

NHS Type 2 Diabetes Path to Remission Programme

*formerly the Low Calorie Diet Programme

NHS

Greater Manchester
and Eastern Cheshire
Strategic Clinical Networks

Greater Manchester Referral Toolkit

What is the NHS Type 2 Diabetes Path to Remission Programme?

The NHS Type 2 Diabetes Path to Remission (T2DR) Programme offers life-changing support for people who are living with Type 2 diabetes and above a healthy weight.

The programme provides a low calorie diet treatment of soups and shakes followed by support to reintroduce healthy meals to:

- improve their diabetes control
- reduce diabetes-related medication
- in some cases, put their type 2 diabetes into remission.

The whole programme, including coaching and all total diet replacement products, is free for participants.

Who is the T2DR Programme for?

To join the programme, they need to meet the following amongst other eligibility criteria -

- Age 18-65 inclusive*
- Type 2 Diabetes diagnosis in the past 6 years
- BMI over 27 (over 25 ethnicity adjusted)
- HbA1c recorded in the past 12 months of
 - 43-87 if on diabetes medication
 - 48-87 if not on diabetes medication
- Not using insulin

[Click here for full eligibility and exclusion criteria](#)

**Clinicians may refer someone over 65 only if the benefits of weight loss outweigh risks (e.g., frailty) after thorough assessment and discussion. Suitability is case-specific, to discuss this assessment, please seek further advice from our NHS GM Diabetes Remission Clinical Lead at Momenta.T2DR-GM@nhs.net.*

What is in the toolkit?

The following pack has been put together to give you the information you need to refer your eligible patients into the programme including –

1. [Check eligibility and make sure no exclusions apply](#)
2. [Inform patient about the offer](#)
3. [Complete referral and medication adjustments](#)
4. [Responsibilities whilst patients are on the programme](#)
5. [Contacts & additional support](#)

1. Check eligibility and make sure no exclusions apply

Inclusion criteria

- Age 18-65 inclusive*
- Type 2 diabetes diagnosis in last 6 years
- BMI of ≥ 27 (≥ 25 ethnicity adjusted)
- Attended monitoring and diabetes review in last 12 months, including retinal screening (unless newly diagnosed) and committed to continue annual reviews, even if remission is achieved.
- HbA1c within 12 months, with values as follows:
 - HbA1c 43-87 mmol/mol if on diabetes medication,
 - HbA1c 48-87 mmol/mol if NOT on diabetes medication

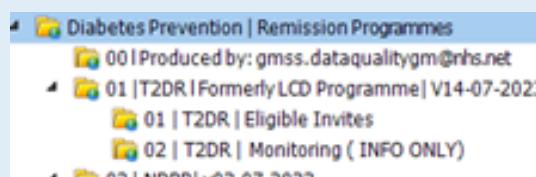
**Clinicians may refer someone over 65 only if the benefits of weight loss outweigh risks (e.g. exacerbation of existing frailty) after thorough assessment and discussion with the individual. Suitability is case-specific and decision should be based on individual context. If you would like to discuss this assessment, please seek further advice from our NHS GM Diabetes Remission Clinical Lead at Momenta.T2DR-GM@nhs.net.*

Exclusion criteria

- Current insulin user
- Pregnant or planning to become pregnant within six months
- Currently breastfeeding
- Has any of the following significant co-morbidities:
 - active cancer
 - heart attack or stroke in last six months
 - severe renal impairment (most recent eGFR less than 30mls/min/1.73m²)
 - active liver disease (not including non-alcoholic fatty liver disease)
 - active substance use disorder
 - active eating disorder
 - Porphyria
 - known proliferative retinopathy that has not been treated
- Has previously had bariatric surgery (unless reversed)
- Has been on the T2DR programme in the past 12 months (unless referred but did not start total diet replacement (TDR))
- **Health professional assessment that the person is unable to understand or meet the demands of the NHS T2DR Programme and/or monitoring requirements**

T2DR Search

The T2DR search can be found in the Data Quality folder on your clinical system under Diabetes Prevention | Remission Programmes as per the folder structure below.



To get a list of your eligible patients run the "01| T2DR| Eligible Invites"

If support is required locating or running the search please contact your data quality lead for assistance.

2. Inform patient about the offer

The 12-month programme has 3 phases:



How are patients supported?

- People will be supported through every stage of the programme by their Momenta coach
- Weekly one-to-one sessions during phases 1 & 2 and monthly sessions in phase 3
- Choice of in person or online meetings with their coach
- Blood glucose, blood pressure (for those on blood pressure medications at referral), weight and BMI for safety checks, and any adverse events (Those meeting their coach digitally will be provided with equipment and training to do this at home)
- Lots of resources to support them including workbooks, trackers and recipes to use at home and an app for those on the digital pathway

What are the expected patient outcomes?

The Diabetes UK DiRECT trial found people who complete a low calorie diet programme -



Lose weight
Average weight loss of 10kg after a year on the programme



Reduce medications
Glucose and blood pressure lowering medications are reduced or stopped on day 1 of TDR



Potentially achieve diabetes remission
46% of people were in remission after a year



“ My coach and support was amazing. I feel more prepared to lead a healthy life. Mentally I like myself more. I feel really proud of myself.”

Juliet took part the T2DR Programme and lost 18kg, reduced her blood pressure and put her diabetes into remission

Are there any resources I can share with patients?

Please share the following:

- Patient Information Leaflet
- Patient Information Website Link
- Patient Case Studies
- Patient Readiness Assessment



3. Complete referral and medications adjustment form

1. Open referral form

The referral form has been installed on your clinical system under the name “T2DR Referral Form v19-05-2023”.

2. Check details & eligibility

Most patient's information will auto populate onto the referral form. Please double check the information and make sure no exclusions apply.

3. Check & adjust medications

Check the medications the person is currently prescribed (including those from other providers) and agree medications to be adjusted on day one of total diet replacement.

Medications to review include -

- Glucose lowering medications
- Blood pressure lowering medications
- Medications which may need to be adjusted due to changes in body weight or diet



Click for medications deprescribing guide

The Medications Deprescribing guide includes an easy-to-follow diagram, medications information and deprescribing examples to support you to identify and deprescribe medications necessary to start on day 1 of total diet replacement.

4. Consent & confirm

Obtain consent to refer and confirm with the patient they will –

- Continue attending reviews/ monitoring
- Notify the practice of any unexpected or concerning symptoms considered urgent
- Notify the practice if they disengage or drop out before programme end
- Only make the advised changes to their medication on the first day they start the total diet replacement products

The patient symptoms leaflet can be shared with patients to inform them of symptoms of low blood pressure and high blood glucose and when to seek assistance

Click for Patient Symptoms Leaflet

5. Make referral

Once completed email the referral and medication adjustment form to momenta.t2dr-gm@nhs.net.

Code the patient record with 1239571000000105 Referral to total diet replacement programme. Please click [here](#) for a full list of programme milestones and SNOMED codes.

4. Responsibilities whilst patients are on the programme

Momenta responsibilities

Once referred Momenta will:

- Contact GP practice if any necessary information (including medication changes) is missing from the referral
- Contact the patient within 5 working days of referral to provide further information, book an individual assessment and confirm medication changes with patient
- Arrange supply of TDR products, provide starter pack and ongoing supply of fibre supplements and start them on the programme. They will be offered a choice of in person or digital programme delivery

Whilst on the programme Momenta:

- Act as initial contact for patients experiencing a concurrent or adverse event which is not considered an emergency and to triage / respond accordingly
- Monitor participants' weight, blood glucose and blood pressure at each session to detect clinically significant hyperglycaemia and high or low blood pressure and communicate with GP practice as indicated
- Will keep the practice informed when a programme milestone has been reached and the relevant SNOMED code to add to the patient record
- Optimise uptake, retention and programme outcomes

Click for
BG and BP
thresholds
for action

Click for
programme
milestones
&
SNOMED
coding

Practice responsibilities

During the patient's time on the programme the practice are required to:

- Arrange review of patient at 6 months and 12 months with repeat HbA1c checks
- Respond to any clinical need to review and/ or adjust medications
- Respond to adverse events if patient contacts practice directly with an urgent need or is directed to the GP practice by Momenta

5. Contacts & additional support

Contacts

For more information about the programme and the referral process please contact isabel.blandford@nhs.net. You can book straight into Issy's diary by visiting the link [here](#).

Tailored Referral Support

Momenta's Primary Care Engagement team can support practices to identify and invite patients to the programme through -

- Programme Text invites
- Programme information sessions

Referrer Drop In Sessions

Referrer drop-in sessions are held every Thursday at 12.30pm. To book your place please visit the link [here](#)

Click for
more
information
on referral
support
offers