Access to Diabetes Technology in West Sussex

1. Introduction

1.1 Diabetes is a long-term condition that occurs when either the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces. The most common types of diabetes are:

- **Type 1 diabetes.** Type 1 diabetes is characterised by deficient insulin production and requires daily administration of insulin. It is an autoimmune condition though neither its cause nor the means to prevent it are fully understood. Type 1 diabetes is usually diagnosed in children and young adults, although it can appear at any age. Management of type 1 diabetes is delivered by specialist diabetes services.

- **Type 2 diabetes.** Type 2 diabetes affects how your body uses sugar (glucose) for energy. It stops the body from using insulin properly, which can lead to high levels of blood sugar if not treated. Type 2 diabetes can be preventable. Factors that contribute to developing type 2 diabetes include genetics, being overweight, not getting enough exercise, and older age. This is the most common form of diabetes. People with type 2 diabetes are predominately cared for by primary care, with specialist services managing the most complex patients.

1.2 The NHS spends over £10 billion each year on diabetes, equating to 6% of its budget, with over half of this money (60%) spent on treating preventable complications[1]. As such supporting people living with diabetes to manage their condition, specifically through improved glycaemic control has the potential to reduce the costs to the NHS in managing the condition, but more importantly supports a healthier population.

1.3 The evolution of diabetes technology is a key component in transforming diabetes care and empowering people living with diabetes to better manage their condition, ultimately leading to improved clinical outcomes. Efficacy alongside safety and cost

[1] Estimation of the direct health and indirect societal costs of diabetes in the UK using a cost of illness model (wiley.com)

effectiveness is driving adoption of diabetes technology[2], which, when used appropriately, improves the lives and health of people with diabetes, and reduces the NHS costs related to management of diabetes and its complications. The focus until recently has been on providing this technology for people with type 1 diabetes, but this has now shifted to include a small cohort of people with type 2.

1.4 In managing type 2 diabetes a whole pathway approach needs to be considered, focusing on early identification (pre-diabetes), prevention and improved diabetes management through embedding sustainable behavioural and lifestyle changes to prevent people requiring technology to manage their diabetes. This contrasts with type 1 where there is no ability to reverse or enable remission although lifestyle factors can impact the condition.

1.5 In February 2024 Diabetes UK (DUK) wrote to the West Sussex Health and Adult Social Care Scrutiny committee asking for the topic of access to diabetes technology to be reviewed, due to concerns around the local Sussex policy for access to wider technology for people with type 1 diabetes not being fully aligned with national guidance and a lack of a commissioned pathway for people living with type 2. This paper will set the context of the current diabetes landscape, alongside providing an up-to-date position on access to diabetes technology in West Sussex.

2. Background

2.1 Diabetes technology can help people live better lives, and guidance from the National Institute of Clinical Excellence (NICE) advocates the use of technology to support some people living with diabetes through both NICE guidance (NG) and Technology Appraisals (TA).

2.2 NICE guidance is developed with health care professionals and people who use services to help with decision making on prescribing and recommended treatment[3]. Apart from Technology Appraisals the use of NICE guidelines is not mandatory. Technology Appraisals are based on a review of clinical evidence and cost effectiveness, with a statutory responsibility for the NHS to make funding available for a

[2] Evolution of Diabetes Technology - ScienceDirect
[3] NICE guidelines | NICE guidance | Our programmes | What we do | About | NICE

recommended drug or treatment with a TA, normally within three months (unless otherwise specified)[4].

2.3 There is a range of diabetes technology available, with multiple guidelines available over the years, which are summarised below.

2.4 Continuous Glucose Monitoring (CGM) systems monitor glucose. These devices are worn continuously on the body and provide a glucose reading to a smart phone or reader. Certain CGM devices are prescribable, however there are some devices with increased functionality which are non-prescribable.

2.5 A Continuous Subcutaneous Insulin Infusion (CSII) pump provides a steady stream of insulin to the body, with the person needing to test blood sugar levels, adjusting administration rate of the pump, and delivering boluses as needed. All CSII pumps are non-prescribable technology, and as such within the scope of this work. Pumps are used by patients to manage their diabetes by working alongside CGM monitors. CSII is almost exclusively used for people with Type 1 diabetes.

2.6 More recently, Hybrid Closed Loop Systems (HCL) have become available; these comprise of a CGM device, and an insulin pump linked to a computer algorithm that can adjust the amount of insulin needed based on glucose readings. This feedback loop responds quickly to changes in glucose levels and "semi-automates" many of the processes people living with diabetes currently use to control their blood glucose levels.

2.7 The NHS Long Term Plan (2019) signalled NHS England's intent to rapidly improve access to diabetes technology. Subsequent NICE guidance (May 2022) for adults with type 1 diabetes (NG17), broadened the offer to state that all people living with type 1 diabetes should be offered CGM, with the device with the lowest cost offered if multiple devices meet the patients' needs and preferences.

2.8 In 2008, NICE recommended CSII pumps to support management of type 1 diabetes in TA151. This recommendation was built on in the 2022 guidance for adults with type 1 diabetes recommending CSII

[4] Technology appraisal guidance | NICE guidance | Our programmes | What we do | About | NICE

pumps for the cohort of patients living with type 1 diabetes who are the most clinically vulnerable and therefore at the greatest risk of accessing unplanned care or developing diabetes related complications.

2.9 In December 2023, NICE published a Technology Appraisal (TA943), which outlined a phased rollout of HCL to people living with type 1 diabetes. The NHS England, HCL implementation strategy describes a three-year plan for Children and Young People (CYP), and a five-year plan for the adult population. It is estimated over 150,000 people will be eligible for HCL in England and Wales by 2030, with 100% of CYP and c70% of adults estimated to be using HCL. This is a significant shift from the current landscape.

2.10 NICE Guidance 28, Type 2 diabetes in adults (NG28), recognises management of blood glucose is a core component of diabetes care, and that if type 2 diabetes is not well controlled, patients are at an increased risk of long-term complications. When NG28 was updated in June 2022 it recommended CGM is offered to adults living with type 2 diabetes who fulfil a specific set of clinical criteria.

2.11 Through dietary changes and weight loss, type 2 diabetes can be improved, or in some cases reversed, enabling someone to reach and hold normal blood sugar levels, living 'diabetes free' without medication. This puts a person's type 2 diabetes into remission (rather than cured) making it possible to go years without needing to control blood glucose and the health concerns that come with living with type 2 diabetes.

3. Strategic Context

3.1 There are more than five million people living with diabetes in the UK with national prevalence increasing year-on-year from 5.4% in 2009/10, to 7.5% in 2022/23[5], and it is predicted to increase to 9% by 2030[6]. Due to the differing aetiology between the types of diabetes this increase is driven by an increasing number of people diagnosed with type 2 diabetes, the causes of which are complex, with age, family history, ethnicity and socio-economic background all

[5] Cardiovascular Disease - OHID (phe.org.uk)
[6] NHS England » NHS scheme reduces chances of Type 2 diabetes for at risk adults

contributing to a person's risk. Obesity also increases this risk, which is also heightened at a younger age.

3.2 In Sussex, just over 105,000 of the adult population are living with Diabetes; 57,275 of which reside within West Sussex (where the total population is 885,100). 92% (96,650) of all adults with diabetes in Sussex have type 2, as opposed to 8% (8,505) of adults living with type 1. This split is reflected in West Sussex with 52,895 people living with a diagnosis of type 2 and 4,380 living with type 1.

3.3 Diabetes does not affect everyone equally, with factors driving inequalities complex and interrelated.

3.4 The links between ethnicity and type 2 diabetes are well documented with a disproportionate number of people diagnosed with diabetes from ethnically diverse groups (excluding white minorities). People from ethnic minority backgrounds are more likely to be living in areas of deprivation than those of white ethnicity, creating multifactorial risk[7]. The proportion of the West Sussex population who are of minority ethnicities has increased from 11.1% in 2011 to 15.8% in 2021, Crawley has seen the greatest overall increase in residents of minority ethnicities, rising from 27.9% of the population in 2011 to 38.2% in 2021. In West Sussex there is a 12.1% prevalence of type 2 diabetes within these groups.

3.5 In Sussex over 96% of people living with type 1 diabetes are from white population groups, or have no recorded ethnicity, with less than 5% known as being from an ethnic minority population group. This Sussex breakdown is reflected in West Sussex.

3.6 Socio-economic factors also influence outcomes for people with type 2 diabetes, with deprivation associated with unhealthy behaviours including access to nutritious food due to economic hardship, and a sedentary lifestyle, which increases the risk of obesity, and type 2 diabetes. People from the most deprived areas in England are 2.5 times more likely to be living with type 2 diabetes than people from less deprived areas.

3.7 Nationally, prevalence of type 1 diabetes by deprivation is equally split across all Indices of Multiple Deprivation (IMD) quintiles. Figure

[7] What Are Health Inequalities? | The King's Fund (kingsfund.org.uk)

one sets out type 1 diabetes registrations by IMD quintile, and it can be noted at a Sussex level there is a lower prevalence than the national distribution in the most deprived areas (10.2% in Sussex contrasted with 19.9% nationally), and a slightly higher prevalence in the least deprived areas (23.0% in Sussex versus 19.4% nationally), with the highest distribution falling within the middle quintile. When looking at West Sussex distribution, the difference in registrations between highest and lowest areas of deprivation are more apparent, with 4.1% of type 1 in the most deprived quintile, and 32.5% in the least deprived quintile. This breakdown is reflective of West Sussex being ranked in the least deprived 20% area in the country overall (129th least deprived upper tier local authority out of 151)[8].

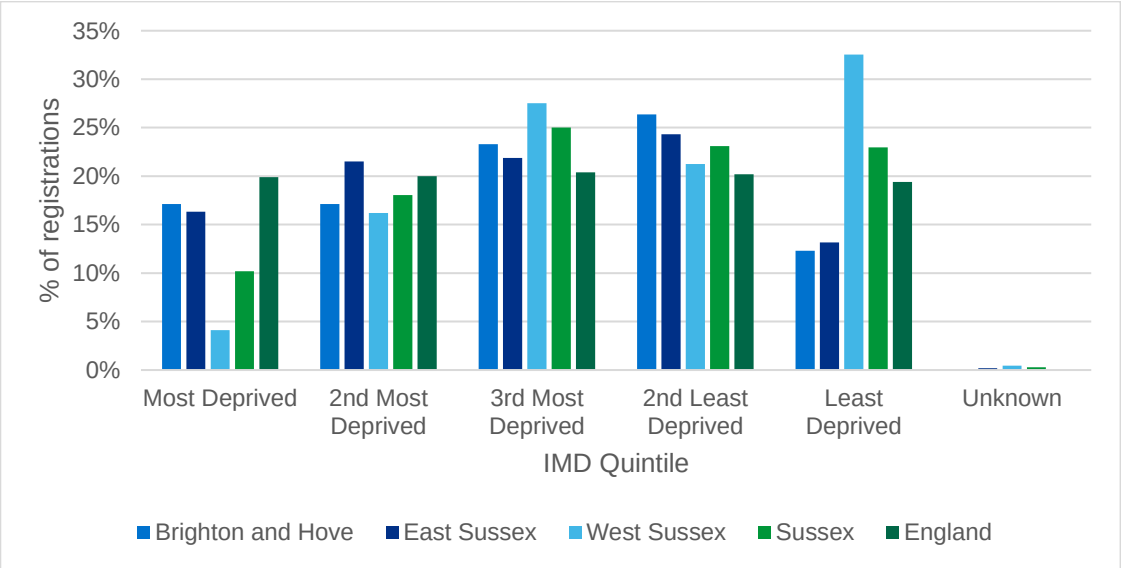

Figure one: Type 1 diabetes registrations by IMD Quintile and place. Source: NDA 2022/23

Nationally there is a higher prevalence of type 2 diabetes in the most deprived areas when compared to the least deprived. This is reflective of socioeconomic factors increasing the risk of type 2 diabetes. Figure two sets out type 2 diabetes registrations by IMD quintile, and it can be noted at a Sussex level there is a lower prevalence than the national distribution in the most deprived areas (11.2% in Sussex contrasted with 23.6% nationally), and a slightly higher prevalence in the least deprived areas (19.4% in Sussex versus 15.0% nationally),

[8] Briefing-West-Sussex-IMD-2019.pdf (westsussex.gov.uk)

with the highest distribution falling within the middle quintile. As with type 1 diabetes, when looking at West Sussex distribution, the difference in registrations between highest and lowest areas of deprivation are more apparent, with 3.8 % of type 2 in the most deprived quintile, and 26.9% in the least deprived quintile.

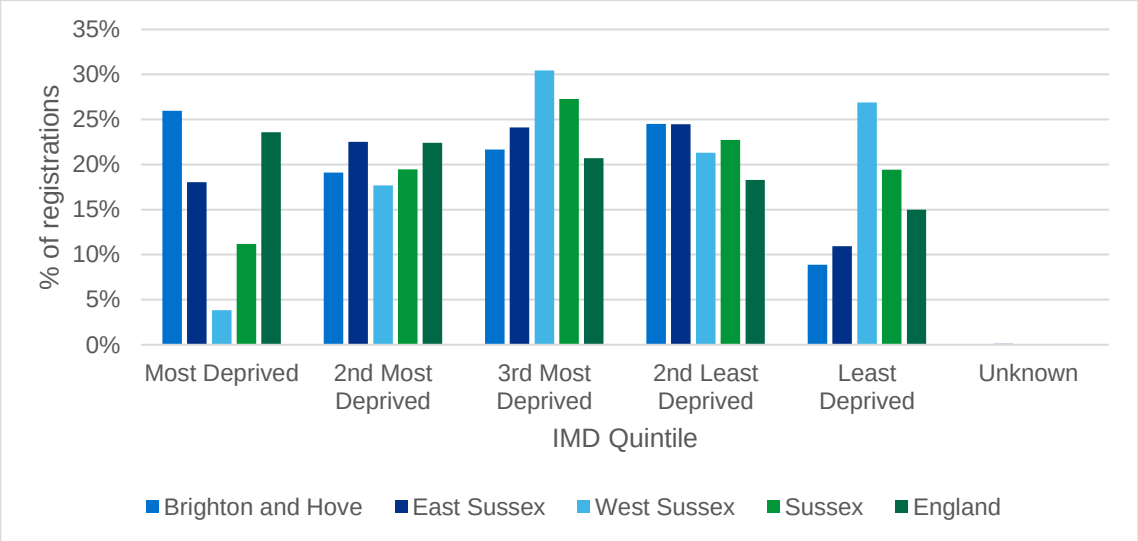

Figure two: Type 2 diabetes registrations by IMD Quintile and place. Source: NDA 2022/23

3.8 Type 2 diabetes is two to three times more prevalent in people living with a severe mental illness (SMI). Various risk factors have been implicated, including side effects of antipsychotic medication and unhealthy lifestyles, which often occur in the context of socioeconomic disadvantage and health care inequality.

3.9 Prevalence of both type 1 and type 2 diabetes in people living with a learning disability (LD) is higher than in the general population[9] According to data, 0.8% of people with LD in England have a diagnosis of type 1 diabetes, compared with 0.4% of the general population, with estimates for type 2 stating prevalence at 10%, almost double than in the general population[10]. There are an

[9] rightcare-pathway-diabetes-reasonable-adjustments-learning-disability-2.pdf (england.nhs.uk)
[10] Diabetes deep dive Canva Version (kcl.ac.uk)

estimated 970 people living with a LD and type 2 diabetes in Sussex equating to 9.2% of the local population.

4. Accessing Diabetes Care in Sussex

4.1 Type 1 diabetes is predominantly managed by specialist services as per national recommendations[11]. For the population of West Sussex this is provided by:

- University Hospitals Sussex NHS Foundation Trust (UHSx) with diabetes specialist centres at the acute hospital sites in Chichester, Haywards Health, Worthing, and the Royal Alexandra Children's Hospital.
- Surrey and Sussex Healthcare NHS Trust (SaSH), with Sussex patients seen at the Earlswood Centre in Redhill, in spoke clinics in Horsham or Crawley, or at East Surrey Hospital if accessing paediatric or antenatal services.

Care within specialist services includes the provision of diabetes technology, foot protection teams, and multi-disciplinary foot team services, transition services (paediatric to adult), antenatal care, inpatient care, combined renal clinics, psychology, LD, HIV, and patient structured education programmes.

4.2 Management of type 2 diabetes is predominantly within primary care. In July 2024, the new 'improving diabetes care' locally commissioned service (LCS) went live resourcing practices to deliver enhanced care over and above the General Medical Servies (GMS) contract and the Quality and Outcomes Framework (QOF). For practices delivering the LCS there is an expected tier one service which includes the maintenance of registers, an enhanced service for newly diagnosed type 2 diabetes, enhanced care planning, pre-pregnancy counselling, optimising care prior to surgery, referral to the NHS National Diabetes Prevention Programmes (NHS DPP) and Type 2 Diabetes Path to remission Programme (T2DR) and ongoing management of insulin in general practice. There is in addition a discretionary tier two within the LCS, supporting risk reviews for patients at high risk of diabetes, and initiation of injectables (basal insulin and GLP-1 analogues). Due to the LCS only being active from 1st July 2024 quarterly claims data

[11] Overview | Type 1 diabetes in adults: diagnosis and management | Guidance | NICE

is not available, however we do know there is 100% practice sign up to the tier one service which is very positive.

4.3 The new LCS is clear that all people living with type 1 diabetes should be offered specialist care in line with national guidance. The LCS does allow for this offer to be made on an individual basis and encourages the decision to be the patients, but care planning for those with type 1 diabetes who have declined specialist services is still supported in primary care under the new LCS. Historically the LCS covering the Crawley area had not been clear on where the management of type 1 diabetes should sit which created some confusion. There has been extensive work to harmonise the seven legacy LCS's and with a new Sussex wide offer now in place there is a real opportunity to continue to improve outcomes for people across the entire diabetes pathway.

4.4 As previously discussed, GPs have access to specialist advice provided by UHSx and SaSH for people with type 1 diabetes. There are also pathways for managing type 2 diabetes in specialist services for the most complex and clinically vulnerable patients. Additionally, UHSx and SaSH both offer advice and guidance to primary care clinicians. This model supports the training and upskilling of the primary care workforce in diabetes management.

4.5 An important service offer within the end-to-end type 2 diabetes pathway are the prevention services. Localised offers within the districts and boroughs of West Sussex compliment the NHS offers which include the NHS Diabetes Prevention Programme (NHS DPP), the NHS Type 2 Diabetes Path to Remission Programme (T2DR), and the NHS Digital Weight Management Programme (DWMP). NHS Sussex have fully engaged with work led by West Sussex County Council to develop the principles of the emerging Prevention Charter to better enable a joined-up approach to early support and prevention across all long-term conditions, including type 2 diabetes.

5. Diabetes Technology in Sussex.

5.1 Access to technology for People Living with Type 1 Diabetes

5.1.1 In Sussex there are pathways for all people living with type 1 diabetes to access prescribable technology with NHS Sussex spending over £6.5 million on this in 2023/24. These prescribable CGM devices are initiated by specialist diabetes nurses or doctors but prescribed within primary care. The prescribable CGM technologies 'Freestyle Libre 2'

and 'Dexcom One' currently support just over 70% (National Diabetes Audit 2022/23) of the adult type 1 population in Sussex. These devices are not suitable for all patients. Some adults and children who are unable to stabilise their diabetes with these devices need access to more complex technology provided through specialist diabetes services and is non-prescribable. Legacy commissioning arrangements from CCGs have led to different commissioned pathways for non-prescribable technology creating variable access to these devices, with Brighton and Hove, and West Sussex having previously far better access than those living in East Sussex.

5.1.2 For the population of West Sussex non prescribable technology pathways are in place to access devices at both UHSx and SaSH. NHS Sussex is looking to implement this year the use of a single system for monitoring these devices (for example blue-teq) to enable higher visibility of device usage.

5.1.3 The new HCL technology will change the current landscape, with a shift away from all current technology towards devices that have the functionality to work as a HCL system, and it is predicted that all CYP and circa 70% of adults will be using HCL within the next five years.

5.1.4 Sussex has been working with providers to develop an implementation plan fully informed by information from NHS England, and aligned with the national plan for prioritisation groups, with local clinicians collaborating to further refine the prioritisation framework to ensure implementation of devices in the early phase (year one) is supporting those who are the most clinically vulnerable including those who are at greatest risk of hospital admission and deterioration of their disease.

5.1.5 We know through baselining that at the start of the five-year implementation (01st April 2024) there were at least 300 HCL devices being used by adults in Sussex to manage their diabetes and over 350 devices in the CYP population. As this is a new technology there is no baseline data to compare the Sussex position against, however, we do

know anecdotally that there are other ICBs who had no or very minimal HCL provision at the start of the five-year implementation.

5.1.6 Since 01st April pathways have been put in place for all acute specialist services in Sussex to access HCL for patients who are clinically vulnerable and assessed as being in a priority group.

5.1.7 On 19th July 2024 NHS England wrote to all ICBs detailing an indicative allocation for year one of the implementation directly linked to a 75% reimbursement scheme. Further detail is expected in September 2024 but work to refine modelling for the first year is in place. The indicative cap signals access in year one will be for maternity and the CYP population as well as switching the most clinically vulnerable who currently use CSII pumps. As further detail for years two to four become available modelling will be updated, reflecting priority groups in each year acknowledging both clinical need and addressing the inequalities in access. Sussex is fully aligned to the national delivery plan.

5.1.8 Sussex has noted efficiencies can be realised through procuring non-prescribable devices through the national HCL procurement framework and is working with specialist providers to shift procurement across to this to support HCL implementation.

5.2 **Access to technology for People Living with Type 2 Diabetes**

5.2.1 In type 2 diabetes, CGM is currently only commissioned for people who are living with a learning disability (recorded on their GP Learning Disability Register) and have their diabetes managed through the administration of insulin. It is also available to people who are on haemodialysis and on insulin treatment requiring intensive monitoring >8 times daily.

5.2.2 The NICE guidance proposes that CGM is offered to a wider group of people living with type 2 diabetes. It is estimated that this would mean about 3.55% of the type 2 population, which would equate to 1,877 people within West Sussex, or 3,431 people Sussex wide.

5.2.3 However, CGM is more expensive to use than the finger pricking method more commonly used for monitoring glucose levels. At present we are spending more than £6.5 million in Sussex on CGM technology for people living with diabetes. To roll out CGM to all

eligible people living with type 2 would require further investment which we estimate will be around £2 million in Sussex.

5.2.4 The diabetes clinical reference group have led on developing proposals for increasing access alongside ensuring that our wider clinical model of care is also fit for the future.

5.2.5 A recent review has been carried out in a small number of GP practices that indicates there is prescribing of CGM, for this wider group of people with type 2 diabetes, taking place outside of the agreed formulary. The impact of this across Sussex is being considered with a focus on ensuring that we are not increasing inequities of access.

6. What are the clinical outcomes for people living with diabetes in West Sussex?

6.1.1 To understand the impact of the current diabetes services and pathways in West Sussex we regularly review clinical outcomes with provider colleagues for the local population. The position for West Sussex is set out below showing how it is performing in relation to the other Sussex Places but also nationally.

6.1.2 **Diabetes Care Processes and Treatment Targets**

6.1.3 There are a range of measures used to inform and benchmark the quality of delivery and outcomes for diabetes services. In line with National Institute of Clinical Excellence (NICE) recommendations, the National Diabetes Audit (NDA) measures eight care processes (8CP) annually delivered by diabetes care providers, with a ninth the responsibility of NHS Diabetes Eye Screening (NHS England), alongside three treatment targets (TTT), outlined in table one, which should be conducted annually for all patients with diabetes.

Nine Care Processes	**Three Treatment Targets**
• Blood glucose level measurement (HbA1c) for glucose control. • Blood pressure measurement for Cardiovascular risk.	• HbA1c target (≤58 mmol/mol) reduces the risk of all diabetic complications.

• Serum Cholesterol, a blood test for Cardiovascular risk. • Serum Creatinine, a blood test for Kidney function. • Urine Albumin / Creatinine Ratio, a urine test for risk of kidney disease. • Weight check. • Smoking status. • Foot surveillance, an examination for foot ulcer risk. • Digital Retinal Eye Screening for early detection of eye disease – delivered by screening services.	• Blood Pressure target (≤140/80) reduces the risk of cardiovascular complications and reduces the progression of eye and kidney disease. • Cholesterol target (<5mmol/L) reduces the risk of cardiovascular complications. Or patients aged 40-80 prescribed a statin

Table One: Diabetes Care Processes and Three Treatment Targets.

6.1.4 Completion of the 8CPs in type 1 diabetes in Sussex is presented in table two and demonstrates a year-on-year improvement in West Sussex since 2020/21 when completion was at 34.1%, following the impact of COVID. The latest validated NDA data showed 47.86% completion in 2022/23. The unvalidated 2023/24 data indicates an 48.43% completion, 0.5% lower than the 2019/20 pre-pandemic baseline. When looking at West Sussex the trend for year on year improvement since 2020/21 is analogous to the whole of Sussex, however at 44.94%, 8CP completion was lower than the rest of Sussex pre-pandemic with the 2020/21 drop to 34.10% also lower than within the wider Sussex population, however a recovery to above pre-pandemic baseline was achieved sooner in 2022/23 with an achievement of 49.54%, and the unvalidated 2023/24 data (validated 2023/24 data is scheduled to be published in December 2024) showing an further improvement with a completion rate of 51.82%, which is above both the Sussex national average. Further exploration of the detail demonstrates that for those who don't achieve completion of all care process, this is driven by only one process

being missed, rather than a non-completion off all the required processes.

	2019/20	2020/21	2021/22	2022/23	2023/24
Brighton & Hove	60.73%	42.29%	51.56%	50.34%	*48.97%
E Sussex	48.90%	34.50%	38.55%	43.78%	*42.73%
W Sussex	44.94%	31.03%	39.98%	49.54%	*51.82%
Sussex	48.95%	34.10%	41.54%	47.86%	*48.43%
England	42.34%	27.39%	35.16%	42.76%	*44.27%

*Table two: Completion of Care Processes in Type 1 diabetes 2019/20 – 2023/24. Source: NDA. * 2023/24 data unvalidated.*

6.1.5 Table three displays 8CP completion for people with type 2 diabetes in Sussex, showing these rose from 53.73% in 2021/22 to 62.81% in 2022/23, outperforming the national average of 57.89%. West Sussex sits higher than the Sussex average completing 65.51% of all care processes in 2022/23, an increase of 10% on the previous year where 55.65% were completed. Looking back to 2019/20 West Sussex and consistently outperformed both the wider Sussex and national completion rates across all years.

	2019/20	2020/21	2021/22	2022/23	2023/24
Brighton & Hove	59.87%	36.03%	47.13%	54.18%	*56.28%
E Sussex	64.61%	38.74%	52.87%	61.43%	*64.33%

W Sussex	66.60%	43.17%	55.65%	65.51%	*66.46%
Sussex	65.16%	40.88%	53.73%	62.81%	*64.53%
England	58.46%	36.88%	47.91%	57.89%	*62.28%

*Table three: Completion of Care Processes in Type 2 diabetes 2019/20 – 2023/24. Source: NDA. * 2023/24 data unvalidated.*

6.1.6 Attainment of the TTT in type 1 diabetes is presented in table four and demonstrates performance in Sussex better than the national average across all years, with a year-on-year improvement seen in England and Sussex since 2019/20, with no impact of the pandemic seen in TTT attainment in 2020/21. In West Sussex, 2019/20 attainment at 19.45% was the lowest out of all three Sussex places, but a year-on year improvement since has been seen resulting in a 2022/23 attainment of 26.26%, the highest of the three places and outperforming the national average. The unvalidated data for 2023/24 indicates this will be similar with West Sussex achieving a 26.99% attainment of the TTT.

	2019/20	**2020/21**	**2021/22**	**2022/23**	**2023/24**
Brighton & Hove	22.62%	25.43%	23.04%	25.46%	*25.69%
E Sussex	21.48%	23.03%	25.49%	25.44%	*25.72%
W Sussex	19.45%	22.24%	23.99%	26.26%	*26.99%
Sussex	20.68%	23.06%	24.29%	25.87%	*26.37%
England	19.98%	21.50%	22.44%	23.92%	*24.71%

*Table four: Attainment of the Three Treatment Targets in Type 1 diabetes 2019/20 – 2023/24. Source: NDA. * 2023/24 data unvalidated.*

6.1.7 For the attainment of the TTT in type 2 diabetes, set out in table five, Sussex has seen some improvement to 37.35% in 2022/23 compared to 33.68% in 2021/22, though falling slightly behind the national average of 37.90%. Focusing on West Sussex, this achievement sits above the national and Sussex average achieving a 38.86% completion in 2022/23, a 3.5% increase from 35.42% in the preceding year. A decline has been seen both nationally and within Sussex, across all three places in the unvalidated 2023/24 data. Following validation, a further interrogation of this data is required to understand further.

	2019/20	**2020/21**	**2021/22**	**2022/23**	**2023/24**
Brighton & Hove	36.84%	31.82%	31.29%	34.75%	*31.54%
E Sussex	37.66%	32.59%	31.63%	35.78%	*34.39%
W Sussex	38.57%	33.69%	35.42%	38.86%	*37.38%
Sussex	38.07%	33.12%	33.68%	37.35%	*35.69%
England	40.09%	35.75%	35.73%	37.90%	*36.37%

*Table five: Attainment of the Three Treatment Targets in Type 2 diabetes 2019/20 – 2023/24. Source: NDA. * 2023/24 data unvalidated*

6.1.8 Overall, West Sussex performs better than both Sussex and national average for completion of both Care processes and Treatment Targets.

6.2 Impact of Diabetes related Complications in Sussex

6.2.1 Poorly managed diabetes can lead to serious foot problems and amputations, many of which are preventable with the right care. Sussex has seen an increase in all amputations from 1.30 (per 100,000 population) in 2021/22 to 1.56 in 2023/24. An increase is also seen when breaking down to minor (0.90 in 2021/22 up to 1.04 in 2023/24) and major (0.40 in 2021/22 up to 0.51 in 2023/24) amputations. Concentrating on West Sussex, minor amputation rates, as presented in figure three, saw an increase from 0.95 in 2021/22 to 1.21 in 2022/23 with a decrease to 1.11 in the following 2023/24 year. However, this has been offset by a significant increase in major amputations as shown in figure four, where West Sussex increased to 0.62 in 2023/24 from 0.40 in the preceding year, and notably making it an outlier in comparison to the other three Sussex places. Data recorded for amputations does not break down to types of diabetes, but it is understood that this increase has been driven by an increasing ageing diabetes population living in the area, with work currently underway to investigate further.

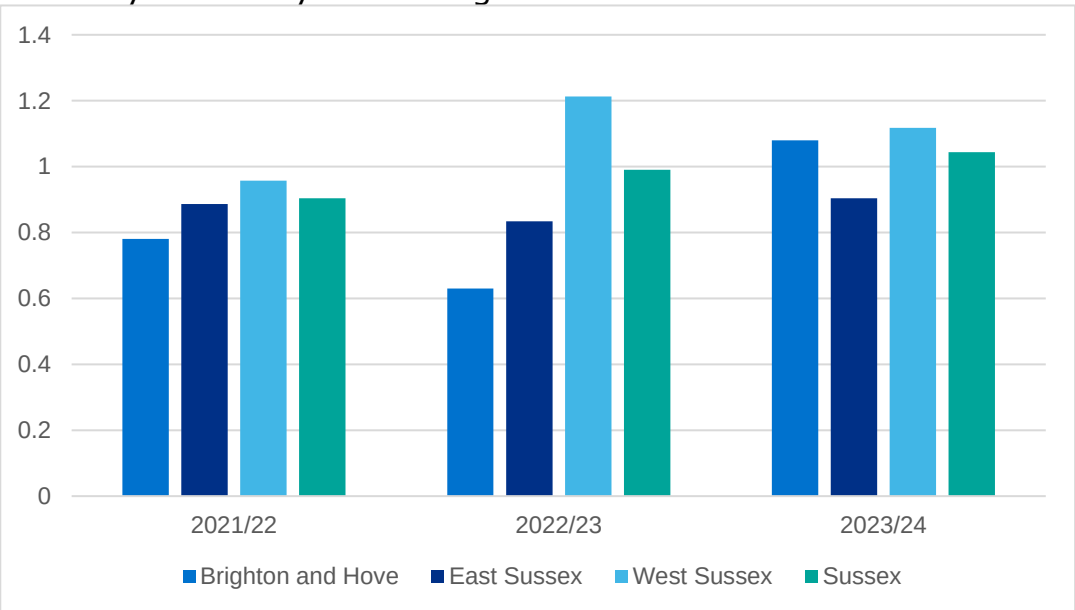

Figure three: Minor amputations in people living with diabetes by place per 100,000 population. 2021/22 – 2023/24. Source: SUS data

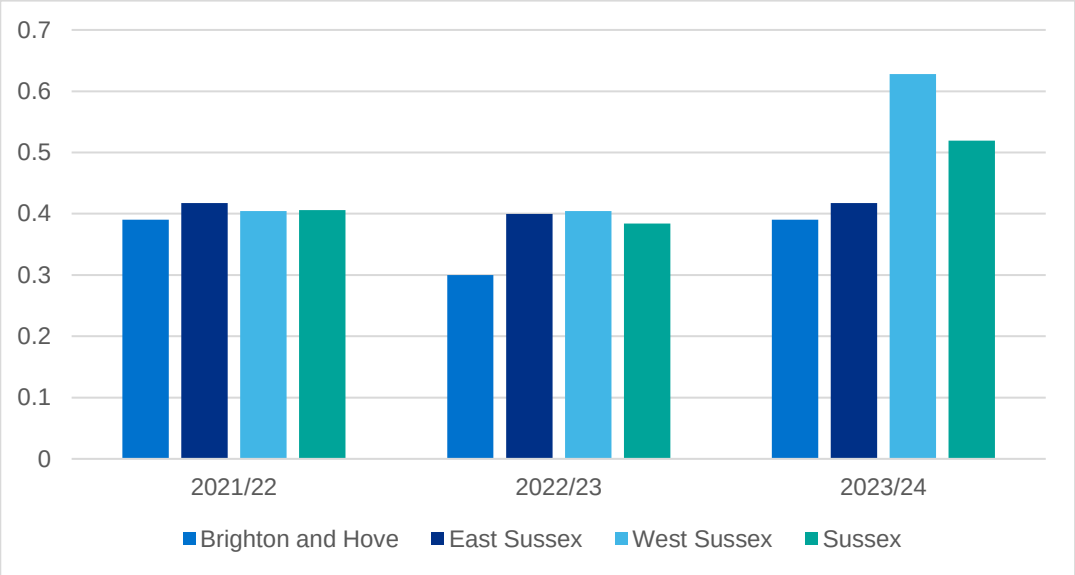

Figure four: Major amputations in people living with diabetes by place per 100,000 population. 2021/22 – 2023/24. Source: SUS data

6.2.2 The Model Healthcare System can inform benchmarking for amputations. This is only available at a provider level, rather than place and therefore the picture is distorted through including Brighton and Hove and Surrey Heartlands activity. For non-elective major amputations in diabetes, Sussex ICB is in the third (second worst performing) quartile with a denominator of 119 benchmarked against a system median of 104.

6.2.3 Diabetic ketoacidosis (DKA) is a life-threatening complication of diabetes and is usually seen in people living with type 1 diabetes, with a rare occurrence in patients with type 2.

6.2.4 When looking at admission per 100,000 population by place there is a fluctuating position across the years. In 2020/21 West Sussex, at 38.5 had a comparable rate of admissions to the 38.3 in East Sussex, with both sitting higher than the 29.1 in Brighton and Hove. In 2021/22 West Sussex saw a decrease down to 31.3, only increasing slightly to 32.6 in 2022/23. This is in comparison to East Sussex staying static across the three years and Brighton and Hove although decreasing to 23.8 in 2021/22 going back up to 29.4 in 2022/23.

	2020/21	**2021/22**	**2022/23**

Brighton & Hove	29.1	23.8	29.4
East Sussex	38.3	38.9	38.4
West Sussex	38.5	31.3	32.6

Table Six: DKA admissions by place per 100,000 population. 2020/21 – 2022/23. Source: SUS data.

6.2.5 DKA admissions can be benchmarked through the Model Healthcare System data platform. This is only available at a provider level, rather than place and therefore the picture is distorted through including Brighton and Hove and Surrey Heartlands activity. Quarter 4 data from 2023/24 shows a national provider median of 206, with UHSx in the fourth (worst performing) quartile, and a value of 348, with a SaSH value of 140, placing then in the first (best performing) quartile. As a system, Sussex sits within quartile 2, the second-best performing quartile, with a value of 540, in line with a national system median of 541.

6.2.6 Primary coded diabetes admissions (Non DKA) data per 100,000 of the population presented in table seven shows admissions for all types of diabetes by place. This cannot be broken down by diabetes type. In 2020/21 West Sussex had a significantly higher rate of admissions than the other two Sussex places with 139.5 per 100,000 in contrast to 77.3 in East Sussex and 45.2 in Brighton and Hove. The rate in West Sussex dropped by 21.2 in 2021/22 to 118.3, but this was still higher than both East Sussex, and Brighton and Hove, who had also seen a decrease. In the latest data there has been a further 32.9 drop in admissions per 100,000 in West Sussex down to 85.4, which is still the highest of all three places, although closer to the East Sussex rate of 74.8, where a slight increase was seen in comparison to the previous year.

	2020/21	**2021/22**	**2022/23**
Brighton & Hove	45.2	36.5	43.8

East Sussex	77.3	73.7	74.8
West Sussex	139.5	118.3	85.4

Table Seven: Primary coded diabetes admissions (non-DKA) by place per 100,000 population. 2020/21 – 2022/23. Source SUS data.

6.2.7 Benchmarking for non-DKA diabetes admissions on the model healthcare system is available through a monthly metric detailing the number of non-elective admissions with hypoglycaemia. As with DKA benchmarking this is only available at a provider level, rather than place and therefore the picture is distorted through including Brighton and Hove and Surrey Heartlands activity. April 2024 data shows a national provider median of 41, with UHSx showing a value of 84, placing them in the highest (worst performing) quartile and a SaSH value of 28, placing then in the lowest (best performing) quartile. As a system, Sussex sits with a value of 152, against a national system median of 140.

6.2.8 Overall, West Sussex compares favourably to the rest of Sussex in data pertaining to diabetes complications. This is except for the increase in diabetes amputations, for which work in underway to explore further to understand whether this is driven by either the pathways at UHSx or SaSH or an increasing ageing population within West Sussex.

7. Next Steps

7.1 Moving through this year and beyond, work in Sussex will continue to enable access to non-prescribable technology for management of type 1 diabetes. This work will be informed by, and align with the national HCL plan, with implementation ensuring there is a strategy to address any known or emerging inequities of access as roll out of HCL progresses.

7.2 For CGM to support more people living with type 2 diabetes, the clinical reference group alongside an NHS Sussex team are reviewing the pathway and advising on the optimal model of care.

7.3 Work to address variation in service provision will continue. As the new LCS matures, data will be reviewed to enable targeted support at

practice level to further improve outcomes for the population. As Integrated Care Teams (ICTs) develop, diabetes services will form part of their core offer to their population. Diabetes prevention will also be an integral part of this offer, working in collaboration with public health and wider community services to support people living at risk of developing type 2 diabetes.

8. Conclusion

8.1 As an outcome of the scrutiny committee investigation, DUK has requested policies in place across Sussex enabling access to technology for all people living with diabetes.

8.2 West Sussex is fully compliant with NICE guidance for type 1 diabetes, with work to reduce legacy pathway variation in place, with the new HCL technology implementation driving this alignment.

8.3 There remains further work in relation to expanding technology access for a defined group of people with type 2 diabetes and this is part of a wider review for transforming our care for people with diabetes, the recent implementation of the new single LCS in primary care being the first step.

8.4 Outcomes for people living with diabetes in West Sussex are in general above both national and Sussex averages. However, we recognise there is further opportunity for continuous improvement. There is commitment to continue to transform diabetes care for our population through collaboration with key stakeholders and ensuring that high quality diabetes care, including a focus on prevention, becomes a key offer within our emergent Integrated Community Teams.