Community diabetes services: fit for the future?

CHRISTOPHER WALTON,[1] VIJAY JAYAGOPAL[2]

Br J Diabetes 2025;25(2):59-60
https://doi.org/10.15277/bjd.2025.495

Key words: community diabetes services, type 2 diabetes, commissioning, diabetes prevention programme

The 10-year Health Plan for England: *Fit for the Future* identifies a move from hospital to community care as one of three key shifts, the others being from analogue to digital, and from sickness to prevention.[1] Since hospital teams are increasingly occupied with implementing new technologies for people with type 1 diabetes (T1DM), the increasing numbers and complexity of people with type 2 diabetes (T2DM) present a huge challenge to community and primary care teams. In this edition of the *British Journal of Diabetes*, Balani *et al*. report an audit documenting that, between 2017 and 2023, people with diabetes referred to the community service in Sutton were more ethnically diverse, had higher mean HbA_{1c} levels, higher rates of microalbuminuria, and were more likely to have three or more significant co-morbidities such as co-existent cancers or cardiovascular disease.[2] In 2023 91% of referrals were for insulin initiation or failure to reach HbA_{1c} targets, compared with 63% in 2017 when approximately a third were for dietary advice alone.

To prepare for these challenges, it is important that commissioners understand that, if one excludes obesity, diabetes is frequently the first condition in the sequence of chronic disease. In a study performed in Lambeth examining the order in which chronic diseases present, the most common initial conditions were diabetes and depression.[3] The diabetes prevention programme, now established in all four nations of the UK, may therefore delay not just a diagnosis of diabetes but other related conditions. More than 900,000 adults have entered the programme since its launch in 2016. The most recently published data on the NHS England programme suggest that those attending all sessions have a 45.5% lower risk of developing T2DM, while attending 60% of sessions (the NHS England definition of programme completion) is associated with a 30.7% risk reduction compared with partial attendance.[4]

Likewise, the national pathway to remission programme for T2DM may delay or prevent downstream diabetes complications and other chronic conditions;[5] every person newly diagnosed with T2DM should be informed about this option in the first phase of care. However, even with these established programmes, there remains much unmet need for diabetes care in the community. With advances in therapy and more uniform provision of services, goals such as large reductions in chronic kidney disease in diabetes are achievable.

In their 2025 document *Delivering Diabetes Care in a Neighbourhood Health Service*,[6] Diabetes UK advocate: 1) integration of diabetes care and prevention across neighbourhood health teams; 2) addressing diabetes-related health inequalities; 3) funding diabetes clinical leadership and networks; 4) assigning data leads responsible for the use and sharing of datasets, such as the National Diabetes Audit, across neighbourhood health teams; 5) funding diabetes care professional roles; and 6) sharing diabetes models and providing support to adapt and implement them.

Whilst funding constraints make aspirations hard to achieve, more systematic sharing of models may realise quality and productivity gains. In many areas, Tier 3 community care now includes community consultant- and/or diabetes specialist nurse-led clinics, and Tier 2 services are supported by consultant- or diabetes specialist nurse-led MDT meetings with the lead specialist GP. In Leicester, where the prevalence of diabetes is very high, there is a long-established model of enhanced primary care,[7] which if adopted across the whole of the UK could save the NHS £276.2M per year.[8] Models which carefully integrate existing services also deserve wider adoption, such as the Jean Bishop Centre in Hull, where an MDT between the frailty and diabetes teams ensures that the increasing number of people with frailty and diabetes receive holistic care without missing out on specialist advice.[9]

No reinvention of wheels is required — the models to develop a national framework are established. Arguably, the greatest barrier to uniform implementation of models is the commissioning process. Local commissioners have no requirement for specialist qualification or specific project management experience and are often working across diverse specialties. In addition, in some areas with wide socio-economic

[1] Hull and East Yorkshire Hospitals NHS Trust, UK
[2] York Teaching Hospital NHS Foundation Trust, UK

Address for correspondence: Dr Christopher Walton
Consultant Diabetologist (Retired 2025), Hull and East Yorkshire Hospitals NHS Trust; Deputy Editor, British Journal of Diabetes
E-mail: drchriswalton@yahoo.co.uk

differences within the same commissioning area, there are historical care deficits that contribute to the commissioning variance and postcode lottery of services delivered. Education and skilled managerial support for commissioners should be at the forefront of measures to provide fit-for-purpose community diabetes services.

Conflict of interest None.
Funding None.

References

1. Department of Health and Social Care. *10-Year Health Plan for England: Fit for the Future*. 2024.
2. Balani J, Emmambux S, Hyer S. Changing pattern of GP referrals: experience from a community diabetes clinic. *Br J Diabetes* 2025; online ahead of publication. https://doi.org/10.15277/bjd.2025.491
3. Ashworth M, Durbaba S, Whitney D, *et al*. Journey to multimorbidity: longitudinal analysis exploring cardiovascular risk factors and sociodemographic determinants in an urban setting. *BMJ Open* 2019;**9**:e031649. https://doi.org/10.1136/bmjopen-2019-031649.
4. Parkinson B, McManus E, Meacock R, Sutton M. Level of attendance at the English National Health Service Diabetes Prevention Programme and risk of progression to type 2 diabetes. *Int J Behav Nutr Phys Act* 2024;**21**:6. https://doi.org.10.1186/s12966-023-01554-7
5. Valabhji J, Gorton T, Barron E, *et al*. Early findings from the NHS Type 2 Diabetes Path to Remission Programme: a prospective evaluation of real-world implementation. *Lancet Diabetes Endocrinol* 2024;**12**:653–63. https://doi.org/10.1016/S2213-8587(24)00194-3
6. Diabetes UK. Delivering Diabetes Care in a Neighbourhood Health Service. 2025.
7. NIHR ARC East Midlands. The Leicester Model of Enhanced Diabetes Care. 2021.
8. Seidu S, Gillies C, Farooqi A, *et al*. A cost comparison of an enhanced primary care diabetes service and standard care. *Prim Care Diabetes* 2021;**15**:601–06. https://doi.org/10.1016/j.pcd.2020.10.011
9. Murtagh FEM, Okoeki M, Ukoha-kalu BO, *et al*. A non-randomised controlled study to assess the effectiveness of a new proactive multidisciplinary care intervention for older people living with frailty. *BMC Geriatr* 2023;**23**:6. https://doi.org/10.1186/s12877-023-03727-2