QiC Diabetes
Quality in Care Programme 2023

2023 CASE STUDIES

The QiC Diabetes programme has been made possible with sponsorship from Sanofi. Sanofi has had no editorial control over any of its contents.

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INTRODUCTION

Prevention, diagnosis and treatment of diabetes in the UK have never been more important, with the prediction that almost one in 10 people in the UK are likely to have diabetes by 2030, impacted by disturbing levels of obesity, causing the increase in Type 2. This is now also impacting on more people under 40, due to the growing numbers of overweight children and young adults. Diagnosis of diabetes have doubled in the past 15 years, putting millions of Britons at risk of the many complications connected with Diabetes.

Therefore, with the pressure on the NHS increasing and financial constraints growing, along with changes to protocols post-COVID, there has never been a better time to recognise and share good practice that improves patient outcomes and drives efficiency.

Launched in 2011, Quality in Care (QiC) Diabetes exists to recognise, reward and share good clinical practice across the UK and highlight the vital contribution made by local teams and individuals. The programme could not happen without the help and dedication of a large number of people and organisations – our thanks to you all.

Particular recognition is due to the Association of British Clinical Diabetologists (ABCD), Association of Children's Diabetes Clinicians (ACDC), Diabetes Psychology Network, Diabetes Research & Wellness Foundation (DRWF), Diabetes Specialist Nurse Forum (DSN) UK, Diabetes UK, the Diabetes Inpatient Specialist Nurse (DISN) UK Group, JDRF the type 1 diabetes charity, The National Children and Young People's Diabetes Network (CYPDN), Primary Care Diabetes Society (PCDS), Training Research and Education for Nurses in Diabetes (TREND) Diabetes, the United Kingdom Clinical Pharmacy Association (UKCPA) and the Young Diabetologists and Endocrinologists' Forum (YDEF) – and, of course, this evening's hosts Sanofi.

Thanks also go to all of you who have entered this year's programme.
Congratulations to all our finalists and good luck!

Further information about the programme, its judging process and how to enter can be found at **www.qualityincare.org**

Continuing to go beyond generalisation and the expected in Diabetes Management.

Sanofi is proud to be the sponsor of QiC Diabetes and support this programme to continue working hard with those who are dedicated to developing diabetes care.

We are committed to helping improve the health and well-being of people with diabetes.

Our goal is to not only develop innovative solutions which could help people with diabetes to live as people, not as patients but also relieve the burden on the NHS by helping with our medicines and solutions to prevent symptoms worsening or complications arising from chronic conditions such as diabetes.

"Sanofi is delighted to support the QIC Programme in 2023 and to recognise and reward the innovations that will benefit people living with diabetes. The QIC programme is at the forefront of sharing best practice to improve the quality of care, through demonstrating novel solutions to problems encountered by health care professionals and those impacted by diabetes on a daily basis. The commitment to quality of care is a core value of the NHS and the QIC programme is a shining example of that value in practice."

Debbie Woods

Head of Medical General Medicines UK and Ireland Sanofi

SUPPORTERS

ABCD
Association of British Clinical Diabetologists

JDRF IMPROVING LIVES. CURING TYPE 1 DIABETES.

DiABETES UK
KNOW DIABETES. FIGHT DIABETES.

UKCPA
CLINICAL PHARMACY ASSOCIATION

ACDC

Children and Young People's National Diabetes Network

Diabetes Research & Wellness Foundation

PCDS
Primary Care Diabetes Society

diabetes psychology network

t·r·e·n·d™
DIABETES

DISN UK GROUP

YDEF
EDUCATION. ADVOCACY. SUPPORT

Diabetes Specialist
Nurse Forum UK

JUDGING LEADS AND JUDGES

JUDGING LEADS

SIMON O'NEILL

Director of Care and Clinical Intelligence

Simon qualified from St Thomas' Hospital, London as a registered nurse in 1989 and specialised in paediatrics at Guy's Hospital in 1991. Following several years working in both general and renal paediatrics, he moved to Diabetes UK in 1995 as a nurse care adviser. All these years later he is still there, although now as Director of Care and Clinical Intelligence. As Director he is responsible for ensuring Diabetes UK produces accurate and up-to-date information and advice on all aspects of diabetes care, based on the latest evidence. Working closely with healthcare professional colleagues, he also advises on the charity's policies and positions. He has had type 1 diabetes since 1992.

DR PARU KING

Consultant Physician, Derby Hospitals

Paru has been a Consultant in Diabetes and Endocrinology in Derby since 2000. Her clinical interests include diabetes and pregnancy and also integrated care. She is the physician lead for the diabetes and obstetrics service, and has clinically led and project managed the award winning PROCEED project, the first integrated service for preconception care. Since 2017, Paru has led the spread of this innovation from Derby City to the whole of Southern Derbyshire. She was one of the first Diabetes UK Clinical Champions, and the role has helped her achieve service development locally as well as given her the opportunity to be involved in her areas of interest at a national level.

DR MARC ATKIN

Consultant Diabetes & Endocrinology

Marc Atkin has been a Consultant in Diabetes, Endocrinology and Internal Medicine in Bath, UK since 2012, where he is now Clinical Lead. He trained on the south coast of England. Marc is also diabetic foot lead for the Royal United Hospital, Bath and has taken part in a SW Peer Review team that has successfully reduced amputation rates across the South West and recently won a QIC award. Marc is clinical lead for the development of an integrated diabetes care service which has now been running since 2015 and is being extended to cover 3 CCGs in the SW of England.

JUDGES

DR SABRINA AHMED
GPwSI in Diabetes, Gower Street Practice, London

ALISON BARNES
Lead Specialist Dietition, Newcastle-upon-Tyne Hospitals NHS Trust

HANNAH BEBA
Consultant Pharmacist, Leeds health and Care Partnership

DR "JASON" WUI HANG CHEUNG
Inpatient Diabetologist Consultant and The Clinical Lead for Inpatient Diabetes Service, Norfolk & Norwich University Hospital NHS Foundation Trust

DR TOM CRABTREET
Diabetes & Endocrinology Registrar and ABCD Research Fellow, University Hospitals of Derby and Burton NHS Trust

DR CARL DEANEY
GP, East Lincolnshire

SARAH GIBBS

ADELE HOLCOMBE
Registered Dietitian, North East Essex

SUZY HULL
Healthcare Engagement Manager, Diabetes UK Northern Ireland

EDELLE IRWIN
JDRF UK's Community Content and Information Lead

PAUL JOHNSTON
Lead Adult Inpatient @diabetes Specialist Nurse, University Hospital Southampton

SALLIANNE KAVANAGH
Senior Lecturer in Pharmacy Practice and Clinical Pharmacy, University of Huddersfield

BETHANY KELLY
Lead Clinical Diabetes Specialist Nurse, Wiltshire

JULIE LEWIS
Primary Care Diabetes Nurse Consultant, clinical Lead for Diabetes in North Wales Health Board (BCUHB) and National Lead Nurse for Diabetes in Wales

DR JULIA PLATTS
National Clinical Lead for Diabetes in Wales

DR AMAR PUTANNA
Diabetes and Endocrine Consultant, West Midlands & National Advisor for Clinical Engagement, Sanofi UK

BECKY REEVE
Head of Customer Engagement & Professional Relations, General Medicines, Sanofi

DR SAM RICE
Consultant Physician and Endocrinologist, West Wales

DR ASTHA SONI
Consultant Paediatrician, Sheffield Children's Hospital

DR ROSE STEWART
Clinical Psychologist, North Wales and Acting Diabetes Psychology Lead for Wales

CANDICE WARD
Diabetes Specialist Dietitian, Cambridge

LAURA WILLCOCKS
Professional Coach, Trainer and Leadership Development

CORRINE WYKES

WINNER

DIABETES EDUCATION PROGRAMMES – HEALTHCARE PROFESSIONALS

Improving Safety at Scale via Concise and Impactful Diabetes Training Across Health and Social Care

by Independent Diabetes Nurse Consultant

An informed health and social care workforce is crucial to patient safety

Social Care Staff

Prison & Police Service Staff

Mental Health Services

Person with Diabetes

Type 1 & Disordered Eating

Community Nursing Teams

Hospital

Midwife

Cambridge Diabetes Education Programme

10 Diabetes Training

SUMMARY

A workforce that understands diabetes is fundamental to safe care. Staff across all health and social sectors share this responsibility. People with diabetes are living longer, many with multiple comorbidities and increasingly complex treatments. Yet diabetes is routinely managed by grassroots staff in different settings, many lacking access to training. Joining up knowledge across all sectors is essential to safe care, enhancing cross-organisational communication, care integration and patient outcomes. The Diabetes 10-Point Training (D10PT) offers focused, relevant training for hospital staff, mental health workers, community nursing teams, adult social care workers and community support workers.

INNOVATION

In 2017, the National Diabetes Inpatient Audit (NaDIA) reported that inpatients with diabetes had high levels of harm and mortality. At this time the project instigator was Clinical Diabetes Lead in an acute London Trust. The core recurring issues resulting in unsafe care and harm included: failure to listen to the person, their family or carer; insufficient training and diabetes knowledge, as well as not seeking specialist support. Concise, relevant training was needed for all staff, so the D10PT was developed for inpatient staff. The 10 points were: 1. the person: listen to the person they live with their diabetes 365 days a year; 2. know the difference between the types of diabetes; 3. feet; 4. hypoglycaemia; 5. hyperglycaemia; 6. how to prescribe and administer insulin safely; 7. how to manage a tube-fed person on insulin; 8. intravenous insulin; 9. diabetic ketoacidosis (DKA) and hyperosmolar hyperglycaemic state (HHS), plus 10. how to refer to the diabetes team and discharge safely. It became clear that staff in all parts of the pathway needed training, so D10PT was developed for mental health workers, community nursing teams, adult social care workers and community support workers (homeless service staff). People with serious mental illness (SMI) and learning disabilities (LD) experience significant health inequalities with high rates of diabetes, complications and premature mortality. Giving health and social care workforces diabetes training creates knowledge to bridge health and social care, improving cross-organisational communication and integration of care. In June 2022, the D10PT partnered with Cambridge Diabetes Education Programme (CDEP) to bring D10PT online with free access, increasing reach, scalability and resilience.

EQUALITY, DIVERSITY AND VARIATION

Diabetes is inextricably linked to socioeconomic determinants. It can also negatively impact psychological and emotional health. A core aim is to reduce health inequality and improve health outcomes for the most vulnerable groups. People with SMI and LD experience significant health inequality and premature mortality. D10PT provides practical and pragmatic advice and information to identify problems and seek help without delay. From 2022 D10PT for mental health workers was adopted by South London and Maudsley NHS Foundation Trust (SLaM) and South London Partnership (SLP) as their core diabetes training. Training via online platforms was cascaded to the mental health workforce via the train-the-trainer approach. Face-to-face and cascaded education was given to staff in homeless hostels and third sector providers. D10PT aims to challenge negative stereotyping, increase awareness around language and reduce stigma. Working closely with a Partners In Diabetes group, resources were created for people with diabetes with content written by people with diabetes (PWD). D10PT offers online free, concise, high quality training and is timely and relevant in a climate of staff shortages, financial crisis and inadequate training budgets in health and social care. D10PT has been adopted outside the trust and local North West London ICS. Pre 2020, face-to-face training was delivered in North West London to 4,000 inpatient staff, 800 adult social care staff, 400 community nursing teams and 500 mental health workers. Since D10PT went online in June 2022, more than 2,000 staff outside North West London have accessed training modules. Further focused training is being developed with CDEP for groups including prison/police service, type 1 diabetes and disordered eating (TIDE) and midwives.

RESULTS

Monitoring the impact of training has always been an essential part of implementing D10PT. Results include those for an acute hospital where more than 3,000 staff were trained between 2018 and 2020. NaDIA data in 2019 indicated significant safety improvements: medication errors down 38.3% to 7.3%; prescription errors down from 16.0% to 2.7%; glucose management errors down from 24.7% to 4.7%; insulin errors down from 24.7% to 4.7%; severe hypoglycaemia down from 10.4% to 4.2%. Online users provide feedback regarding knowledge, confidence and guideline familiarity. The e-learning offers focused learning based on the person's role and who they support. Real-time results (as at early July 2023) showed that 65% of staff who started D10PT completed the training. Users can access training in bite-sized chunks to fit it into their busy lives, so staff are in the process of completing the training. However, the high average completion rate demonstrates that the majority find the training accessible and worthwhile.

USER FEEDBACK

User feedback is collected on CDEP following successful completion of topics or modules. Users complete evaluations that generate their certificates, ensuring 100% feedback. Users note current ability before starting online training and reevaluate at the end. Both questions utilise a five-point scale to standardise answers allowing robust audit of results. There are also qualitative questions to gain insight into user experience.

DISSEMINATION AND SUSTAINABILITY

The D10PT was originally delivered face-to-face. This approach was limited, so the train-the-trainer approach expanded dissemination via nominated diabetes champions within services and across health and social care organisations. Finally, to maximise D10PT scalability and sustainability, D10PT was delivered online in partnership with CDEP, across the UK and beyond. Online training with inbuilt, robust assessment methods supports a blended, flexible approach to training. Trusts can still use face-to-face training, but with CDEP before or afterwards to enrich, affirm or refresh knowledge. CDEP certificates offer COPD endorsement to make training more appealing, as they can be utilised for professional revalidation and appraisal. The training can be revisited, supporting ongoing learning, as well as accessed via a computer, smartphone or tablet. As it is free for users, payment or trust funding is not a barrier to access, further supporting dissemination and accessibility.

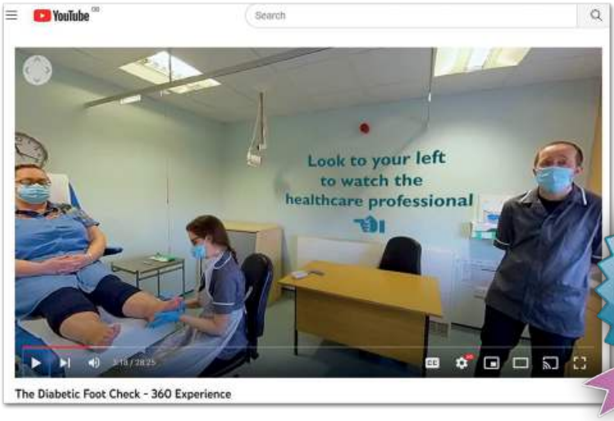
JUDGES' COMMENTS:

> “ *The Independent Diabetes Nurse Consultant has produced an impressive and well-executed programme targeting particularly at-risk individuals. It was clear that the patients were at the heart of this project, which the judges thought came out very strongly throughout the whole process. The objectives were smart, the results section clear, and the dissemination clever. An overall excellent project that can, and should be, translated to wider use.* ”

DIABETES EDUCATION PROGRAMMES – HEALTHCARE PROFESSIONALS

Footcare Education in Primary Care

by Suffolk GP Federation



The Diabetic Foot Check - 360 Experience

SUMMARY

The initiative was to create a comprehensive foot screening education programme that utilises both traditional and innovative training methods for primary care across the Integrated Care System (ICS) (Suffolk and North East Essex). In order to enable accurate diabetic foot risk categorisation and appropriate referral based on the integrated care foot pathway, standardised virtual training sessions with clear objectives, utilising live polling systems, unique immersive 360 video and live facilitated sessions with a specialist podiatrist were developed. This ensured that the skills of staff undertaking diabetic foot screening were embedded in primary care, despite COVID-19 restrictions.

INNOVATION

Delays in presentation to specialist foot care have been linked to reduced healing rates and increased risk of amputation. The ICS had multiple foot pathways, but they were face-to-face only and not effective in primary care. The team reviewed the options, including what worked nationally, such as virtual DAFNE. The plan was to: provide a first-class foot screening education programme using traditional and innovative training methods; devise standardised, virtual training sessions with clear objectives, utilising live polling systems, immersive 360 video and live sessions with a specialist podiatrist; disseminate knowledge of the ICS-wide integrated foot care pathway, ensuring skills were embedded in primary care, plus offer a range of training options. The aim was to provide consistency, improve the quality and accuracy of foot screening, embed awareness of the pathway for people with diabetes, plus improve the National Diabetes Foot Care Audit interval. Staff at 90 GP practices were given equal access to the training, to deliver consistent foot screening in line with national guidelines.

EQUALITY, DIVERSITY AND VARIATION

The engagement of specialist podiatrists, consultants, DSNs and management across the ICS allowed all input into developing the pathway and training plan. As face-to-face training was often poorly attended, remote training opportunities were a priority during the pandemic. Collaborative working ensured training was consistent and equitable. The MDT reviewed and modified the script and storyboard for a 360^0 foot check video to ensure that the content was engaging, relevant and understandable for HCPs from different educational backgrounds. A suite of education options was developed for different levels of knowledge and experience. Staff could select the training most suited to them. Opportunities, such as shadowing specialist foot services, were available and all had access to the video and other resources. Deprivation varies across geographical areas and the training was mandated as equal for all. All in primary care could access the training, regardless of time, distance from training site, affordability of travelling for face-to-face training and additional learning needs. Teaching plans were written by the training development team for each type of training session and the same resources were utilised across the ICS. During COVID-19, virtual training delivery increased. Face-to-face training was only delivered when deemed safe. The integrated foot care pathway and education programme were advertised to all primary care practices and consultant diabetologists advocated the importance of attending training.

RESULTS

This project was initially financed by East of England transformation funds. However the plan was to ensure the project would be sustainable in future with minimal costs. The video – produced in collaboration with the University of Essex, which paid for it – is not region- or care pathway-specific and free to other areas. The only ongoing costs are clinician time in delivering training, minimal stationary costs and occasional room hire. Adding virtual training minimised costs. Between November 2021 and July 2022, 340 HCPs received foot training across North East Essex and Suffolk, despite pandemic challenges. North East Essex saw the greatest uptake (n=146), followed by East Suffolk and Ipswich (n=138) and then West Suffolk (n=56). The split was fairly equal between face-to-face (54%) and virtual (46%) training. The majority of attendees were practice nurses (56%) and HCAs (28%). However, eight other designations attended (16%). Other specialist staff, such as pharmacists, paramedics and minor injury staff, also attended. A small number of practices did not engage with the programme. North East Essex had the most GP practices with three or more people trained. This diabetes service is outcome-focused, with strong primary care links and financial incentives for practice engagement in delivering key services to diabetes patients. It also has a significantly higher rate of diabetes diagnosis, which could drive greater attendance at training. The 'did not attend' (DNA) rate for face-to-face training sessions was low (8%) and was nearly half that of virtual sessions (15%). The new pathway is embedded with an audit of 50 records in Suffolk revealing that no low-risk patients were referred, saving at least £50 on every inappropriate referral. Datix incident reports around late presentation to foot services have halved since training began.

User Feedback

Anonymised feedback was sought. The 360^0 video was found to be clear and understandable and viewers felt more confident in undertaking foot screening. The project team was thrilled with the feedback received from the training initiative. The training programme was adapted over time. It was suggested that patients also needed educating on foot disease and when and how to seek emergency foot care. This led to the development of animated patient education videos and an ICS-approved information leaflet.

Dissemination and Sustainability

There was emphasis on making both the integrated foot care pathway and training programme as user-friendly as possible. This project was delivered ICS-wide, but many of the resources were designed to be used free of charge across the UK. Links to the resources have been circulated to the East of England Podiatry leads and an article has been written for a UK-wide diabetes publication. Virtual training is financially astute and enables training to reach a wider and larger audience. A rolling education programme continues, with face-to-face and virtual options to cater for differing learning styles and needs. The programme will be modified, at low cost, for community nursing teams and residential home staff. Free animated videos about foot care are being produced for people with diabetes, which will be disseminated widely.

JUDGES' COMMENTS:

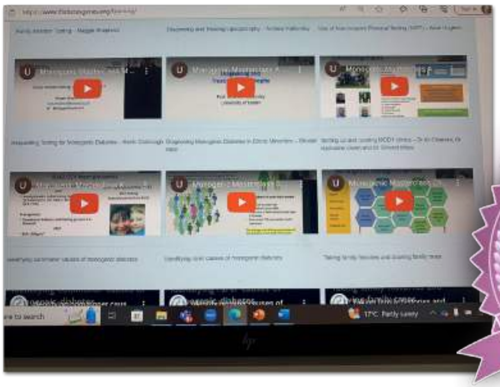
> “ *The Suffolk GP Federation has designed a thoughtful and innovative programme that has produced some impressive results. The team clearly identified the need for an education programme and used innovative methods to deliver it. The judges commended the collaborative approach taken to the project and thought the concept was sustainable and could be translated to other areas, where it is desperately needed.* ”

COMMENDED

DIABETES EDUCATION PROGRAMMES – HEALTHCARE PROFESSIONALS

Ensuring Recognition of Monogenic Diabetes Through a National Initiative

by Royal Devon University Healthcare NHS Foundation Trust



SUMMARY

Monogenic diabetes (MD) accounts for 3.6% of diabetes diagnosed <30 years but ~80% are initially misdiagnosed, resulting in inappropriate management. An estimated 12,800 UK MD cases are still to receive a correct diagnosis, so a national transformation project was instigated to reduce variation in referral/identification. The aim was to train a diabetes consultant and DSN in every trust in England as MD leads to increased awareness/referrals for genetic testing. A two-day, virtual introductory MD training course was developed and held on four occasions (June 2021-Oct 2022). Training resources were added to www.diabetesgenes.org, enabling self-paced access. Referral/pick-up rates were collated pre and post training.

INNOVATION

A national network of Genetic Diabetes Nurses (GDN) was initiated in 2002 with Diabetes Specialist Nurses (DSN) trained in MD and tasked with increasing awareness across their regions. However, some areas had no GDN and there was widespread geographical variation in identification of MD. Despite increased referral and recognition of cases over a 10-year period, geographical variation remained, with >12,000 cases undetected. Working with NHSE and the Genomic Medicine Service Alliances (GMSA), this project aimed to identify and train a named lead for MD in every trust with a diabetes service in England. It evolved from a model with a single regional expert (a GDN) to one with a local expert in each trust supported by MD experts (a diabetes consultant and GDN in their GMSA region). Each organisation set out to identify and train both a DSN and consultant lead in MD (ideally from both adult and paediatric teams) and other staff to provide resilience and ensure greater awareness and best practice for patients with MD wherever they lived. The challenge was to move from about 15 regional GDNs to leads in all 128 trusts in England with a diabetes service. The Exeter team worked with NHSE and the GMSAs to provide free, virtual training, adapting a face-to-face two-day course into a two-day virtual training course, with recorded training sessions for HCPs unable to attend. Those trained were asked to become leads for MD in their organisations and details were provided to the expert diabetes consultant and GDNs in the GMSA regions to offer ongoing support through virtual case discussions and follow-up. The Exeter team maintained the register, supplying named leads if areas had patients requiring review or support. This was the first time that named individuals trained in MD had been identified across England.

EQUALITY, DIVERSITY AND VARIATION

Barriers to genetic testing have largely been removed as the cost of genetic testing is now centrally funded. The criteria for genetic testing were developed by the Exeter team and ensure appropriate referrals. Pick-up rates have been maintained throughout to raise awareness and recognition of MD at every trust. MD is identified in all ethnicities. Guidance regarding eligibility for genetic testing on www.diabetesgenes.org includes adjusted BMI and age of diagnosis for those from high prevalence ethnic groups. Sessions on recognising MD in different ethnicities have been included in the two-day course and subsequent masterclasses and are available on the website. There have been more referrals across all geographies, leading to a reduction in variation of detection of MD. The expert consultants and GDNs within the GMSA regions continue to provide support to trust MD leads to ensure that trend continues.

RESULTS

A total of 1,054 individuals, from nine different adult/paediatric HCP groups (consultants, registrars, DSNs, midwives, dietitians, pharmacists, health care scientists, GPs, practice nurses), attended the two-day course, 256 attended masterclasses and 376 registered for online self-paced training. This included 46 international delegates from 44 different countries. Now, 122/128 (95%) trusts in England with a diabetes service have a named MD lead: 71% with consultant and DSN lead, 20% with a consultant lead and 4% with a DSN lead. Plus, 86% of organisations have additional staff who have attended training, ensuring sustainability. Referrals have increased >threefold with no deterioration in pick-up rate, with 618 new diagnoses. This includes 297 with GCK MODY, 140 HNF1A MODY, 52 HNF4A MODY, 35 with mitochondrially inherited diabetes and deafness (MIDD), 31 HNF1B MODY and 65 with rarer genetic causes. The correct diagnosis means those with GCK MODY can stop all treatment and be discharged from follow up, many of those with HNF1A or HNF4A MODY can transfer from insulin to sulphonylureas and all patients can receive guidance on management, likely clinical course and risk to offspring. Correct diagnosis also reduces costs. NHSE Diabetes Programme and the GMSA supported this initiative with two-year funding. This enabled the training to be provided free for those attending the two-day courses and the masterclasses and the talks are free on the website. The funding also supported the seven expert diabetes consultants within the GMSA regions and two Exeter team members.

USER FEEDBACK

All sessions were evaluated by delegates via an electronic feedback form. Participants were asked to score sessions on relevance and enjoyment and there were opportunities for free text responses. A total of 80% scored the course 5/5 for relevance and 18% 4/5, with 78% scoring the course 5/5 for enjoyment, 21% scoring 4/5. Feedback led to revised timings of some sessions and short breaks. Some delegates said they would have preferred a face-to-face course, but a virtual format was preferred by others.

DISSEMINATION AND SUSTAINABILITY

The virtual training is open to HCPs across the world. All talks have been uploaded onto www.diabetesgenes.org to enable free access for HCPs and patients. The benefits are seen in the patients receiving a correct diagnosis following genetic testing. Ongoing virtual Masterclasses will continue to be scheduled to continue to increase knowledge and engagement among HCPs. This model is sustainable, with all sessions pre-recorded and accessible, but with the opportunity to add and update as required. Other services could easily replicate this model of training in other areas; it is low cost and easy for HCPs to access it. The work has been disseminated via the Diabetes UK annual conference and the International RCN research nursing conference. It is being written up for publication.

JUDGES' COMMENTS:

> “*Royal Devon University Healthcare NHS Foundation Trust has created a well-designed and incredibly important initiative addressing a hugely under-diagnosed and unrecognised area. The entry itself was well-written, the results section impressive, and the judges agreed that the impact this programme could have on the diabetes community could be huge. A very strong submission with enormous potential.*”

FINALIST

DIABETES EDUCATION PROGRAMMES – HEALTHCARE PROFESSIONALS

Diabetes: Start with the Diabasics

by University Hospital Southampton

SUMMARY

Inspired by the 'Surviving Sepsis Campaign', the 'Start with the Diabasics' initiative was started – the first inpatient diabetes-branded initiative seeking to raise the hospital-wide profile of the need for all ward-based healthcare professionals to support the basic diabetes care needs of their patients. It seeks to ensure that supporting diabetes care is 'business as usual' for all clinical staff. Since launch, awareness of their role in supporting diabetes care has increased among other clinical teams, referral numbers to the diabetes team and referral quality have reduced and increased, respectively, in a replicable initiative.

INNOVATION

University Hospital Southampton hosts 200 inpatients with diabetes daily. The specialist diabetes team often received inappropriate referrals from other teams, with queries that could be resolved using easily accessible guidance. Adverse events had occurred when teams ignored diabetes. Addressing basic queries reduced time spent on greater needs. Diabetes UK selected Southampton to receive support from its Health Systems Change team on an improvement project. Meetings with the Change team (June 2022 to March 2023) established the goals and benchmarks for success. Based on feedback from 200 staff and people with diabetes, 'D1ABETES' was launched – an acronym for 'Diabetes identification, type 1 diabetes, Acute admission, Blood glucose monitoring actions, Eating and drinking, diabetes Treatments, Education & Safety', underpinning the 'Start with the Diabasics' initiative. Following the official launch in May 2023, the diabetes team visited all wards to deliver themed project merchandise and talk to staff to reinforce awareness. Service referrals would be scrutinised for appropriateness and evidence of guideline use. The Diabasics brand would be used for all formal staff training sessions to maintain awareness. The aim was that all staff should be able to contribute to basic care confidently. The innovation was in: taking a systematic approach to problems; using perspectives from clinical staff outside the team to challenge assumptions and sense-check the approach; brainstorming prototypes, with external feedback; creating a distinct brand differentiated from other NHS materials, plus creating an initiative, not just a campaign, including significant relationship building with stakeholders across the hospital, to lay the foundation for Diabasics' launch.

EQUALITY, DIVERSITY AND VARIATION

All inpatients should expect a high standard of diabetes care, regardless of ward, social background or ethnicity. The team is inclusive and diverse and will support any patient. Project planning included checking ideas with ward staff from culturally and ethnically diverse backgrounds outside the team and patients with diabetes. The Diabasics marketing posters contain visuals of healthcare workers from different ethnic groups. Through this initiative, Diabasics marketing, ward visits and presentations, the importance and need for all staff to support basic diabetes care was embedded. The need to only refer after basic actions have been commenced, using existing guidance, is clear to staff. The aspiration is to create a better and safer hospital experience for all patients with diabetes. The 'D1ABETES' pillars of Diabasics guidance give staff a framework from which to update their knowledge, including a local guidance app. Wards with high levels of inappropriate referrals or patient harm received enhanced support. Reducing 'inappropriate referrals' gives the inpatient team more capacity to assess patients with more complex needs. New members of staff view an 'introduction to diabetes in hospital' safety video, which covers the Diabasics initiative. This video can be easily shared at scale with all staff.

RESULTS

Before project launch, the diabetes service typically received 20-30 referrals a day from other teams. Often, the information provided was limited and diabetes needs had not been acknowledged. It was made clear that inappropriate referrals would no longer be accepted. Two months into the campaign, referral numbers had fallen by 10-20%, with reason for review more clearly outlined. There was no evidence of reduced referral rates at the expense of persistent hyperglycaemia or hypoglycaemia, based on networked blood glucose meter daily notification data. Teams only contacted the diabetes team to sense-check their approach and confidence increased among staff on wards with high diabetes prevalence. Many of the 44 hospital wards had Diabasics posters displayed and the diabetes team wore Diabasics T-shirts on ward visits to maintain awareness. Most staff appreciated the need to collectively support patients. A diabetes study day, attended by 80 nurses working trust-wide, increased confidence in their ability to deliver basic diabetes care. More are booked. The aim is to reduce the likelihood of clinical errors and harm to people with diabetes, resulting in a better, safer hospital experience. The relationships built supported the importance of diabetes care and the role of all staff. Constant reinforcement will be needed. The project was funded through an educational grant from Diabetes UK. The two medical and nursing service leads gave their time free. It was designed so that the basic diabetes requirements were relevant to all 44 wards and easily translatable to other ward-based settings. Most of the grant was spent on producing Diabasics-themed merchandise to maintain brand awareness.

USER FEEDBACK

Feedback statements were obtained post launch by the team, from individuals who were at the launch or heard through internal communications or social media. Responses were positive.

DISSEMINATION AND SUSTAINABILITY

The project was devised for the whole 1,100-bed hospital, to raise the profile of diabetes care needs, which can be overlooked and not prioritised. Pressure will be maintained to ensure that other teams address the basic diabetes needs for their patients. If this is undertaken repeatedly and at scale, this should help reduce diabetes-related delays in care, risks of diabetes-related patient harm, plus length of stay, while giving a more positive patient experience. The rates and nature of adverse clinical events will be monitored and fully investigated, with shared learnings disseminated widely. Social media generated enquiries from 10 hospitals on how the project was developed. A presentation will be made to the NHS England Patient Safety Team. The branded visuals have been shared freely nationally, so other teams can use them. This approach can be adapted for use in other hospitals, without the need for significant new investment. Learnings will also be shared with the Diabetes UK Diabetes Leadership Community.

JUDGES' COMMENTS:

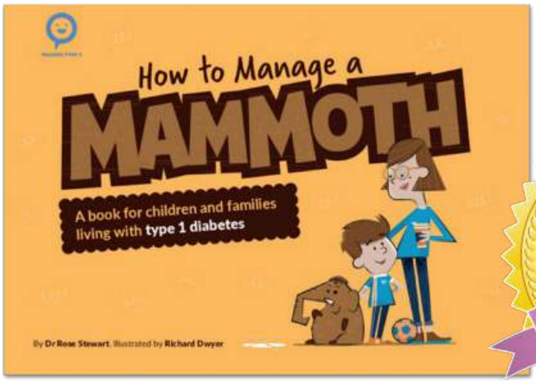
> “*Diabetes: Start with the Diabasics is a passionate and impactful initiative. The judges agreed that there is a desperate need for this project and particularly liked that the posters reassured patients on the ward team's diabetes knowledge. The messaging was brilliant, the feedback very positive, and the concept sustainable.*”

WINNER

DIABETES EDUCATION PROGRAMMES – PEOPLE WITH DIABETES

How to Manage a Mammoth: Psychoeducation for Children with Type 1 Diabetes and their Families

by Talking Type 1 / NHS Wales



QiC WINNER

SUMMARY

How to Manage a Mammoth is a book-based psychoeducation intervention for young children with diabetes and their families. By incorporating elements of acceptance and commitment therapy into an engaging and interactive story, the book supports diabetes teams and families to discuss difficult topics, such as diabetes distress and burnout. The book has been published across NHS Wales, England and beyond, and has been made in to an animation, as well as forming the basis for multiple therapeutic groups and individual interventions across the UK and Ireland.

INNOVATION

Diabetes psychology support is often in short supply. Many are reluctant to see a psychologist or have lower levels of distress, but would still benefit from increased psychological knowledge and skills. The Talking Type 1 book range uses a bibliotherapy approach to give people with diabetes information and strategies to help them manage common psychological issues related to living with diabetes. How to Manage a Mammoth is the first Talking Type 1 book for children. It is a professionally illustrated story and activity booked aimed at children aged 4-8 with type 1 diabetes. It was written by a diabetes specialist clinical psychologist with children and families living with diabetes, and uses aspects of acceptance and commitment therapy to help children and their parents understand and communicate about difficult subjects like diabetes distress, self compassion and burnout. The book tells the story of Jake, an eight-year-old boy who lives with Mel, a magical diabetes mammoth, who grows as Jake's diabetes distress increases. Jake and his mum work with their diabetes team to shrink Mel down to a manageable size. The book is appealing to children and families, with the feel of a bedtime story book, rather than an NHS leaflet. It uses a guided self-help model, providing basic-level psychological intervention reinforced and boosted by the child's diabetes team. The activity section encourages children to think about their own skills and to create their own diabetes creature; these activities can be completed at home or during a clinic appointment, giving non-psychology staff an additional resource to support conversations about emotional wellbeing. For parents, the book can be used in conjunction with another Talking Type 1 book: Diabetes Distress and Burnout for Parents and Carers. The book was co-produced with parents of children with type 1 diabetes and provides education on normal reactions to diabetes, stress management, communication strategies and self-compassion.

EQUALITY, DIVERSITY AND VARIATION

The books were written with children and families from across Wales who live with diabetes and have a range of backgrounds. These collaborators reviewed the story and character concepts, and feedback was incorporated. The books can be used by the diabetes team, the child's family or school teachers. This significantly increases the accessibility of psychological education and strategies, and can be particularly useful in areas where there is no psychology provision, or where there are long waiting lists, thereby reducing variation in access. The book illustrations include characters from a range of ethnicities and include characters in non-traditional gender roles to promote positive role modelling and reduce stigma. The book also introduces the character of Annesha, a young girl of South Asian heritage who lives with Sid, the diabetes hedgehog. It was important to incorporate this character so that children from minority ethnic communities could see themselves and their diabetes represented positively. Aneesha also features in the sequel, How to Hold a Hedgehog, and is illustrated wearing a continuous glucose monitor – another deliberate choice to provide culturally matched positive role models. Most of the books are distributed free through NHS services, allowing children from deprived backgrounds to access them. Every book released in Wales is bilingual and printed in a 'tilt and turn' format. Training videos and handouts were created for staff.

RESULTS

The reviewing panels reported that their learning outcomes included a normalisation of struggles and difficult feelings, acceptance of diabetes, understanding that 'I'm not my diabetes, but it's part of me', recognition of family feelings, support networks, plus the book as a helpful tool for siblings, extended family members and friends without diabetes. Initially, 3,000 copies of the books were distributed to paediatric diabetes centres across Wales. Following the NHS Wales publication interest resulted in a commercial publishing deal with Cambridge University Press. Working with industry and NHS England, a further 50,000 copies were distributed to paediatric diabetes centres across England. The books are for sale globally through major retailers. Royalty payments to NHS Wales will be ringfenced and used to fund future editions and print runs in Wales. Paediatric services in Wales, England and Ireland have been using the books as a core component of psychological well-being groups, where children are invited to read the story, discuss the themes and then create their own diabetes creatures. Paediatric diabetes clinics around the UK are using the activity sections in clinic appointments, to reduce anxiety and start conversations about psychological health.

USER FEEDBACK

Feedback was collected from social media and comments from online webinars where the books were presented. There were also blinded reviews as part of the publication process. Paediatric diabetes HCPs, people with diabetes and the third sector all responded positively.

DISSEMINATION AND SUSTAINABILITY

The book has been presented at national diabetes conferences and in online webinars for HCPs and people living with diabetes. It was used as an example of good practice in a recent parliamentary inquiry into psychological health in diabetes services. Additional colouring resources, design competitions and Christmas card templates are available online for download. In 2022, Digibete received a charitable donation to turn the book into a short animation narrated by a nine-year-old boy with diabetes, which is on their website. To date, the animation has had 25,150 views and has been posted out twice via the Digibete app news to 25,000+ users. The book has been featured in diabetes publications and is being put forward for the children's national reading well scheme.

JUDGES' COMMENTS:

> “*Talking Type 1 / NHS Wales have produced a simple but incredibly powerful campaign that stood out to the judges. The team collaborated with the intended audience from the off and ensured that equality and diversity was at the core of this project. The level of dissemination was huge, the results impressive, and the concept translational to so many other areas. The panel agreed that the long-term benefits of this initiative could be huge.*”

DIABETES EDUCATION PROGRAMMES – PEOPLE WITH DIABETES

SEREN Moving to Year 7

by Cardiff and Vale University Health Board

SUMMARY

The transition from primary to secondary school can be a time of great change for children and young people (CYP) with type 1 diabetes. They often go from a smaller, supportive environment to a setting where they are expected to manage their diabetes independently. This module was developed to help equip CYP for this transition. It is a group session for CYP who are in school year 6, designed to be interactive and enable them to problem-solve different scenarios. Part of the Structured Education Reassuring Empowering and Nurturing (SEREN) programme, the module is Quality Institute for Self Management Education and Training (QISMET) accredited and includes detailed educator curricula, interactive resources and quality assurance.

INNOVATION

Before the module was launched, most teams in Wales offered a session to CYP to prepare them for the transition to secondary school, but delivery was variable and unstructured. The SEREN group decided to develop a new All Wales resource. The working group included dietitians, nurses, doctors and a psychologist, plus parent representatives. They pooled existing resources and good practice from across Wales to develop the module in line with the other SEREN modules. Interactive resources were developed to facilitate activities in a non-didactic manner, enabling the CYP to problem-solve and encouraging discussion. The educator curriculum took the same format as the SEREN Diabetes at Diagnosis module. It contained learning objectives and outcomes, lesson plans, plus notes and tips for delivery. The half-day session could be delivered outside the hospital setting and could include a fun activity to encourage peer support. The module contains a quality assurance (QA) process enabling peer review of delivery to maintain high standards and equity of care across Wales. The child-friendly images are consistent with other SEREN branding. Resources include flash cards, a generic school map and games. The activities encourage CYP to apply existing experience and knowledge in different scenarios, problem-solve and increase confidence in self management. Older 'diabetes ambassadors' can share their experiences. The module is QISMET-accredited, which noted: a comprehensive programme available to every child in year 6 in Wales; an excellent, evidence-based and professionally produced curriculum handbook for HCPs with an outstanding 'Group Facilitation Skills Guide', plus positive feedback and evaluation.

EQUALITY, DIVERSITY AND VARIATION

All of the resources are child-focused and interactive, with few worksheets. They are designed for a range of learning styles and can be adapted to individual needs. The facilitation skills guide includes information and tips on increasing accessibility to CYP. The resources are in English and Welsh and can be used with children for whom English (or Welsh) is not their first language. The plan is to supply them in other languages. There are clear aims and objectives and the curriculum reduces variation across diabetes teams. The QA component ensures standard delivery. All staff in Wales must attend SEREN programme training, including the group modules and use of the curriculum. All teams now offer this module, providing equity of care. The images are diverse and include cartoon images of CYP from different ethnic backgrounds and appearances. During the COVID-19 pandemic, the resources were provided virtually to ensure accessibility. Topics covered include: hopes and fears; high and low blood glucose; carbohydrate counting; mishaps – when things don't go to plan; where is school to look after your diabetes; telling new people about diabetes, and dealing with other people's unhelpful comments about diabetes.

RESULTS

Since it was launched in 2019, the SEREN 'Moving to year 7' module has been delivered by all health boards across Wales. At least 200 CYP have attended a session. Diabetes teams have given positive feedback and say the CYP benefit enormously. The CYP all reported that they learned something useful and parents gave positive feedback. The main change since the launch is that all children in Wales are now offered the same education at this transition stage. The interactive nature of the activities builds confidence by encouraging them to problem-solve in a safe and supportive environment. Development of the programme was funded by the Welsh government via the All Wales Diabetes Implementation Group. Other paediatric diabetes teams across the UK have purchased the module and other SEREN resources, with income generated used to develop further modules. There has been interest from other countries. The vision is to make the programme self-sustainable and free for CYP in Wales through overseas sales. Delivering group sessions is cost effective and having a standard module available with evidence-based resources means that teams do not have to develop their own. 'Moving to year 7' aims to empower young people and increase self confidence to manage their condition, thereby reducing the burden on healthcare systems throughout their lifetimes.

USER FEEDBACK

Feedback was provided via Google Forms and a QR code for CYP to access the form at the end of their session. This was completed in participants' own time to minimise risk of bias. The CYP were asked to record two things that they had learned. Feedback is reviewed annually and, although all feedback has thus far been positive, appropriate changes can be made. All SEREN modules are reviewed every five years, or sooner if there are significant changes to clinical guidelines. HCPs who have delivered the session report that they enjoy delivering the session and find it a valuable use of time.

DISSEMINATION AND SUSTAINABILITY

SEREN is an All Wales programme. In addition, 11 paediatric teams in England have purchased the 'Moving to year 7' resources. The module is adaptable and could be delivered by other centres across the UK. It is now embedded in clinical practice across Wales. Feedback from educators and users has been positive. All children with type 1 diabetes living in Wales can now attend the structured session to support self management. The skills learned are usable in all areas of their lives. The success of the group sessions has led to the development of further SEREN group modules. Resources could be adapted by other services and conditions.

JUDGES' COMMENTS:

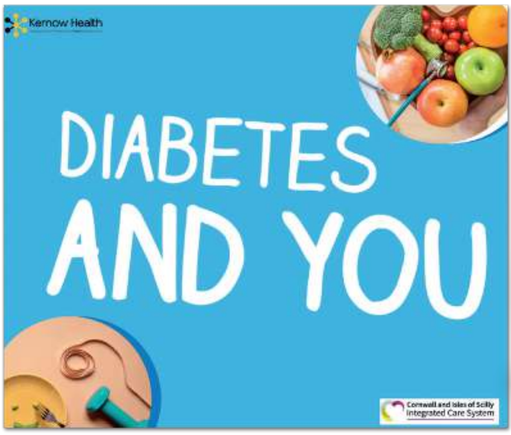
> “*SEREN Moving to year 7 is a much-needed and adaptable programme that delivered some excellent outcomes. The judges could clearly see that the resources had been developed with the target audience in mind and were impressed that the team had considered alternative ways to deliver the programme. A really strong entry.*”

FINALIST

DIABETES EDUCATION PROGRAMMES – PEOPLE WITH DIABETES

Diabetes and You Cornwall

by Kernow Health CIC



SUMMARY

Diabetes and You (D&Y) is structured education for adults with type 2 diabetes. The free course is delivered with local GP practices and led by trained diabetes educators. The course is delivered over three, 90-minute sessions (usually one per week), covering general messaging for anyone with type 2 diabetes and helping them to better self-manage the condition. In March 2021 D&Y was piloted with three GP practices in Cornwall. The courses were delivered virtually because of the pandemic, with the aim to develop a structured education course locally that could be embedded within primary care.

INNOVATION

NHS Kernow's nationally available diabetes education and self-management programme had low uptake locally, with about 17% of referred patients attending. Programme delivery was detached from practices with provision spread thinly across the county. The number of affordable educators was restricted and resources were nationally based and directed. The new programme sought to address these issues and to embed the delivery of diabetes structured education in primary care activity for practices/PCNs. When courses are promoted/delivered by people the patient already knows and trusts (ie local practice staff), they are more likely to engage with the training. The vision is to improve the provision and uptake of D&Y so that everyone with type 2 diabetes can learn skills and gain confidence to take control of their condition, thereby reducing the likelihood of long-term complications. The pilot courses were facilitated by two educators who had delivered nationally accredited diabetes self-management programmes. The social prescribing teams at the practices were instrumental to success and encouraged participants to join the course and reminded them to attend, resulting in higher attendance figures. The initiative is an integrated collaboration with primary care and their MDTs, making D&Y a co-designed, place-based project. Rather than use a central booking system referring patients to an external provider, the courses are embedded in primary care through a partnership approach, with local courses delivered by practice staff who know their patients, the demographics, challenges and local signposting opportunities to encourage patients to attend and to make healthy living choices. Primary care can get funding to support delivery of D&Y, with access to a free educator training package delivered by the training hub, Kernow Health CIC. Around Cornwall, 39 educators from different healthcare backgrounds have been trained. A mixed skill set is valuable as educators share resources and experiences.

EQUALITY, DIVERSITY AND VARIATION

D&Y has been developed alongside the education team at Kernow Health CIC, drawing on the expertise of the structured education working group and educators to ensure the information suits different learners, is easy to understand and is useful. D&Y was delivered virtually via Microsoft Teams through the pandemic and now offers in-person courses close to people's homes. The curriculum remains consistent, but the format can be adapted to the audience. D&Y can also be booked via Healthy Cornwall, the local provider of health improvement programmes. The NHS healthy living programme offers digital, self-led learning. People with learning disabilities and autistic spectrum conditions on the team co-designed an accessible course for this patient group. Patients who are digitally excluded or lack basic digital skills are directed to the Council's digital inclusion team and kit and connectivity can be accessed through its Device and Connectivity Lending Scheme. Live Q&A sessions and refresher courses are also planned. Offering a blended model of delivery with a menu of options supports patient choice and reduces variations in access to this support. A new, self-paced digital option for educator training is available.

RESULTS

A total of 64.7% of newly diagnosed patients were offered D&Y in the local structured education offered alongside NHS healthy living (Jan-Dec 22). Between April 2022 and March 2023, 56 courses were delivered, 563 people booked to attend, 74% attended at least one session and 55% completed the whole course, with a 26% DNA rate. A total of 31 courses (304 booked) were delivered virtually and 25 (259 booked) in person. On the virtual course 72% attended at least one session and half completed the course, while face-to-face 75% attended at least one session and 61% completed the course. Data from a cohort of patients who attended D&Y courses (Jan-Nov 2022) showed 83% of patients decreased their Hba1c and 83% of patients lost weight/decreased BMI. This PCN uses the Social Prescribing/Health Coaching model of support for patients with follow-ups post course and a case study being prepared to demonstrate effectiveness. D&Y is enabling more people across Cornwall to access Structured Education and reap the rewards it can bring. It is estimated that D&Y will have a cost per patient of £58.25 and should show cost savings in the long term.

USER FEEDBACK

Confidential evaluation surveys from participants post course are used to improve the offering. Those who have not attended are contacted to understand their reasons. A total of 92% of participants said they would recommend the course to family and friends and 95% reported they had improved their confidence to achieve their diabetes management goals. 100% of HCP respondents viewed structured education as an important part of the diabetes management pathway. Quarterly educator forums address issues and improve delivery. A patient workbook was developed based on their suggestion and feedback has been that patients find it extremely useful.

DISSEMINATION AND SUSTAINABILITY

D&Y is a Quality Institute for Self-Management Education and Training (QISMET) approved, cross-Cornwall model delivering diabetes structured education to NICE standards. It has been developed by local clinicians and delivered at place. Its working group meets regularly and has representatives from primary care, secondary care and community services, as well as educators. Courses are delivered in collaboration with 12 of the 15 PCNs across Cornwall alongside the self-registration option and the accessible course. A new booking system will streamline administration and improve attendance. The D&Y model was presented at Southwest diabetes meetings and other areas in the region are interested in replicating it. Diabetes UK is helping to improve patient experience, peer support and engagement with hard-to-reach groups.

JUDGES' COMMENTS:

> *“Kernow Health CIC has created an incredibly important programme that produced some great results. The team identified a clear barrier to education and came up with an innovative way to address it, all the while ensuring they were hitting the mark in terms of equality and diversity. The judges were impressed by the patient-centric and flexible approach and noted the social prescribing element was particularly thoughtful.”*

FINALIST

DIABETES EDUCATION PROGRAMMES – PEOPLE WITH DIABETES

DWELL (Diabetes and WELLbeing)

by Medway Community Healthcare, Canterbury Christ Church University, The Health and Europe Centre, Kent County Council and Blackthorn Trust

DWELL- Diabetes & WELLbeing

SUMMARY

DWELL (Diabetes and WELLbeing) is a patient education programme for people with type 2 diabetes, a staff training programme and an ambassador training programme for people who attended the DWELL programme and want to support continued delivery by becoming a DWELL ambassador. The DWELL project brought together a range of organisations, professionals and people living with type 2 diabetes to co-design, deliver and evaluate its effectiveness.

INNOVATION

Most diabetes education programmes for people with type 2 diabetes are targeted at the newly diagnosed, but there are many people diagnosed before education programmes were routinely offered who have not instigated behaviour change. Often, they have low motivation and the depression associated with living with a long-term condition and may feel isolated and unsupported. The DWELL project investigated developing and evaluating an innovative education programme for this group. It was funded by the EU Interreg 2 Seas programme 2014-2020 and co-funded by the European Regional Development Fund and participating partners. It started in 2016, when funding was approved, and continued to March 2023. An extension and additional funding were provided as the project was suspended during the COVID-19 pandemic. Partners from the UK, France, Belgium and the Netherlands and people living with type 2 diabetes, co-designed the programme. Professor Eleni Hatzidimitriadou from Canterbury Christ Church University led the evaluation, ethical approval to conduct the project as formal research was gained, and it was adopted by the NIHR as a portfolio study. DWELL focused on creating a learning environment that allowed people time to bond with the other participants and space to share issues. This was achieved by having a maximum of eight participants per programme, with groups lasting 2.5 hours. The philosophy was for the diabetes professional facilitator to travel alongside the participants on their journey. The programme included 1-2-1 motivational conversations at weeks one and 11 to help people identify motivators and set smart goals. Activities included guided relaxation, support to help overcome hurdles and information sessions about type 2 diabetes, presented using a conversational approach.

EQUALITY, DIVERSITY AND VARIATION

The DWELL programme was open to all adults with type 2 diabetes free of charge. Programmes were offered at different times of the day to allow access for all. The locations were selected to be non-clinical, with good transport links and disabled access, parking etc. Sign-up was encouraged via a wide range of sources. Participating partners used their local contacts and knowledge to advertise the DWELL programme widely. Participants could self-refer or were signposted to the project and had to commit to attending for 12 weeks. The content was adapted to take account of cultural and dietary aspects. Variations in the outcomes achieved were on a par, regardless of ethnicity or cultural background. Small groups and long contact time enabled participants to gain the most from attendance. The safe and supportive environment allowed them to disclose problems and issues they had not shared before, thereby improving outcomes.

RESULTS

Self-management is essential for people with diabetes. Literature searches highlighted a paucity of evidence around psychological and motivational support and an emphasis on need for research into impact and/or cost-effectiveness. DWELL assessed participant outcomes and programme impact in terms of quality of life, empowerment, physical activity and self-care, as well as attitudes and behaviours regarding self-management, experience with the programme from participants/staff/ambassadors' perspectives and analysis of cost benefits. A quasi-experimental design adopted a longitudinal, mixed methods approach across five sites, including two in the UK (Medway and Maidstone in Kent). The MRC Process Evaluation framework was adopted. Data collection was via an online survey tool, focus groups and interviews, plus secondary analysis of other sources. A total of 593 people with type 2 diabetes took part in the study, across four countries. Significant positive changes were noted, which were sustained at 6 and 12 months post programme. Statistically significant changes in metabolic health and self-reported attitudinal and behavioural benefits were reported by the end of the programme, including average weight loss of 3.55 kg, average waist circumference reduction of 2.7cm, average BMI reduction of 2.62, average HbA1c reduction of 20.5 mmol/mol, enhanced empowerment and self-efficacy, improved diabetes management, greater perceived personal control and understanding of diabetes, decreased negative feelings associated with diabetes, increased optimism for treatment and long-term prognosis, decreased eating in response to emotions and external cues, increased restrained eating, improvements in self-care attitudes and adherence to professional advice.

USER FEEDBACK

Feedback from participants was positive and collected in the focus groups as part of the evaluation process. In order to reduce bias, these were undertaken by an experienced researcher who had not been involved in delivering the programme. Participants expressed their belief in the course by becoming DWELL ambassadors. They helped to recruit to the project and spoke at events.

DISSEMINATION AND SUSTAINABILITY

For the purposes of this award only the UK sites are discussed. When the EU funding ended in March 2023, the results helped secure funding from the Medway and Swale ICB to continue for a further year, to March 2024. A business case is being made to continue the DWELL programme as a commissioned service in the Medway and Swale region and as an option for people with type 2 diabetes. As part of this process the programme is going through QISMET accreditation. The DWELL project team is keen for the programme to continue, having seen the difference it makes to the lives of people living with type 2 diabetes, not just in terms of metabolic health, but also in terms of improved wellbeing, self esteem and motivation. Participants report that HCP consultations are more meaningful and constructive, that they have an increased knowledge and understanding of their condition, what to do to get back on track and when to seek help. Quality of life is improved and additional skills have been gained. The resources developed could be used by other groups in the UK and the current DWELL team would support this.

JUDGES’ COMMENTS:

> *“DWELL (Diabetes and WELLbeing) is a refreshing and effective programme with demonstrable outcomes. The judges were impressed by the person-centred approach taken to the project and by the entry itself, which was clear and very well presented. The evidence provided was rich and the feedback incredibly positive. A well described initiative with solid execution and results.”*

EQUALITY, DIVERSITY AND HEALTH EQUALITIES

Improve Access to Diabetes Technology for Children and Young People with Diabetes Living in Low-Income Households by Children and Young People's NE and N Cumbria Diabetes Network

by Children and Young People's NE and N Cumbria Diabetes Network

SUMMARY

Diabetes technology is developing rapidly; insulin pumps and continuous glucose monitors (CGM) increasingly require compatible mobile phones and laptops for them to be used efficiently and effectively. High levels of deprivation across NE and N Cumbria (NENC) are creating barriers for some families to access this life-changing technology. Simultaneously, hospital trusts need to consider the environmental and sustainable impact of disposing of unneeded IT equipment. This project brings these two challenging situations together and creates a solution for them both by donating repurposed NHS equipment to families to access diabetes technology and improve outcomes.

INNOVATION

Diabetes technologies, such as insulin pumps and CGM, improve the health and quality of life outcomes of children and young people (CYP) living with diabetes. However, there is persistent inequality in the uptake of such technology among families in ethnic minority groups and low-income households. In NENC, 34% of CYP live in poverty and 49% of those with diabetes live in the most and second most deprived quintiles. This project aimed to level-up access to diabetes technology across the CYP diabetes community. The COVID-19 pandemic highlighted an emerging 'digital divide'. Several charities began to offer refurbished equipment. The CYP diabetes teams in the NENC region accessed a limited amount of equipment to support their families during the pandemic, but availability was sporadic and unreliable. After the pandemic, charities stopped the service. The CYP NENC Diabetes Network used NHSE Levelling-Up Access to Technology funding for a project to refurbish unneeded NHS devices and give them to families so they could access diabetes technology. It was estimated that over 400 families across the NENC could be supported. A collaboration of services developed, with equipment donated from Gateshead Health NHS Foundation Trust, project management from the CYP NENC Diabetes Network leadership team and charity partners Investing in Children and Town and Community. This partnership added minimally to the workload of paediatric diabetes healthcare professionals (HCPs). In addition, Vodafone supplied SIM cards for the phones that were donated.

EQUALITY, DIVERSITY AND VARIATION

This project was designed to tackle the variation in accessing diabetes technology by patients living in low income households. The diabetes team at the QE Hospital in Gateshead had participated in a parallel programme called 'Poverty Proofing', delivered by the charity Children NE, to tackle misconceptions around poverty and ensure healthcare services were accessible to all. One theme highlighted was the inability of some families to access diabetes technology because of their financial situation. Poverty Proofing training was offered to the wider CYP NENC Diabetes Network members, regarding the issue of the shame/embarrassment of accessing items via 'charity'. To combat this, referral into the project was made standard practice for all families; everyone offered diabetes devices to improve their diabetes management was also offered a mobile phone and/or laptop and/or SIM card from the project. The majority of households accessing the project were in the lower deprivation deciles. By the end of June 2023, 107 referrals had been received. Of these, 27% were in the bottom 10% and 40% were in the bottom 30%. These referrals and subsequent receipt of a phone, laptop or SIM card allowed CYP to access technology such as CGM, insulin pumps and Hybrid Closed Loop systems. Families could upload their data for their clinical team to view, allowing the clinics to give advice remotely and save families travelling to clinic.

RESULTS

Aside from the devices supplied to families, there have been benefits to the wider system. Input from HCPs was deliberately kept to a minimum; their workload was ever increasing, but their engagement in the project was essential. A sound process assured early success: phones/laptops were repurposed and given to the T1 Kidz family support team for secure storage; HCPs referred a family via a simple, online form to the T1 Kidz team; over a three-week lead time the T1 Kidz team matched a phone/laptop to the family's needs; the phone/laptop was delivered in person to support set up, or by courier if the family was confident; the family attended clinic appointment/diabetes device start with the phone/laptop, which was theirs to keep. Gateshead Health NHS Foundation Trust was the only donation site. The devices were appropriately repurposed with ADISA certification via the partnership with Town and Community. This project is expected to show improved diabetes health outcomes over the long term; in the short term, quality-of-life benefits are fed back to the project team. The second element of this project was to speak to hospital trusts about disposal of their unneeded technology and relevant NHS departments are being shown the possibilities that this project opens up. In addition, diabetes technology companies were approached about donating equipment to the project, with one company agreeing to donate all its unneeded company phones and laptops. Another bonus was to succcessfully persuade one of the technology companies to add a new model of phone to their compatibility list, as a large number of donated phones were not compatible with one of the devices. The project received funding from the NHSE Inequalities Access to Technology fund in October 2023 for the involvement and support of trained, professional partners across the ICS. This enabled assessment of the feasibility of delivering and replicating the project, while identifying ways to reduce project costs.

USER FEEDBACK

Every patient that receives a device is asked to complete an impact report and share feedback. Positive comments were received from patients and HCPs. Contact is maintained with referring HCPs, with feedback reviewed and changes implemented.

DISSEMINATION AND SUSTAINABILITY

The project is accessible to HCPs in the eight acute trusts supporting almost 1,800 families living with diabetes across the NENC ICS, currently focusing on CYP. Creating a robust, replicable project model was central and integral to the funding application. There will be a report and step-by-step guide to deliver similar projects in other regions and for other health conditions. The joint remit has attracted attention from departments across the NHS and externally.

JUDGES' COMMENTS:

> “*The entry from Children and Young People's NE and N Cumbria Diabetes Network didn't discriminate between families from different income sectors. It is inclusive and sustainable and the judges liked that they collaborated with people outside of healthcare. Truly an example of equality and diversity, because individuals are using and engaging.*”

WINNER

TYPE 1 SPECIALIST SERVICE

CONCEPTT-2-Care

by Project Leads – Professor Eleanor Scott and Professor Helen Murphy Professors of Diabetes and Maternal Health/ Antenatal Care. A collaboration between: University of Leeds and University of East Anglia; NHS England Diabetes programme and NHS England Maternity programme; Diabetes Technology Network-UK; Diabetes-UK; JDRF; National Pregnancy in Diabetes Audit; NHS Local Maternity Systems and NHS Diabetes in Pregnancy clinical teams across England.

CONCEPTT-2-Care

Improving pregnancy outcomes for women with Type 1 diabetes through nationwide implementation of Continuous Glucose Monitoring technology

A collaboration led by Prof Eleanor Scott & Prof Helen Murphy together with NHS England Diabetes and Maternity Programmes, Diabetes Technology Network-UK, NPID Audit programme, Diabetes-UK, JDRF, Local Maternity Systems, NHS Diabetes and Maternity Clinical Networks, NHS services, Experts by Experience

The NHS is offering continuous glucose monitors – a small device that sticks to the skin and measures glucose levels continuously – to all pregnant women with Type 1 diabetes.

Diabetes Technology Network support videos and user stories for using CGM during pregnancy

SUMMARY

The CONCEPTT trial established that continuous glucose monitoring (CGM) improved maternal glucose control and neonatal outcomes for pregnant women with type 1 diabetes (T1D). Working with stakeholders across traditional boundaries, an implementation package was co-produced, delivering CGM to all pregnant women with T1D in England. To date, 98% of pregnant women with T1D have been offered CGM with no inequalities based on ethnicity or social deprivation. NPID data showed significant improvements in maternal glucose across pregnancy and pre-term births, plus large-birthweight babies and neonatal care admissions started to decline for the first time, saving the NHS ~£9.5 million/year.

INNOVATION

Women with T1D have poor pregnancy outcomes; half have pre-term births and large-for-gestational-age babies, with one in every two babies admitted to a neonatal care unit (NCU). Maternal glucose is the major modifiable risk factor, but there has been no improvement in this or pregnancy outcomes for the past two decades. CGM, with its detailed, real-time glucose information, should help pregnant women achieve their glucose targets more readily than the fingerprick test, but it is far more expensive. The CONCEPTT trial set out to show that CGM in pregnancy improved maternal glucose and babies' health outcomes. CGM was not only clinically- and cost-effective, but was cost-saving for the NHS. The challenge was to rapidly and uniformly translate this into NHS care, so that all pregnant women with T1D, across all antenatal clinics, were offered CGM. The organisers worked with NHS England Diabetes Programme leads on a national implementation model and predicted costs. Ring-fenced funding was obtained for two years. The core working group involved regional Local Maternity Systems (LMS) networks, holding meetings and regional webinars with them to explain the process. The LMS collected data on CGM offered/ NHS maternity clinic. The NPID audit was modified to record who was offered/ accepted CGM and determine its effect on maternal and neonatal outcomes.

EQUALITY, DIVERSITY, VARIATION

The women with T1D who have the poorest pregnancy outcomes are those with suboptimal glucose control, as assessed by HbA1c. Those more likely to have poor pregnancy outcomes are also those who are socioeconomically deprived and of ethnic minority origin. These two groups are less likely to have access to technology, with associated healthcare inequalities. Data shows that pregnancy outcomes are influenced more by individual characteristics of the women with T1D, not variations in their care. This meant that any intervention had to be delivered system-wide, to all pregnant women. Work with regional LMS teams built confidence, reducing variation in access at different sites. Diabetes Technology Network-UK (DTN-UK) helped to develop an educational support toolkit for workers and pregnant women, with input from diverse patients, diabetes charities and healthcare teams. A Best Practice Guide on Technology in Pregnancy was produced with DTN-UK and HCP- and patient-led videos provided support throughout pregnancy. During COVID-19 restrictions, CGM workshops were run to upskill and support HCPs, 'Top Tips' leaflets were produced for pregnant women, plus ACADEMY educational training modules were developed, so HCPs could gain accreditation, again reducing variation. CGM reduced the chances of maternal and neonatal morbidity, reducing inequalities. Improving the sizes of the babies reduced future risk of inequality from obesity, diabetes and cardiometabolic disease.

RESULTS

Widespread stakeholder engagement and ring-fenced funding from NHS England to implement CGM to all pregnant women with T1D, across all NHS maternity services, were attained and a national implementation pathway was activated. Educational support provided CGM safely and effectively, in collaboration with DTN-UK, JDRF, Diabetes UK, Digibete and service users. Uptake was measured and ensured no access inequalities. Preliminary NPID audit data on maternal and neonatal outcomes showed real-world beneficial effects of using CGM. The plan was implemented between March 2021-March 2023, with March 2023 surveillance data from LMS showing 98% of all women with T1D pregnancy across NHS England had been offered CGM, with no healthcare inequalities based on ethnicity or social deprivation. Following implementation, NPID audit data showed the first national improvements in maternal glucose control throughout pregnancy, across all clinics. Early pregnancy HbA1c was lower, with improvements in maternal glucose levels sustained throughout pregnancy and lower HbA1c in late pregnancy. Pre-term births, large birthweight babies and neonatal care admissions declined for the first time since NPID records began. The total annual costs of managing pregnancy and delivery in women with T1D in the UK are £23,725,648 with fingerprick, and £14,165,187 using CGM. Efficiency cost savings to the NHS are approximately £9.5 million/year.

USER FEEDBACK

This translational project involved people across many organisations. Working collaboratively, without boundaries, transformed NHS patient care. Cloud-based access to CGM data enabled healthcare teams to monitor women remotely, improving clinic flow, plus patient and HCP satisfaction. It also enabled the team to focus on tailored treatments. Feedback from women with T1D was that CGM implementation for pregnancy had been transformative. The toolkit had positive feedback. It has been accessed by all NHS trusts and remains freely available.

DISSEMINATION AND SUSTAINABILITY

This project was implemented uniformly across the NHS in England, involving collaborative work between departments, across organisations and local boundaries. It included patient-focused charities and experts by experience. Results on CGM uptake have been shared with all stakeholders, through the National Diabetes Programme Board, Diabetes Clinical Networks and National Diabetes Audit Partnership board, plus presented at conferences and through social media. Data collected by NPID audit showed improved maternal and neonatal outcomes and pregnancy experience and is being prepared for the State of the Nation report 2023 and international peer reviewed publication. Although funding for CGM has finished, a new diabetes element has been added to the Saving Babies Lives Care Bundle (May 2023), focused on improving outcomes through mandatory use of CGM in T1D pregnancy. Stakeholder comments to NICE Quality Standards for Diabetes in Pregnancy 2023 ensured that using CGM was one of five standards. This process is a great example/model for future projects within the NHS and internationally. It will be used for the rollout of closed-loop technology.

JUDGES' COMMENTS:

> “*CONCEPTT-2-CARE was an excellent entry, with clear cost savings and it really looked at the national picture. It had well-articulated sustainability and is clearly replicable. The judges liked that it was open to all women, had a brilliant reach with informative user feedback. It was also impressive that other countries are now looking at replicating and genuinely has a commendable impact on diabetes care.*”

TYPE 1 SPECIALIST SERVICE

Intensive Support Package for Glucose Optimisation in Type 1 Diabetes During Pregnancy

by St Helens & Whiston Hospitals – Mersey & West Lancashire Teaching Hospitals NHS Trust

SUMMARY

An intensive support package was introduced for pregnant women with type 1 diabetes (T1D). The package consists of a band 7 diabetes speicalist nurse (DSN) dedicated to antenatal care, intensive band 7 dietetic input, weekly appointments, telephone support, longer appointment times, MDT meetings, mental health support, alongside provision of continuous glucose monitoring (CGM). An audit was completed to establish whether the package had increased the number of women achieving a third trimester HbA1c of <48mmol/mol and if it improved neonatal outcomes. Results showed an increase in women achieving this, as well as fewer babies with macrosomia or admitted to NNU at birth.

INNOVATION

The National Pregnancy in Diabetes (NPID) audit found marked variation between units across the country regarding diabetes control and pre-conception care. NPID demonstrated that women with T1D who used insulin pumps early in pregnancy were more likely to achieve their HbA1c target. In addition, achieving a HbA1c <48mmol/mol in late pregnancy, even if glycaemic control was suboptimal in early pregnancy, reduced the pre-term delivery rate by >15%. This suggested that more aggressive management would achieve better outcomes. Prior to 2021, despite rising numbers of new and follow-up patients, staffing for the Joint Diabetes Antenatal clinic (JANC) remained unchanged. The service consisted of two diabetes consultants and one part-time DSN. The consultants saw all new patients (pregnant or planning pregnancy) in the same clinic. The DSN worked part time (one session per week). Problems included minimal dietetic input, delayed access to carbohydrate counting and pump therapy, different documentation systems for the diabetes and maternity teams, little communication between diabetes, midwifery and obstetrics teams, no structured antenatal MDTs and minimal psychological support. The team made a case for a full-time band 7 antenatal DSN and increased service provision across the wider antenatal team. Launched in 2021, the intensive support package comprised: increased JANC appointments for insulin adjustment, regular monitoring and optimisation of glycaemia; regular band 7 antenatal DSN input 1-2 weekly, support between appointments and a 4-weekly pre-conception clinic; all women began flash/CGM within seven days of referral; insulin pump therapy was provided quickly; dedicated, weekly band 7 diabetes dietitian-specific antenatal clinics supported overall diet quality for pregnancy and blood glucose management; a dedicated diabetes midwife coordinated appointments and arranged input from the mental health midwife; a monthly diabetes antenatal MDT discussed cases and other issues; one shared documentation system was used. Patient data was audited and shared at the pregnancy quality assurance meeting.

EQUALITY, DIVERSITY AND VARIATION

St Helens and Knowsley (STHK) are among the top 10 most deprived boroughs in the UK Index of Multiple Deprivation. The prevalence of diabetes and obesity is slightly above the national average. Deprivation and multiple health conditions are common. The cost-of-living crisis affected the most vulnerable individuals particularly, potentially exacerbating existing health inequalities. Nearly a third of people with T1D experienced diabetes-related distress or mental health conditions. Financial burdens, stress and burnout related to managing blood glucose targets during pregnancy placed women with T1D at risk of further mental health deterioration. Inadequate nutrient intake during pregnancy could increase the risk of low birthweight, pre-term birth and developmental issues. Women with T1D were already at a higher risk of complications if their blood glucose levels were not managed. Pregnant women from BAME communities were supported through face-to-face interpreters, leaflets in different languages and personalised support. All patient clinic letters were sent in the woman's first language.

RESULTS

2021 results showed an improvement to HbA1c, 10% more women taking Folic Acid 5mg daily prior to conception, compared to 2018, plus 22% more patients referred to the team at <8 weeks pregnant. STHK results from the NPID audit in 2022 showed many improvements in 12 months, compared with 2018 (prior to the care package). Although numbers remained low, efforts were being made to increase them, particularly in the pre-conception clinic, which had around 80% of patients with T1D. Awareness of the clinic was low, so the team worked with St Helens primary care to ensure women with established diabetes were referred. Initiatives included posters for GP waiting rooms and pharmacies, an outreach team to discuss pre-conception and pregnancy with GPs and practice nurses, plus patients commenced on CGM in a timely manner. Compared to patients in 2018, women who used CGM showed a 17% reduction in third trimester HbA1c, 15% fewer babies were admitted to NNU, fetal weight at birth reduced by 6% and macrosomia reduced by 35%. The antenatal service now offers weekly DSN input with longer appointments, intensive dietetic support and education and increased dietetic slots, quick access to consultant clinics with an emergency T1D slot, access to a pre-conception clinic with DSN four-weekly, quick access to CGM and pumps, a monthly diabetes/antenatal MDT dedicated to complex cases, a diabetes specialist midwife arranging timely appointments, plus access to a mental health midwife.

USER FEEDBACK

Prior to the intensive support package, patient experience and satisfaction were poor. Since the launch of the package, feedback from healthcare professionals (HCPs) and service users has been positive, shown by anonymous patient experience and satisfaction surveys. There is a feedback box in the antenatal waiting area and non-clinical staff can assist with the forms. A member of the antenatal team has worked with Diabetes UK on educating HCPs on the importance of patient and public involvement (PPI) in diabetes research. It is hoped that informal PPI meetings with those who have experienced the support package will give them the opportunity to share their views. The antenatal DSN had been nominated for the Trust's 'Maternity Star' award.

DISSEMINATION AND SUSTAINABILITY

This project was produced locally and carried out by the diabetes antenatal MDT across the joint diabetes antenatal clinics. The positive results have been shared at meetings locally and nationally, including with the local Diabetes UK service user group and maternity voice partnership. The plan is to disseminate findings via social media and publications. This service represents a good benchmark to support future business cases in T1D and pregnancy.

JUDGES' COMMENTS:

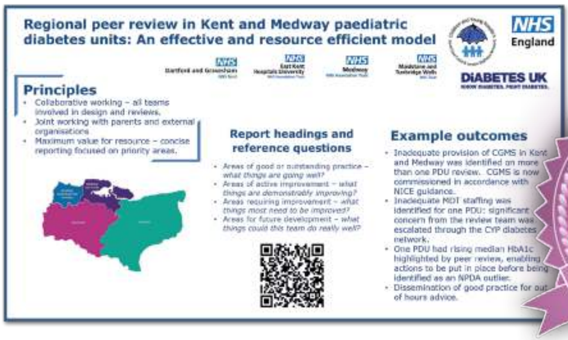
> “ *St Helens & Whiston Hospitals have produced a project with a hollistic approach in a very deprived area that has literacy issues. The Quality and diversity section is very well done and the judges could see how this would be replicable in other areas. It is about the whole person and shows how a properly resourced service benefits outcomes.* ”

COMMENDED

TYPE 1 SPECIALIST SERVICE

Regional Peer Review in Kent and Medway Paediatric Diabetes Units: An Effective and Resource-efficient Model by East Kent Hospitals University Foundation Trust

by East Kent Hospitals University Found Trust



Regional peer review in Kent and Medway paediatric diabetes units: An effective and resource efficient model

Principles

- Collaborative working – all teams involved in design and reviews.
- Joint working with parents and external organisations
- Maximum value for resource – concise reporting focused on priority areas.

Report headings and reference questions

- Areas of good or outstanding practice – *what things are going well?*
- Areas of active improvement – *what things are demonstrably improving?*
- Areas requiring improvement – *what things most need to be improved?*
- Areas for future development – *what things could this team do really well?*

Example outcomes

- Inadequate provision of CGMS in Kent and Medway was identified on more than one PDU review. CGMS is now commissioned in accordance with NICE guidance.
- Inadequate MDT staffing was identified for one PDU: significant concern from the review team was escalated through the CYP diabetes network.
- One PDU had rising median HbA1c highlighted by peer review, enabling actions to be put in place before being identified as an NPDA outlier.
- Dissemination of good practice for out of hours advice.

SUMMARY

The four paediatric diabetes units (PDUs) in Kent and Medway (Dartford, Medway, Maidstone & Tunbridge Wells, East Kent) piloted a regional peer review programme in 2021-22. All four units responded positively to the reviews. One unit was required by the children and young people (CYP) diabetes network to provide an urgent action plan. The review process delivered useful feedback within a reasonable resource commitment. The regional model simplified logistics of the review visits, promoted collaboration and allowed identification of regional themes. Oversight by the CYP diabetes network provided accountability for the PDUs following review. The review process will be refined and repeated in 2-3 years.

INNOVATION

It is essential to continually improve the care of CYP with diabetes to reduce the risk of future complications. Peer review is an essential driver, alongside national initiatives, such as national CYP networks and the best practice tariff (BPT). A national peer review programme brought positive changes for many PDUs, but funding was cut and a subsequent programme funded by participating units was too expensive. In February 2020 the four PDUs in Kent endorsed a pilot, Kent-wide peer review programme. A guidance group was formed, with representatives from all disciplines in the PDUs. It was supported by the South East Coast (SEC) and London CYP diabetes network manager and endorsed by the network and the Integrated Care Board (ICB) for Kent and Medway. Regional NHSE transformation managers helped design the programme. Support was provided by a Diabetes UK (DUK) staff member and the Paula Carr Diabetes Trust. The programme requirements were set out in a handbook. The process was piloted at one site, refined and rolled out to the remaining three sites. Four reference questions were used to define three points in four areas: good or outstanding practice; active improvement; requiring improvement, plus future development

EQUALITY, DIVERSITY AND VARIATION

The value of peer review rests in the ability of true peers to make meaningful comparisons between the team under review and a standard position. Within the guidance group and each review team there was equal participation, with the key disciplines represented in all meetings. Parent representatives were actively involved and gave positive feedback. Equality and diversity were prioritised for reviewers; requirements were kept simple to ensure that any professional could consider taking part, but certification of up-to-date equality and diversity training had to be provided. NHSE and DUK representatives brought valuable insights, and the ICB and CYP diabetes network chairs worked to ensure equitable delivery. The overall purpose of a peer review is to promote equity of care across diverse teams. The commissioning of continuous glucose monitoring (CGM) following the programme demonstrates its value in reducing inequality.

RESULTS

This programme demonstrated the feasibility of conducting a regional peer review programme at a cost achievable within existing commissioning/funding pathways. All four units were reviewed as specified in the handbook. Each unit developed an action plan based on its report, integrated with existing work plans. Members reported that regional peer review allowed them to prioritise and escalate issues within their organisations and beyond. Examples of resulting improvements included: developing countermeasures when rising HbA1c was identified; an action plan enabling appointment of additional staff; sharing of good practice regionally; commissioning for CGM made consistent with NICE guidance. The resource burden for teams under review was reduced. Each team presentated its educational resources and attended the review day. Required documents were considered normal business. DUK and NHSE supported the pilot using existing resources. The handbook defined the peer review process, including the required documents, timetable and the model for the report. Review teams included a consultant, specialist nurse, dietitian and a parent representative. The same improving care manager from DUK attended the reviews, providing unbiased oversight. A representative from the regional NHSEI team reviewed all reports, observed two of the reviews and provided feedback. Review visits took 3.5 hours.

USER FEEDBACK

The senior leader of the trust was invited to the feedback discussion, to promote recommendations within its leadership structure. Learning discussion and feedback immediately following the review ensured the process was completed on time, that all stakeholders participated and good or improving practice could be shared. Feedback reports were copied to stakeholder organisations, including NHSE, DUK and commissioners. The final report was shared with the senior leadership team and individual unit action plans were created. Inadequate provision of CGM systems in Kent and Medway was identified on more than one PDU review. One PDU had rising median HbA1c, enabling corrective actions to be put in place. Concern from a parent representative about staff well-being added gravitas to feedback with internal managers. Escalation of serious concerns regarding staffing levels resulted in positive outcomes for two units.

DISSEMINATION AND SUSTAINABILITY

The project was designed and delivered by the four Kent and Medway PDUs with regional support and endorsement from the ICBs, NHSE improvement team and DUK. The regional CYP diabetes network provided oversight, financing and administration. Regional priorities and local improvements were identified with individual teams working through their action plans. CGM is now commissioned. Rollout in accordance with NICE guidance will reduce inequality. Following escalation regarding staffing, two PDUs appointed additional whole-time dietetic staff. The structured education programme SEREN at diagnosis was working well in just two PDUs; the other two focused on this to ensure equity for families across the area. The process will be reviewed and repeated in 2-3 years. CYP will be involved, as well as parents, and a means of disseminating feedback to CYP/parent groups will be incorporated. Embedding administrative support within PDUs will decrease reliance on the network coordinator. The pilot project was disseminated through the regional CYP diabetes network and nationally (DUK Professional conference 2023). Local dissemination between units provided opportunity to share good practice. The aim was for replication and local collaboration, rather than expansion. The guidance group will consider the appropriate scaling model during review evaluation, eg effectiveness of regional expansion or series of regional reviews.

JUDGES' COMMENTS:

> “ *The judges liked the entry from East Kent Hospitals University Found Trust and could see the wider access dissemination opportunities. It is a well-rounded project and embodied the Type 1 Specialist Service category. It was very well-written and explained.* ”

FINALIST

TYPE 1 SPECIALIST SERVICE

Enhancing Young Adult Services with Youth Work by BCUHB

by BCUHB

QiC
COMMENDED

SUMMARY

Supporting people with diabetes to effectively self-manage their condition is key to reducing their psychological distress, improving self-management and achieving long-term health outcomes that benefit both the person living with diabetes and their wider healthcare and social systems. For vulnerable young people, the addition of youth work allows services to provide bespoke interventions that are tailored to the individual needs of young people, while working at a population level to increase education and management confidence through the use of resources that are developed for, and with, the young people who will use them.

INNOVATION

Many people struggle to manage their type 1 diabetes, with adolescents and young adults demonstrating the highest levels of difficulty and worst management because of psychological distress, interpersonal problems, plus social and environmental stressors. Putting processes and support in place to protect young adults as a priority group can improve short- and long-term health outcomes, as well as reducing burdens on the NHS. BCUHB had already invested in psychological support for young adults with type 1 diabetes, but many young people continued to struggle, owing to their complex needs, which often led to disengagement with services. The pilot project trialled expanding the role of an existing youth worker from the Wrexham paediatric diabetes team on a temporary basis and had three aims: to investigate whether the youth worker could positively impact population health though promotion and use of digital information platforms; to find engaging ways to deliver diabetes education, and to support a small population with complex needs in individual youth work interventions. In 2006 Wrexham County Borough Council, in partnership with Wrexham Maelor hospital (WMH) Paediatric department, gained Big Lottery funding for a five-year project working with young people attending hospital with self-harming behaviours. The Inspire (Youth Work in Hospital) team secured ongoing grant funding once that finance had ended. Over time, the team started to work with a small number children and young people who were struggling to manage their type 1 diabetes. The paediatric diabetes youth work service has consistently delivered excellent outcomes for children with diabetes, and was identified as an area of excellence in a 2023 RCP peer review. However, funding restrictions meant youth work input ceased when the young person turned 18. Health-board wide adult diabetes services, paediatric services, psychology services and Inspire discussed ways to commission the pilot project. Using slippage monies from an underspend in the Adult Diabetes Psychology budget, a youth worker with significant experience of working with children with diabetes was seconded from Inspire for 12 months at 0.8 whole time equivalent to the young adult diabetes service at WMH. Project oversight and clinical supervision was provided by the diabetes psychology team, with overall line management responsibility with Inspire.

EQUALITY, DIVERSITY AND VARIATION

Young adults aged 17-25 are at high risk of poor diabetes self-management, with suboptimal glycaemic control and a higher incidence of emergency admissions due to diabetes mismanagement. Psychological issues including depression, anxiety, eating disorders and suicidal ideation are consistently found at higher levels in those living with diabetes and, as increased psychological distress reduces diabetes management and increases Hba1c, this creates a toxic 'vicious cycle'. Many also have physical, psychological and social issues that interact with, and further compound, their difficulties in self-managing diabetes. Young adults rely on adult diabetes services, yet barriers include differences in the service they experience after transition, a lack of preparation for these differences, plus a lack of tailoring of adult services to their individual needs. Further, despite having psychology provision in the young adult diabetes team, local data indicates that young men are less likely to engage with ongoing therapy. The need for specialist services and clinic models has been recognised in Wales.

RESULTS

Having the youth worker meant resource was focused on improving self-management for young adults. The youth worker made changes at a population level by increasing uptake of a digital diabetes information and communication app ('Digibete') and developing an online version of a group diabetes education programme ('Seren Connect') across the health board. All resources created by the youth worker were co-produced with a young adult advisory group. The youth worker also held an individual caseload of young adults with complex needs who were struggling to manage their diabetes. Many had long histories of disengagement with diabetes services despite additional input from the diabetes MDT, and were already starting to experience significant diabetes complications as a result. A bespoke approach to support was taken with each young person, based on what mattered to them personally. The project significantly increased pan-BCUHB uptake of digitally delivered diabetes information for young adults and identified strategies to improve uptake of education on a population basis. It showed that youth work intervention work was well received by young adults and effective, with overwhelmingly positive patient ratings. The individualised approach allowed the youth worker to support them to reach their goals, re-engage with the diabetes team and enjoy improved outcomes in many areas of life. Further, as the youth worker worked as a co-therapist with the psychology team, supporting the most vulnerable individuals, the burden on overstretched diabetes staff and the wider healthcare system was reduced. The individual youth work resulted in reductions in the number of emergency attendances to hospital, improved attendance rates for clinic appointments and increased engagement with the specialist psychology service. This was especially significant for those who had never attended clinic previously. There are likely to be great cost savings to the NHS, society and the young people.

USER FEEDBACK

The positive experiences of the young adults were echoed by the reports of the healthcare professionals within the young adult diabetes team.

DISSEMINATION AND SUSTAINABILITY

A service evaluation report is being circulated to heads of service, the BCUHB diabetes board and the All Wales Diabetes Network, with recommendations that the pilot is scaled up across the wider health board, and commissioned as an 11-25 service to offer seamless transition. Further promotion will be through conference presentations and publishing outcomes in peer-reviewed journals.

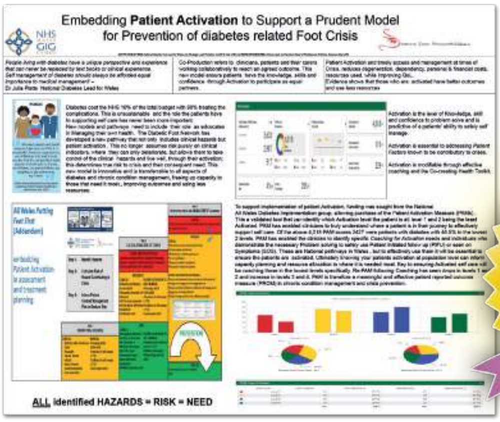
JUDGES' COMMENTS:

> “*The judges liked what this project by BCUHB is doing by utilising youth workers, which was impressive. There is also important psychological support and it got individuals re-engaging in their diabetes care. It is important to have contact with this ransition group and BCUHB provide a great service initiative with good qualitative detail.*”

PATIENT CARE PATHWAY, SECONDARY, PRIMARY AND SPECIALIST CARE

Embedding Patient Activation to Support a Prudent Model for Prevention of Diabetes-related Foot Crisis

by Diabetic Foot Network Wales



Embedding **Patient Activation** to Support a Prudent Model
for Prevention of diabetes related Foot Crisis

ALL identified HAZARDS = RISK = NEED

SUMMARY

Diabetes costs the NHS 10% of it budget, with 80% of that directed at treating complications. This is unsustainable and the role the patients have in self care has never been more important. New models and pathways need to include their role as advocates in managing their own health. The Diabetic Foot Network developed a new pathway that not only includes clinical hazards, but also patient activation, to determine true risk to crisis. This new model is innovative and transferable to all aspects of diabetes, freeing up capacity to those who need it most, improving outcomes and using fewer resources.

INNOVATION

Analysis of amputations in Swansea Bay (2015) showed that 40% were a result of human factors. Models and pathways to manage diabetes foot disease were created, but all focused on clinical indicators, without considering the role of patients. The Putting Feet First (PFF) initiative was seen as paternalistic and resource intensive, offering little opportunity for patients to reduce their risk scores. Therefore the Diabetes Foot Network secured money for 'care aims' training. This was delivered to the network, facilitated by Kate Malcolmess, a consultant specialising in ethical practice. The training was important as it was not just the pathway that was being changed, but also the culture around delivering person-centered supported care. The Prudent Healthcare model for prevention of diabetes-related foot disease rated the importance of assessing patients' activation levels to support their care on a par with the clinical hazards, giving a true risk to crisis measurement and establishing subsequent need. The All Wales Diabetes Patient Reference Group, Welsh national standing advisory groups for diabetes, the NICE facilitator for Wales and the Welsh Endocrine and Diabetes Society were involved early on. Insignia's Patient Activation Measure (PAM) licence (a validated, web-based tool) was purchased to measure patient activation.

EQUALITY, DIVERSITY AND VARIATION

The PFF pathway directed need based on perceived risk categories and recommended interventions for all within that risk category. This approach assumed risk could only stay the same or get worse, giving no incentive for the patient to try self care. The new pathway personalised need based on the clinical test and patients' willingness to actively support their own outcomes. This allowed the team to determine true need for individuals, allowing them to reduce risks through improved activation. Those with the greatest need received coaching for activation through increased service capacity. The Insignia platform showed subsets of the service, identifying areas of need for activation support. This activation approach to support equity of care is transferable across health boards. The licence has been extended to patients attending podiatry without diabetes. Implementing patient activation within the Prudent pathway not only uses resources more effectively and efficiently, but also ensures equity and diversity of care.

RESULTS

The PAM13 questionnaire was core to identifing patients' activation levels. The All Wales Diabetes Implementation Group funded the licence for a year, which was rolled over for another year, with four of the seven university health boards' podiatry services looking to continue the funding. Data collection started at the end of 2021. Over 2,400 patients with diabetes across three health boards were assessed under PAM, showing distribution of activation score and levels across subgroups and individual health boards, highlighting capacity needs and efficiencies to provide a value-based service. The PFF pathway recommended patients should be seen 1-12 times a year on top of their annual foot assessment. The new pathway allows patients with level 3 and 4 activation to use patient-initiated follow up (PIFU), freeing up capacity and removing unnecessary appointments. The PAM is also a patient-reported outcome measure. Applying the PAM before and after an intervention should see increased activation levels if patients' knowledge, skills and confidence have improved. The PAM trend over time showed a decrease in those with low activation levels 1 and 2 and an increase in levels 3 and 4. Significant improvements were seen in level 1 (70.6%) and level 2 (63.4%). The Clinician Support for PAM (CS-PAM) was used to identify changes in importance scores among clinicians after a period of using and coaching for activation. It found low importance scores reduced, while moderate and high increased. Clinician understanding of patient activation is core to co-production as equal partners in shared decision making.

USER FEEDBACK

The All Wales Diabetes Patients Reference Group was engaged with the project from the outset. Patients' experiences were core to shared decision making. The new model and pathway received feedback before presenting to the health boards' Diabetes Service and Improvement Groups, which had patient representation. Early dialogue with the NICE facilitator for Wales reassured that this was an exemplar of practice that could support NICE. Delivery commenced through Podiatry across Wales and is now supported by the new All Wales Podiatry Taxonomy. The development and implementation of the pathway relied on a change of culture for both clinicians and patients, so it was important to capture all their views and experiences. Compliments were received from both groups.

DISSEMINATION AND SUSTAINABILITY

Patient activation is now part of the consultation process with patients attending podiatry services in Wales and is as important as clinical tests in determining outcomes and patients' engagement to support self care. It is used in three of the seven health boards in Wales, with a fourth joining imminently. Prudent Healthcare is embedded into Welsh Healthcare and co-production is highlighted as a key principle. For co-production to be effective, patients need knowledge, skills and confidence. They feel listened to and supported to achieve their goals. Although this project set out to change the diabetes pathway, it also changed the All Wales Podiatry Taxonomy. The aim is to spread and scale this work across social care. The model has been disseminated through presentations and via life sciences hub webinars. Interest has been shown inside and outside Wales to improve supported self care through activation, with some looking to use it in cancer care settings.

JUDGES' COMMENTS:

> *"The judges were impressed with the activation levels. There is a national catastrophe with podiatrists, so initiatives like this are really worth sharing. The innovation was good and it's great to see the patient at the heart of the management of diabetes in this project. A great one to disseminate, with strong online resources. This was a different approach through patient activation, a real innovation."*

PATIENT CARE PATHWAY, SECONDARY, PRIMARY AND SPECIALIST CARE

Medway Community Diabetes Team by Medway Community Healthcare

by Medway Community Healthcare

SUMMARY

The aim was to improve the review of those vulnerable, housebound patients who have insulin administered by community nursing teams. Embedding technology (flash glucose monitoring) into community nursing teams allowed safe and appropriate review of those patients on insulin. Also, community nursing teams were trained in recognising the risks of hypoglycaemia and hyperglycaemia, and the appropriate treatment pathway for these often challenging situations.

INNOVATION

Community nursing teams often have a substantial caseload of elderly, frail or vulnerable people with diabetes who require support and assistance with insulin administration. During COVID-19 in 2020, the specialist diabetes team supported the community nursing teams with insulin administration. At one point, there were 103 visits per day for insulin administration. In the long term, having other specialist teams to support community nurses and 'fill the gaps' was not viable. Holistic assessment was needed as these people did not always have an annual review and medication review opportunities were limited. There had been Datix adverse event incidents surrounding insulin timing, particularly with mealtime/mixed insulin and community nurses did not have a broad knowledge of insulin regimens, timings or management of hypoglyaemia/hyperglycaemia. The diabetes specialist team believed that available technology should become the 'norm' and embedded into community nursing caseloads. The plan was not only to enable more enhanced reviews, but also to upskill them. The diabetes specialist team worked with community nurse leads and senior representatives within their organisation to embed the technology in community nursing caseloads, agreeing ongoing and substantive support for these teams and the patients. The work relied on current resources, so a review of caseloads and prioritising teams were the initial foci. Committing experienced staff to support the community nursing teams improved integrated working and allowed a comprehensive caseload review.

EQUALITY, DIVERSITY AND VARIATION

Equality and diversity is under-reported in this community population of people with diabetes, and technology deprivation played a big part in implementing this work. Vulnerable, housebound adults, or those in a care environment, are often overlooked by the evidence. Reliance on others to administer insulin means access to technology is limited, because community nurses do not necessarily know the benefits and there are challenges in setting it up and offering ongoing support. The patients do not have the variety of, or access to, technology, or the IT support needed. A majority do not have WiFi, or an email address, and supported living/care homes have shared internet services. Many patients are unable to self scan. This lack of 'basic' technology is a barrier to the use of flash glucose monitoring and supporting those patients is time-consuming and challenging. Despite the barriers, these groups are a priority to consider for the technology, because they do not have the robust reviews of insulin regimens or the ability to self manage.

RESULTS

The results demonstrated the need for using technology in this particular group of people. The main outcomes measured were: number of visits by community nursing teams pre- and post-intervention; HbA1c measurement, plus prescribing costs. The priorities were to improve outcomes for people with diabetes and to increase safety around insulin prescribing and administration. Prescribing costs were also important. At the start, there were over 70 people having their insulin administered by community nursing teams, totalling 105 visits per day. The technology was new to community nursing teams, so the work involved educating them while identifying patients most at risk. Data was collected from April 2021 to October 2022. A total of 72 patients had Freestyle Libre (FSL) to measure their glucose levels. A Band 5 educator from the diabetes specialist team supported the patients and set up a caseload. Clinical decisions were made by the clinical lead and senior DSNs in the team. The senior nursing team supported with review of the data and changes to any regimens, but a Band 4 post helped with application of the sensors plus the education and support of the community nursing teams. At the end of the period, 48 patients had been discharged from the caseload (either self managing or needing no specialist support); 12 of these had been taken off insulin and 23 had their insulin regimen changed. Community nursing visits reduced by about a quarter. The average HbA1c improved from 85mmol to 66mmol, but, importantly, the percentage of those patients with a HbA1c below 55mmol decreased from 19% to 12%. Pre-intervention prescribing costs of £902.02 reduced to £674.85 post intervention.

USER FEEDBACK

Feedback was not formally invited, but the results and improved working were shared at board level and used as an example of successful integrated and innovative working across the organisation. The support from the diabetes specialist was well received. Access to the diabetes specialist team was easier, with a DSN at the end of the phone to give advice. This gave the community nurses more confidence when administering insulin, and the organisation is now investigating 'delegation of insulin' for staff who are not registered nurses, or in care homes. There is increased understanding of the different insulin regimens, with community nurses more confident. READ (Recognise deterioration, Escalate, Act and Document) training gave staff formal education around diabetes care and a practical session with the FSL, where they wore a sensor and learned to upload data and interpret it in a basic way. The feedback from these days was positive.

DISSEMINATION AND SUSTAINABILITY

This joint-working approach has now become standard. The majority of community nursing teams can now initiate FSL for their vulnerable patients on insulin. Dissemination has been in place since its inception and its success and the reduction in insulin errors and hospital admissions demonstrate its value. There are now two Band 4 members of staff working across the two services. The work has been published in diabetes journals and shared with external HCPs, plus primary care colleagues. This wider training and dissemination of the work is supported by Abbott primary care team.

JUDGES' COMMENTS:

“ *Medway Community Healthcare's project resonated that c ommunity case load administration is underserved population and it's an important platform to encourage others to replicate. It showed an improvement in clinical parameters and showed innovation in terms of doing things differently.* ”

PATIENT CARE PATHWAY, SECONDARY, PRIMARY AND SPECIALIST CARE

Diabetes Virtual Ward Pathway - An Adjunct Between Primary and Secondary Care Improving the Patient Pathway

by University Hospitals of Leicester

SUMMARY

The diabetes virtual ward (DVW) pathway allows patients to receive the care and support they need at home, safely and conveniently, rather than in the hospital. The ward offers different approaches to care, narrowing the gap between demand and capacity for secondary care beds, offering an alternative to admission or early discharge. It also presents educational opportunities for the team supporting people living with diabetes. This pathway demonstrates optimisation of care, positive patient feedback and continued investment for growth. Finally, DVW supports collaborative working across the patient pathway in primary and secondary care within Leicester, Leicestershire and Rutland.

INNOVATION

Unplanned attendances at emergency departments (EDs) and readmissions of people with diabetes soon after discharge are disadvantageous to patients and healthcare systems. For some patients and carers, lack of support on discharge can be detrimental to managing recovery at home and can increase the need for readmission. Existing national guidance recommends that people with diabetes (PWD) are not discharged until their clinical condition is stable. Discharge plans need to consider the level of care and support that can be provided once the patient is discharged. While there are recommendations regarding input from MDTs and opportunities for home-based care, there is no mention of virtual wards or the value they could offer patients. VWs involve healthcare and social care teams identifying high-risk patients who may be destabilising, resulting in admission to hospital. In the longer term, VW MDTs would offer care working jointly with primary, secondary care and community care providers. The benefits include limiting disruption for PLWD and reduced costs to the NHS trust. There is increasing pressure to provide same-day emergency care (SDEC) services. A review of avoided admission data (defined as seen in ED or GP assessment unit or seen in ED and asked to return for a diabetes review), showed 45 would have been eligible to move into a VW over a three-month period. NHS teams are encouraged to use digital technology to deliver care closer to home, offering individualised care, no admissions and early discharge of patients. This pathway was created to offer PWD appropriate follow up and support after being admitted or attending the ED. The DVW is defined as similar to hospital care provided by an interdisciplinary team, delivered at home, via telephone or video consultation along with telemonitoring. Patients have clear MDT oversight. The pathway uses diabetes technology and digital health monitoring along with Spirit Health's ClinitouchVie app to connect patients and clinicians. The patient completes daily health questions, with data reviewed daily alongside remote continuous glucose monitoring (CGM) (Libre 2) and connected insulin pens (where applicable). If necessary, changes are made to treatment plans, with face-to-face support available. Key components include: predictive risk modelling and risk stratification; locality working; holistic care assessment and personalised case management plan, plus dedicated care coordination.

EQUALITY, DIVERSITY AND VARIATION

The online platform is user friendly and can be used by all ages. Data can be entered by carers on behalf of patients and there is a multiple language interface. This is a hospital-level DVW accessible to all patients and all UHL staff involved have completed equality and diversity training. Onboarding and supply of equipment is personalised to every patient, regardless of background. Enabling patients to be monitored and treated in their own homes maintains their individuality and independence. Socially deprived patients without smart phones are provided with electronic tablets to ensure digital inclusion; disabled patients use the service either with carer support or by tailoring the daily tasks to their needs. All patients with diabetes are eligible, regardless of their age (16+), sex, race, gender or social background. Leicester's cultural diversity contributes to the city having 10% of residents diagnosed with diabetes. Over two thirds of the Leicester population live in the most deprived 40% of areas nationally. Health education is an integral part of the service and prolonged remote monitoring includes advice on lifestyle and improved management of blood glucose levels.
An audit highlighted a need to improve access to CGM technology for all, including staff. Improvements in mobile compatibility increased uptake from 38% to 43%.

RESULTS

Since December 2021, 357 patients have experienced this DVW pathway. Of these, 153 were classed as avoided admissions, with step down of early discharges 62 and likely readmission 36. Those likely to have returned to SDEC services totalled 15. Since the introduction of this pathway there has been a reduction in admissions from ED where diabetes is included in the diagnosis. Monthly data collection includes referral areas, patient satisfaction and reduction in symptoms. Follow-up offers referral to GP, community DSN team, or a secondary care consultant, with most returning to their normal care provider. ED attendances have reduced from 62% to 57%. The current pathway capacity is 15, with average length of stay 11 days. The team bid for an Advanced Nurse Practitioner as lead, Band 7 DSN, two Band 6 DSN, two Band 3 support staff and one administrator. Staff recruitment was difficult. The team has been encouraged to expand this pathway to take direct referrals from EMAS and primary care, but funding and staff need to be secured. Funding for the DVW is secure for the next 18 months and it is anticipated that this will continue after full evaluation.

USER FEEDBACK

Patient feedback is collected electronically or by telephone. Patients were included during the design stage and most were very happy with the service. Areas for improvement, such as limited cover over weekends and bank holidays, are being reviewed.

DISSEMINATION AND SUSTAINABILITY

The local diabetes delivery group and ICB receive updates bi-monthly, with weekly reports on numbers and delivery. Technology support email daily to support on any challenges the team may have. This is also fed back to the speciality within the Trust for wider appreciation of the ward. Kent and Derby have shown interest in the Leicester model. It is part of the GIRFT pilot for VW pathways, demonstrating that other trusts would be able to implement it.

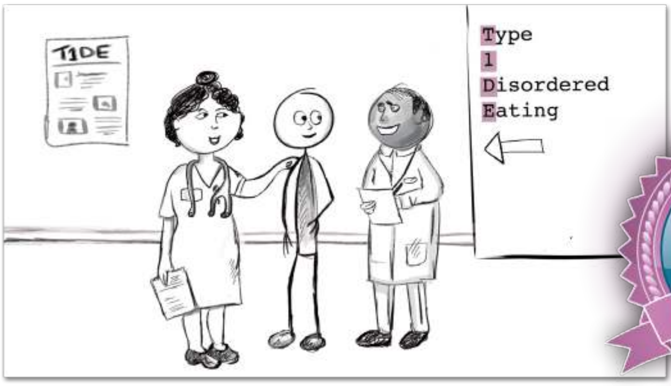
JUDGES' COMMENTS:

> “*University Hospitals of Leicester have put together a well-written application. It had positive outcomes, which can be replicated. The judges liked that patients were able to monitor from home and is a good tool to safely manage diabetes. The judges loved the idea of the virtual ward, which was very well set-up for people with diabetes. A lovely resource to support integrated care.*”

WELLBEING

Swimming with the T1DE

by NHS Executive



SUMMARY

Adults from Wales with type 1 diabetes and eating disorders (T1DE) participated in a therapeutic, creative project led by Breathe Creative, an arts-based company from Cardiff. Through virtual workshops, participants reflected on their experience of T1DE using creative writing, poetry, art and music, identifying common themes and key messages. The end result was a powerful animation of their collective experience and the need for continued awareness and further collaborative working among HCPs to improve support, treatment and outcomes for patients living with T1DE.

INNOVATION

Eating disorders in the presence of T1D has only recently been recognised as a mental health condition. Diabulimia has been used to identify an eating disorder, but this does not fit patients with variations in eating disorder behaviours. These include insulin omission, restriction or over-injection, food restriction, binge-eating, disordered or dysregulated eating and compensatory behaviours, which include purging, laxative/diuretic overuse and over-exercising. The new MEED Annexe 3 guidelines on ‘Type 1 Diabetes and Eating Disorders’ propose diagnostic criteria and a diagnosis of T1DE. Exploring how T1DE impacts people’s lives is crucial to improving patient support, care and outcomes. The patient voice can create positive change. Adults living with T1D in Wales were invited to a virtual focus group to explore how having T1D may have altered their relationship with their body, weight and shape. Being a sensitive topic, representatives from BEAT led discussions and the clinical lead from Service for High risk Eating Disorders (SHED) was present. Participants expressed an altered relationship with their body, weight and shape and a negative, complicated relationship with food following diagnosis, and many engaged in T1DE behaviours. They were invited to explore their experience of T1DE and create an awareness-raising animation, led by Breathe Creative. The workshops were held virtually over Zoom, led by a trained counsellor and arts facilitator, Katja Stiller. Each session used therapeutic techniques to provide a relaxed, safe environment for reflection and creative inspiration.

EQUALITY, DIVERSITY, VARIATION

Adults from Wales with T1DE were invited to participate in the virtual focus group and follow-on creative project. Participants did not have to have a formal diagnosis of an eating disorder. Three females and one male were involved, with representation from the LGBTQ+ community and one with neurodiversity (ADHD). There were also Welsh-speaking participants. Participants were under different health boards, so could compare awareness of T1DE, interventions/treatment and support. Breathe Creative facilitated the virtual workshops, which were held in the evening. A paediatric diabetes specialist nurse attended to ensure that participants were safe in exploring their experiences. Eating disorder behaviours discussed were associated with anorexia nervosa and bulimia nervosa, disordered eating or insulin omission. All experienced eating disorder behaviours and a negative relationship with food and diabetes management. The majority had not had a formal eating disorder diagnosis and had their own coping strategies. Through drawing, painting, creative writing and poetry, they explored how their experience of T1DE did not necessarily fit traditional eating disorder labels, resulting in a lack of knowledge and support. It also helped to challenge Diabulimia as a diagnosis. The aim was to create a powerful animation to inform and educate HCPs, encouraging a wider perspective of T1DE and highlighting the need for a collaborative, multi-disciplinary team (MDT) approach. All participants completed the project. The animation is available in English and Welsh.

RESULTS

There was 100% engagement from the participants. The animation was shared with HCPs across the Welsh health boards, plus charities, including JDRF, Diabetes UK and BEAT, and viewed at national eating disorder conferences in Wales and England. In Wales, it was viewed by the All Wales CYP Diabetes Network and the NCACE Arts and Health Event. The project was also presented at the All Wales Clinical Forum Steering Group and All Wales Patient Reference Group. The animation is a resource on T1DE on the JDRF and BEAT websites. There was a Parliamentary Inquiry into T1DE, and JDRF shared the animation on social media to coincide with this. It has also been shared by a support group in America, plus in Northern Ireland. Although this was a low-budget project (£5,000 AWDIG fund), the animation has raised awareness and encouraged discussions on T1DE. It has received over 1.1k views on YouTube, over 1.8k views on Facebook and almost 13k on Instagram. It has increased HCP awareness of the need for courageous conversations and collaborative working around T1DE. It has also been shared by Diabetes UK Research. In Wales there is funded national work for T1DE, with a funded All Wales Project Lead, a clinical forum steering group and local health board steering groups meeting regularly. MDT collaboration has been encouraged within diabetes and eating disorder services to improve communication, screening, referral and support. Consultation groups have been set up in diabetes and eating disorder services to enable early discussions on patients of concern, providing a better referral pathway. The clinical lead for SHED appointed the first Highly Specialist Diabetes Nurse in 2022.

USER FEEDBACK

Following positive feedback from BEAT and JDRF the animation is embedded in their websites. Importantly, it has given a voice to those experiencing T1DE. BEAT has launched its first CPD-accredited workshop on T1DE. Diabetes UK Wales sponsored the first All Wales Professional T1DE event in Cardiff in September 2023 in collaboration with the All Wales Lead for T1DE.

DISSEMINATION AND SUSTAINABILITY

The animation has been shared nationally and internationally, being accessible on YouTube and shareable across multiple platforms. it has reached thousands of people, giving them an opportunity to voice their own experiences of T1DE. The animation is timeless and will remain relevant to people living with T1DE. Phase two of the project, Courageous Conversations, is underway with further funding from AWDIG. Participants are exploring T1DE through their individual experiences and producing projects to be shared nationally and internationally. The first All Wales Professional T1DE event enabled HCPs in diabetes, mental health and eating disorder services to learn more. HCPs working with patients living with Hepatitis C heard about the animation and funded their own creative project with Breathe Creative.

JUDGES’ COMMENTS:

> “ *Swimming with the T1DE is a great idea, well-considered, with lots of background and information. It has easily accessible videos and really engaged young people, normally a difficult group to reach. The judges liked the discussion around experiences through art therapy. It was a creative and inspiring approach.* ”

FINALIST

WELLBEING

ACT Now! - A Brief Supported Self-Management Intervention to Improve Glycaemic Control and Emotional Wellbeing in Type 2 Diabetes

by NHS Grampian

SUMMARY

In line with the Scottish Government's 'A Healthier Future' framework, NHS Grampian developed psychology provision within its prevention and early intervention pathway for type 2 diabetes (T2D). ACT Now! is a brief supported self-management intervention designed to improve glycaemic control and emotional well-being in people who are at risk of, and living with, T2D. Based on the principles of acceptance and commitment therapy, the 1:1 sessions focus on promoting self-management behaviours (eating, physical activity), exploring the links between cognitions, emotions and behaviours and introducing strategies to support individuals to better manage barriers to self-management.

INNOVATION

Education regarding nutrition, physical activity and treatment regimens is essential. However, research demonstrates that psychological distress (anxiety, depression and/or diabetes distress) reduces engagement in self-management behaviours, in turn reducing glycaemic control. NHS Grampian developed psychology provision within its prevention and early intervention pathway for T2D. The aim was to embed evidence-based and innovative brief 1:1 intervention, based on the principles of acceptance and commitment therapy (ACT) and delivered digitally across the Grampian region, for the target populations. ACT teaches individuals to accept their thoughts, feelings, sensations and internal experiences (acceptance and mindfulness-based strategies) and to behave in ways consistent with their own valued goals and life direction (commitment and behaviour change strategies). The hypothesis was that an ACT intervention could help improve glycaemic control and health-related behaviours and reduce levels of stress, anxiety, low mood and diabetes-related distress. ACT Now! comprises six-to-eight weekly appointments, each lasting approximately 50 minutes. Sessions are delivered 1:1 with a psychologist via NHS Near Me, with an in-person option. Six core sessions focus on self-management and health-related behaviours, with two optional sessions on anxiety and depression. Sessions explore personal values and how they relate to diabetes/health, using ACT techniques for managing stressful thoughts and feelings. Weekly goals promote changes. A participant manual reinforces content and provides links to further information. Baseline and post-intervention measures monitor individuals' progress and evaluate the programme.

EQUALITY, DIVERSITY AND VARIATION

Diabetes psychology provision was commissioned by NHS Grampian in 2019/20 to widen access and provide new options for self-management support. In collaboration with primary care, this service is available to all individuals at risk of or living with T2D in Grampian. The NHS Near Me video appointment system was adopted to expand reach and accessibility of the ACT Now! programme and reduce travel and time off work. While most participants were happy with digital-first appointments, in-person appointments were also available. Patients could self-refer or be referred by a healthcare professional. Promotional materials were developed, with posters and business cards for primary care practices and third sector supports. Service and referral information was shared at local diabetes conferences and training sessions.

RESULTS

From April 2020-March 2023, 81 individuals had an initial assessment with a psychologist and joined ACT Now!, with 71% completing the programme. The average number of sessions attended was 8.6 and the average time taken to complete the programme was 12.7 weeks. Findings showed clinically and statistically significant improvements in participants' glycaemic control (mean decrease in HbA1c of 8.6mmol/mol), anxiety (mean decrease in HADS-A score of 3.9), depression (mean decrease in HADS-D score of 3.9) and diabetes-related distress scores (mean decrease in PAID score of 16.0), plus physical activity levels post-intervention (mean increase of 2,685 steps and 2.2 days where a participant was moderately active for at least 30 minutes). ACT Now! was funded by the Scottish Government. Independent evaluation in 2017 found it was cost-effective and cheap to deliver, with a reported +0.21 gain in quality-adjusted life years, as well as a lower lifetime cost of diabetes complications of £248 per patient.

USER FEEDBACK

Anonymous feedback forms were sent to all participants after their final session. They were also invited to an interview with a member of the diabetes psychology team. A total of 24 survey responses were received and nine interviews conducted. ACT Now! helped participants to feel more confident and motivated to make and maintain changes, focus their thinking and goals into something manageable, and feel better equipped to manage their diabetes. Participants described improvements in emotional well-being post intervention and felt that the interventions, session content and materials used were well-structured and relevant. Some participants said a follow-up session would be beneficial, while others wanted content in more depth. There were some challenges experienced with digital delivery but most participants enjoyed its flexibility. Several participants reported that email contact between appointments was beneficial to reinforce their learning. Following feedback, a 'postcard' completed in the final session is emailed to the participant three-months post intervention as a reminder of helpful strategies.

DISSEMINATION AND SUSTAINABILITY

ACT Now! focuses on initiating and maintaining changes in key health behaviours, developing skills and responsibility. Moreover, 82% of participants had other chronic medical problems, which the lifestyle changes can help too. HbA1c is an important indicator of long-term glycaemic control, and correlates well with the risk of diabetes-related complications. It is hoped that ACT Now! will delay the intensification of diabetes drug treatment and thereby decrease overall healthcare spend. At baseline, nearly three quarters (73%) of participants were already on at least one diabetes medication. Up to 50% of these would next move on to the DPP-4 inhibitor class of diabetes medication, which costs an average £431 per patient per year (NICE, 2015). ACT Now! is supported with participant and therapist manuals. Future delivery requires only one direct recurring cost, associated with the salary of a psychology practitioner(s) to deliver the 1:1 sessions. Ways to sustain and spread the innovation include: continuing to embed signposting with general practice; facilitating engagement with third sector and community groups in the region, targeting difficult-to-reach groups and those at increased risk of developing T2D, plus developing audio/video materials to improve accessibility.

JUDGES' COMMENTS:

> “*ACT Now! Is innovative and helps support people newly diagnosed with diabetes. It is there at the beginning of the patient journey, which is great. It had good results and is cost effective. Look forward to seeing it develop.*”

WINNER

IMPLEMENTATION OF NEW TECHNOLOGIES

Data-Led Prioritisation

by Guy's & St Thomas' NHS Foundation Trust

Improving care and reducing health inequalities

We have trialled Data Led Prioritisation in the Diabetes service, demonstrating the following impact.

We expedited care for high risk patients...

>120 high risk (red) diabetes patients seen sooner than initially planned

"Thank you for seeing me. I thought I'd been forgotten about"

Preventing harm by seeing them sooner...

40% of patients whose appointment was expedited had harm prevented

By doing this we also reduced health inequality

49% of diabetes patients seen sooner than planned were from **ethnic minority groups**. High risk patients are also disproportionately represented by **high socio-economic deprivation.**

A sizeable proportion of patients are low risk...

17% of the Diabetes cohort demonstrate encouraging data since their last consultation

Meaning we can safely see them less...

10% of Diabetes patients are consistently low risk and are still travelling to hospital regularly

They are supportive of this approach

100% of green patients interviewed would be happy to have their appointment moved back

CITI Centre for Innovation, Transformation & Improvement
Better, Faster, Fairer Healthcare

Supported by Guy's & St Thomas' Charity

NHS
Guy's and St Thomas'
NHS Foundation Trust

SUMMARY

COVID-19 resulted in large backlogs of diabetes patients, with no way to manage risk for those waiting. Working in conjunction with diabetologists, service leads and analytics, Guy's & St Thomas' NHS Foundation Trust (GSTT) defined, coded and validated clinical rulesets to objectively identify patients on waiting lists who might be deteriorating between appointments. Over 120 high-risk patients were identified and appointments were expedited based on their pathology tests. These patients were disproportionately represented by ethnic minority groups and areas of high deprivation. Clinical evaluation indicated that harm was prevented in ~40% of cases.

INNOVATION

Data-Led Prioritisation (DLP) was co-designed with diabetologists, service leads and analytics experts. It brings together the best of what is available but often difficult to aggregate, using technology. The project delivered impact within 18 months. Adopting surgical pathways' well-recognised terminology of P1-P4 (highest to lowest priority) in Outpatients provided clarity, without creating more risk prioritisation processes. The clinician-facing dashboard was co-designed with colleagues from the service. It presented each patient's risk category against all relevant events, pathology data and wait time for next scheduled routine appointment, reducing assessment time to two minutes from over five. In addition, a bespoke clinic administrator dashboard showing appointment allocations according to risk and guide booking practice around clinical urgency was developed. The front end was designed in Power BI, which is available to every NHS organisation. The trust is implementing a new Electronic Health Record (EHR) and the technology was developed with sustainability in mind. The outputs are easily integrated with other data portals and new systems can be incorporated. The new EHR will enable further development of DLP so that patients have a summary of their pathology data and risk score. DLP optimises existing knowledge, processes and data to harness the power of available information.

DISSEMINATION AND SUSTAINABILITY

The DLP pilot was specific to the diabetes department at GSTT, but learnings and methodology are being shared with diabetes departments across the country and Europe. An iteration is being created with South East London to facilitate population health management and address diabetics with comorbidities. The clinical diabetes team has drafted papers for publication and presented them at European conferences. It is hoped that the HSJ award for 'Driving Change through Data and Analytics' will support the dissemination of the methodology and associated benefits. Five 'fast follower' specialities with similar serology to diabetes are working to adopt the DLP methodology for risk score data. A 'clinical library' of rules across the specialities will be available to other trusts wanting to develop DLP.

IMPLEMENTATION OF NEW TECHNOLOGIES

The enterprise data warehouse was used to collate and integrate data from trust clinical systems. By leveraging a range of data points across various systems, DLP provides clinicians with the most up-to-date view of a patient's health in one place using a 'risk scoring engine', not automated decision making. The front end can be embedded in the trust's existing infrastructure and deliver insights through a simple traffic light system. No new technology had to be purchased or licensed, so actionable insights were delivered in months. Clinicians are alerted to new patient risk factors seamlessly and without logging into multiple care systems. COVID-19 necessitated bulk cancellations of outpatient activity, resulting in enormous backlogs. GSTT's diabetes follow up waiting list was ~8,000 patients, with 10% not booked. Manually assessing the waiting list to identify deteriorating patients was not feasible. The project was clinically led and translated the rules that diabetologists use into simple rulesets that could be applied to data. Overlaying the risk scoring assessment with patients' next booked appointment slot revealed high-risk patients who were not due to be seen for over three months and stable patients who were being seen regularly. A strategy was developed, centred around these principles: treat those patients in most clinical need and measure this through reduced harm; ensure that the solution actively reduces existing health inequalities; be clinically driven and leverage the knowledge of clinicians when designing, shaping, implementing and evaluating the solution; ease the operational burden associated with booking patients; fully utilise trust data. Customer input helped shape the health analytics model. During the pilot phase, appointments for >120 high-risk diabetes patients were expedited. Clinical evaluation indicated that harm was prevented in ~40% of these cases. A total of 600 low-risk diabetes patients were contacted to put back their appointments. Clinicians reported that the tool assured them that they were making informed decisions about the waiting list. The methodology also helped to standardise decisions across the department and streamlined administrative processes. Leveraging all of the information in the GSTT data warehouse had ancillary benefits. Patient safety was at the heart of the programme. A panel of 10 diabetes specialists identified the most appropriate clinical risk criteria, focused on the modifiability of risk and accessibility of information in the EHR database. This included a robust evaluation of risk criteria proposed by a national organisation for risk stratification in diabetes. The model used seven risk criteria, including new data on HBa1c, EGFR lab results, A&E attendances and diabetic eye treatments. An independent medical statistician developed the validation methodology. Blind tests were carried out with 450 diabetes patients and nine clinicians to ensure the sensitivity of the model to detect high-risk people. When there was discordance, cases were reviewed to obtain consensus on the final risk category status. The tool detected 83% of cases that were flagged as concerning by clinicians, as well as 81% of lower-risk patients. Next came 'real world testing'. Over 350 checks were run on the stability of the data before it was ingested into the scoring platform. Expediting appointments for high-risk patients has patient and system benefits, with associated cost savings. Having identified 17% of the cohort as low risk and demonstrated that ~42% of those can avoid an appointment saved ~500 follow-up appointments a year, worth approximately £70,000 to the trust if they can be used to see more patients awaiting their first consultation.

JUDGES' COMMENTS:

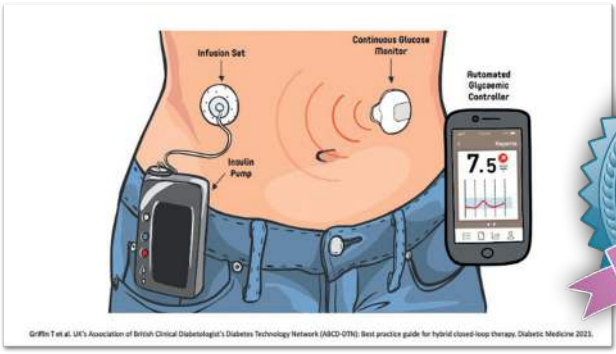
> *Guy's & St Thomas; NHS Foundation Trust have produced an exceptional project. It is a simple concept, extremely well put together and is exciting. The technology is impressive and useful. It is easy to join up the information and looks to be not only innovative, but future proof. Patient feedback is strong and the judges could see that it is easily transferable, as well as reducing the workload for clinicians.*

HIGHLY COMMENDED

IMPLEMENTATION OF NEW TECHNOLOGIES

Hybrid Closed Loop Pilot in Adults: A Collaboration Between NHS England and ABCD DTN-UK

by NHS England and the Association of British Clinical Diabetologists Diabetes Technology Network UK



Griffin T et al. UK's Association of British Clinical Diabetologist's Diabetes Technology Network (ABCD-DTN): Best practice guide for hybrid closed-loop therapy. Diabetic Medicine 2023.

SUMMARY

NHS England (NHSE) and Association of British Clinical Diabetologists (ABCD) DTN-UK worked to deliver and evaluate the adult Hybrid Closed Loop (HCL) pilot. The results have been presented at international meetings and submitted for publication. Most importantly, the data from 520 users was submitted to NICE and made a significant impact on the cost-effectiveness evaluation of the NICE HCL multiple technology appraisal recommendations. These are currently in draft form, with a full updated version being released soon, enabling improved care of for over 100,000 people living with type 1 diabetes in England and Wales.

INNOVATION

Never before has novel, automated, life changing diabetes technology been delivered at such scale and over a such a short period. The HCL pilot accelerated understanding of not only the clinical and psychological benefits but also how best to deliver at scale. Fortnightly catch-up meetings covered safe practice and successful delivery. The ABCD DTN-UK used an innovative, secure online tool to capture data from over 500 users over a short space of time. Previously, no study had evaluated the real-world outcomes of this technology in such a large and high-risk population. The results informed the NICE cost-effectiveness evaluation. HCP experiences from the pilot informed the development of ABCD-DTN-UK National Best Practice Guide for HCL therapy. The pilot provided real-world evidence on the glycaemic benefits of HCL therapy and learning to guide large-scale onboarding.

DISSEMINATION AND SUSTAINABILITY

The HCL pilot was delivered across many centres to over 500 people living with type 1 diabetes from a broad range of backgrounds, inlcuding 37% from the two most deprived quintiles and 9% from a non-white background. The pilot demonstrated uniform outcomes regardless of demographics. People who would not typically have taken part in a randomised controlled trial were able to access HCL therapy. The learnings will support the implementation of this life-changing technology at scale, when the NICE TA recommendations go live later in 2023.

IMPLEMENTATION OF NEW TECHNOLOGIES

In 2021 Simon Stevens announced that NHSE could pilot HCL technology. This technology keeps glucose levels in range by automating insulin delivery. In clinical trials it improves glucose levels and quality of life; however, trials focused on safety, underestimating impact compared to real-world clinical experience. The NHSE pilot investigated the real-world benefits of these systems at a wide scale. The pilot population was medically complex, with an HbA1c ≥8.5% (≥69mmol/mol), despite a high level of care with an insulin pump and intermittently scanned continuous glucose monitoring (isCGM). A total of 31 adult diabetes MDTs across England started the participants on HCL between August and December 2021. Coordination and support from NHS England, DTN-UK and clinical leads was essential to ongoing engagement, robust data collection and liaison with industry. Data demonstrated a significant improvement in HbA1c and diabetes-related distress. This was one of the most significant datasets used for the NICE TA recommendations. The objectives were: to discover whether HCL could help people with diabetes manage their condition safely and effectively in a real-world setting; to evaluate whether it could improve outcomes over the combination of an insulin pump and flash glucose monitoring in people living with diabetes with an elevated HbA1c; to gain insight into the challenges of delivering this technology at scale. NHS England led and funded the pilot. The ABCD HCL study was designed to capture routine anonymised outcome data from adults who participated in the NHS England closed loop pilot. The aim was to assess the real-world effectiveness and safety of HCL systems commercially available in the UK in an NHS outpatient setting. The 31 teams provided evidence to ABCD, which was submitted to NICE to inform its technology appraisal. The resulting recommendations, which widen access to HCL, will fundamentally alter the standard of care in type 1 diabetes. A pragmatic, observational study of participants was undertaken, along with a mixed-methods study to explore the impact on people living with diabetes and their families. Longitudinal changes associated with commencing HCL in adults with type 1 diabetes and elevated HbA1c levels despite the use of isCGM and insulin pump therapy were explored. Patient-reported outcomes were also captured. Outcomes included: change in HbA1c; sensor glucometrics; diabetes distress score; gold score (hypoglycaemia awareness); acute event rates and user opinion of HCL. In total, 570 HCL users took part. They had a median age of 40, 67% were female and 85% White. Baseline HbA1c was 9.4±0.9% (78.9±9.1mmol/mol) with median follow-up of 5.1 months. Of 520 continuing HCL at follow-up, mean adjusted HbA1c reduced by 1.7% (18.1mmol/mol). Time in range (70-180mg/dL) increased from 34.2% to 61.9%. Individuals with HbA1c of ≤7.5% (≤58mmol/mol) at baseline rose from 0% to 39.4% and those achieving ≥70% time in range and <4% time below range increased from 0.8% to 28.2%. Almost all rated HCL therapy as having a positive impact on quality of life (94.7%). Data demonstrated a vast improvement in glucose control (HbA1c -18.1mmol/mol), diabetes-related distress reduced (69% to 22%). In total, 125 participants completed post-intervention INSPIRE, DTSQc and bespoke questionnaires. Total score for INSPIRE was 88/100 and DTSQc scored 17/18, indicating high levels of satisfaction. Importantly, 98.4% of respondents were more satisfied with HCL therapy than insulin pump and isCGM therapy. HCL therapy was deemed more flexible and convenient. It was associated with improvements in HbA1c, time in range, hypoglycaemia and diabetes-related distress and real-world quality of life. The 2023 NICE Technology Appraisal recommends wide access. Reported hospital admissions related to hypoglycaemia and hyperglycaemia/DKA and paramedic callouts (not resulting in admission) were low and no increase in per 10-person/year events was observed. A total of 37 adverse events were reported, the majority related to either pump or cannula issues or sensor failures, inaccuracies and skin reactions. A total of 50 users (8.8%) discontinued therapy. Retinopathy outcomes showed progression within usual rates. From the quantitative questionnaires, 87% and 76% felt HCL reduced their perceived risk of long-term complications and the burden of hypoglycaemia, respectively. NHSE provided funding for the CGM to enable transfer from pump alone to HCL. ABCD DTN-UK funded the national audit.

JUDGES' COMMENTS:

> *The judges liked this well publicised, well balanced and well backed entry. It revolutionises healthcare from a patient perspective and had a lot of real-world data, demonstrating clear improvement in quality of life. It was slick, brilliant and, overall, an excellent project.*

PEER SUPPORT

#diabeteschat
by Peer Support Community

WINNER

SUMMARY

#DiabetesChat fosters connections among individuals affected by diabetes, providing a trustworthy platform for exchanging ideas and raising awareness. The @diabetes_chat hosts weekly Twitter Spaces with open discussions, #thursdaythreads, fun facts and guest speakers. This secure community brings together people with diabetes, caregivers, healthcare professionals (HCPs), athletes and advocates worldwide. With a reach of over 150,000 in under 18 months, it has set its foundations organically and strongly in the diabetes community. The mission is to connect, share experiences, support each other, transfer knowledge and promote diabetes awareness across all types.

INNOVATION

Tom founded #DiabetesChat because he wanted to connect with others living with diabetes, to combat feelings of isolation and to gain knowledge and support. At its inception and with gaining confidence from accessing a glucose sensor for the first time, he recognised the challenges of living with diabetes. At that time, in early 2022, it was difficult to meet up, but he wanted to talk to others who could benefit from this technology. The objective was to provide a safe space for individuals with diabetes to share experiences, raise awareness and foster a sense of unity. #DiabetesChat created a supportive, online community through the use of #DiabetesChat Twitter Spaces, podcasts, YouTube channels and guest speaker chats. These platforms offered convenience and accessibility for participants, allowing them to engage in discussions, ask questions and share their stories. Including HCPs from various fields of diabetes care demonstrated the commitment to a comprehensive approach to support and education. The weekly #DiabetesChat Twitter Spaces provided an accessible forum for individuals to listen, tweet or join the speaking panel, allowing them to engage at their own comfort level. The podcasts on the website and the YouTube channel further enhanced accessibility and inclusivity, while respecting anonymity. #DiabetesChat expanded to include #DiabetesChatstories events, facilitating connections between HCPs, researchers, parents and the community. Topics included Smart Insulin Pens and Hybrid Closed Looping, as well as research updates from around the world. The weekly #thursdaythreads, led by trusted DSN and EDEN educator James Ridgeway, ensured the provision of accurate information, community conversations and real-life experiences. In-person #DiabetesChat events at JDRF discovery days are also planned. This expansion to in-person gatherings provided an additional avenue for peer support and knowledge sharing. Measurement tools included engagement levels, feedback from participants and the growth and reach of the community across platforms. By continuously adapting and evolving, #DiabetesChat remains unique in its comprehensive approach to diabetes support, education and community building.

EQUALITY, DIVERSITY AND VARIATION

#DiabetesChat has become more inclusive and accessible over time, meeting the diverse needs of its audience, evolving from a Twitter Space to a weekly podcast, topical webinars streamed on YouTube, private hangout event chat space on the website, quiz nights, book clubs, open chat forums, weekly interactive Tweetorials by an HCP, to a global, multi-hosted, 24-hour chat experience. #DiabetesChat's reach includes not just the UK, but many continents. Embracing anonymity, #DiabetesChat allows individuals to express themselves freely without fear of judgment or stigma. This encourages participation from those who may hesitate to share experiences, promoting equality and reducing barriers to access. Through active listening, the platform identifies gaps in knowledge and resources to address. Appropriateness is also emphasised and the platform embraces the concept of 'Your Diabetes May Vary'. By incorporating diverse perspectives, #DiabetesChat promotes inclusivity. Each meeting is available every Monday from 8pm through the individual's phone. The interventions by #DiabetesChat positively influence the outcomes and experiences of community members. It creates a sense of belonging and trust, eliminating feelings of shame or judgment. This reduction in variation is evident through balanced topic coverage, increased engagement and positive participant feedback.

RESULTS

Since its creation on 14 February 2022, #DiabetesChat has achieved significant results and demonstrated its effectiveness in reaching its objectives. These include: 70 Twitter spaces with 245 hours of engagement; the 24-hour live Twitter space for World Diabetes Day raised awareness for diabetes, connected with global communities and showcased how #DiabetesChat brought people together; the launch of #DiabetesChatStories events on YouTube gained over 1,500 viewers, facilitating education and awareness on important topics; the YouTube channel has 64 pre-recorded and live-stream videos with 117 subscribers, 9,000 views and 600 hours of watch time since June 2022; the website and podcast archive, established in June 2022, have accumulated around 11,000 views and feature guest speaker chats; more than 10,000 live listens/replays of #DiabetesChat Twitter Spaces; 22 #thursdaythreads with over 131,000 views. The growth and impact of the community are evident in the expansion of platforms, high engagement levels and positive feedback from participants. The initiative has increased knowledge, encouraged proactive conversations with healthcare teams, and empowered individuals to make informed decisions. #DiabetesChat is privately funded by its founder. It maximises resources by utilising digital platforms and a team of nine volunteers, all living with diabetes.

USER FEEDBACK

Diabetes Professionals have recongised the value of #DiabetesChat as a platform for people with diabetes and their support networks. Users describe it as supportive, understanding, relatable and a place for open dialogue. Feedback is collected organically on Twitter in chat spaces and across other event types. The questions the community ask during the events play a vital role in understanding knowledge gaps and identifying wants and needs. This information is used to shape future events. The involvement of trustworthy professionals and educators from DAFNE and DESMOND adds credibility to the content and discussions.

DISSEMINATION AND SUSTAINABILITY

#DiabetesChat has a global reach. Elements that can be developed further include peer support, accessible and inclusive platforms, collaboration with HCPs and continuous improvement based on user feedback. Peer support is a crucial aspect. Diverse digital platforms ensure accessibility and inclusivity. Adopting similar strategies in other services can reach a broader audience and cater to diverse needs. Integrating HCPs in similar initiatives can improve patient experience and promote accurate information. A similar initiative would require a dedicated team to organise and moderate discussions, manage digital platforms and engage with participants. #DiabetesChat will continue to prosper with an in-person conference and community-led events.

JUDGES’ COMMENTS:

> *“The judges loved that the #diabeteschat offers 24-hour support and allows users to control their own visibility. It is a unique and novel project, done extremely well in a modern way. The entry was exceptionally well-written and bought to life with brilliant media. It brings everyone together and the use of social media means access to a large number of individuals. An amazing project!”*

HIGHLY COMMENDED

PEER SUPPORT

Type 1 Kidz Project

by Investing in Children

SUMMARY

Type 1 Kidz (T1KZ) is a project for children and young people living with type 1 diabetes (T1D) and their families in North East and North Cumbia, facilitated by Investing in Children CIC. T1KZ aims to improve the confidence of children and young people (CYP), their health outcomes and clinical experiences, by working in partnership with all local clinical teams. CYP are at the heart of the project, which is led by a Young Person's Coordination Group and overseen by a professional steering group.

INNOVATION

Investing in Children (IiC) was established in 1995 as a partnership between Durham County Council and the NHS and now runs independently via the IiC CIC and the IiC Foundation. IiC promotes the rights of CYP and ensures that their voices are heard in decisions that affect them in public and voluntary sector services. IiC began working with CYP with T1D in 2001, looking at how they could have a say in their medical care and the service provided by the paediatric diabetes team in Co. Durham and Darlington. A group of CYP researched what was on offer at their local hospitals, new technologies and new ways of working. IiC developed a peer mentoring programme to provide a forum for in-depth discussion between peers, where they could share views on living with diabetes and get support to control it. A support session was added for parents, families and other adults. In 2012, IiC established Type 1 Kidz, an award-winning peer support group for CYP, parents, carers and families. Links with the CYP's North East and North Cumbria Diabetes Network provided opportunities for dialogue between CYP, families and clinicians across the region, supported by IiC. The project has served the whole of the North East and North Cumbria Integrated Care Board (ICB) region since 2021. The purpose of T1KZ is to engage CYP with T1D in their own emotional health and well-being, promoting self-care and management through peer support, as well as giving them a space to build relationships with their paediatric diabetes teams and engage in dialogue that leads to change, service improvement and development. It is quality assured through the IiC Membership Award. Further, it aims to promote family-centred care, recognising the vital support CYP get at home, from parents, carers and siblings. Project success is measured through feedback from CYP and parents and an impact survey comparing the results before and after attending.

EQUALITY, DIVERSITY AND VARIATION

Network funding delivers the project across the region to ensure all CYP have access to the same level of support. Feedback from sessions influences clinical practices and dialogue across the region addresses variations in practice and outcomes. 'Harder to reach' young people were not accessing the project because of lack of transport and/or parents being unwilling to bring them, so now a volunteer driver brings them. IiC has staff, risk assessments and policies in place so CYP can attend group sessions without their parents. Around 10% of the CYP had an additional need so the organisation worked with these families to set up a sub-group, allowing them to meet in smaller groups and quieter environments, such as sensory cafes and inclusive centres. Other sub-groups are the Under-7's Group and Teen Group. Twenty laptops are on loan to children and families to help them upload their data to clinics, attend clinic virtually, plus access support and advice websites and groups.

RESULTS

Over 10 months: 55 sessions were offered for CYP with T1D and their families across the region; monthly face-to-face sessions resumed after the COVID-19 pandemic; specific groups were established. Activities included a family fun day, two-night residential trip, cookery and sports workshops, monthly support meetings and newly diagnosed sessions. The Coordination Group enables young people from across the project to meet and discuss how to develop it and research topics to feed back to clinics and the CYP's North East and North Cumbria Diabetes Network. The young people's steering group meets regularly. Two episodes of the original podcast 'The Highs and Lows of Type 1 Diabetes' have been recorded and research has been conducted into access to insulin pumps for over-12s. Agenda days (adult-free discussions) have been held with other young people about poverty proofing diabetes clinics and moving from children's to adults' care. Thirty families attended a three-night residential to encourage independence, experience new activities away from home in a safe environment and build relationships. Funded by NHS England, it cost £40 per family, with donations covering costs for any who could not afford it. T1KZ has an established Facebook group with 900 members. Clinical Champions from every clinic help promote the T1KZ project. Staff from T1KZ regularly visit clinics to promote the project to families and get feedback. For the past two years the project has been funded by the ICB and now it is funded by the ICB with Novo Nordisk and donations. Regional events have been run in partnership with NHS teams.

USER FEEDBACK

Feedback is collected at the end of group sessions. There is also an annual online survey, which is anonymous. The Young Person's Coordination Group meets four times a year and provides feedback and ideas.

DISSEMINATION AND SUSTAINABILITY

This project has been facilitated by IiC, in partnership with all local children's diabetes teams - for all children and young people in the North East and North Cumbria. The beneficial elements to take forward include growing the Professional Steering Group to share good practice and improve patient care across the whole region. Funding is required to run the project but changing from the Community Interest Company to a Registered Charity has increased funding and fundraising opportunities. It would be difficult to implement this inititive elsewhere as the organisation's ethos and values are a core part. However, aspects like newly diagnosed days, fun days, day trips and the residential would be easier to transfer.

JUDGES' COMMENTS:

> “*The Type 1 Kidz Project goes above and beyond expectations. Every detail was thought through and the feedback was great. The judges really liked that it allowed focus on families, particularly siblings and were struck by efforts at inclusion. Results show the breadth and success of the project.*”

PEER SUPPORT

Diabetes UK Northern Ireland 'Live Well Hubs'

by Diabetes UK Northern Ireland

SUMMARY

Diabetes UK is the leading diabetes charity in Northern Ireland, where 112,000 people live with diabetes. Its Live Well Hubs are innovative, one-stop shops providing information, advice and peer support to improve the health and wellbeing of people living with diabetes in the community. The Hubs provide free support for individuals and their families covering general awareness and resources, mental health, physical activity, weight management and nutritional advice. By creating a warm and welcoming environment, people using the Live Well Hubs gain knowledge, confidence and empowerment to enable them to live well with their diabetes.

INNOVATION

Following the COVID-19 pandemic, Diabetes UK NI (DUKNI) sought to complement its considerable digital support, realising its in-person reach was limited and stymied by the pandemic. While the pandemic strengthened DUKNI's online presence, large numbers of individuals remained digitally excluded and unable to access support, including that provided by the health service. The idea was to move from a local support group structure to target areas of need, with emphasis on supporting people living with type 2 diabetes who had been underrepresented in receiving peer support under the previous structure and were more likely to be disengaged from clinical pathways. First, it held an awareness-raising session in a trusted community setting with a high level of local engagement. Next, it introduced the Live Well Hub, comprising a five-week education and peer support programme connecting people with diabetes to experts and HCPs providing free support on diabetes awareness and resources, mental health, physical activity, weight management, health MOTs and nutritional advice. The final stage was to invest in volunteers – 'Live Well Champions' – identified during the programme, and keep them motivated and engaged to maintain a local Diabetes UK-supported presence, freeing staff to scope other areas of need.

EQUALITY, DIVERSITY AND VARIATION

Issues related to equality and diversity were identified in the scoping work, which was conducted within DUKNI. The whole team was involved in selecting the Live Well Hubs, choosing two sites: The North Down Community Network's Wellbeing Centre, Bangor and the The Ballykeel Community Centre, Ballymena. Both areas had pockets of considerable deprivation and the highest diabetes prevalence rates in NI. DUK strives to be as inclusive and adaptive as possible. Its research shows that those living in poverty are 2.5 times more likely to have diabetes and twice as likely to develop complications, requiring specific support. So, while the selection of both venues was partly determined by the rates of deprivation and levels of engagement with the health service, the organisation is aware that both areas have suffered from the intergenerational legacy of the Northern Ireland conflict and are considered Protestant/Unionist. DUK will therefore scope Catholic/Nationalist areas as further Live Well Hub areas in NI, while maintaining a focus on health inequalities. In Ballykeel there was also a separation between the local/settled population and a relatively new minority ethnic population. As this ethnic community is more likely to be disengaged from the health service, the charity is driving the work of a recently appointed DUKNI Engaging Communities Officer.

RESULTS

This project is funded by the National Lottery Community Fund's People and Communities Grant. The objective is to create two Live Well Hubs per year in not-for-profit, established community venues, plus identify a Live Well Champion volunteer to continue a Diabetes UK-supported presence in Hub areas. This, along with inviting HCPs and other charities and experts to deliver sessions to attendees, demonstrates cost efficiency to the charity. The Bangor Hub began in May 2022 with an initial awareness-raising session with 28 participants. This established interest to take forward the education and peer support programme for a further five weeks. Sessions included talks on nutrition, diabetes management, community pharmacy, eye care and foot care, with 20 people attending regularly. In February 2023, the Ballymena Hub began, with an awareness-raising session with 32 participants, then rollout of the programme, with 15 people attending regularly. All participants in both areas found the sessions helpful and informative, felt comfortable sharing diabetes concerns and said it met their expectations. A total of 91% in Bangor and 80% in Ballymena said it increased their confidence. During Diabetes Week, two participants delivered broadcast media interviews on the impact of the Hubs, with Gemma, from Bangor, becoming the first Live Well Champion. This initiative supported improved outcomes by building participants' confidence in managing their diabetes and building connections for peer support.

USER FEEDBACK

Live Well Hub session attendees were encouraged to complete a pre-questionnaire and post evaluation form. Participants praised the usefulness of the sessions and friendliness of the groups and HCPs noted that attendees had proactively booked appointments. At each session attendees were asked what topics they would like to hear more about. Suggestions included diet, exercise and well-being and specific sessions were held as a result. One attendee delivered their own talk on nutrition and shared ideas and advice on portion control. Another gave a cookery demonstration and shared diabetes-friendly recipes. A local council representative talked about its Move More Programme and a mindfulness practitioner gave a session on self-care and self-compassion.

DISSEMINATION AND SUSTAINABILITY

Equipped by Diabetes UK, and from their own lived experience with diabetes, the Live Well Champion maintains a Diabetes UK-supported presence in the area, providing peer support and assistance to people living with diabetes, including helping them access local community-based activities. Diabetes UK's Engaging Communities and Volunteering team focuses on scoping and building further Live Well Hubs in other areas, while ensuring the peer support provided in established Live Well Hub areas is seamlessly transferred from staff member to volunteer. The Live Well Champion receives a package of support from Diabetes UK, including monthly catch-ups with a member of the team, quarterly reviews and training. Diabetes UK is also committed to supporting established community resources. This encourages signposting to existing and trusted support networks so, ultimately, the person living with diabetes can access the right local support at the right time.

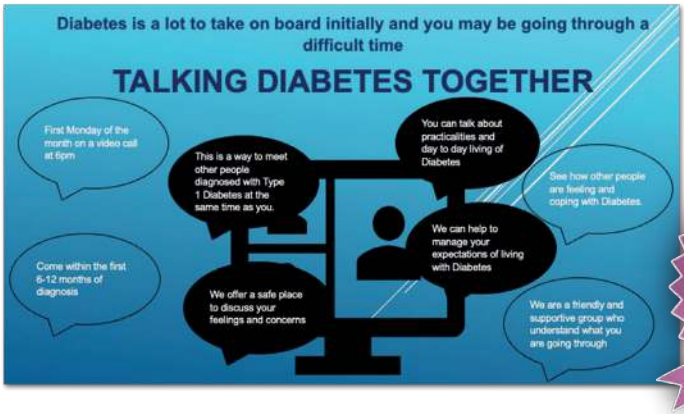
JUDGES' COMMENTS:

> *“Diabetes UK Northern Ireland have produced a really good piece of work looking at both T1 and T2. It is a strong model to follow and the judges could see the improvement in engagement for more deprived areas. It was very well written and demonstrated good patient understanding, with a clear definition of the challenge and concept. It also provides great psychological health support.”*

PEER SUPPORT

Talking Diabetes Together: A Peer Support Group for People Newly Diagnosed with Type 1 Diabetes

by Swansea Bay University Health Board



SUMMARY

People newly diagnosed with type 1 diabetes (T1D) can feel overwhelmed, alone and find it difficult to cope. They may find education difficult to take on board and need support from healthcare professionals, creating multiple appointments and demands on time. This initiative aims to support people newly diagnosed with T1D within Swansea Bay University Health Board. It provides an opportunity to come together to attend a virtual, monthly support group to discuss living with diabetes to promote self management. People can discuss their emotions, frustrations and how to deal with diabetes day to day.

INNOVATION

A quarter of people with T1D have diabetes distress, which may occur at, or soon after, diagnosis. If not addressed, it can lead to depression and impact outcomes. Support groups offer a safe space for people to share their experiences and emotions. Those who attend the group are diagnosed at a similar time. They can offload the burden that they feel and take control of diabetes from the start. A dietitian who supports people soon after diagnosis realised that people need to talk to each other to create positivity in the future and set about establishing a group. The main challenges were around facilitating discussion, managing expectations and emotions. It was also important to create a safe and welcoming experience. An initial group supported people who were diagnosed at the same time, some of whom were distressed and unable to take their own insulin because of needle phobia. They needed to talk to someone in the same position as themselves, to share their experiences to help each other. Each person was asked if they would like to speak to someone else about their diagnosis and all showed an interest in further support. The team psychologist provided guidance on setting objectives, as the aim of the group was more of a counselling/supportive role, not a dietetic one. The dietitian accessed psychology training for further information. Ground rules on confidentiality and patient safety were set and the group moved to an evening to support greater attendance. Benchmarking with colleagues across Wales showed that there were no groups of this nature running in Wales. It differs from usual support groups as it encourages people to attend together at diagnosis. Topics of concern, such as insulin injections, are unique to the type 1 diagnosis so people can talk to others in the same situation.

EQUALITY, DIVERSITY AND VARIATION

The health board has three hospital sites with three diabetes units. People diagnosed across all the units have been offered access to the group, ensuring an equitable service. The group is run virtually to reduce travel and facilitate attendance. As attendees are in their own homes, they are more likely to be relaxed, creating a safe space for people to express their feelings and concerns. A group setting is a problem for people with language barriers, but they can be offered translation or family/friend support to engage. The Nutrition and Dietetic Service supports people to access digital platforms and encourages anyone without access to use the family's internet and email address to join the group. A different platform is being investigated so people do not have to download an app to join. The topics discussed are appropriate to all as the participants choose the agenda. A person-centred approach increases engagement and improves outcomes. The dietitian runs the group so there is continuity of topics discussed from one session to another.

RESULTS

Questionnaires were completed after the first group and at six months. Initially, participants felt alone, but the group gave them confidence and support. With better mental health and coping strategies, self-management improved over the long term. The three sites now promote the group. A poster was developed advertising the group, which is discussed and given to people at diagnosis. The initiative reduced anxiety and fear about living with diabetes after diagnosis, reducing risk of diabetes distress. Evaluation forms showed that people benefited from attending and understood they were not alone. They felt that life with diabetes was more normal after attending. The people with fear of insulin injections were given reassurance and confidence and, as a result, started to take their own insulin. Funding was not required for this initiative and the group has reduced the number of individual appointments and phone calls. Long-term costs may be saved as people are empowered from the start of diagnosis to look after themselves.

USER FEEDBACK

The psychologist fully supported the group and praised the facilitator for her warm and compassionate manner. Participants were positive about their experiences and their feedback helped to develop the group. As a result, people who had had diabetes for over a year were invited to attend to discuss how they had managed. Six months was suggested as a good time period for people to attend, but this does not suit all, with 17% of people wanting longer. Now people are asked if they still want to attend after six months. Difficult topics are addressed sensitively in a relaxed atmosphere.

DISSEMINATION AND SUSTAINABILITY

The project was offered to people across one health board in Wales, covering three diabetes teams. Feedback showed that people felt better able to live with diabetes by sharing experiences and emotions. Participants frequently mentioned that meeting others in the same situation was extremely helpful. Patient information booklets for managing a new diagnosis and diabetes burnout provide a good basis for discussion and these will be used more frequently in the group and as an additional point of reference to turn to outside of the group. Using the Diabetes Distress Scale prior to and after the group will be considered to demonstrate effectiveness and outcomes that matter to people. Given the positive feedback, it is important to encourage others to develop more groups. This work, and how it can be easily replicated, will be promoted across Wales with diabetes dietitians and DSN groups. The feasibility of peer support groups for parents of newly diagnosed children and teenagers, as well as teenagers themselves, is being investigated.

JUDGES' COMMENTS:

> “*Swansea Bay University Health Board had written a straightforward, high-quality entry. The results, feedback and dissemination were of an exceptionally high standard. The judges liked the commonality of the group, the focus on newly diagnosed patients and could see the clear improvement in pre and post users.*”

PEER SUPPORT

Derby T1 Diabetes Peer Support Model

by The Derby Peer Support Model: A collaboration between University Hospitals of Derby and Burton and the local population living with Type 1 diabetes

SUMMARY

The Derby Peer Support Model, established in 2016 from collaboration between people living with type 1 diabetes and the local healthcare team, has been hugely successful. It now supports over 800 people to connect and share experiences via the Derby T1 Diabetes Facebook group. Underpinned by the NHS England six principles of peer support, almost all would recommend the group to others. The model is a source of information and emotional support – at no cost and with positive outcome data presented at Diabetes UK 2023. This model could easily be adapted and used in other diabetes localities.

INNOVATION

In 2016 Dr Wilmot had discussions with Nick Rycroft and Shaun Carpenter who highlighted that many people living with type 1 diabetes (T1D) had no mechanism for sharing experiences or gaining emotional support from others with diabetes. Nick and Shaun wanted to overcome this isolation through 24/7 peer support. The Derby team worked with Shaun and Nick and the Derby Peer Support Model was born. Historically, most diabetes peer support groups had been face-to-face and for people living with T1D and T2D, with low turnouts. The new model recognised that these groups had different needs. The Derby T1D Facebook page was set up, providing an online forum for people living with type 1 diabetes in Derbyshire to connect and support each other from home. In addition, face-to-face get-togethers were organised between members, and occasionally by the healthcare team. These involved discussions and open forums regarding the latest developments and innovations in T1D. The convenience of Facebook, coupled with the enthusiasm of the healthcare team to promote access and support the group, saw it grow from an administration group of three people with T1D in 2016 to 823 members in 2023. The group allows regular communication and support, as well as disseminating diabetes-related updates. There are usually four posts per day. This is thought to be one of the largest online local peer support groups. The team has provided input into the NHS England national recommendations on peer support models. To overcome medico-legal considerations healthcare staff did not become members themselves, but signposted people to the group. The team screen, review and moderate membership posts and ensure the group is for sharing experiences, not for the provision of medical advice.

EQUALITY, DIVERSITY AND VARIATION

The online format removes barriers such as the time and money required to attend a face-to-face meeting. In 2023 98% of the UK population have internet access of some description, making the online format accessible for many, regardless of social status, deprivation or ethnicity. This 24/7 access on any online device negates variation in accessibility and allows people to reach out anywhere at any time. The Derby T1 Group is advertised by the healthcare team at diabetes clinics and members use word of mouth to grow the membership.

RESULTS

Since 2016 there has been a substantial increase in the number of people joining and engaging with the group. People pre-emptively post their diabetes clinic appointment times and recognise each other from the Facebook group, creating a friendly, lively waiting room. The group is promoted by HCPs in the University Hospitals of Derby and Burton NHS FT. Cards were printed with DTN-UK flash glucose monitoring education links on one side and information about how to access the Derby T1 Facebook group on the other. These are available in clinic for professionals to hand out and to prompt discussion about holistic support. A total of 59 respondents were included in a user survey. They had a modal age of 41-60 years (66%) and were mostly female (78%). The mean diabetes duration was 25-40 years (32%) and mean HbA1c 54+/- 10mmol/mol. The majority used Facebook as their primary source of diabetes social media peer support (86%) and 64% had diabetes-related distress. Almost all (92%) would recommend the Derby T1 group to others and 56% had. The main reasons for membership were: 'information and updates' (54%); 'emotional support' (18%), 'to help others' (12%), 'support when things get tough' (8%) and 'socialising (2%). The top reasons for posting were: 'to help others with their diabetes' (43%), 'to get help with diabetes' (31%), 'socialising' (10%), 'venting frustrations' (10%) and 'sharing advancements and updates' (3%). The majority (>70%) found the peer support offered useful. The set-up costs were zero. The group needed a small number of motivated people with diabetes as volunteer administrators and HCPs who recognised the value of peer support and directed people to the group.

USER FEEDBACK

The Derby diabetes multi-disciplinary team is invested in the importance of peer support and remains keen to direct people to the Derby T1 diabetes Facebook page. The University Hospitals of Derby and Burton team obtained ethical approval from the University of Notitngham to conduct a survey of the Derby T1 Facebook group membership in 2022 to assess the impact. The survey remained open for a couple of months, giving members the opportunity to feed back. Quantitative and qualitative data were gained, alongside anecdotal feedback from the group administration team. People said they enjoyed the sense of community and emotional support. Practically, members believed that their control had been improved by exposure to their peers' experiences and advice. Individuals also made suggestions for improvements to the group. Some recommended subgroups, such as 'Preparing for pregnancy', or practical interventions like 'More weekend meet-ups', which are being considered for the future. Having a self-driven population allows the group to be flexible and shaped by user feedback.

DISSEMINATION AND SUSTAINABILITY

The Derby Peer Support Model delivered a mechanism for peer support for the local T1D community. It is a no/low-cost model, which can be replicated elsewhere easily. The success of the group is evidenced by its seven-year duration and the ongoing active engagement and discussion within the group. Optional low-cost mechanisms for spreading the word about the group include cards in clinic, posters in waiting areas, plus dissemination about the group via primary care. Translation of similar initiatives to other medical areas with long-term, high-burden conditions would be feasible too.

JUDGES' COMMENTS:

> “*The Derby T1 Diabetes Peer Support Model was a well-run project, with an excellent video. The judges liked that safety considerations had been included and it was about shared experience. They were very impressed by the passionate Facebook group. The objectives were simple and clear and it is available and accessible for all. The survey results were nice and clear, it is low cost and easily replicable.*”