. It should also be used to tailor targeted support offers.
- There should be clear accountability and alignment at ICB and neighbourhood health level for data collection and reporting to support care improvements.
- IT systems and data sharing need to be fully integrated, with technology suppliers adhering to common information standards that ensure consistent health records and enable data to move between different systems.
- Seek ways to better capture community health services data, which is poor currently compared to primary and secondary care.

Hampshire and Isle of Wight ICB identifying people with pre-diabetes

Hampshire and Isle of Wight ICB have improved referrals to the NHS Diabetes Prevention Programme from primary care services by using data to identify practices with poor referral rates. The ICB set up a team consisting of a healthcare assistant, a doctor with a specialist interest in diabetes, and project management support. The team searched the data, sent out AccuRx invites, fielded responses and dealt with any queries. They offered education and support in finding eligible patients to primary care services who hadn't been referring to the programmes. The results led to a marked increase in referrals, exceeding the national average.

6 Underpin neighbourhood health with a move to digital health care

- The NHS app should be established as a digital front-door to the NHS. Neighbourhood healthcare will be enhanced if a full range of services can be accessed within the NHS App, including booking appointments, ordering repeat prescriptions and consenting for health data to be used in research.
- Non-digital routes to interact with neighbourhood healthcare must also be developed alongside this for people who experience digital exclusion or prefer not to use the NHS App.
- Digital tools should be linked with third sector organisations to provide information on conditions like diabetes to healthcare professionals and their patients, to support better management and self-management of conditions.



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