ABCD diabetes clinical update
Diabetes and mental health workshop

Marietta Stadler & Chris Garrett & Sarah Alicea

28.1.2026- 30.1.2026

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outline

- Setting the scene
- Overview mental health comorbidity in diabetes
- Case 1
- Participants' choice (1 out of 3 QI projects and 2 cases)

Diabetes and mental health- isn't that a bit niche?

- Every clinician working with people with

diabetes will encounter people with diabetes who have mental health comorbidity caused by or aggravated by diabetes and vice versa.

- Mental health comorbidity of diabetes causes significant morbidity and mortality, impacts on quality of life and productivity.

- Clinicians championing this field, research and clinical service development are urgently needed (we will give some examples today).

Learning objectives

- To appreciate that nearly every category of ICD-10 Chapter F

(mental disorders) is associated with diabetes and with worse outcomes and premature mortality and that, in addition, many people with diabetes suffer from diabetes related distress.

- To describe the increased risk of premature, potentially avoidable mortality in people with diabetes and mental disorder and consider strategies to mitigate this increased risk.
- To understand the clinical settings in which people with both diabetes and mental disorder may present and why their care is often suboptimal.
- To recognise that an acute admission in a window of opportunity to optimise the management of both diabetes and mental disorder and that this works best through collaborative working.
- To promote the need for equivalent levels of care for diabetes in people with and without mental illness in order to improve mental health and reduce the risk of diabetes complications.
- To consider the need for local audit, research and development of services to improve care for this group of vulnerable patients.

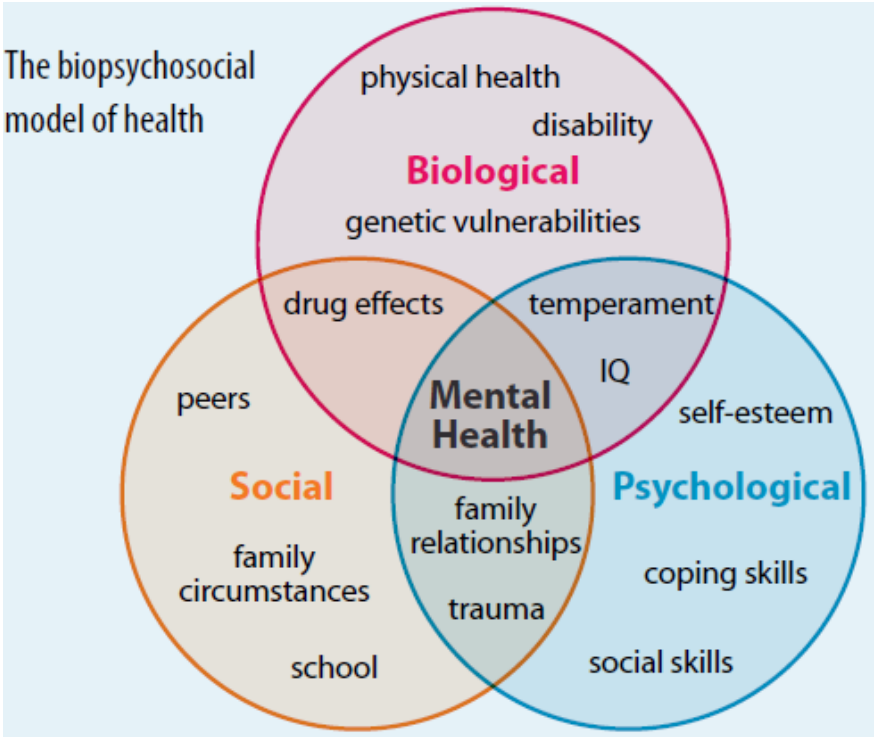
The Need for a New Medical Model: A Challenge for Biomedicine

Science, 1977

George L. Engel *

3) Diabetes and schizophrenia have in common the fact that conditions of life and living constitute significant variables influencing the time of reported onset of the manifest disease as well as of variations in its course. In both conditions this results from the fact that psychophysiologic responses to life change may interact with existing somatic factors to alter susceptibility and thereby influence the time of onset, the severity, and the course of a disease. Experimental stud-

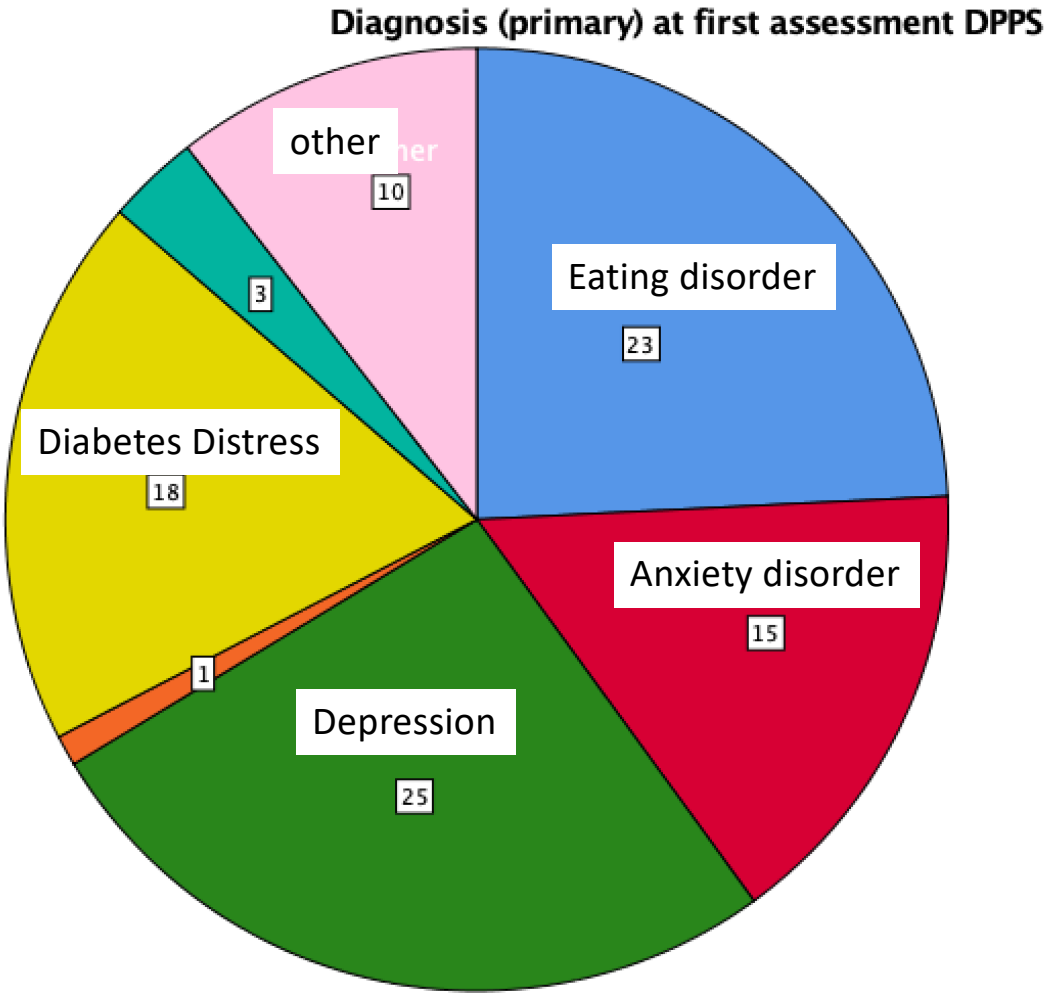
4) Psychological and social factors are also crucial in determining whether and when patients with the biochemical abnormality of diabetes or of schizophrenia come to view themselves or be viewed by others as sick. Still other factors of a similar nature influence whether or not and when any individual enters a health care system and becomes a patient. Thus, the biochemical defect may determine certain characteristics of the disease, but not necessarily the point in time when the person falls ill or accepts the sick role or the status of a patient.



Thus, insulin requirements of a diabetic patient may fluctuate significantly depending on how the patient perceives his relationship with his doctor. Furthermore, the successful application of rational therapies is limited by the physician's ability to influence and modify the patient's behavior in directions concordant with health needs. Contrary to what the exclusionists would have us believe, the physician's role is, and always has been, very much that of educator and psychotherapist. To know how to induce peace of mind in the patient and enhance his faith in the healing powers of his physician requires psychological knowledge and skills, not merely charisma. These too are outside the biomedical framework.

*George Libman Engel was Physician / Psychiatrist/Psychoanalyst in NY

Diabetes Psychiatry Psychology Service at KCH (n=95/ 1 year



NHS
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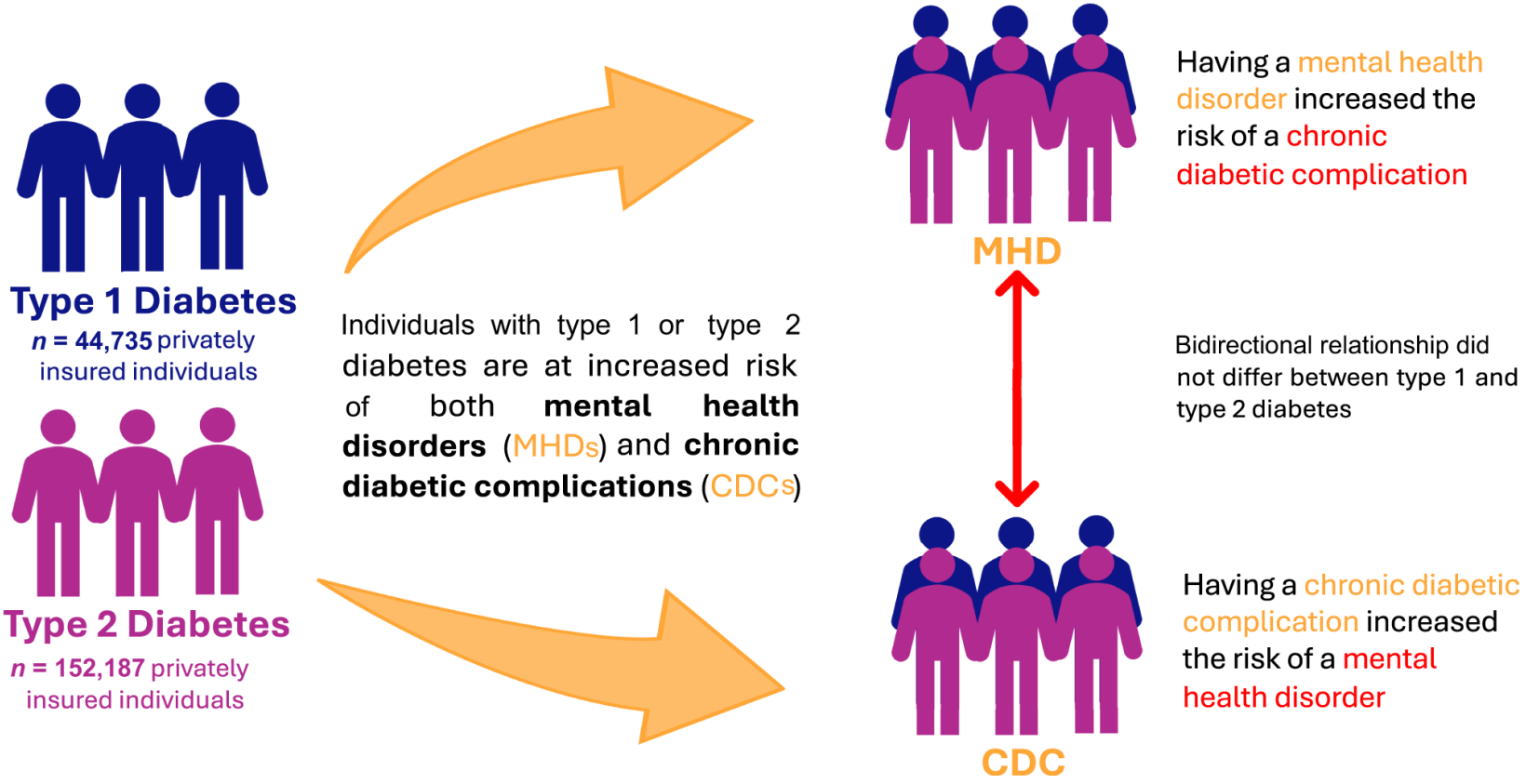
From: **Bidirectional Associations Between Mental Health Disorders and Chronic Diabetic Complications in Individuals With Type 1 or Type 2 Diabetes**

Diabetes Care. 2024;47(9):1638-1646. doi:10.2337/dc24-0818

Consistent bidirectional association between mental health disorders and chronic diabetic complications in individuals with type 1 or type 2 diabetes



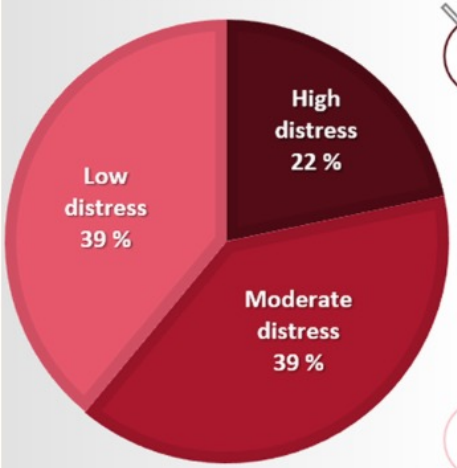
Diabetes distress data from a nationwide register-based cohort of adults with type 1 diabetes (*N* = 10,186)

Prevalence of diabetes distress. Associations with demographic and clinical variables.

Data from the Norwegian Diabetes Register for Adults.

The 20-item Problem Areas in Diabetes (PAID-20) scale.

Distress levels:



The five most endorsed PAID-20 items:

1. Worry about the future and diabetes complications
2. Feel diabetes is taking up too much energy every day
3. Feel burnt out by diabetes self-management
4. Feel guilty about not self-managing "well enough"
5. Worry about hypoglycemia

Associations:

Higher distress

- Female sex
- Higher HbA1c
- Hypoglycemia
- Continuous glucose monitoring
- Daily smoking
- Treated retinopathy
- Reduced foot sensitivity

Lower distress

- Older age
- Longer diabetes duration
- European origin
- University/college education
- Employment

The findings underline the importance of addressing diabetes distress to improve the health of adults with type 1 diabetes.

Diabetes Care

Reference: Hernar I, Cooper JG, Nilsen RM et al. https://doi.org/10.2337/dc23-1001

American Diabetes Association.
Connected for Life

DIABETICMedicine

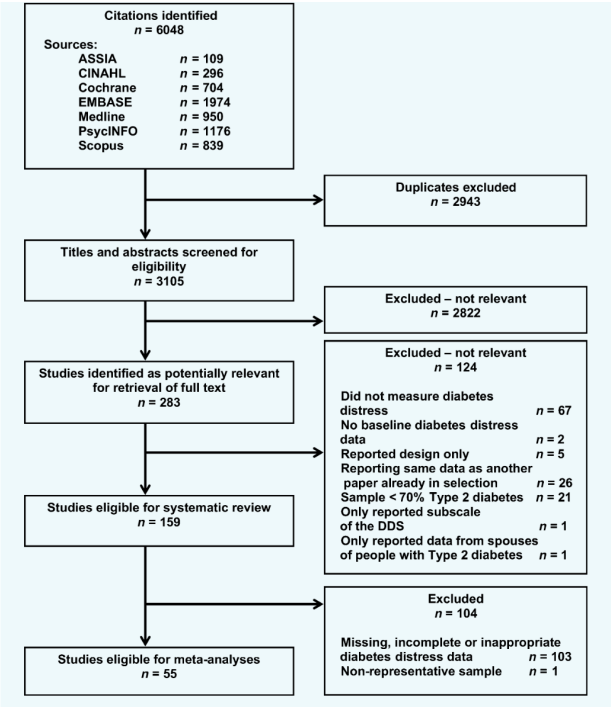
DOI: 10.1111/dme.13448

Systematic Review or Meta-analysis

The prevalence of diabetes-specific emotional distress in people with Type 2 diabetes: a systematic review and meta-analysis

N. E. Perrin[1], M. J. Davies[1], N. Robertson[2], F. J. Snoek[3] and K. Khunti[1]

[1]Diabetes Research Centre, [2]School of Psychology, College of Medicine, Biological Sciences and Psychology, University of Leicester, Leicester, UK and [3]Department of Medical Psychology, VU University Medical Centre, Academic Medical Centre Amsterdam, the Netherlands



Diabetes Distress prevalent in 36% of people living with Typ 2 Diabetes

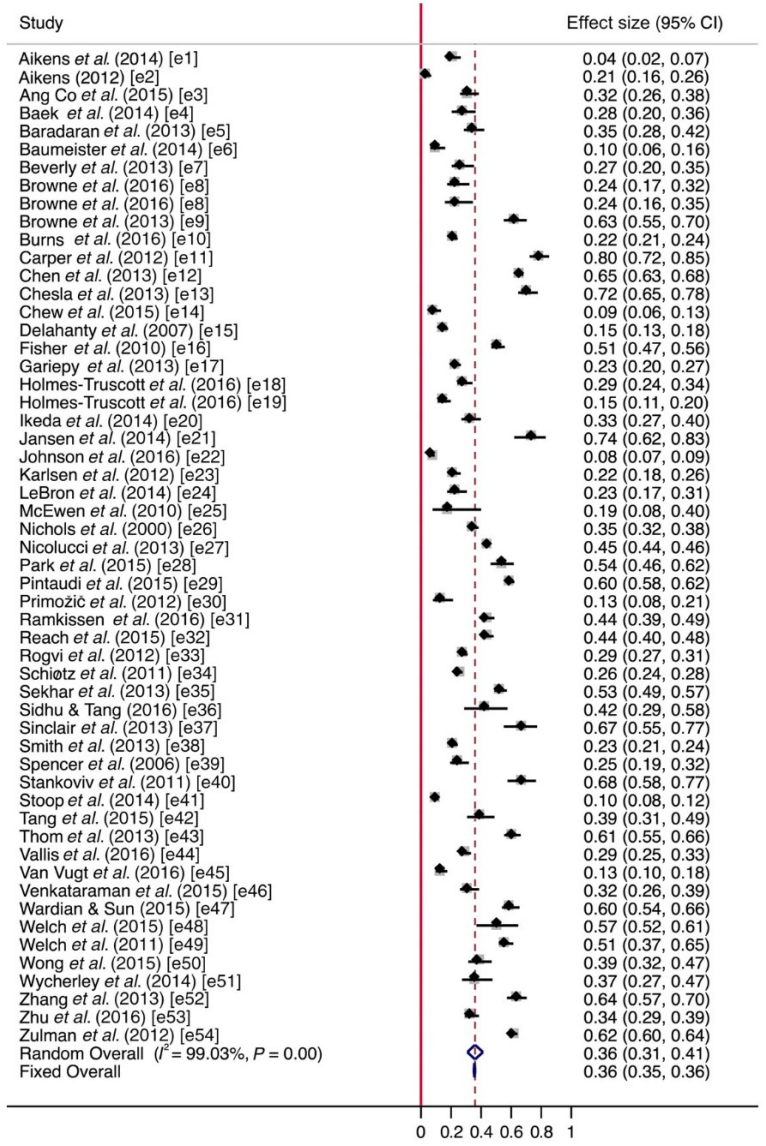


FIGURE 2 Forest-plot demonstrating the findings of the primary meta-analyses to determine overall prevalence of diabetes-specific emotional distress in people with Type 2 diabetes. CI, confidence interval; References are given in Supporting Information Doc. S1.

Typ 1 Diabetes – psychiatric comorbidity

Contents lists available at ScienceDirect

General Hospital Psychiatry

journal homepage: www.elsevier.com/locate/genhospsych

Review article

Prevalence of mental disorders in people living with type 1 diabetes: A systematic literature review and meta-analysis

Madeleine Benton [a], Bryan Cleal [b], Mathew Prina [c], Jeni Baykoca [d], Ingrid Willaing [b], Hermione Price [d], Khalida Ismail [a,*]

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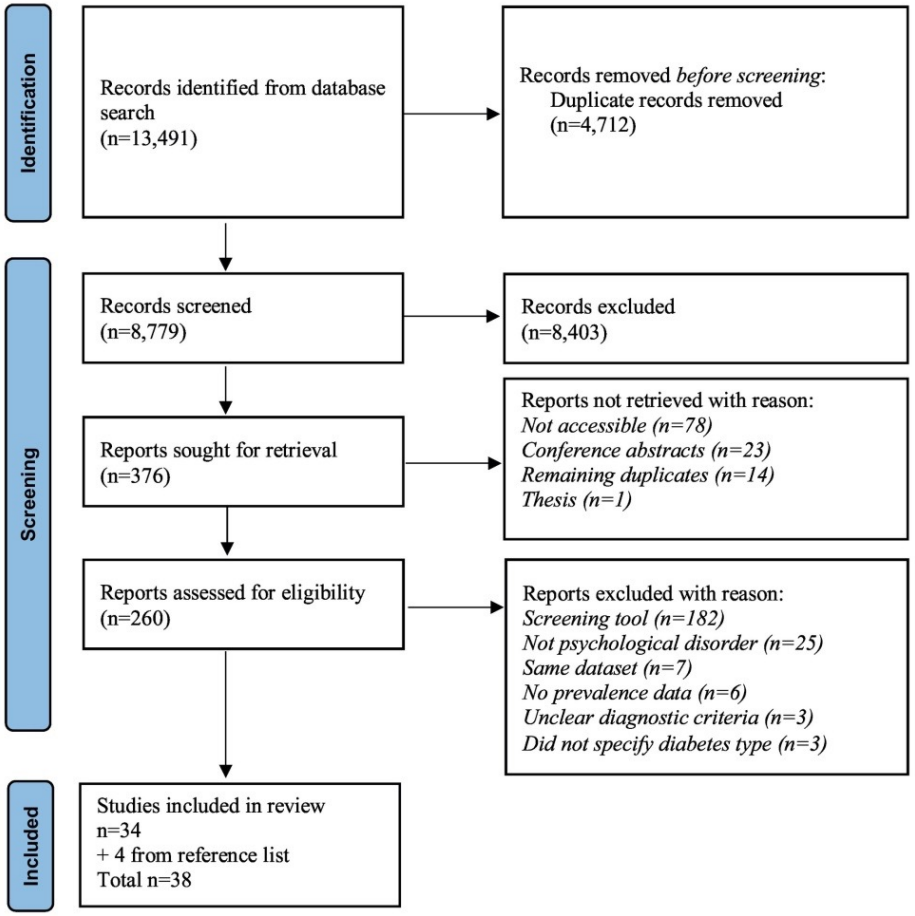
[b] Steno Diabetes Center, Borgmester Ib Juuls Vej 83, 2730 Herlev, Copenhagen, Denmark
[c] Social Epidemiology Research Group, King's College London, 18 De Crespigny Park, London SE5 8AF, United Kingdom
[d] Southern Health NHS Foundation Trust, Southampton, Tremona Rd, Southampton SO16 6YD, United Kingdom



Prevalence of ALL psychiatric diagnoses increased in T1D population

	Typ 1 Diabetes	Background population
Depression	3.5-58%	0.6-5%
Anxiety disorder	2- 32%	0.6-10%
Eating disorder	1-33%	0.2-4.6%
OCD	0.3- 8%	0.4%
Schizophrenia/ psychotic disorder	0-1.5%	0.5-0.9%
PTSD	0-4%	0.6%
Substance abuse	0-35%	0.7-4.1%

Benton M et al. Gen Hospital Psychiatry 2023

Prevalence of Type 2 diabetes in psychiatric illness Review&Metaanalysys of 245 observational studies and 32 systematic reviews

Psychiatric disorder	No. of systematic reviews	No. of primary studies	No. of included primary studies	No. of participants	Prevalence of T2DM (95% CI), %	I^2, %	Publication bias (LFK index of asymmetry)
Schizophrenia	7[a]	35	32	149,295	10.05 (8.07, 13.13)	>99	4.49 (major)
Bipolar disorder	4	26	23	23,493	11.44 (7.84, 15.60)	99	0.22 (no)
Depression	3	24	21	12,568,442	9.08 (6.41, 12.15)	>99	0.58 (no)
Substance use disorder	3	14	14	9926	15.58 (10.33, 21.66)	98	−4.42 (major)
Anxiety disorder	2	10	10	45,899	13.66 (7.71, 20.92)	>99	−0.99 (no)
Binge eating disorder	2	6	6	969	20.65 (7.64, 37.43)	97	−2.13 (major)
Intellectual disability	2	23	20	42,378	8.07% (6.49, 9.81)	96	0.71 (no)
Psychosis	2	11	11	4744	11.06 (7.25, 15.54)	95	1.70 (minor)
Sleep disorder	2	15	15	186,274	39.73 (34.90, 44.66)	89	−0.85 (no)
Mixed group of psychiatric disorders	7	153	138	13,524,005	9.95 (9.28, 10.73)	>99	2.69 (major)

[a]In two of the seven systematic reviews describing people with schizophrenia, primary studies were not reported and therefore only primary studies from five systematic reviews were included in the meta-analysis

T2DM, type 2 diabetes

Lindekilde, N., Scheuer, S.H., Rutters, F. *et al.* . *Diabetologia* **65**, 440–456 (2022).

Incidence (new diagnoses) of T2D in psychiatric conditions

Mental disorders	Type 2 diabetes incidence		Direction of effect and grade of evidence
Depression	RR	2.10 (1.86, 2.36) in women	↑
	RR	1.62 (1.43, 1.82) in men	
	RR	1.60 (1.37, 1.88)[a]	
Insomnia	RR	1. 74 (1.30, 2.34)[a]	↑
Anxiety	OR	1.47 (1.23, 1.75)	↑
Eating disorders	RR	1.70 (1.20, 2.50)	↑
	OR	3.34 (0.85, 13.12)	
Schizophrenia	RR	2.10 (1.86, 2.36) in women	↑
	RR	1.63 (1.38, 1.94) in men	
Bipolar disorder	RR	1.65 (1.35, 2.02) in women	↑
	RR	1.50 (1.22, 1.84) in men	
Post-traumatic stress disorder	HR	1.80 (1.50, 2.10) in women	↑
Intellectual disability	-	?	↑
Substance use disorder	-	?	↑

Diabetes incidence 1.5- 2 fold increased

Direction of effect:
↑ Higher incidence of type 2 diabetes
? Effect sizes not reported

Grade of evidence:
↑ Weak evidence: single observational study
↑ Moderate evidence: multiple RCTs/cohort studies or reviews without meta-analyses (or fewer than three studies)
↑ Strong evidence: reviews combined with meta-analyses of multiple studies (three or more studies)

Disparities in diabetes treatment and monitoring for people with and without mental disorders: a systematic review and meta-analysis

Elias Wagner, Mikkel Højlund*, Jess G Fiedorowicz, René Ernst Nielsen, Søren Dinesen Østergaard, Anne Høye, Ina H Heiberg, Laura Poddighe, Marco Delogu, Richard I G Holt, Christoph U Correll, Samuele Cortese, Andre F Carvalho, Laurent Boyer, Elena Dragioti, Ebba Du Rietz, Joseph Firth, Paolo Fusar-Poli, Catharina A Hartman, Henrik Larsson, Riccardo De Giorgi, Kelli Lehto, Peter Lindgren, Mirko Manchia, Merete Nordentoft, Karolina Skonieczna-Żydecka, Areti-Angeliki Veroniki, Wolfgang Marx, Mattia Campana, Matin Mortazavi, Alkomiet Hasan, Brendon Stubbs, Heidi Taipale, Davy Vancampfort, Eduard Vieta, Marco Solmi, for the ECNP PAN-Health Group*

negative associations between any mental disorder and the likelihood of receiving any recommended diabetes monitoring (29 studies, OR=0·81 [95% CI 0·70–0·94], p=0·0049)

HbA1c measurement, retinal screening, lipid and cholesterol measurement, foot examination and renal investigation

Any mental disorder was significantly associated with higher odds of receiving insulin (ten studies, 1·52 [95% CI 1·16–1·99]; p=0·0022) negatively associated with treatment with a GLP-1 receptor agonist

49 studies (42 cohort and seven case-control) 5503712 individuals with diabetes, of whom 838 366 (15·2%) had a diagnosed mental disorder

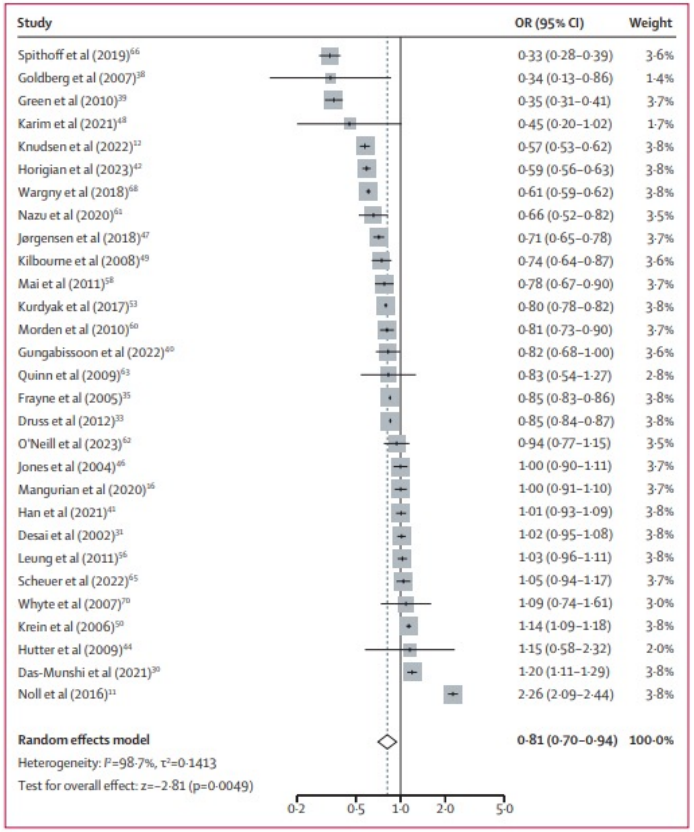


Figure 2: **ORs for diabetes monitoring in people with diabetes and a mental disorder versus people with diabetes and no mental disorder**
OR=odds ratio. SE=standard error.

Lancet Psychiatry 2026; 13: 112–24 Published Online January 5, 2026 https://doi.org/10.1016/ S2215-0366(25)00332-3

Diabetes and mental health- is there a guideline, care pathway or algorithm I can follow?

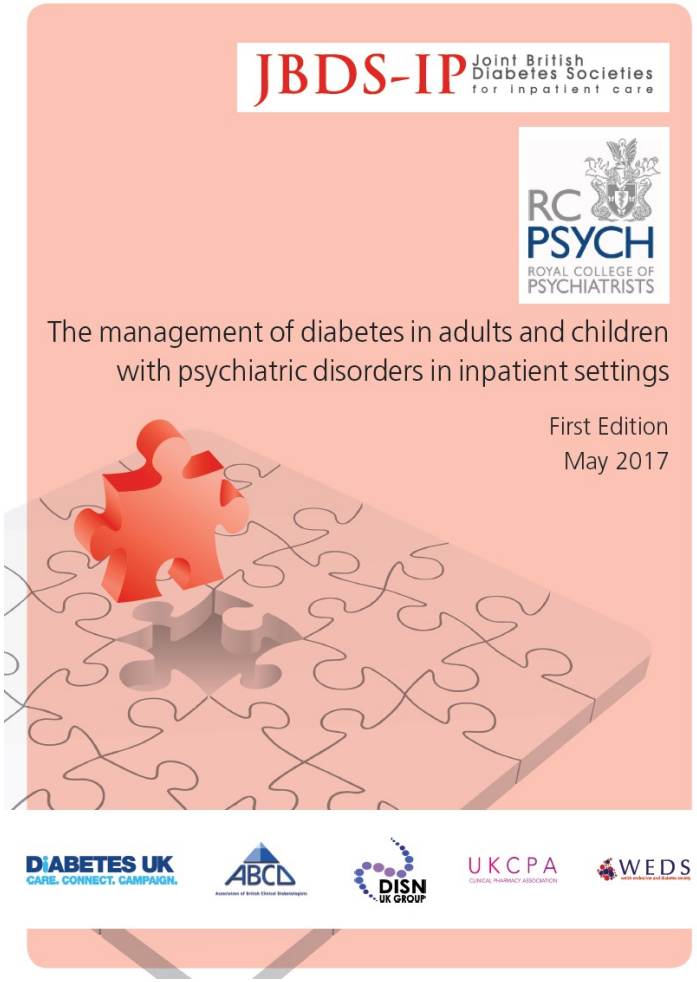
- Nope. There is no nationally applicable algorithm or care pathway. You will need to scope the provision of mental health care where you work, make contact and form working relationships with mental health care professionals by working jointly on case-by-case basis.

- We learn from each other by working with mental health professionals, through case discussions and MDTs and through meetings like these.
- We need clinicians in research and clinical service development championing the diabetes/ mental health theme.

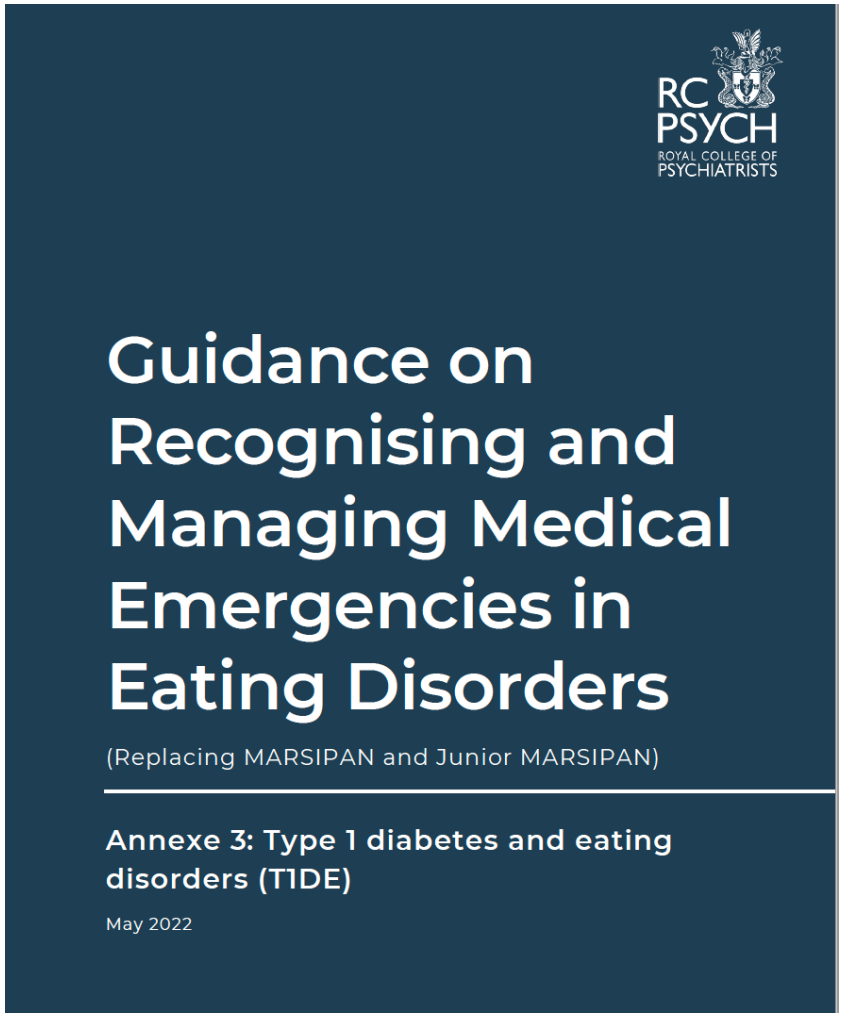
- Guidelines for severe mental illness and diabetes in the inpatient setting
- T1DE guidance RCPsych
- Oxford textbook Diabetes and Endocrinology Diabetes and mental health chapters

JBDS-IP
Inpatient diabetes management in adults and children with psychiatric disorders

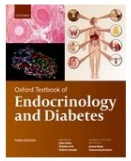
www.diabetologists-abcd.org.uk/JBDS/JBDS.htm



Type 1 diabetes and eating disorders guidance RCPsych



Diabetes and mental health literature



Oxford Textbook of Endocrinology and Diabetes (3 edn)

John Wass (ed.) et al.

CHAPTER

15.11.1 Type 1 Diabetes and Psychiatry

John A.H. Wass (ed.), Wiebke Arlt (ed.), Robert K. Semple (ed.), Khalida Ismail, Chris Garrett, Marietta Stadler

https://doi.org/10.1093/med/9780198870197.003.0273 Pages 2116–2119

Published: January 2022

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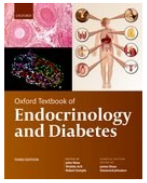


Oxford Textbook of Endocrinology and Diabetes (3 edn)

John Wass (ed.) et al.

CHAPTER

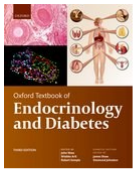
15.11.2 Type 2 Diabetes and Psychiatry

John A.H. Wass (ed.), Wiebke Arlt (ed.), Robert K. Semple (ed.), Marilia Calcia, Clare Whicher, Hermione Price, Khalida Ismail, Calum Moulton

https://doi.org/10.1093/med/9780198870197.003.0274

Pages 2120–2124

Published: January 2022



Oxford Textbook of Endocrinology and Diabetes (3 edn)

John Wass (ed.) et al.

CHAPTER

15.6.2 Psychological and Behavioural Aspects of Type 1 Diabetes Management

John A.H. Wass (ed.), Wiebke Arlt (ed.), Robert K. Semple (ed.), Christel Hendrieckx, Jane Speight

https://doi.org/10.1093/med/9780198870197.003.0256 Pages 2032–2034

Published: January 2022

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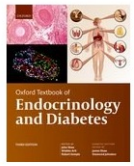

Oxford Textbook of Endocrinology and Diabetes (3 edn)

John Wass (ed.) et al.

CHAPTER

15.7.2 Psychological and Behavioural Aspects of Type 2 Diabetes Management

John A.H. Wass (ed.), Wiebke Arlt (ed.), Robert K. Semple (ed.), Timothy C. Skinner, Jane Speight

https://doi.org/10.1093/med/9780198870197.003.0260 Pages 2053–2056

Published: January 2022

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Chapter 65

Mental Disorders and Diabetes

Najma Siddiqi, Marietta Stadler, Richard I.G. Holt

Book Editor(s): Richard I.G. Holt MA, MB BChir, PhD, FRCP, FHEA, Allan Flyvbjerg MD, DMSc

First published: 12 January 2024 | https://doi.org/10.1002/9781119697473.ch65

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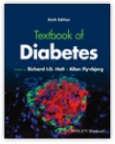

Textbook of Diabetes, Sixth Edition

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SERIES | CLINICAL

Diabetes and brain health

https://www.thelancet.com/series-do/diabetes-brain-health

Older People Mental Health

Type 2 diabetes is associated with a **60% greater risk of developing any dementia**

1 in 5 of older adults have type 2 diabetes

In **residential or nursing homes**, 1 in 3 has diabetes

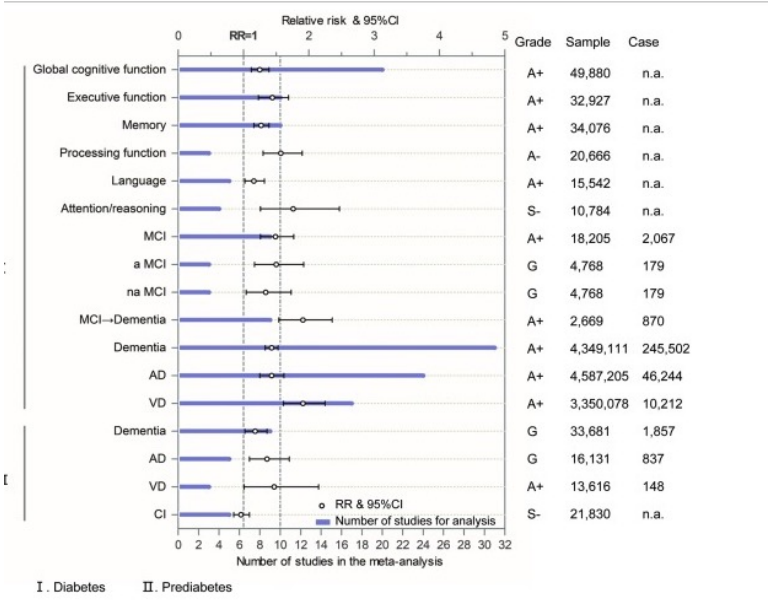
Prevalence in OPMH ward 20% versus 5% in an acute medical ward

https://www.thelancet.com/series-do/diabetes-brain-health

Diabetes and dementia

Cognitive impairment is associated with suboptimal diabetes self-management

- reduced medication adherence
- missed clinic appointments
- poor insulin administration technique
- inability to recognise and self-manage episodes of hypoglycaemia
- Hypoglycaemia compounds poor cognition and increases risk of falls, admissions and death
- No structured screening for cognitive decline in diabetes clinics



Diabetes mellitus and risks of cognitive impairment and dementia: A systematic review and meta-analysis of 144 prospective studies

Mei Xue[a], Wei Xu[a], Ya-Nan Ou[a], Xi-Peng Cao[b], Meng-Shan Tan[a], Lan Tan[a], Jin-Tai Yu[c,*]

[a] Department of Neurology, Qingdao Municipal Hospital, Qingdao University, Qingdao, China
[b] Clinical Research Center, Qingdao Municipal Hospital, Qingdao University, Qingdao, China
[c] Department of Neurology and Institute of Neurology, Huashan Hospital, Shanghai Medical College, Fudan University, Shanghai, China

https://www.thelancet.com/series-do/diabetes-brain-health

Liaison psychiatry

- A common clinical conundrum for acute medical teams is differentiating formal ICD 10 psychiatric disorders from psychological distress
- The most common comorbid presentations are recurrent DKA in young people with type 1 diabetes
- Typically, the DKA admission is not medically explained and may be regarded as a form of self harm
- Gold standard: review by liaison psychiatry before discharge, when admitted in DKA (? Self harm, eating disorder), or severe hypoglycaemia (? Intentional overdose)
- Laison psychiatry embedded in outpatient diabetes MDT

Mentally disordered offenders

- Often prescribed combinations of antipsychotics
- May spend many years institutionalised in secure hospitals
- Limitations of the forensic environment on the management of diabetes including:
  - limited access to lancets for self-glucose testing
  - restricted meal choices and opportunities for physical activity
  - Lack of structured education

Substance misuse

- Significantly increased premature death from diabetes complications including amputations
- Alcohol reduces compliance with medications and recommended lifestyle measures
- Chronic alcohol dependence may lead to acute and chronic pancreatitis
- Alcohol can increase the risk of hypoglycaemia and mask the symptoms of hypoglycaemia

Ask about substance (ab-)use during clinic consultation

Learning Disability

- Healthcare needs of people living with LD are less likely to not be met than people without LD
- They are less likely to see their GP and more likely to die prematurely
- Diabetes is common in part to lifestyle factors and a genetic predisposition in certain groups (such as those with Down's syndrome)

LD continued

- Patients with LD are three times more likely to be obese than the general population
- Fewer than 20 per cent engage in physical activity
- Less than 1 in 10 adults with LD living in supported accommodation eat a healthy diet
- Literacy and social capabilities mean that typically commissioned structured group education may not be appropriate

CAMHS

- Many young people with diabetes may have psychological distress which may not meet formal diagnostic criteria for a psychiatric disorder but can be very disabling
- Eating disorder, depression and distress typically emerges as the young person (usually female) negotiates ‘diabetes independence’
- Best Practice Tariff for paediatric diabetes provides annual review by psychologist

Eating Disorders/ Disordered eating

- Seen in both type 1 and type 2 diabetes
- Focus tends to be on those with type 1 diabetes because it precipitates medical emergencies, but high prevalence in T2 as well
- Includes dieting, fasting, binge eating, excessive exercise and use of diuretics and laxatives
- A dangerous behaviour not seen in other EDs is insulin restriction or omission to facilitate weight loss/ prevent weight gain

ED continued

- reported to occur in up to 40% of young women with type 1 diabetes
- Strongly associated with mortality (threefold compared to T1D without eating disorder)
- Established psychological therapies used routinely in the treatment of eating disorders (CBT) do not achieve the expected outcomes in patients with co-morbid diabetes

Type 1 diabetes and mental health comorbidities- causative relationship

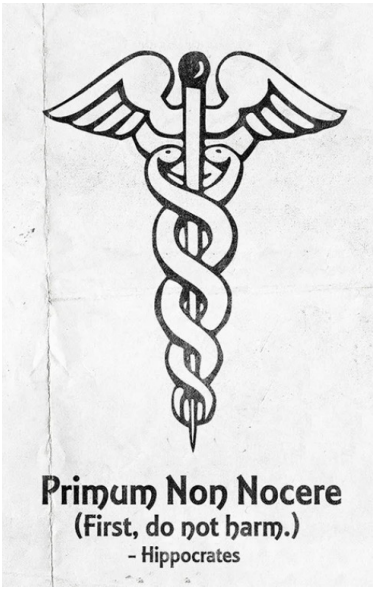
- Psychological burden of diabetes management per se
- Subclinical pre-existing mental health difficulties are tipped into an overt psychiatric diagnosis

- Focus on food and energy it contains/ heightened requirements of self control -> eating disorder
- Relentless requirements of diabetes self care -> low mood/depression
- Diabetes-specific fears: fear of hypoglycaemia, fear of complications, fear of insulin as weight gaining

Type 1 diabetes and mental health comorbidities- clinical red flags

- Recurrent admissions in diabetic ketoacidosis (15% mortality!)
- Recurrent severe hypoglycaemia
- Persistently high Hba1c (>9.5%/ 80mmol/mol)
- Not attending clinic appointments repeatedly
- Other signs of neglecting diabetes self care (e.g. not checking BG)

What role do HCPs play in the ‘pathogenesis’ ?



- ’non-compliance’ is no longer a term we use as diabetes clinicians; not engaging with diabetes self care is often a sign of mental health comorbidity we have not diagnosed or addressed.
- We need to adjust the way we deliver diabetes services and conduct consultations to reach those who are ‘hard to reach’.
- Integration of mental health care professionals (clinical psychology, liaison psychiatry) into diabetes services should become gold-standard.
- There is a clear iatrogenic component to diabetes distress and triggering and maintaining diabetes mental health comorbidities.

Do's and Don't's if person with type 1 diabetes and suspected mental health problem gets admitted in DKA

- Ask open questions about what happened, show empathy, no judgement
- Consider other psychiatric morbidity (depression, eating disorder, anxiety, PD)
- Refer to diabetes team and liaison psychiatry
- Slow insulin/BG titration to avoid too rapid shifts
- Supervise insulin self injections
- Adjust insulin fixed rate, if this is a person who chronically runs their BG high (less tolerant to rapid BG drops- 'phantom hypos'; fear of insulin)
- Make safe discharge arrangements and involve all care providers in this

- Avoid phrases like "non-compliance", "insulin manipulation", "frequent flyer", "oh, you again" (please communicate this point to the ward staff too)
- Avoid too rapid BG drop
- Don't discharge before mental health assessment- DKA is a cry for help and high risk situation.

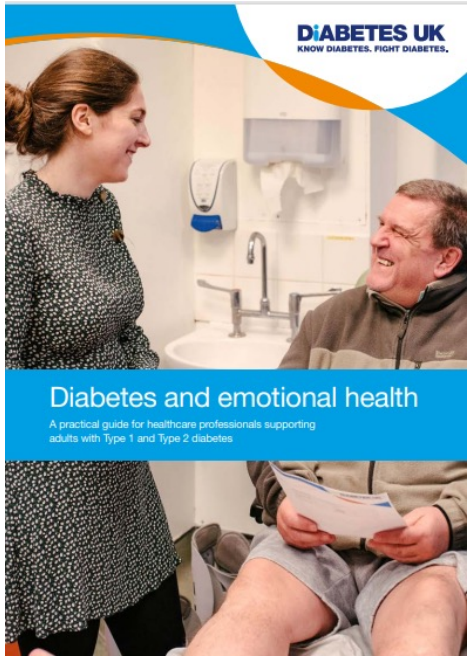
Resources

Cambridge Diabetes Education Programme

Online diabetes training for health and social care staff

CDEP's Mental Health and Diabetes training:

- Raises health and social care worker's awareness of the prevalence and range of mental health conditions in people living with diabetes
- Specifically targets staff working outside specialist mental health services
- Can be completed, on average, in 45 minutes



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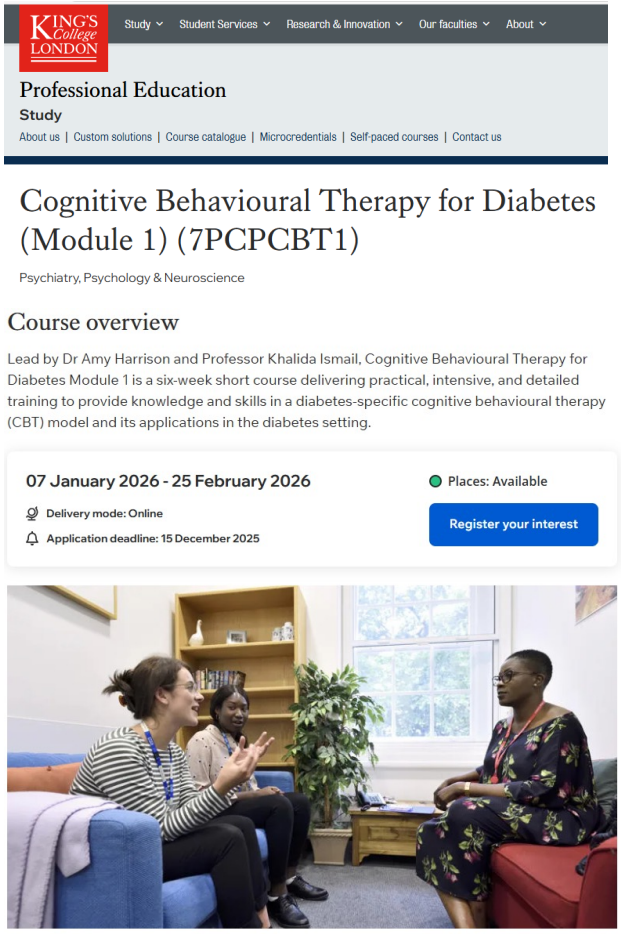
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Psychiatry, Psychology & Neuroscience
Course overview
Lead by Dr Amy Harrison and Professor Khalida Ismail, Cognitive Behavioural Therapy for Diabetes Module 1 is a six-week short course delivering practical, intensive, and detailed training to provide knowledge and skills in a diabetes-specific cognitive behavioural therapy (CBT) model and its applications in the diabetes setting.
07 January 2026 - 25 February 2026
Delivery mode: Online
Application deadline: 15 December 2025
Places: Available
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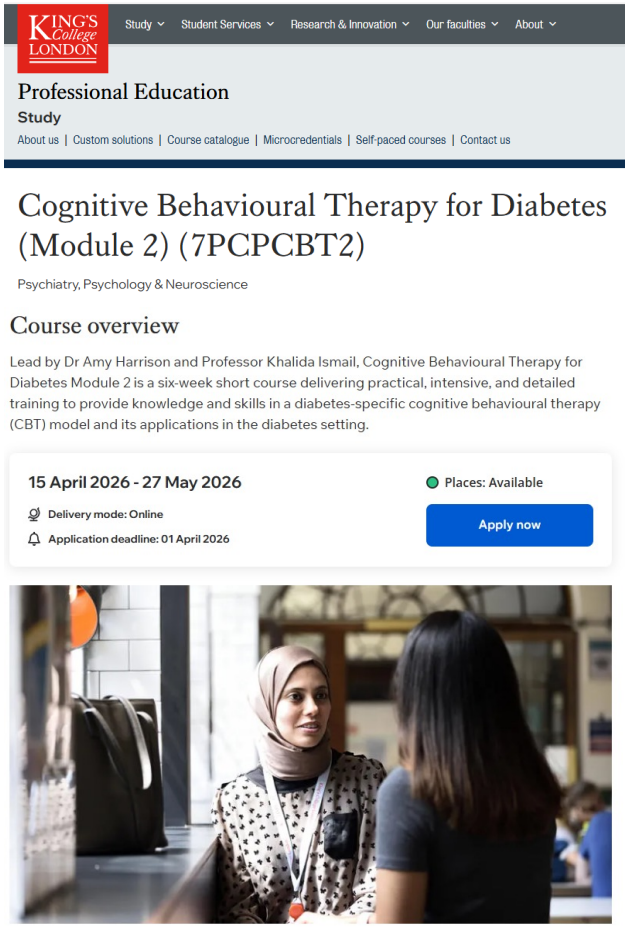
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Course overview
Lead by Dr Amy Harrison and Professor Khalida Ismail, Cognitive Behavioural Therapy for Diabetes Module 2 is a six-week short course delivering practical, intensive, and detailed training to provide knowledge and skills in a diabetes-specific cognitive behavioural therapy (CBT) model and its applications in the diabetes setting.
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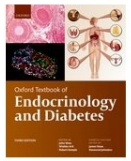

Oxford Textbook of Endocrinology and Diabetes (3 edn)

John Wass (ed.) et al.

CHAPTER

15.11.1 Type 1 Diabetes and Psychiatry

John A.H. Wass (ed.), Wiebke Arlt (ed.), Robert K. Semple (ed.), Khalida Ismail, Chris Garrett, Marietta Stadler

https://doi.org/10.1093/med/9780198870197.003.0273 Pages 2116–2119

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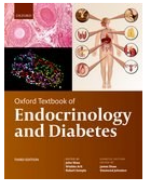

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CHAPTER

15.11.2 Type 2 Diabetes and Psychiatry

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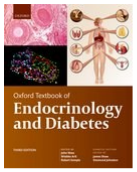

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CHAPTER

15.6.2 Psychological and Behavioural Aspects of Type 1 Diabetes Management

John A.H. Wass (ed.), Wiebke Arlt (ed.), Robert K. Semple (ed.), Christel Hendrieckx, Jane Speight

https://doi.org/10.1093/med/9780198870197.003.0256 Pages 2032–2034

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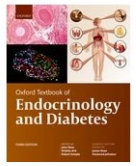

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John Wass (ed.) et al.

CHAPTER

15.7.2 Psychological and Behavioural Aspects of Type 2 Diabetes Management

John A.H. Wass (ed.), Wiebke Arlt (ed.), Robert K. Semple (ed.), Timothy C. Skinner, Jane Speight

https://doi.org/10.1093/med/9780198870197.003.0260 Pages 2053–2056

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Chapter 65

Mental Disorders and Diabetes

Najma Siddiqi, Marietta Stadler, Richard I.G. Holt

Book Editor(s): Richard I.G. Holt MA, MB BChir, PhD, FRCP, FHEA, Allan Flyvbjerg MD, DMSc

First published: 12 January 2024 | https://doi.org/10.1002/9781119697473.ch65

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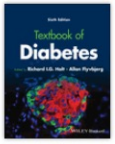

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Diabetes and brain health

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Thank you very much for participating!

- There are lots of opportunities in diabetes and mental healt
  - Research?
  - Audit?
  - QI projects?
- What can you do where you work?
- Can you find out about the mental health care colleagues/ pathways where you work?
- Which training can you access?

Feedback and questions, please email us:

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Sarah.Alicea@nhs.net