QiC Diabetes
Quality in Care Programme 2024

sanofi

2024

CASE STUDIES

Association of British Clinical Diabetologists

ACPC

diabetes psychology network

Diabetes Research & Wellness Foundation

Diabetes Specialist Nurse Forum UK

Diabetes Specialist Nurse Forum UK

DISN UK GROUP

JDRF IMPROVING LIVES. CURING TYPE 1 DIABETES.

Children and Young People's National Diabetes Network

PCDS Primary Care Diabetes Society

t·r·e·n·d™ DIABETES

YDEF EDUCATION. ADVOCACY. SUPPORT

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**

Sanofi is proud to be the sponsor of QiC Diabetes and support this programme that is dedicated to recognise, share and reward excellence in diabetes care.

Sanofi is an innovative global healthcare company, driven by one purpose: we chase the miracles of science to improve people's lives. Our team, across some 100 countries, is dedicated to transforming the practice of medicine by working to turn the impossible into the possible. We provide potentially life-changing treatment options and potentially life-saving vaccine protection to millions of people globally, while putting sustainability and social responsibility at the centre of our ambitions.

"Sanofi is delighted to support the QIC Programme in 2024 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."

Debbie Woods
Head of Medical General Medicines UK and Ireland Sanofi

SUPPORTERS

Association of British Clinical Diabetologists

Breakthrough T1D™ Formerly JDRF

DIABETES UK
KNOW DIABETES. FIGHT DIABETES.

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Children and Young People's National Diabetes Network

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diabetes psychology network

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EDUCATION. ADVOCACY. SUPPORT

Diabetes Specialist Nurse Forum UK

WINNER

TYPE 1 SPECIALIST SERVICE

Dinky-Betes: A dedicated clinic for the under-7s

by Leeds Children's Hospital (Leeds Teaching Hospitals NHS Trust)

SUMMARY

The challenges of caring for very young children with diabetes are well recognised. Dinky-Betes is an innovative diabetes service providing valuable peer support to children aged under 7 years and their families. A multidisciplinary team (MDT) comprising a health play specialist, a clinical psychologist, specialist nurses, dietitians and doctors work collaboratively to offer a friendly and supportive environment to optimise diabetes care, access to advanced technology and deliver developmentally appropriate targeted education. Dinky-Betes also nurtures emotional well-being through providing a safe space for children and their families to share experiences with positive clinical and psychosocial impact.

INNOVATION

In 2023, there were 45 children aged under 7 years in Leeds Children's and Young Person's (CYP) service accessing an under-12s' clinic with a health play specialist and psychology support. A micro-MDT explored ways to improve support for them and their families. To improve access to technology, health outcomes and peer support, an under-7s first year of care (FYOC) pathway was introduced, as well as a dedicated under-7s clinic with activities organised by a diabetes health play specialist. Families requested support with procedural preparation, play and stories around diabetes, plus emotional well-being resources, alongside non-diabetes activities. Children also wanted to practise skills on their teddies. In July 2023, the monthly, play-based Dinky-Betes clinic launched. A clinical psychologist provides parallel support for caregivers. Children contribute to their MDT clinic appointment or play with peers. A diabetes nurse specialist supports diabetes care and carbohydrate-counted snacks are available. Clinical outcomes are collected alongside child and parental quality of life (QoL) scores. The team believes this is the UK's first dedicated under-7s clinic.

EQUALITY, DIVERSITY AND VARIATION

A total of 83% of 45 families within the service surveyed in April 2023 regarding a dedicated under-7s service said they wanted one. Clinic planning considered multiple factors, including school-age patients coming earlier in the morning, avoidance of toddler nap times, spoken languages, ethnicity, length of diagnosis and observed developing relationships. Reasonable adjustments are made for children with special educational and developmental needs. Children's individual interests are explored with appropriate toys and activities. Primarily, Dinky-Betes is for children with type 1 diabetes, but a patient with monogenic diabetes has also benefitted. A total of 33 patients have accessed Dinky-Betes since July 2023, 52% of whom are male. Six ethnic groups are represented, although most are White British. Over a third live in the most socially deprived areas of Leeds. The FYOC pathway aims to provide hybrid closed loop (HCL) technology within 12 weeks of diagnosis. HCL technology is offered to all children using tailored educational resources, targeted play involving teddies, consideration of family preference and opportunities for peer support. Donated phones with data have helped six families to date. All Dinky-Betes patients are using CGM. Only three are on multiple daily injection (MDI) therapy, two of whom plan to commence HCL.

RESULTS

The holistic and friendly environment has benefitted children, siblings and caregivers. MDT staff actively participate in play activities and provide opportunistic education. Children fearful of pump therapy have seen their peers wearing devices and wanted to try them, resulting in enhanced uptake of HCL systems, with positive impacts on glycaemic control and QoL for families. The health play specialist has normalised medical play using a pedagogical approach. Children have participated in tailored education, including procedural preparation for pump and sensor changes and carbohydrate counting under supervision. Themed story times have created opportunities to explore emotional well-being. Parents value meeting others in similar circumstances, with support fostered through careful consideration of appointment scheduling. Of the 33 patients, five transitioned to the older clinic at age seven and two can no longer attend. Ten patients are in their FYOC and have accessed Dinky-Betes since diagnosis. All children are using CGM, with all but three on HCL technology and two of these planning to start HCL. Seven children are participating in the Medtronic LENNY research study. Clinical outcomes, including HbA1c and CGM data, are collected alongside child and parental QoL scores using an adapted Likert scale and T1DAL measure, respectively. Clinical data is collected at three-monthly intervals, with preliminary six-month data demonstrating an overall reduction in median HbA1c from 57 mmol/mol (excluding FYOC data) to 53.5 mmol/mol, improved median TIR from 50.5% to 66.5% and stable time below range (TBR) at 3.0% and GV at 3.5. FYOC patients have a lower median HbA1c at six months compared to non-FYOC patients (47 mmol/mol cf. 59 mmol/mol), influenced by a higher TIR (67.5% cf. 56.5%), highlighting the challenges of maintaining clinical targets over time. Qualitative QoL data is collected with children. They fill in an adapted Likert Scale to identify positive and challenging experiences. A total of 57% of children one year or more post diagnosis noticed an improvement in their diabetes experiences since joining the clinic.

USER FEEDBACK

The Dinky-Betes clinic has been enjoyed by children, their families and the wider diabetes MDT. Positive feedback was gathered through questioning and direct observation and positive outcomes have been noted by HCPs. Dinky-Betes received the 2023 Leeds Children's Hospital Kite Award for Innovation of the Year and the 2024 Peg Belson Award by the Society of Health Play Specialists.

DISSEMINATION AND SUSTAINABILITY

As a tertiary service, Dinky-Betes has sufficient patient numbers for a dedicated monthly clinic. Access to an education space enables play-based activities to run alongside a standard MDT clinic appointment, with a diabetes health play specialist and a clinical psychologist. Educational and emotional well-being resources have been donated or funded by the families. Staff have secured £3,500 for Dinky-Betes and wider peer support activities across the age ranges from the Leeds Hospitals Charity. The aim is for all newly diagnosed under-7 patients to access Dinky-Betes. A dedicated under-7s FYOC pathway and parallel peer support activities, including teddy bear clinics and group activities, complement this model. Dinky-Betes has enhanced diabetes health outcomes, access to technology and psychosocial well-being for children and caregivers. The model could be adapted to smaller services with support from MDT members. The team would support any service wanting to implement a similar clinic.

JUDGES' COMMENTS:

Dinky-Betes was a great initiative, recognising the importance of learning within play. It is innovative and supportive of families helping young ones learn more about their condition through play. It also recognised the importance of having clinics with people of the same ethnic background enabling them to share a common language. The engagement with families was evident and it was just brilliant!"

HIGHLY COMMENDED

TYPE 1 SPECIALIST SERVICE

Seeing the whole person: piloting an integrative model of care at Sherwood Forest Hospital Young Adult Diabetes Service

by Sherwood Forest Hospital NHS Foundation Trust

SUMMARY

Sherwood Forest Hospital has piloted a specialist service for young adults (YA) of 18-25 years old, with Type 1 diabetes (T1D). A fully integrated approach has been developed, placing the clinical psychologist and dietitian as core members of the YA diabetes team in clinic with the consultant and the diabetes specialist nurse and contributing to all diabetes multidisciplinary clinic appointments. The aim is to provide a proactive and holistic care approach to a vulnerable cohort, by destigmatising discussion about psychological issues and reinforcing the view that the team weighs mental and physical health equally.

INNOVATION

This innovative service puts holistic care at its heart, providing an integrated MDT, with clinical psychology and dietetics in the team. This not only destigmatises conversations around mental health and eating-related distress but encourages a more psychologically minded approach to care delivery. A 'Hello to Adult Services' welcome letter and a YA pre-clinic questionnaire help tailor the MDT clinics to patients' needs. Person-centred care is delivered in a flexible and amenable style designed for YA. Communication by text and email is encouraged and educational materials and workshops for TikTok, YouTube and Instagram are being developed, as social media is the norm for YA and its use improves engagement. Dedicated specialist nurse time provides rapid-access clinics and YA-focused pump clinics in a seven-day service. Another aspect is routine psychological screening. Having a clinical psychologist in the specialist YA service has enabled more open conversations about psychological well-being.

EQUALITY, DIVERSITY AND VARIATION

The team understood the importance of developing an equitable service and discussed approaches to mitigate against barriers to equality. Finding ways to address neurodiversity and social deprivation was important as neurodiversity is more prevalent in childhood onset T1D than in the general population and associated with poorer glycaemic control. Approaches included keeping healthcare professionals consistent, a quieter waiting room, tailoring communication style, and offering one-to-one appointments to support familiarisation with diabetes technology/carbohydrate counting, etc. YA are also involved in planning. Raising awareness, promoting patient education, implementing screening campaigns and activating patients to take charge of their own healthcare are approaches that have brought a more equitable and appropriate patient-centred specialist YA diabetes service. The service reduces the burden on services and paves the way for a healthier, happier population. People are not 'hard to reach' but they are easy to miss so the service was designed to work for local people, in an area with high levels of deprivation. Multi-site clinics were instituted to support and encourage attendance. In the pilot phase patients in focus groups reported that accessibility and reduction in travel costs for attending appointments were key issues. To support YA with low incomes, hypo packs were given out at the regular (four-monthly) MDT appointments.

RESULTS

The service seeks to 'see the whole person' and has achieved high attendance rates, significant reductions in HbA1c levels, marked reductions in emergency DKA hospital admissions and meaningful improvements to mood and quality of life. For example, the service helped a T1D patient with a history of adverse childhood experiences who had had frequent hospitalisations for DKA and overdoses. The integrated MDT worked with her complex presentation from a medical and psychological perspective. Consistency in staff was paramount in building trust. With flexible reviews by the diabetes specialist nurse and regular text contact, she engaged with the MDT. She now has a continuous glucose monitor, has engaged with mental health services and has greater control over diabetes management. Diabetes practitioners should assess their patients to better understand potential contributors to the disease, and to uncover more about the individual's social environment. In addition to more common screening assessments of depression or anxiety, they should also assess for trauma. National NHS funding was won to implement this model of enhanced care for YA diabetes services, over a two-year period. The pilot phase completes in March 2025 and final reports will be disseminated in summer 2025. Preliminary results include improved health outcomes and patient engagement, with a 93% attendance rate, a 30% reduction in DKA admission numbers and 40% reduction in Length of Stay. Over the past six months 65 patients have completed self-reported Patient Reported Outcome Measures. These show 35% of YA patients are experiencing significant emotional distress due to diabetes, 52% are in the clinical range for depression, with 20% severely depressed. Also 50% of patients screened have identified eating-related distress. Focused support of mental health and emotional issues and promotion of psychological resilience are priorities in the service. Following psychologically informed care by the MDT and individual therapy for more complex patients, reductions in disordered eating and overall diabetes distress, and improvements in mood and well-being are being observed.

USER FEEDBACK

Feedback questionnaires from YA are positive, demonstrating an appreciation of access to specialist support from the full team in the same place, with consistency of staff, including diabetes specialist nurse, consultant, clinical psychologist and dietitian. YA report greater confidence and empowerment relating to diabetes self-care and management. Praise and recognition for the model have come from Sherwood Forest Hospital Trust, Regional Integrated Care Board, NHS England, Diabetes UK, pharmaceutical companies and other NHS Trusts.

DISSEMINATION AND SUSTAINABILITY

The model has been presented at Sherwood Forest Hospital Trust Board, NHS England meetings and Regional Steering Group meetings. The team has also liaised with Diabetes UK and pharmaceutical companies about the service. NHS England has been collecting data since January 2024, with publication of findings due in September 2025. The data will be linked to the National Diabetes Audit and the Secondary Uses Services datasets in order to assess the impact. A YouTube video has been made promoting and disseminating this work. This pilot supports a clear role for an integrated physical health and clinical psychology service as part of routine care for young adult patients with diabetes. With funding beyond the pilot, this can be a model of care to be mirrored across Nottinghamshire and beyond. Protocols are being developed to support rollouts at other sites.

JUDGES' COMMENTS:

"Sherwood Forest Hospital NHS Foundation Trust is a great demonstration of holistic working, which should be happening. It demonstrated impressive reductions in DK and the judges thought it was novel and brilliantly achieved. It is a lovely intervention and imaginative in the way in engaged. It was an excellent, gold standard service and should be easily replicable."

HIGHLY COMMENDED

TYPE 1 SPECIALIST SERVICE

Community large group rollout of hybrid closed loop pump therapy in type 1 diabetes
by University Hospitals of Leicester NHS Trust

SUMMARY

Implementation of the NICE Technology Appraisal (TA) on hybrid closed loop (HCL) pump therapy requires over 1,500 people with type 1 diabetes to start insulin pump therapy over the next five years in the Leicester area. Monthly large group starts have been implemented using two community halls, and 110 patients have commenced HCL pump therapy since December 2023, using the Omnipod 5 pump. Follow-up has been virtual, using Glooko, supported by the local Omnipod peer support group. Every patient has continued HCL pump therapy with no diabetic emergencies, and substantially improved glycaemic parameters.

INNOVATION

The NICE TA on HCL pump therapy requires over 300 new adult insulin pump starts per annum in the Leicester area. This is a 10-fold increase on historic starts over each of the next five years. This could not be achieved with a small-group approach at the Diabetes Outpatient Centre, so following a 10-patient pilot in December 2023, monthly sessions have been run since March 2024, with 10 patients in both the morning and afternoon, using two community halls. Staffing usually includes one pump nurse, one dietitian, one consultant and an Omnipod trainer at each session. Ten new insulin pump patients are trained in the morning, and ten pre-existing pump users are upgraded to HCL in the afternoon. Since August 2024, every patient is a new insulin pump patient, with most pre-existing pump users now upgraded to HCL. Ten community sessions are planned per annum, as well as more smaller groups at the Diabetes Centre. Historically insulin pump starts have happened on Mondays, but the new programme is on Tuesdays and Thursdays, to increase capacity overall. Patients are encouraged to join the Leicester Omnipod peer support group.

EQUALITY, DIVERSITY AND VARIATION

Using two community halls has improved accessibility for both patients and staff, with easy parking at both venues and good road access. The Diabetes Outpatient Centre is at Leicester General Hospital in the east of the city, with one community hall in West Leicester (New Parks) and the other in Market Harborough (15 miles south-east of Leicester). GIRFT Feedback from late 2023 suggested patients from more deprived areas of Leicester had less uptake of continuous glucose monitoring (CGM), hence New Parks was chosen, it being in one of the most deprived areas in England. This venue has had 100% attendance, with 60 patients commencing HCL pump therapy. It is now handling HCL pump starts for patients from Hinckley, Coalville and Charnwood. The Market Harborough hall supports HCL pump starts for patients from Harborough, Oakham and Melton, as well as neighbouring villages. The age range is 17-76 years and young people have attended both venues. The team includes two Adolescent DSNs. Almost half the attendees are aged under 30, including young adults with histories of diabetic ketoacidosis and diabetic microvascular complications, including limited vision. Dexcom G6 sensors have been used on four days, and Libre 2+ sensors on two days. The first use of Omnipod 5 pumps with Libre 2+ CGM worldwide occurred in New Parks in early April 2024. Forty patients are on Libre 2+ sensors, with the other 70 on Dexcom G6 CGM. Virtually all patients have stayed on their initial CGM with Omnipod 5 pumps. Overall the community Omnipod 5 HCL pump starts have been accessible and flexible, with students being incorporated through the summer holidays.

RESULTS

Over each of the next five years, 200 HCL pump starts in a community setting are envisaged. People with type 1 diabetes are commencing HCL pump therapy closer to home, taking less than half a day with no additional face-to-face attendances. Being tubeless, the Omnipod 5 pump removes a barrier to pump therapy for many. A simple controller also improves accessibility, as does the option of several locations for the pump (arms, abdomen and thighs). Importantly, this is a safe and effective means, with no diabetic emergencies and every patient remaining on an Omnipod 5 pump in HCL. Patients continue in their usual clinic, and can join the Omnipod peer support group. The website (podding.co.uk) has additional resources, many patients join the WhatsApp group and some attend the monthly face-to-face meetings. Further peer support groups are planned for other pumps. The first large group Omnipod 5 HCL pump start was in December 2023, with monthly starts for 20 patients per day since early March 2024 in New Parks or Market Harborough. In total, 110 patients have commenced Omnipod 5 HCL pump therapy, with no episodes of either severe hypoglycaemia or diabetic ketoacidosis. This has been achieved with virtual follow-up via Glooko, and no formal additional face-to-face follow-up. Most patients have achieved CGM Time in Range of 65-85% and Time below Range at less than 2%, whether using Dexcom G6 or Libre 2+ CGM. While there has been consistent improvement in glycaemic control, there have been substantial weight differences.

USER FEEDBACK

The community rollout of HCL pump therapy has been appreciated by patients. The only negative feedback has been a couple of patients wanting face-to-face follow-up, and issues with Libre 2+ connectivity. Having all 110 patients successfully commence Omnipod 5 HCL pump therapy is rewarding for the multidisciplinary pump team.

DISSEMINATION AND SUSTAINABILITY

The community pump starts have substantially increased the HCL insulin pump starts, the key components being days later in the week, virtual follow-up and support from an Omnipod Trainer. Patient selection is important, plus the patient having some technical ability. The administration team is also key, ensuring that the Omnipod kit is available, and CGM with either Dexcom G6 or Libre 2+ is organised. Most specialist pump teams could implement this initiative. The Omnipod 5 pump is the easiest device for a community start. Ensuring that patients are linked up to Glooko at the end of the session is crucial, and a local peer support group is important. Regular MDT pump meetings identify the most suitable patients, and those who would benefit from a smaller group start in the Diabetes Outpatient Centre.

JUDGES' COMMENTS:

“The University Hospitals of Leicester NHS Trust's project had impressive results and the community-based clinics were great. It was a really good project, based on a strong model. It stood out and is the way forward.”

WINNER

EQUALITY, DIVERSITY AND HEALTH EQUALITIES

Overcoming inequality in access to diabetes technologies - diabetes intervention worker pilot
by Somerset NHS Foundation Trust

SUMMARY

The Trust had significant inequality in access to diabetes technologies – both insulin pumps and real-time continuous glucose monitors (rtCGM) – as a result of socioeconomic deprivation scored using the Index of Multiple Deprivation (IMD) quintiles. A 'diabetes intervention worker' (DIW) role was piloted, seconded from the Family Intervention Service (FIS), to better understand and address barriers to technology. Interventions included direct work with young people and families, provision of mobile phones, laptops and SIM cards, plus team focus on promoting technologies to all patient groups. These actions resulted in a significant increase in pump and rtCGM use in IMD 1 and 2 (most, and second most, deprived), resolution of inequality in technology use, plus a corresponding reduction in median HbA1c.

INNOVATION

This one-year, NHS England-funded project employed a new staff member in a pilot DIW role, who was dual trained in diabetes technologies and family intervention work (FIS). The aims were for children and young people (CYP) with diabetes in IMD quintiles 1 and 2 to achieve the same use of diabetes technologies as E&W average levels by March 2024, to appropriately support CYP with diabetes to understand and use technologies effectively, to reduce median HbA1c for patients in IMD 1 and 2 by at least 5 mmol/mol, to build CYP and carers' confidence in technology use, plus for the service to learn more about working effectively with families experiencing deprivation. Support was offered in patients' homes or close to home, via telephone or video. There was a holistic approach to the work, supporting families with social needs before focusing on new technologies. Patients in IMD 1 and 2 were identified by their postcodes, and prioritised according to current use of technology and HbA1c as a clinical outcome measure. Initially the focus was on improving use of a dose calculation app, providing more real-time CGM devices (rtCGM) and insulin pump therapy. Local funding changes shifted focus to delivering more pump upgrades to hybrid closed loop (HCL) options and HCL starts. Use of rtCGM, insulin pumps and HCL systems was recorded. HbA1c was recorded at the start and end of the project. The DIW kept records to help understand common themes.

EQUALITY, DIVERSITY AND VARIATION

Some families had low awareness of the technology options available. Teaching in their own homes was effective. Another issue was lack of compatible devices (eg. mobile phone/computer) and costs of data, even where a phone could be provided. The DIW secured charitable donations of 30 rtCGM-compatible mobile phones and five laptops, and 50 free data SIM cards came from a national mobile phone company. Some families thought they had to access training online, or travel (with associated costs). Here, education and training in patients' homes helped. Where online training was essential, the DIW sat alongside patients to build confidence. Some patients needed transport to clinics or technology starts. Some young people anxious about wearable technology were helped by relationship building, home demonstrations and in-person support for the first sensor changes. The DIW worked flexible hours to support families where necessary and shared patients' difficulties with other professionals. Most support was needed with direct, practical help using diabetes technologies. Much of the work could be delivered at lower cost by a band 4 health care assistant trained in diabetes technologies.

RESULTS

The project saw an overall increase in use of technologies, particularly rtCGM and HCL systems, for the whole patient cohort. There was an increase from 12% to 40% of patients in IMD 1 using an insulin pump. The NPDA 2022-23 E&W average was 45.7%. IMD 2-4 also increased pump use, but the changes were smaller. There was no overall change in IMD 5. There was a reduction in inequality gap between IMD 1 and 5 from 38% at project start to 10% at project finish. There was a substantial increase in use of rtCGM in IMD 1-4 during the project, with the largest increases in IMD 1 and 2. At the end, IMD 1 (49%) and IMD 2 (51%) had similar use of these rtCGM devices compared to IMD 3-5 and to NPDA 2022-23 E&W average of 50.4%, showing closure of the inequality gap. HCL therapy was not widely available at the start of the project and, while numbers were small, there was evidence of inequality. The proportion of patients using HCL rose sharply during the project as a result of increased funding from July 2024. This improvement in access to HCL was similar over the five IMD groups. The service is currently a statistical outlier for poorer-than-expected HbA1c outcome measures compared to regional and national outcomes because of staffing difficulties and historical funding restrictions on use of diabetes technologies. One element of the action plan to address this was to improve use of diabetes technologies. Over the project year, median HbA1c reduced by 5 mmol/mol in IMD 1, by 3.5 mmol/mol in IMD 2, and by 4.5 mmol/mol for the whole cohort. The Trust extended the project for three months.

USER FEEDBACK

A survey of users has not been completed, but feedback has been positive.

DISSEMINATION AND SUSTAINABILITY

The results have been presented to the two CYP diabetes teams in the Trust, the Integrated Care Board, a local Health Inequalities Board meeting, plus regional teams at the South West Children and Young People's Diabetes Network meeting. The project showed that there were significant benefits to be gained from a dedicated practitioner offering holistic care, and that there is a case for embedding key areas of learning into local practice. The intention is to review the feasibility of future team roles with flexible hours and increase face-to- face outreach options in service delivery. IMD quintiles will be included in quarterly reviews of data on HbA1c and technology uptake and noted for each patient when planning support. There is an ongoing need for sustainable sources of allied technologies. It would be relatively straightforward for another service to implement a similar initiative, using a healthcare worker with similar remit, or an allied worker with a social care background.

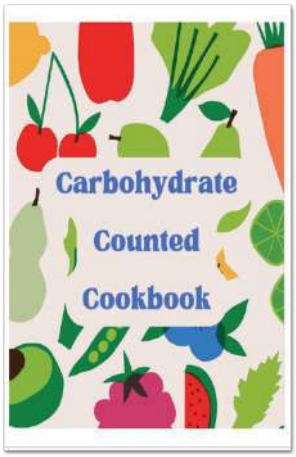
JUDGES' COMMENTS:

"This project by Somerset NHS Foundation Trust was well planned and innovative. The drive and focus and how it was delivered really impressed the judges, and it described the diversity and equality element brilliantly. It demonstrated that you don't have to be a diabetes specialist to support families and had impressive patient stories."

FINALIST

EQUALITY, DIVERSITY AND HEALTH EQUALITIES

Carbohydrate-counted recipe book
by Guy's and St. Thomas NHS Foundation Trust and King's College Hospital



SUMMARY

The dietitians in the paediatric diabetes team were keen to support all families to confidently manage their traditional cultural food. Both of these hospitals are based in central London with large population diversity. Often at diagnosis with diabetes families have requested support with carbohydrate counting for traditional foods. Therefore the dietitians were keen to produce a carbohydrate-counted recipe book using recipes provided by local families. This book is provided to all families within the service and at diagnosis with diabetes. The aim is to support families from all backgrounds with carbohydrate counting.

INNOVATION

The team identified a need for a locally relevant, carbohydrate-counted recipe book for families from various backgrounds. It was noticed that sometimes young people and their families avoided eating traditional foods through fear and lack of support with carbohydrate counting. The dietitians approached all families receiving diabetes care from the team and asked if they would like to share a traditional meal recipe, which would be carbohydrate counted and added to a cookbook. This cookbook would then be shared with all families under the care of the paediatric diabetes teams at the Evelina London (Guy's and St. Thomas' NHS Foundation Trust) and King's College Hospital, London. All young people diagnosed with diabetes would be offered this cookbook, along with support to carbohydrate count any meals they were unsure about. This offer was always available, but it was hoped that this recipe book would reinforce it and ensure families were aware that the dietitians would help with calculations for food from any culture.

EQUALITY, DIVERSITY AND VARIATION

During annual review appointments and reviews soon after diagnosis, it was noticed that many young people were avoiding traditional cultural foods as they were not listed in the carbohydrate counting resources. Often these were foods that the rest of the family continued to enjoy, or the young person enjoyed before diagnosis with diabetes. The families commented that they did not feel it was something that they wanted to bother the busy team with, or they thought that the team may not know the foods they were eating. This feedback resulted in the creation of the cookbook, with familiar foods and ingredients, to be distributed to all the families. The hope was that it would highlight to families the importance the diabetes team placed on supporting children and young people to celebrate their culture and to continue to enjoy these traditional family foods. The cookbook has received positive feedback from all families who have a copy. It was decided that the recipe book should be provided free of charge to all families with diabetes. However, a QR code was included on the book for recipients to make an optional contribution towards the supply of mobile phones for diabetes technology to families who could not afford them.

RESULTS

Feedback from patients has all been positive. The dietitians enjoyed engaging with families in a different way to obtain the recipes and learn more about the foods the families were eating. It has also strengthened relationships between families and the team, particularly the dietitians. It has made conversations around food and eating more open with families and highlighted that the paediatric diabetes team is keen to adapt and support equality and diversity across the patient caseload. This project was not funded, but completed by the dietitians during work hours as part of regular discussions about meals and carbohydrate counting during appointments with families. They also spoke to families before or after appointments with the diabetes team, plus virtually via email. The dietitians analysed the recipes when they had time, or after work. The team had access to Canva software to formulate the recipe book so no additional funding was required. The diabetes and dietetic team used work time to complete the recipe book as the aim was to support families with their diabetes management and to create a useful future resource to continue to support young people and their families. The recipe book was shared with the paediatric diabetes specialist group of the British Dietetic Association (BDA) and has been shared as a national resource so all paediatric diabetes dietitian members can access and share it with young people and families.

USER FEEDBACK

Feedback was positive from families and the dietitians were nominated for an Excellence in Dietetics award from the lead paediatric dietitian.

DISSEMINATION AND SUSTAINABILITY

This cookbook was compiled by the Evelina London and Kings College Hospital Paediatric diabetes teams. It was shared with the adult diabetes team at Guy's and St. Thomas NHS Foundation Trust, as well as nationally via the paediatric diabetes subgroup of the BDA. Other services said that this project had prompted them to create a similar version for their local population. The team who created this cookbook are also keen to make a second edition, with further recipes, in the future. Some families commented that they would have liked to contribute a recipe but were unable to do so for the first volume.

JUDGES' COMMENTS:

"The Carbohydrate Counted Recipe Book" is a cultural family cook book – a great idea! It was great to see the collaboration with families and it seemed to strengthen diabetes support within the family group. Very accessible and can be continually added to, which is a big plus."

WINNER

PATIENT CARE PATHWAY, SECONDARY, PRIMARY, SPECIALIST OR COMMUNITY CARE

Barts Health Young Adult Diabetes (YAD) service
by Barts Health

SUMMARY

Young people with diabetes are a high-risk group with poor clinical outcomes and subject to significant health inequality. A pilot project was implemented to improve engagement and clinical outcomes. This included: a cross-site Young Adult Diabetes (YAD) team to work across all four Barts health sites; a high-risk YAD pathway to find young people not engaging, understand their barriers and address their priorities; peer support and education, plus support for psychosocial factors like housing, financial resources and mental health.

INNOVATION

As part of an NHSE-funded pilot, Barts Health set out to deliver equitable care across all four sites and develop a cost-effective service to improve clinical outcomes. A mobile, cross-site YAD team was set up, comprising a diabetes nurse, dietitian, psychologist, youth worker and social prescriber. Baseline data demonstrated that 40% of the cohort was high risk (recurrent DNAs, frequent DKA admissions, homeless, learning disabilities, mental health, HbA1c over 100mmol/mol). Feedback from young people in the service and the paediatric diabetes teams led to the creation of a high-risk pathway to improve engagement and reduce DNAs, a robust transition process from paediatric to adult care, joint appointments with the paediatrics and YAD team, close working with community services to deliver healthcare and education outside the hospital in youth centres and cafes, maximising the impact of each clinical appointment, plus promoting self-management and independence.

EQUALITY, DIVERSITY AND VARIATION

This project delivered equitable YAD services across all the sites through the cross-site YAD team and implementing the initiative for young people in Tower Hamlets, Newham, Waltham Forest and Redbridge. The high-risk pathway allows understanding of the individual needs of young people and having a psychologist, social prescriber and youth workers in the team directly addresses the challenging psychosocial factors that stop them accessing care. Meaningful contact has been achieved with 68% of them. Staff in three day centres have been trained to offer better support. In the low-risk cohort, care has been streamlined and treatment enhanced using diabetes technology, resulting in an HbA1c improvement from 71.5mmol/mol to 67.9mmol/mol in people with T1D and a reduction in HbA1c from 67.7mmol/mol to 62.1mmol/mol in people with T2D.

RESULTS

The high-risk pathway helps understand the needs of individual patients and cater to them. MDT appointments can fast-track patients on to technology, with pump assessments offered straight after the clinic appointment. The initiatives have supported young people with diabetes by addressing their priorities first. This has built their trust with the team and given them the time and space to start thinking about, and working on, diabetes management. The initiatives encourage independence, improved diabetes education and knowledge and promote and encourage the use of diabetes technology. Baseline data from April 2022-April 2023 and outcome data from April 2023-April 2024 from two sites have shown an increase in the number of young people being seen in the service. There are now 156 people with T1D across the two services compared to 109 at end of December 2022 and 46 people with T2D, compared with 26 a year before. Clinic DNA rates have reduced from 39% to 12% and the number of clinic appointments per month has risen. There has been a reduction in average HbA1c for people with T1D from 71.5mmol/mol to 67.9mmol/mol and a reduction in HbA1c for people with T2D from 67.7mmol/mol to 62.1mmol/mol. Meaningful contact has been made with 33 of the 44 individuals who were not previously accessing healthcare services. Findings from all four sites showed: 30% of the cohort had completed structured education compared with only 10% at the end of December 2022; a 36% reduction in the number of hospital admissions with DKA across the three Barts Health sites at Whipps Cross, Newham and Royal London; 20 were helped into safe housing, 15 into employment and 28 receive financial benefits; the service is cost effective, saving the trust £62,597 per year in direct costs.

USER FEEDBACK

Feedback is collected by anonymous post-clinic questionnaires, a scrap book for young people to write in after peer support/education sessions, written and video testimonials, invitations to contribute to away days, plus informally in person.

DISSEMINATION AND SUSTAINABILITY

This project included the four Barts Health sites and was a proof-of-concept project aimed at expanding across the whole of North East London. MDT appointments minimise time away from university or work and allow young people to start newer diabetes technologies faster. Recognising that diabetes is not always the patient's priority and that poor engagement is usually a symptom of bigger psychosocial problems allows more compassionate care delivery. Having a social prescriber, youth workers and psychologist embedded in the service to address the patient's priorities, like mental health, financial concerns or homelessness, allows the young person to feel listened to and supported. This helps them to trust the service, giving them more time and space to think about their health. Bringing together secondary care, primary care, social workers and mental health is a useful way of making sure everyone involved in a young person's care is part of the discussion. It is an effective way of communicating between professionals and aligning care, making sure the specific needs of the young person are met. Peer support is used to disseminate education, build independence, discuss mental health and build networks for these young people. It has helped some of them to feel more confident and secure with the service and their diabetes, plus allowed the team to hear their voices and connect better. This project has demonstrated financial viability. Provided that the NHS trust/ICS agree to fund a YAD team, the implementation of this service in other diabetes teams across the UK would be straightforward and much more efficient. These interventions could be implemented across other specialities as the focus is on engagement and personalisation of care.

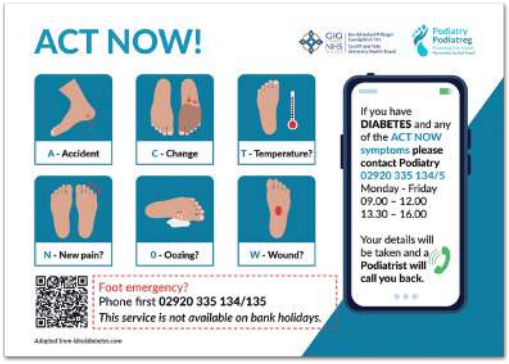
JUDGES' COMMENTS:

"Barts Health Young Adult Diabetes Service' is an impactful initiative targeting a hard-to-reach group with a large number of different demographics. The person-centred approach stood out to the panel, as well as the social prescribing element. The service directly addressed health inequalities and the clinical outcomes were impressive, even in the programme's early stages. There was clear evidence of support from service users, and a demonstrable cost benefit. An excellent project with a model that could be applied to other long-term conditions."

FINALIST

PATIENT CARE PATHWAY, SECONDARY, PRIMARY, SPECIALIST OR COMMUNITY CARE

Diabetic Foot emergency early triage service (DFEET)
by Cardiff and Vale UHB Podiatry



SUMMARY

In 2018 Cardiff and Vale (CAV) UHB introduced a 'walk-in clinic' (WIC) for patients with diabetes and a foot emergency. This service, while successful, needed to adapt to meet the demands of the health service. A pilot 'phone first' diabetic foot emergency early triage (DFEET) service was trialled, where patients living with diabetes with a foot emergency could contact the department, speak to a triaging podiatrist and be offered advice and an appropriate appointment. The service is a 'one-stop shop', with access to interventions such as X-rays, microbiological sampling, independent prescribing and MDT access.

INNOVATION

The 2018 WIC ran twice weekly but, despite increasing to three times a week, its format did not meet current demand and was unsustainable. The aim was to enhance and expand the offering of urgent care by changing to a community-based, 'phone first' DFEET system offering virtual consultations with a triaging podiatrist and appropriate appointments. The service also provided a 'one-stop shop' with access to investigations such as X-rays, microbiological sampling and phlebotomy, plus timely access to antibiotics using patient group directives and independent prescribing. The plan was to reduce the numbers of patients waiting longer than three days for their first expert assessment by 20% within the project cycle, to prevent inappropriate A&E attendance and GP contact for diabetic foot-related emergencies and, longer term, to offer phone-first contact to all patients with foot wounds. Using a PDSA approach, a pilot service commenced one day a week, running alongside WIC for six months prior to moving to DFEET four days a week. Co-design with stakeholders was central and a focus group was held with patients to capture views on the changeover.

EQUALITY, DIVERSITY AND VARIATION

DFEET supported the Equality and Diversity Act (2010) and the NHS equality, diversity and inclusion improvement plan. DFEET also aligned with the Podiatry Strategy 2022-2024 with the incentive to promote equality in health and well-being for all by targeting health inequalities. It also supported the Well-being of Future Generations (Wales) Act, contributing to the cultural well-being goal by increasing the number of Welsh speakers to allow patients to interact in their chosen language. It utilised the Wales Interpretation and Translation Service to provide linguistic services to provide improved quality and safety in interpretation and translation for all cultures in face-to-face appointments. ACT Now leaflets designed by the podiatry service were developed with equality and diversity in mind, with cultural appropriation in the images. Embracing technology and digital communications for triage freed clinical locations and appointments in face-to-face clinics closer to home. Future ambitions include expanding the phone first service to a five-day working week for all pathologies, not just the diabetic foot. A business case will be submitted to ensure funding and clinical capacity to initiate this expansion. DFEET was provided to all, regardless of age, gender reassignment, disability, race, religion, sex and sexual orientation.

RESULTS

In total, 320 patients were reviewed by the DFEET service in a seven-month period between July 2023 and January 2024. A total of 93.4% (n=299) patients were seen within three days of referral, with 6.6% (n=21) waiting longer than three days. This was a 30.4% reduction in the number of patients waiting longer than three days, compared with NDFA data from 2021-2022. In terms of clinical outcomes, 115 patients had a new active foot ulcer, 47.7% (n=52) of whom were alive and ulcer-free at 12 weeks. A total of 24.8% (n=27) had an unhealed ulcer, 0.9% deceased (n=1), 26.6% (n=29) were lost to follow up or no outcome was recorded. The average healing rates of all ulcerations nationally is 26% and DFEET recorded a 50% healing rate. In terms of reducing A&E and primary care appointments, 59% (n=240) of patients who attended a DFEET clinic stated they would have attended a GP appointment if DFEET did not exist and 5% (n=21) stated they would have attended A&E. Of 324 patients attending the DFEET service, 115 attended a GP appointment first and were then referred to DFEET. This cost the NHS two separate appointments for the same pathology. DFEET wants to eliminate duplicate appointments and offer a one-stop shop. Of the 324 patients, 74 were seen by the practice nurse before referral to DFEET. Only six patients attended A&E before being referred to DFEET. Considering the costs of patients attending primary care services prior to, or instead of, the DFEET service, DFEET saved £14,177 a year.

USER FEEDBACK

Out of all responses from GP surgeries, 55% reported that they had used the new DFEET system and were positive about the initiative. However, only 36% of ACT Now DFEET posters were advertised in waiting rooms. Rating the service from 1-5, the average mean rating was 4. Feedback from primary care services acted as a motivational tool for all DFEET staff to believe in and support the project. This feedback was delivered to healthcare staff to applaud their clinical performance over the seven months. A patient experience questionnaire was used in person to allow patients to consent, understand and digitally complete the survey. Paper copies were provided for those who were not literate in digital technology. The form was devised to collect data throughout the DFEET journey.

DISSEMINATION AND SUSTAINABILITY

One of the aspirations of the project was to promote sustainability with digital technologies to support appropriate use of high-risk clinics. This redirection and reduction of interventions with the highest skilled members of the podiatry team and duplication within the podiatry service helped to reduce delays in appropriate care, variation and waste. Despite data signalling a reduction in GP and A&E visits, further work is needed in primary care to ensure that patients present at the earliest convenience. Cost-benefit analysis showed DFEET will decrease money spent on diabetic foot ulcers in primary care. Incorporating virtual technology was an integral asset in the DFEET clinic. Use of virtual consultations for effective triage reduced the need for expert assessment in DFEET by 31%.

JUDGES' COMMENTS:

"Diabetic Foot emergency early triage service (DFEET)' is an important programme that has had a great impact on patient care. The need, context, aims and objectives were all clearly identified, and the cost savings were well demonstrated. The results were brilliant and the user feedback was really positive. An excellent project that should be widely disseminated."

COMMENDED

PATIENT CARE PATHWAY, SECONDARY, PRIMARY, SPECIALIST OR COMMUNITY CARE

Waiting Well Diabetes: a novel, dietetic-led approach to pre-surgical diabetes optimisation

by Collaboration between North East and North Cumbria (NENC) ICS, Newcastle upon Tyne Hospitals NHS Foundation Trust, Northumbria Healthcare NHS Foundation Trust

SUMMARY

Uncontrolled diabetes is the main reason surgical operations are postponed. Surgery is delayed for considerable periods, often without optimisation services in place, placing strain on primary and secondary care services. Patients often end up on increasing numbers of medications without underlying issues being addressed. This new intervention combined specialist dietetic support with new technologies to allow patients to optimise their diabetes with feedback loops to the hospital teams, reducing workload and leading to better surgical outcomes and longer-term health.

INNOVATION

The diabetes optimisation pathway prior to this project was ineffective, often involving escalation in diabetes medications over months and multiple primary care appointments. Patients often returned for a repeat pre-assessment (PAC) review without sufficient reduction in their HbA1c for surgery to proceed. In May 2023 diabetes dietitians devised a one-year pilot service for patients in the most deprived areas across the North ICP area (Newcastle, Northumbria and Gateshead NHS Trusts) to improve the optimisation pathway and clinical outcomes. It ran between June 2023 and June 2024 and was integrated into the pre-assessment processes for two large NHS Trusts. Eligible patients with HbA1c over 69mmol/mol were referred directly to the service. This Waiting Well Diabetes programme comprised diabetes education alongside funded flash glucose monitoring. Service users were supported to interpret sensor data and make changes to achieve the NCPOC perioperative glycaemic targets. Once optimised, results were sent to the surgical team to advise readiness for surgery. Service users were supported until their surgery date and followed up afterwards before discharge. Pre-identified outcomes included numbers of referrals, patient uptake, numbers optimised and having had surgery, time to optimisation, and change in HbA1c, medication use, and Diabetes Distress.

EQUALITY, DIVERSITY AND VARIATION

This intervention was commissioned for adults with any type of diabetes meeting the following criteria: listed for non-emergency elective surgery; HbA1c ≥ 69mmol/mol; primarily Index of Multiple Deprivation (IMD) decile 1 or 2 (most deprived). Interviews with 10 people who met these criteria informed the service design. Interviewees expressed a preference for glucose sensor technology. Support for those not proficient with smartphones/apps was also needed. To address potential financial barriers, sensors and other patient resources were costed into service provision. During the initial optimisation period, patients were provided with two glucose sensors and a Carbs & Cals book. Another sensor was provided two weeks prior to surgery, enabling all patients to access the technology for a defined period and find out what factors impacted their blood glucose levels. A5X devices were supplied to those without smartphones and more basic readers for those without home wi-fi access or who did not use mobile apps. Flexible delivery included weekly clinics at NHS sites in the target areas, home visits and telephone follow-up support. A structured, six-week group programme held in community venues facilitated peer support and more time-efficient programme delivery. Referrals to a local hub for support or onward referral for wider psychosocial factors were available. Two people living with type 1 diabetes and dyslexia were supported with carbohydrate counting education using visual resources.

RESULTS

During the first year, 149 referrals were received, of which 137 were eligible (92%). Five people declined to participate. Complete data is available for 57 of the 58 patients who had planned surgery by end of June 2024. Average age at referral was 61±11.4 years, 58% male, 91% White British. Regarding types of diabetes, eight (14%) were type 1, 47 (82%) were type 2 and two (4%) were type 3c. A total of 42 (74%) were on insulin at referral. In terms of deprivation, 65% were from IMD deciles 1 and 2. The median (IQR) duration of dietetic support provided was 8(6) weeks, with 81% having one-to-one appointments. For this intervention, optimisation is defined as achieving HbA1c less than 69mmol/mol as per Perioperative Society guidelines. As HbA1c takes three months to reflect improved glucose levels, sensor GMI (estimated HbA1c) was used for end-of-intervention values, based on two weeks of data with sensor use ≥70% to provide a validated HbA1c estimate. Mean ± sd HbA1c at referral was 89±19 mmol/mol (median [IQR]: 84[19]mmol/mol); mean GMI (end of intervention) was 58±11mmol/mol (median [IQR]: 56[11]mmol/mol); mean HbA1c reduction (referral to end of intervention): 32±19mmol/mol (median[IQR] reduction: 29[18]mmol/mol). A total of 95% of patients (54/57) achieved optimisation. Although three did not reach optimisation before their surgery, they achieved clinically significant HbA1c reductions (120 down to 76mmol/mol, 88 to 75mmol/mol and 154 to 123mmol/mol, respectively). No adverse events or increase in hypoglycaemia were observed. To maximise outcomes with a limited period of sensor use, education around dietary impact on glycaemia and guidance around portions was provided prior to first sensor application. Individualised dietary counselling was provided. To achieve the improvements in glycaemia outlined, non-insulin medication changes were required for patients with Type 2 diabetes. Of 42 patients on insulin, the net change in TDD was a reduction of 388 units/day (141,629 units/year), saving 472 insulin Flexpens.

USER FEEDBACK

Feedback was positive, with constructive criticism actively encouraged and acted upon.

DISSEMINATION AND SUSTAINABILITY

Waiting Well Diabetes is an ICP-wide service based in Newcastle Hospitals Trust (NUTH). It is a collaboration between NECS (North East Commissioning Support), NUTH and Northumbria NHS Trusts, with Gateshead joining soon. The initiative links with specialist diabetes teams and GP practices, and refers on to community teams for holistic patient support. The project is part of an NENC ICS-wide Waiting Well pilot across the North-East region, with inequalities funding that has been extended for another year. It has been shortlisted as a finalist in the Trust's Celebrating Excellence Awards 2024. The initiative has been shared at meetings and outcomes published in a peer-reviewed journal. The business case for permanency proposes making the service available to all patients with diabetes awaiting surgery. Funding is approved for a 0.6wte Band 3 Dietetic Support worker to support the total 1.5wte diabetes dietitians delivering the service. The Band 8a dietitian has received approval for supplementary prescribing to reduce waiting time/additional HCP appointments. An online version of the programme is planned.

JUDGES' COMMENTS:

"Waiting Well Diabetes: A novel, dietetic-led approach to pre-surgical diabetes optimisation' has created a simple but highly effective intervention addressing many aspects of diabetes care. The judges thought the approach was innovative, and liked that the team addressed diabetes distress, as well as types 2 and 3c. The impact of the programme was well evidenced, with great testimonials from patients and healthcare professionals. An excellent piece of work with impressive data outcomes."

COMMENDED

PATIENT CARE PATHWAY, SECONDARY, PRIMARY, SPECIALIST OR COMMUNITY CARE

Diabetes and frailty; creating holistic care using an MDT approach to integrate primary, community and specialist care

by Joint project between the Community Frailty Team from the Jean Bishop Integrated Care Centre and Community Nursing services within the City Health Care Partnership CIC, and the Diabetes Department of the Hull University Teaching Hospitals NHS Trust

SUMMARY

Diabetes, frailty and community nurse services in Hull collaborated to establish a diabetes frailty MDT based in the Jean Bishop Integrated Care Centre (JBICC). The MDT provides access to specialist advice for hard-to-reach service users without hospital visits. Thematic study data and stakeholder feedback indicate that transfer of skills and knowledge between services has changed the nature of referrals into the MDT and improved access to continuous glucose monitoring (CGM). Learnings from the diabetes frailty MDT have informed the development of other speciality MDT meetings at the JBICC.

INNOVATION

The establishment of the JBICC in Hull in 2018 provided opportunities to rethink care pathways for frail people with diabetes. In 2019 the frailty team invited the diabetes team to set up a joint MDT meeting. In 2022 the community nursing services joined the MDT. The 2019 objective was to facilitate an integrated approach to the management of diabetes in frailty, identifying patients through a comprehensive geriatric assessment process. The number of cases discussed increased from six within two hours to 14 within three hours. The core team is: an advanced nurse practitioner and MDT co-ordinator (frailty); diabetes specialist nurse and consultant (diabetes); community nurse and professional lead for community nursing. Meetings are held in the JBICC. During the COVID-19 pandemic meetings were held virtually and further referrals came from Yorkshire Ambulance Service, primary care network MDT, podiatry and diabetes inpatient team. A referral template was developed on SystmOne. Conclusions are documented and communicated to the GP by SystmOne task if medication changes are required. Referrals are made to other professionals electronically. Care for those with frailty and diabetes is focused on practical issues and quality of life, so evaluation is qualitative. Evaluation suggests that initial objectives have been realised, together with additional benefits, such as increasing access to technology, and transfer of knowledge and skills between teams. In 2023 a pathway was initiated for people with impaired mental capacity and intermittently declined insulin injections. There are other frailty hubs but it is believed that none has MDTs to enhance access to specialist care without bringing people to hospital. As many individuals are housebound or in care homes, the frailty team performs comprehensive geriatric assessments in these locations.

EQUALITY, DIVERSITY AND VARIATION

The former Hull CCG area served by the MDT has a high level of urban deprivation, and the frail diabetes population is diverse, with individual needs. The MDT addresses these needs, having social workers with access to sensory teams, specialist mental health nurses and a GP with specialism in older people's mental health. Equality of access is addressed by frailty team outreach. This proactive approach has expanded to the deprived coastal areas of East Riding, which have significant health inequalities. Risk stratification tools identify patients at risk of frailty and GPs refer them proactively. Patients are also referred by other health or social care practitioners, including the ambulance service, emergency department and fire service. The JBICC is in one of the most deprived postcodes in England. Free parking on site and hospital transport have improved access and reduced 'did not attend' rates compared to older people's medicine clinics based at the acute hospital sites. The JBICC core MDT includes geriatricians, GPs with extended roles in frailty, advanced nurse practitioners, mental health nurses, physiotherapists, occupational therapists, social workers, carers' supporters, pharmacists and pharmacy technicians, chaplains, specialist paramedics, clinical support workers and non-clinical coordinators. Other enhanced MDTs have been established following the success of the diabetes frailty MDT, including frailty and Parkinsons, COPD, dementia and heart failure. Ethnic diversity is relatively low in Hull but is rising, with 16.1%of people (2021 census) identifying as BAME (including white non-British), compared with 25% nationally. Translation facilities are available at the JBICC and Allam Diabetes Centre.

RESULTS

The electronic records for the last 100 people referred to the MDT were reviewed as part of a service evaluation. The median age was 78 years (range 53-96) and the median Rockford frailty score was 6 (range 4-7). There were 59 females and 41 males. Following a thematic analysis of issues discussed by the MDT, codes were created for each theme. The subsequent coding of each MDT discussion used the electronic records of the diabetes team, the frailty team, and the community nursing team, all on SystmOne, including a template for MDT outcomes. A total of 169 codes were recorded. The most frequent themes were: hyperglycamia (25) or elevated haemoglobin A1c (15), indicating that high glucose levels remain the most common source of referral; cognitive/memory/capacity issues (25), including declining medication associated with capacity issues (9) and fluctuating capacity (6); consideration for comprehensive geriatric assement (23); consideration for CGM (23); advice on appropiatiate target level of haemoglobin A1c for an individual (15); deprescibing (11), and intensification of treatment (11).

USER FEEDBACK

Staff and patient experiences have been overwhelmingly positive. Staff retention rates and recruitment levels are high, in a traditionally hard-to-recruit region and discipline. Patient experience has been independently evaluated by the University of Hull through a non-randomised controlled trial, which demonstrated sustained improvements in patient-reported physical and psychological well-being.

DISSEMINATION AND SUSTAINABILITY

Three services from two NHS organisations in Hull partnered on this project. The Humber and North Yorkshire Integrated Care Board Diabetes Steering Group is an interested stakeholder. The flow of referrals is now as much from the diabetes team identifying people with increasing frailty warranting a comprehensive geriatric assessment, as from the frail team requiring advice on diabetes management. The increase in referrals for CGM is noteworthy. The development of this service was made easier by a purpose-built integrated care centre, but no additional resource was used. Integration of specialities is as important as vertical integration between specialist and primary care. The increasing proportion of people identifying as BAME will increasingly impact on frailty services. Diabetes and community nursing teams need to increase the use of appropriate technology and support more carers to give insulin injections. However, the MDT approach is the best way to confront these challenges.

JUDGES' COMMENTS:

"Diabetes and Frailty' has designed an innovative and sustainable service that addresses a major issue in a hard-to-reach population. The panel liked the all-encompassing approach taken by the team, as well as the cross-fertilisation of knowledge. The need was clearly identified and the user feedback was excellent. A really strong entry."

COMMENDED

PATIENT CARE PATHWAY, SECONDARY, PRIMARY, SPECIALIST OR COMMUNITY CARE

A novel approach to preoperative diabetes optimisation in cardiac surgery to improve HbA1c and reduce length of stay in hospital

by Royal Brompton and Harefield Hospitals/Guy's and St Thomas' NHS Trust


An innovative pharmacist led diabetes pre-operative optimisation service to optimise glycaemic control and macrovascular risk prior to cardiac surgery

SUMMARY

Cardiac surgery outcomes are worse in patients with poorly controlled diabetes and an elevated HbA1c. Surgery may also be cancelled or delayed. This study assessed the effectiveness of a pharmacist-led diabetes pre-operative optimisation service (DPOS) in reducing HbA1c and enhancing cardiovascular optimisation prior to cardiac surgery. Patient consultations focused on a holistic approach to diabetes management in the context of impending surgery. Results demonstrated improved HbA1c and subsequent reduction in hospital length of stay. Interventions also resulted in improved cholesterol and hypertension management plus provision of lifestyle and dietary advice associated with improved long-term cardiovascular health.

INNOVATION

The challenge was to optimise diabetes care preoperatively to improve surgical outcomes and reduce hospital stays via a DPOS at the Royal Brompton & Harefield NHS Foundation Trust. The DPOS clinic took a holistic, multidisciplinary approach, surpassing traditional face-to-face consultations by integrating interventions tailored to each patient's needs. Key innovations included holistic diabetes management, multidisciplinary collaboration, motivational interviewing and patient empowerment, flexible consultation formats, strategic governance and oversight, reduction of HbA1c levels, plus optimising blood pressure and cholesterol levels, with effectiveness measured using demographics, initial health status, interventions and outcomes.

EQUALITY, DIVERSITY AND VARIATION

The initiative aimed to ensure equitable access, appropriate interventions and improved outcomes for all patients, regardless of background. The DPOS clinic offered flexible appointment options, including virtual consultations, to accommodate patients' varying schedules and locations. Translation services and multilingual staff were employed to assist non-English speaking patients. Interventions were tailored to individual patients' cultural, social and economic contexts. For example, dietary advice was adapted to include culturally appropriate food choices. Motivational interviewing techniques engaged patients in managing their health, considering their personal beliefs and circumstances. Staff received training in cultural competence. Outreach programmes were developed to educate communities about the importance of preoperative diabetes management and the services available. By offering virtual consultations and translation services, the clinic increased access for patients who previously faced geographical and language barriers. Customised care plans led to better engagement and adherence to preoperative optimisation protocols among patients from minority backgrounds. Patients reported feeling understood and respected. The clinic observed a reduction in HbA1c levels across all patient groups, indicating effective diabetes management. Length of hospital stay and post-operative complication rates showed a consistent decline, particularly among minority groups. Patient satisfaction surveys indicated high levels of satisfaction with the personalised and respectful care received.

RESULTS

The DPOS demonstrated significant improvements in clinical outcomes over six months. HbA1c levels saw an average reduction of 16.7%. Baseline HbA1c levels were compared to levels just before surgery, demonstrating substantial improvement in glycaemic control. The average length of preoperative and postoperative hospital stays was reduced. Preoperative stays were shortened to 0-5 days for 95% of clinic patients compared to 81% of non-clinic patients. Postoperative stays also saw a significant reduction, indicating faster recovery times and fewer complications. There was a decrease in postoperative complications, such as infections and wound healing issues, directly correlating with better preoperative diabetes management. Tailoring care to individual patient needs resulted in improved patient satisfaction and adherence to treatment protocols. Through motivational interviewing and continuous support, patients were more engaged and proactive in managing their diabetes. Shorter hospital stays reduced the strain on hospital resources, allowing better allocation of beds and reducing risk of hospital-acquired infections. Virtual consultations increased accessibility and reduced the need for in-person visits, saving time for both patients and healthcare providers. The comprehensive approach addressed not just blood glucose levels but also blood pressure, cholesterol, diet, exercise, smoking cessation and alcohol reduction. Multidisciplinary collaboration ensured cohesive and comprehensive care. Regular follow-ups and continuous monitoring helped maintain patient progress and quickly address any issues. The project was funded through a combination of internal NHS resources and potential grants aimed at improving patient care and outcomes. It proved cost effective and economically viable.

USER FEEDBACK

The initiative garnered significant support from stakeholders, including healthcare professionals and service users. Based on feedback, the clinic introduced more flexible scheduling options with 30-minute appointments. Patients could choose how they were reviewed. The frequency of follow-up consultations was adjusted to ensure patients received adequate support, particularly during critical pre-operative periods. Improved educational materials were developed to provide clearer guidance on managing diabetes and preparing for surgery.

DISSEMINATION AND SUSTAINABILITY

The project has garnered interest from other healthcare organisations, suggesting potential for wider adoption and influence across the NHS and possibly beyond. The success of virtual consultations highlights the potential for further expanding telehealth services. Increasing the availability of virtual follow-ups and remote monitoring tools and digital tools can enhance patient convenience and continuity of care. Developing more comprehensive educational resources, including online tutorials and interactive platforms, can provide ongoing support and information to patients. This can help maintain engagement and adherence to care plans beyond the preoperative period. Extending outreach programmes to educate broader communities about the importance of diabetes management and preoperative optimisation can increase awareness and uptake of such services. Collaborations with local organisations and primary care providers can support this effort. Utilising data collected from patient outcomes and feedback can continuously refine and improve the service. Implementing advanced data analytics can help identify trends, predict outcomes and tailor interventions more effectively. The DPOS initiative's framework makes it relatively straightforward for other healthcare services to implement.

JUDGES' COMMENTS:

"Royal Brompton and Harefield Hospitals/Guy's and St Thomas' NHS Trust has produced an excellent programme that positively impacted patient care. The entry itself was concise and particularly well written. The need was clearly identified, the objectives and measurement tools were considered, and the areas of improvement were highlighted, which the judges appreciated. The team used feedback and different approaches to drive further improvements. A sustainable initiative that ticked all the boxes."

HIGHLY COMMENDED

PATIENT CARE PATHWAY, SECONDARY, PRIMARY, SPECIALIST OR COMMUNITY CARE

HELENA (northEast London prEconception iN diabetes) project

by North-East London Integrated Care Board

SUMMARY

Many women with type 2 diabetes in North-East London (NEL) are not well-prepared for pregnancy. The HELENA (northEast London prEconception iN diabetes) project was established to address this need, led by a multi-disciplinary group, including diabetologists, GPs, practice nurses and commissioners. A standardised annual review template for preconception across NEL and a practice-level monthly dashboard were launched on EMIS, with primary care network-focused MDTs. A desktop primary care guide, leaflets for women, primary care education sessions, patient webpage/webinars, an ad campaign, standard GP text/letters and a local incentive scheme (LIS) to increase folic acid prescription were also introduced.

INNOVATION

In 2017 a core NEL Sustainability and Transformation Partnership preconception workstream was formed to launch the HELENA project. The team engaged with public health, sexual health and family medicine, community pharmacy and the NEL Business Intelligence Unit, North of England Care System Support (NECS), the Clinical Effectiveness Group, Diabetes UK, a private advertising/marketing company and the NEL Maternal Medicine network. NEL has a large population of women of childbearing age with type 2 diabetes so onward referral to a secondary care preconception clinic was unlikely to be feasible or effective. In phase 1 (2017-2019) a NEL-wide preconception template was designed for use during the primary care annual review. It worked with EMIS, SystmOne and Vision and contained SNOMED coded options and hyperlinks to information for healthcare professionals (HCPs). This facilitated a monthly, practice-level NEL-wide dashboard focused on: folic acid prescription; HbA1c ≤48 mmol/mol; HbA1c ≥83 mmol/mol, plus ACE inhibitor/statin prescription in women not known to be using contraception. Education sessions were run for GPs and practice nurses to raise awareness of preconception, referral pathways and template training. Phase 2 (2020-2021) involved virtual MDTs with local primary care teams at borough level where practice-level dashboards were discussed. Phase 3 (2021-2023) focused on raising awareness among women with diabetes. A preconception webinar was run with Diabetes UK and adverts were placed on billboards at supermarkets and bus shelters. A preconception leaflet was designed to accompany retinal screening letters and for use in GP waiting rooms. A desktop primary care guide for HCPs, GP practice and pharmacy posters, plus a standard text and letter for practices to send to women were created. A LIS was launched to increase folic acid prescription by 10% in Barking, Havering and Redbridge.

EQUALITY, DIVERSITY AND VARIATION

More than half (53%) of the population in NEL is Black, Asian or Mixed ethnicity. Across NEL, approximately 489,000 (24%) people live in areas ranked the most deprived 20% in the country. A quarter speak a language other than English as their main language, with Bengali (4%), Urdu (2%) and Turkish (2%) the most prevalent. The HELENA project leaflets sent to women were published in 11 languages and supported by Diabetes UK's Engaging Communities team. A 'Diabetes and Planning a Pregnancy' webinar was held in January 2022, supported by Diabetes UK, with 215 women registered and 86 attending the live event. The advertising posters were located in areas in Tower Hamlets with the largest expected footfall of target demographic population, namely Bengali women of childbearing age. The Mile End Hospital preconception clinic provided a Bengali link worker for consultations, and education sessions were offered in English and Bengali. The Royal London Hospital offered English and Bengali dietary education and had a Bengali advocate on site.

RESULTS

The standardised template is now part of the routine annual review. The practice-level dashboard is effective at monitoring key outcomes. Phases 1 and 2 were successful in establishing the template, dashboard and the borough-level MDTs. These interventions raised HCPs' awareness of the importance of preparing for pregnancy in women with diabetes. Phase 3 determined the impact of the awareness campaign through post-marketing analysis and the outcome dashboard. The two adverts ran in digitally rotating billboards in 40 Tower Hamlets locations. Analysis showed that over three months, these reached 1,144,024 individuals and were seen between 2.2 and 5 times per individual. The patient webpage was viewed via the QR code on the advert 12-91 times per day. Preconception advice doubled from a median of 6% of annual reviews in April 2022 to a median 12% in January 2023 in Tower Hamlets GP practices. Data for 83 women with type 1 diabetes attending their booking appointment at the Royal London Hospital showed an improvement in pregnancy preparation, with 33.3% of women achieving HbA1c <48mmol/mol in the first trimester in 2018-2022, compared to 17.6% in 2014-2017. Folic acid usage prior to pregnancy increased from 60% in 2014-2017 to 62.5% in 2018-2022. In Barking, Havering and Redbridge the LIS on folic acid prescription in women with diabetes showed prescriptions increased from a median 16% to a median 21%. Preconception advice increased from median 2.2% in 2021-2022 to median 29% in 2023-2024.

USER FEEDBACK

The project was supported enthusiastically by all stakeholders. The borough MDTs were well attended by primary care clinicians and commissioners. The primary care template was adapted to be shorter following feedback and practice nurses encouraged to signpost to other resources or refer for more detailed medical consultations with their GP or in the preconception clinic. Women were also referred to the community diabetes team for tightening of glycaemic control. The desktop Primary Care Guide was co-designed with primary care clinicians and incorporated key facts for consultations, based on their requirements.

DISSEMINATION AND SUSTAINABILITY

The HELENA project successfully embedded preconception advice into the primary care diabetes annual review and resulted in increased folic acid prescription. The incentive scheme in the pilot BHR area increased preconception advice and folic acid prescription, and rollout to the other NEL boroughs is planned. Women with type 1 diabetes were better prepared for pregnancy (2018-2022). Initial proposals presented at the Diabetes UK Diabetes and Pregnancy Conference in 2019 received significant interest and requests to share the template. The preconception template and local dashboard would be replicable in all UK health systems. Local incentive schemes could be utilised to increase preconception advice and folic acid prescription.

JUDGES' COMMENTS:

North-East London Integrated Care Board have created an important and well-executed programme aimed at a patient population that can be difficult to engage with. The project was a great example of collaborative working and its impact was well demonstrated, with positive user feedback and impressive advert reach. It was sustainable, replicable and could have a huge impact if rolled out widely. A brilliant programme that every surgery should have.

FINALIST

PATIENT CARE PATHWAY, SECONDARY, PRIMARY, SPECIALIST OR COMMUNITY CARE

Spotlight-AQ
by Spotlight Consultations Ltd

SUMMARY

Spotlight-AQ sets out to transform diabetes healthcare delivery, replacing ineffective, inefficient appointments with routine visits that focus on physical, mental and social well-being. Deliverable by any healthcare professional (HCP), in any setting, with any person with diabetes (PWD), Spotlight-AQ is designed to fit seamlessly within existing workflows and is time- and cost-saving. It results in significantly improved glycaemia and quality of life for PWD and increased efficiency and reduced burnout for HCPs. It sends a short, holistic questionnaire to each patient before a routine visit, with immediate results mapped to evidence-based resources supported by HCP discussion.

INNOVATION

Spotlight-AQ is a cloud-based clinical tool that addresses physical, mental and social aspects of diabetes management in every visit. It sends a brief, pre-clinic questionnaire to each patient up to a week before a routine visit. The AI algorithm adapts to each individual, identifying patient-identified concerns across psychological burden, social environment, therapy and skills gaps. It presents this complex information immediately in an easy-to-understand format for discussion at the visit. This tool identifies behavioural influencers and drivers that aid or obstruct self-management and maps safe, evidence-based resources to each identified need. This personalised approach enables HCPs to better understand patients' individual needs. Spotlight-AQ has been proven to reduce visit length, reduce HCP burnout, streamline workflows and save money. It is available for adults with type 1 diabetes, type 2 diabetes or obesity, children with diabetes and their parents/caregivers.

EQUALITY, DIVERSITY AND VARIATION

Spotlight-AQ provides every PWD the same opportunity for their voice to be heard. Presenting all users with questions that are relevant to their own lived experience, from a database of hundreds of questions, gives a clearer understanding of how different areas of a person's life impact their diabetes management and vice versa. Each question has a mechanism of action to improve physical or mental health outcomes, so all priority concerns identified through the questionnaire (and other linked data, where desired) are insightful, personalised and action-focused. Spotlight-AQ has been validated in participants with different socioeconomic status. It was co-designed with hundreds of people with diabetes, from different communities and backgrounds. Charities, community and advocacy groups have also been consulted. Validated UK English, US English and LATAM Spanish versions are available and the team is working with South Asian communities in the UK to add tailored resources for them. An independent review by the Organisation for the Review of Health and Care Apps (ORCHA) achieved a score of 84%. The company is working with partners in Argentina, Chile and Colombia to transform care for underserved populations with diabetes. A multi-country randomised clinical trial (RCT) is being conducted using Spotlight-AQ in and between visits to prevent deterioration of glycaemic control and exacerbation of diabetes distress. Combining continuous glucose monitoring devices, if participants are <20% missing glucose data or <50% with a glucose time in target range, they automatically receive a new link to the Spotlight-AQ questionnaire and mapped resources according to their unmet need. This enables the delivery of routine care to include support for education and psychological well-being alongside glycaemic control.

RESULTS

Spotlight-AQ was co-designed with PWD and HCPs, using focus groups, one-to-one interviews, surveys and feedback through pilot studies, feasibility studies, real-world evaluations and multi-centre RCTs. The team also engaged with the allied health science network and health innovation centres to ensure streamline workflow integration for health systems. Health Innovation Manchester, Leicestershire health system and Wessex are collaborating here. In one study mean HbA1c improvement was 15mmol/mol (1.4%), psychosocial outcomes improved, work-related QoL for HCPs improved and visit duration for intervention participants was shorter by 0.5-6.1mins (3-14%) versus no change in the control group (-0.9 - +1.28 mins). HCPs reported improved communication and greater focus on patient priorities in consultations. Cost-effectiveness analyses found the intervention to dominate usual care and have 68% probability of being cost-effective (threshold value: £30,000 per QALY gained). Artificial Intelligence examination highlighted therapy and psychological burden were most important in predicting HbA1c levels. Natural Language Processing semantic analysis confirmed the mapping relationship between questions and their corresponding concerns. The machine learning model revealed that type 1 and type 2 patients had different concerns regarding psychological burden and knowledge. It also emphasised that individuals with varying levels of HbA1c exhibited diverse levels of psychological burden and therapy-related concerns. A three-centre feasibility study was conducted in primary and specialist care settings in the UK and US to determine acceptability and usability. Results were positive.

USER FEEDBACK

Data showed that Spotlight-AQ was acceptable, relevant and tailored to individual needs, and that it could be implemented in clinical practices. Positive themes were ease of use, relevance, personalised feedback and simplicity of the tool. The wording of some questions was updated to aid clarity and remove ambiguity. The second phase analyses focused on acceptability for people with diabetes, as well as usefulness and relevance within routine clinical care for healthcare professionals. One-to-one interviews were conducted with 12 PWD and eight HCPs. All participants expressed enthusiasm for the tool and reported that it accurately identified personal priorities and clear appropriate care pathways to meet those needs. All HCPs stated that it would be useful in clinic to reduce consultation times and improve communication, as well as aiding greater understanding of patient needs.

DISSEMINATION AND SUSTAINABILITY

Spotlight-AQ fits into routine care for every PWD (complete at home or in waiting room), with every HCP, in every visit. It has been used across primary and secondary care, with ongoing research with underserved populations. At an annual licence fee of £5,000 per centre (2,500 patients with diabetes or obesity), Spotlight-AQ is cost-effective. There are also cost savings through shorter visits. Key elements include improved communication, better understanding of patients' unmet needs and reduced burnout for HCPs. Spotlight-AQ has multiple modes of communication, including written, oral and visual. Spotlight-AQ's underpinning theory and structural framework can be applied to other health conditions and it has been used in COPD. The company has worked with PWD, charities and advocacy groups to disseminate results to the diabetes community.

JUDGES' COMMENTS:

> *Spotlight-AQ' is an interesting and promising programme with really good evidence of support from both healthcare professionals and service users. The programme is very scalable, and would be cost-effective and valuable going forward. A great example of co-design and a brilliant way to bring psychological care into consultations.*

COMMENDED

DIABETES EDUCATION PROGRAMMES – HEALTHCARE PROFESSIONALS

Implementing glucose sensing in primary care

by Eden, Leicester Diabetes Centre, University Hospitals Leicester NHS Trust

SUMMARY

'Implementing Glucose Sensing in Primary Care' is an online learning platform developed by Eden in collaboration with Diabetes Technology Network (DTN-UK) and Primary Care Diabetes Society (PCDS). The programme aims to enhance the skills of healthcare professionals (HCPs) working in primary care to support patients living with diabetes in using continuous glucose monitoring (CGM), following the change to NICE guidance in 2022. Since its launch, the programme has engaged 1,036 users from 13 professions, including GPs, practice nurses, clinical pharmacists, allied HCPs and social prescribers, reflecting a broad and inclusive approach to diabetes care education.

INNOVATION

In 2022, NICE updated its guidance for people living with type 1 and type 2 diabetes, promoting the use of CGM in all people living with type 1 diabetes and some living with type 2 diabetes using insulin therapy. This allowed some CGM devices to be prescribed in primary care. Previously, all people starting and using CGM were supported by secondary care diabetes services. This meant primary care HCPs needed training and support in the use of the technology. 'Implementing Glucose Sensing in Primary Care' is an online education programme endorsed by the PCDS and DTN-UK. It aims to increase knowledge and confidence in starting and supporting people living with diabetes using CGM. It provides a variety of interactive learning opportunities to help the bespoke needs and interests of participants, including recorded discussions, online learning modules about FreeStyle Libre 2 and Dexcom ONE CGM systems and their compatible cloud-based systems. Interactive case studies and an implementation toolkit help embed theory into clinical practice. Post pandemic, there is an abundance of education available to all HCPs, much of it online, some free to access. The value of education in changing clinical practice and outcomes has been hard to assess, as it is difficult to directly correlate patient outcomes with a HCP receiving education. Through work with Leicester, Leicestershire and Rutland ICB, Eden has demonstrated that intensive education positively affects patient outcomes. Eden is competency based and supports HCPs to gain both knowledge and the confidence to apply it.

EQUALITY, DIVERSITY AND VARIATION

It has been highlighted in previous local and national audit data that people who live in more deprived areas or are from ethnic minority backgrounds have a lower uptake of CGM. The Diabetes UK campaign 'Diabetes Tech Can't Wait' is focused on ensuring everyone gets the right device. They recognise the significant variation in technology access across ICBs. Policy variation means that many people may face barriers to access. Many primary care HCPs are not familiar with CGM in their day-to-day practice. There is also the perception that the use of CGM can be labour-intensive and time consuming, requiring extra training and skills among a pressurised workforce. While any new technology requires a period of training and familiarity, CGM use can save time in the longer term. The education programme raises awareness about inequality and highlights what HCPs can do to make a positive difference. The programme has been recognised for its value in providing appropriate education in a number of places. To ensure equitable access for HCPs the NHS Library Health Literacy tool's guidance on written and oral communication was used in the development and review phases. The materials underwent comprehensive testing and quality assurance, from professor to support worker, to ensure appropriateness.

RESULTS

The initiative has shown significant effectiveness in improving the quality and efficiency of diabetes care within primary care settings. Since launching in August 2022, 1,036 HCPs across 13 different professions have completed the training. The success of the programme was evaluated through structured participant feedback where participants rated their confidence and skills across five key areas on a scale of 1 to 5. The high mean scores – ranging from 4.38-4.88 – demonstrate a substantial improvement in the participants' ability to identify eligible patients, explain CGM technologies, apply and manage CGM, discuss its impact and interpret sensor data. By equipping primary care providers with crucial skills, the programme has facilitated more widespread and effective use of CGM, leading to better glycaemic control and overall health outcomes for patients. Participants reported a high ability to identify patients suitable for CGM (mean score: 4.88) and to interpret glucose data for safe and effective clinical decision-making (mean score: 4.38), underscoring the programme's impact on clinical practice. The programme was funded through a combination of grants and partnerships ensuring economic viability and alignment with NHS cost-efficiency goals. By upskilling primary care providers, the programme reduces the need for specialist referrals and hospital-based diabetes management, thereby minimising NHS costs.

USER FEEDBACK

The feedback process used structured evaluation forms and anonymous online surveys. Responses from stakeholders were positive and participants appreciated the clarity provided by the programme on who met the criteria for using CGM. Many participants highlighted the value of case studies in the programme and the importance of the training on glucose data interpretation. Based on participants' suggestions, more interactive elements have been introduced, such as hands-on workshops and real-time case study analyses. The need for clearer guidance on interpreting glucose data led to the development of supplementary materials and focused training sessions. Feedback on CGM usage criteria has prompted closer working with primary care providers to ensure that more patients who meet the criteria can benefit from CGM technology.

DISSEMINATION AND SUSTAINABILITY

One key benefit of the programme is that it is free for HCPs nationwide to register and participate. The aim is to reach as many HCPs as possible. It has reached clinicians across the four nations and beyond. There have been high numbers of registrations and module completions. There have been requests for further education, including face-to-face training, more modules and local implementation sessions at ICB-level across the country. Eden will continue its work in CGM with regard to reducing hospital admissions, reducing glycaemic variability and HbA1c, while improving quality of life. In addition, wider use of CGM is being seen, particularly in type 2 diabetes, with expectations of a change in NICE guidance in the future.

JUDGES' COMMENTS:

"Implementing Glucose Sensing in Primary Care' was a great solution, supporting access, good results and good feedback. The fact that it's free enables good dissemination. It had a lot of strengths, and addressed a massive gap."

HIGHLY COMMENDED

DIABETES EDUCATION PROGRAMMES – HEALTHCARE PROFESSIONALS

Educate Diabetes – a new, virtual diabetes training programme pilot for schools in Leicester, Leicestershire and Rutland

by Heal.med in partnership with the Leicester Children's Diabetes Team

SUMMARY

Children and young people with type 1 diabetes (T1D) can find school and college difficult to manage and can suffer from mental health problems due to staff and teachers' lack of support and knowledge. Working with the NHS Leicester Royal Infirmary children's research and diabetes teams, HEAL.med CIC created an e-learning portal, called Educate Diabetes, to deliver effective training to school staff. The programme can be accessed by all primary and secondary schools across Leicester, Leicestershire and Rutland.

INNOVATION

Children have been sent home from school because teachers did not know what to do when their glucose was not in range and reprimanded for beeping or noises created by technology, such as pumps and scanners. They have also hidden their diabetes from teachers out of shame. Children feel stigmatised and embarrassed because of a lack of staff education and support. There is also an impact on parents, who are called to the school/college to look after their child. Working with the NHS Leicester Royal Infirmary Children's research and diabetes teams, HEAL.med CIC created an e-learning portal to deliver effective training to school staff. Since the pilot started in August 2023, over 1,000 staff have successfully completed the programme. The website/e-learning platform hosts bespoke training, comprising 10 modules, 60 video slides with a narrated voiceover, plus a light-touch multiple-choice question at the end of each section. Once a user completes the e-learning, they are invited to join an interactive webinar with the Leicester School Diabetes Team. This utilises flipped learning methods to give school staff the knowledge to engage in the session. Mentimeter, an interactive quiz platform, allows participants to answer questions remotely and in a more engaging way. Finally a short quiz automatically provides a certificate to users. The information is aimed at those who have no, or little, diabetes knowledge, helping them to feel comfortable dealing with a child or young person with T1D in school. Access is 24/7, allowing school staff to refresh their knowledge at any point. The aim is to roll out the training programme to the wider diabetes community across the UK, using a phased approach, starting with two additional NHS trusts. The content will be changed to meet the needs of each local education authority. Practical training will be provided on how to use the system, with ongoing technical support. It will be updated yearly to meet international guidelines.

EQUALITY, DIVERSITY, VARIATION

A quarter of adolescents with diabetes experience depression (greater than twice the general population). 'Diabetes burnout' is a common mental health issue with people with T1D, where they no longer manage their diabetes sufficiently due to stress, environmental reasons, poor support and stigma as a result of not feeling 'normal'. The hope is that the staff training will help them recognise these symptoms and help the students feel less isolated and different. Students will be able to participate more in after-school activities and trips, without feeling they are a burden, which many students have reported. Educate Diabetes has increased the amount of teachers and other members of staff attending diabetes education by delivering training directly to them. Ensuring staff have a better understanding of T1D will help avoid public confrontation between staff and pupils and remove misconceptions before incidents occur that would impact a pupil's mental health. It has helped create a more inclusive and supportive environment that acknowledges and accommodates their specific needs. The video content (from the diabetes education app, Deapp) used in this programme is also available in other languages.

RESULTS

This intervention aims to create better understanding of T1D in schools and a more empathetic environment for children and young people with T1D. Previously, the training was a three-hour online PowerPoint presentation and teachers would sign up and then not attend or switch off before it had finished. Gaps in knowledge were not being addressed and it was not engaging. Now the training time is significantly reduced to two, one-hour sessions. Staff responded positively to the Educate Diabetes pilot, particularly favouring the reduced training time and flexible opportunities to complete it. To date, 1,006 staff have attended an engage session with a member of the diabetes team and teachers have logged on to the website 3,137 times. Based on 453 responses via evaluations or feedback, 62% said they had never had any diabetes training before, 51% scored the usefulness of the session 10/10, 44 % scored the engagement of the content 10/10, plus 45% gave 10/10 when asked if they felt more confident about T1D than they had before. The online booking system has meant that the hospital diabetes team does not need to handle emails or queries from schools, reducing administrative time to 0.5 hours – a decrease of 98.78% – and costs. Educate Diabetes is supported by Diabetes UK, the National Institute for Health and Care Research and Leicester Education Authority.

USER FEEDBACK

There has been lots of positive feedback for this new system, which has reduced the diabetes team's workload immensely so staff can concentrate on patient care. Teachers' feedback has led to further improvements, such as adding more content and providing more instructions on how to use Mentimeter, sign up to a session, take the quiz and download certificates.

DISSEMINATION AND SUSTAINABILITY

Educate Diabetes will be offered across the UK, starting with two more NHS trusts, then expanded further once the functionality and capacity of the system has been tested. The content will be changed to meet the needs of each local education authority to incorporate any differences in practice. Practical training will be provided on how to use the system and ongoing technical support will be available. The programme will be updated yearly to meet international guidelines. Educate Diabetes has been used in Leicester, Leicestershire and Rutland schools, covering approximately 270 primary schools with 5,021 teachers serving 89,100 students. There are 114 secondary schools that serve 72,348 students. Plans include recruiting a project manager for the rollout, tailored programme updates to support an increased number of education authorities and staff, plus keeping content current.

JUDGES' COMMENTS:

"The judges really liked the intervention, and impact across the persons lifespan. Educate Diabetes had a clear and far-reaching impact, backed up with strong feedback. It will be easy to roll out and it resonated that the impact can change somebody's experience. It inspired the judges, and provided support to patients during such a vulnerable time. It is a good example of working across boundaries, with a video that is available in different languages, making it accessible across multi-ethnicities."

WINNER

DIABETES EDUCATION PROGRAMMES – HEALTHCARE PROFESSIONALS

Operation DiaMED: Diabetes Matters in ED – learning from patient safety incidents to improve insulin safety at the Front Door

by Manchester University NHS Foundation Trust

SUMMARY

Emergency Departments (EDs) across the country are experiencing unprecedented pressure with record-breaking waiting times. Crowded EDs pose a threat to safe diabetes management and people living with diabetes (PLwD) are vulnerable in the department. Manchester Royal Infirmary (MRI) has seen a rise in avoidable diabetes harms associated with ED crowding, damaging inter-speciality partnerships and reputation. 'Operation DiaMED – Diabetes Matters in ED' provides a collaborative, cross-speciality solution, focused on shared learning from patient safety incidents, to improve diabetes management at the front door.

INNOVATION

MRI's ED is one of the largest in the country, experiencing increasing patient demand and high bed occupancy. Incident reporting (Ulysses) analysis (December 2022-April 2023) highlighted 32 ED diabetes-related incidents, including issues with management of Diabetic Ketoacidosis (DKA) and Hyperosmolar Hyperglycaemic State (HHS), insulin prescribing, plus problems with Variable Rate Intravenous Insulin Infusion (VRIII). A collaborative, interprofessional, cross-speciality group – Operation DiaMED – was created, including members of the nursing, medical and pharmacy teams in diabetes and emergency medicine. It addressed operational and educational issues, including the lack of mandatory, bespoke insulin safety education for ED staff involved in diabetes management. Operation DiaMED is a data-driven, incident-focused initiative aligned to the Patient Safety Incident Response Framework (PSIRF) methodology. Objectives included: reducing diabetes-related harms and improving management of diabetes emergencies in the ED; developing and delivering a cost-effective mandatory educational programme from insight of incidents; evidence improvement in outcomes by incident reporting re-analysis and feedback from users; building a positive reporting culture to highlight areas for continuous improvement and promote self-reflection; investing in partnerships between the diabetes and ED teams, as well as identifying and sharing best practice. The strategy featured two cycles of mandatory education for ED nurses and prescribers. From May to June 2023 incident analysis was conducted to raise awareness and ensure rapid turnaround of shared learning. From October to November 2023 protected time was allocated to consolidate knowledge. The education programme featured drop-in and half-day inclusive sessions designed to accommodate different roles and learning styles. Topics included the basics of insulin therapy, hypoglycaemia, hyperglycaemic emergencies (DKA, HHS, VRIII), safe prescribing and incident-based case studies. In-reach diabetes support provided a proactive inpatient diabetes service with twice-daily visits to the ED to identify and triage admissions.

EQUALITY, DIVERSITY AND VARIATION

MRI has a culturally and ethnically diverse workforce serving a population with a high prevalence of diabetes alongside high levels of socioeconomic deprivation. Operation DiaMED aimed to create a safer care system by reducing variation in clinical care and supporting staff to achieve the same knowledge levels. Resources were user-focused and delivered in an inclusive and adaptable way. The nursing sessions were designed around real-world incident scenarios with a maximum of 10 staff per session. Staff had space for reflection and learning at different paces. A third of the trained ED nursing workforce was from ethnic minorities and the sessions were planned for all grades and expertise. Prescribers' sessions were delivered in a drop-in format, hosted every 30 minutes during lunchtime and focused on case-based discussions. Attendees were from diverse ethnic groups and included different grades of doctors in training, consultants, non-medical prescribers and pharmacists. The sessions were planned in repeated cycles to support inclusivity and enable engagement. The patient experience questionnaire contained four simple questions delivered by the inpatient diabetes team, including Urdu, Hindi, and Portuguese-speaking staff who could deliver the information in different languages.

RESULTS

Operation DiaMED provided high-level education and a positive reporting culture, fostering interdisciplinary collaboration and knowledge-sharing through engagement and improvement work with increased diabetes team visibility and reputation. There was over 50% reduction in core recurring issues. The incident-focused educational programme was carried out successfully. May and June 2023 were acknowledged as diabetes months in ED with local initiatives for nursing staff led by practice-based educators, such as a diabetes board display and dissemination of information through nursing handovers and safety huddles. Overall, 54 registered nurses took part. For prescribers, nine targeted, case-based drop-in sessions were delivered by the diabetes team, supported by the ED consultant quality and safety lead and ED pharmacist. Incident scenarios were discussed by 51 prescribers from all grades. In the second phase, nursing staff had nine diabetes study mornings delivered by the diabetes team, targeting gaps in knowledge identified by incident reporting. The full ED nursing workforce attended (65 nurses). Prescribers had three mandatory, case-based drop-in sessions supported by an ED consultant with an interest in medical education (37 prescribers). Pre- and post-teaching questionnaires were completed by nursing staff and showed areas with the greatest improvement were in managing VRIII, ketones, DKA and subcutaneous insulin.

USER FEEDBACK

Up to 83% of 64 staff evaluated each topic with the maximum score of 5 (very good). The highest scores were achieved on 'basics of insulin therapy', 'hypoglycaemia' and 'hyperglycaemic emergencies'. Qualitative and more specific feedback resulted in changes, such as having discussion of case-scenarios throughout each presentation and sharing presentations with staff. An anonymised patient experience survey was delivered to inpatients and outpatients admitted to the ED during May 2024. Nine forms were collected and gave an average score of 4 (maximum 5), reflecting overall patient satisfaction. Almost 90% of respondents felt that ED staff met their needs. Two felt that staff had little awareness about their diabetes diagnosis and this feedback was used to promote continuous education.

DISSEMINATION AND SUSTAINABILITY

Operation DiaMED was piloted at one site but it could be adapted to other sites and Trusts. The PSIRF was used as a guide to provide insight and develop a safety action plan, engaging staff through a learning response. The education was also aligned with JBDS and provided scope to implement the GIRFT interactive pathways. The senior leadership team made diabetes a safety priority and staff were supported to attend sessions. The programme was also delivered at every ED Doctors' and Nurses' induction and ACP forums. An annual refresher is planned and a diabetes link nurse programme is under discussion. The team was invited to share the learning at a Medicines Safety Committee meeting.

JUDGES' COMMENTS:

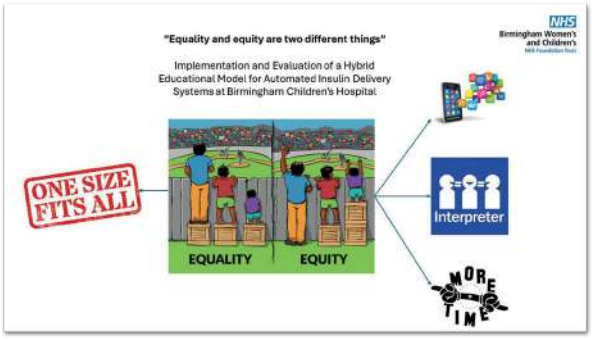
"The winner was a really strong entry, in a massive area of need. It was deliverable, enabling many people to attend and a great programme. The results were impressive and it was translatable to other clinical teams. A really important project, proving that lunchtime seminars work well, with a good systematic approach to using data and patient feedback to escalate change."

WINNER

DIABETES EDUCATION PROGRAMMES – PEOPLE WITH DIABETES

Equality and equity are two different things" implementation and evaluation of a hybrid educational model for automated insulin delivery systems at Birmingham Children's Hospital

by Birmingham Women's and Children's Foundation Trust



SUMMARY

Responding to the challenge of equitable onboarding of children and young people (CYP) with type 1 diabetes (T1D) to Automated Insulin Delivery (AID) systems, the team at Birmingham Children's Hospital designed a hybrid model of diabetes education. It blends digital and face-to-face flipped learning, improving glucose management and equitable access across diverse patient demographics. The results demonstrate equal glucose control across ethnic groups, socioeconomic strata, and school age. A training package based on the model has been used across the CYP Networks and internationally.

INNOVATION

2022 analysis showed that 44 children and CYP with T1D onboarded were predominantly from white, middle-class backgrounds. At a November 2022 service improvement meeting, objectives were set: by November 2024, ensure every CYP desiring an AID system can access one, tripling the monthly onboarding rate from four to 12 CYP, and ensure onboarding reflects the demographic 60% from ethnic minority groups and 60% from the most deprived socioeconomic quintiles. The team drew on 'CGM Academy' success that highlighted the necessity of providing equitable educational support rather than mere equality. More CYP from ethnic minority backgrounds and very disadvantaged social circumstances require intensive, tailored educational interventions. Conversely, CYP with families with higher educational levels could use self-directed learning through a flipped classroom model. For those capable of independent learning, a competency-based educational approach was introduced, utilising Google Forms, a comprehensive workbook and a succinct 'Survive and Thrive' (S&T) guide. For those needing more direct support, face-to-face education was provided with interpreters, using the same materials but with personalised support. HCP tools were developed, such as starting dose calculators and interactive assessment tools. To measure effectiveness, a comparative analysis was made between CYP onboarded before the hybrid model (pre-April 2023) (Group A) and those onboarded in the six months after (April-September 2023) (Group B).

EQUALITY, DIVERSITY AND VARIATION

Although only 38% of the cohort were white, they constituted 60% of the CYP onboarded. Additionally, half came from the two least-deprived quintiles, despite making up only 10% of the cohort. Three barriers were noted. First, CYP from less educated and non-native-language-speaking families struggled with the prerequisite tasks necessary for onboarding, such as understanding detailed processes and completing competency-based activities. Second, the previous face-to-face educational approach spanned five sessions per AID onboarding, limiting capacity and inadvertently favouring those more educationally capable. Third, there was unequal access to smartphones. CYP from disadvantaged backgrounds should not be stigmatised but supported more robustly with pre-onboarding tasks. The new model combines virtual, self-guided education for those who can navigate the onboarding process, with enhanced, personalised support for those who need it. This support includes completing preparatory work alongside them, facilitating interactions with interpreters and ensuring materials are accessible. Patients selected their AID system during an in-person session before implementing the virtual hybrid model. However, those without a compatible mobile phone faced limited options, preventing the AID system from automatically uploading data. These patients had to visit the centre to download data from their devices, creating an unintentional disparity in support and choice for families unable to afford mobile phones. In April 2023, 30 phones were purchased with charity funds, enabling patients to select any AID system and benefit from automatic uploads. This significantly improved access for 25 most-deprived families. A charity grant secured an additional 40 phones – part of an ongoing plan to purchase 20 phones per year.

RESULTS

Group A comprised 74 CYP (53% male) with median age of 13.9 years and Group B 91 CYP (54% male) with median age of 12.7 years. From baseline to 90-days, Group A lowered mean time above range (TAR, >10.0 mmol/L) from 47.6% to 33.2% and increased time in range (TIR, 3.9-10.0 mmol/L) from 50.4% to 64.7%. From baseline to 90 days, Group B lowered TAR from 51.3% to 34.5% and increased TIR from 46.5% to 63.7%. There was no difference from baseline to 90 days for time below range (<3.9 mmol/l) for Group A and Group B. TAR, TIR and TBR for both groups were comparable. Group B consisted of CYP with higher socioeconomic deprivation, greater ethnic diversity, and lower carer education achievement. Most of Group B (n=79, 87%) chose virtual flipped-learning, halving diabetes educator time and increasing onboarding cadence five-fold. Therefore, the new programme increased onboarding cadence and capacity to offer equitable AID system onboarding. Enhancing equity in access to hybrid closed loop (HCL) systems using the model achieved a 16% improvement in TIR (3.9-10.0 mmol/L). Retrospective analysis (2019-2024) of CYP transitioning from CGM to HCL considered data on demographics and glucose metrics collected from patient records and manufacturers' online databases. Ninety-day CGM data pre- and post-HCL were compared. A total of 169 CYP (53% male) with mean age of 12.4 years and T1D duration of 6.0 years were included. The majority (n=95/56%) were of non-white ethnicity [South Asian (SA), n=59/35% and Black (B), n=26/15%] and 44% White (W) (n=74). Categories were: most deprived (T1, n=56/33%), second most deprived (T2, n=56/33%), least deprived (T3, n=57/34%), with 20 (12%) CYP who required an interpreter. At baseline, W, SA and B had comparable TBR, TIR and mean blood glucose (MBG). After 90 days of HCL, these groups had comparable TBR, TIR and MBG. At baseline, T1, T2 and T3 had similar TBR, TIR and MBG. After 90 days of HCL, there were no significant differences for TBR, TIR and MBG across T1, T2 and T3, respectively. These results show that equitable onboarding to CGM and HCL reduced ethnic and socioeconomic disparities in glucose control among CYP with T1D.

USER FEEDBACK

Engagement with all stakeholders throughout ensured that the programme was tailored to the needs of CYP and their families and supported by HCPs. Engaging with 10 CYP and their families already using AID systems was critical. Their feedback was invaluable, particularly their suggestion to condense the workbook into the S&T guide.

DISSEMINATION AND SUSTAINABILITY

The results were published in BMJ Diabetes Research & Care, shared at conferences, ICB meetings, the CYP Network National HCL Study Day (2023) and the National Canadian Pediatric Diabetes Study Day (2024). Access was provided to all generic, adaptable materials, further supporting international outreach. A 'Train the Trainers' initiative is planned by the national CYP Network Technology group.

JUDGES' COMMENTS:

This winning entry had clear aims and objectives, and it solved a problem. An extremely positive project, which was innovative and refreshing especially as it clearly was designed with equality in mind. It stood out with its thought-provoking design and the judges loved it!

COMMENDED

DIABETES EDUCATION PROGRAMMES – PEOPLE WITH DIABETES

An Innovative Mixed Media Footcare Video

by Suffolk GP Federation

SUMMARY

Lack of knowledge of the seriousness of diabetic foot disease and the vital need for prompt specialist input directly impacts patient care and increases the risk of poor patient outcomes and litigation. An innovative educational footcare video was created as an alternative to paper leaflets and ad-hoc face-to-face education. Based on national guidance, this high quality, mixed media video is free and accessible via YouTube. It promotes appropriate self-care and monitoring to prevent more serious foot problems.

INNOVATION

Previously, the ICS had multiple dull education leaflets, many with outdated information, poor imagery or sponsored by drug companies. Apart from ad hoc patient engagement events and leaflets there were no other education materials and no clear strategy to improve knowledge of diabetic foot disease within the population. No one held overall responsibility for patient foot care education provision and footcare education took place during face-to-face appointments, meaning a lack of consistency in content and delivery. The solution was to create a free, innovative educational video that was stimulating, engaging and easily accessible to people with diabetes (PWD).

EQUALITY, DIVERSITY AND VARIATION

Engaging with PWD, specialist podiatrists, consultants, diabetes specialist nurses and management across the ICS guaranteed equal opportunities to help develop an effective patient education strategy. It was essential to remove barriers to PWD having access to first-class, evidence-based foot care education. Research and UK-wide audits showed that people from certain ethnic backgrounds or low socioeconomic areas were less likely to receive good diabetes care and education. This was echoed in a local review of lower limb amputation that found the amputation rate was 11 times higher for those living in areas of high deprivation compared to those living in areas of low deprivation. This project aimed to make sure that every PWD would have a baseline level of knowledge on how diabetes can affect the lower limb and feet and, importantly, what to do should a foot problem develop. Existing videos on diabetic footcare education were unprofessional, boring, out of date, not applicable to the UK or did not follow national guidance. A collaborative working approach ensured that healthcare professionals (HCPs) from different professions and ethnic backgrounds had input into the new video content, helping to ensure that complex pathologies, such as peripheral neuropathy and peripheral arterial disease, were explained in an accurate yet simplified way.
The video was animated so it could be amended easily and voiced over in different languages. Also, publishing on YouTube enabled the viewer to select subtitles in multiple languages and those with hearing difficulties could utilise subtitles. The video was of a quality suitable for a large screen so those with visual impairment could access it.

RESULTS

The project was funded with transformation funds from East of England. However, to ensure the project and future expansion of patient education videos would be sustainable with minimal costs, the team purchased a software package so animated video could be built in-house, with full control over the product. A 50% reduction in the software package fee was negotiated, as it was being used for health promotion, so the cost was £300. YouTube was chosen as it is the most widely utilised free video hosting site in the UK. The video was highlighted to any PWD referred into podiatry services, including those who self-referred. An invitation to view the video with a direct link was texted out to all existing patients of the diabetes team across the ICS who had consented to receive text messages. A poster was developed with a QR code and web address to display in pharmacies and primary care waiting rooms. A JPEG of the poster was emailed to all GP practice managers, for display on monitors/TV screens in waiting areas. The video was made available on both North East Essex and Suffolk GP Federation websites. It went public in March 2023 and has received nearly 3,000 views to date. A local audit of 50 new referrals revealed that no low-risk patients were referred, saving at least £50 on every inappropriate referral, plus there were no incident reports on late patient presentation for acute diabetic foot pathology six months following the dissemination of the video.

USER FEEDBACK

The patient engagement team, including patients, reviewed and modified the script and storyboard to ensure that the content was engaging, relevant and understandable, with simplified language. It was vital that the video was honest and that the level of risk and potential for serious foot problems were highlighted effectively. The best approach to convey difficult information was a combination of animation, photos and video. A draft video was released to HCPs and patient representatives and feedback collected anonymously via SurveyMonkey. This resulted in changes like reducing references to loss of limb and life and greater use of darker skin tone imagery. After release it received positive feedback from HCPs and the public.

DISSEMINATION AND SUSTAINABILITY

There was focus on making sure that the educational resource was sustainable. The purchase of the animated software program and the skills gained from developing this video allowed the ICS to develop a suite of free videos to support footcare education provision, including 'Advice for cutting your toenails', 'Poor blood supply due to peripheral arterial disease', 'Footwear advice' and 'What to expect at your diabetic foot screening'. By using animated content, the videos are less likely to become dated, prolonging their usefulness. This project was developed ICS-wide, but the 'Footcare for people with diabetes' video is available on YouTube and was deliberately made to national guidelines. A link to the video has been circulated to the East of England Podiatry leads for wider dissemination. The video can be made more generic and the Diabetes UK representative for East of England may promote an edited version to those members. An article for a UK-wide diabetes publication will promote this project to the wider HCP workforce.

JUDGES' COMMENTS:

"The Suffolk GP Federation's work had striking data about deprived areas and it did change clinical practice. With an easily editable format, it can use for other projects, which is incredibly useful. Their brave investment in the software was clear; plus it had brilliant animation! It was free to access and use. It was a possible game changer for footcare services and was beautiful in its simplicity."

WINNER

WELLBEING

Diabetes care and support for university students

by University of Essex & University Medical Centre (part of the Colte Partnership, Colchester)

SUMMARY

The ADAPT programme for university students with diabetes is a collaboration between NHS primary care, universities and specialist diabetes care. It focuses on close collaboration between clinical and university services to ensure students experience a coordinated and easily accessible diabetes service on campus. The service runs monthly diabetes clinics and invites a specialist diabetes team and academic staff for pastoral care, a group lunch and diabetes education in both the clinic and lecture halls. This has increased patient engagement and physical and mental well-being. The programme is expanding in the UK and has been disseminated internationally.

INNOVATION

The University of Essex is the only university with a dedicated programme to support students with diabetes. The team comprises both NHS and university staff with the following aims: to ensure that all students with diabetes register and engage with the NHS primary care on campus and are seen by diabetes specialist nurses and GPs; to support students in their academic trajectories, as diabetes is known to interfere with studying due to difficulties with glycaemic control; to bring students with diabetes together to create peer-support and new friendships, as many of them are often isolated and lonely with their disease; to bring specialist diabetes services to campus because travel to specialist services is often difficult; to educate students about diabetes because many have not received structured diabetes education; to work with the university's academic and disability services to ensure that barriers to studying are resolved, plus to reach out to and support other universities to create a similar safe university campus for students with diabetes. The ADAPT programme relates to the transitions students go through. It began in 2022 and runs monthly diabetes clinics, education sessions, and peer-support lunches combined with psychosocial support. This programme has received excellent feedback from stakeholders and colleagues, nationally and internationally.

EQUALITY, DIVERSITY AND VARIATION

Data analysis suggests a barrier in access to university education for young people with diabetes. Anecdotal reports state that they are discouraged from going to university out of fear of difficulties with managing the disease in the hectic university environment. The ADAPT programme has shown that creating an accessible and safe university environment for young adults with diabetes is possible in a cost-effective way. It not only addresses the general issue of access, but also works with the diversity within the group of students. The university's students with diabetes are a racially and socioeconomically diverse group from around the world with different cultures and dietary patterns. The team explains diabetes care in England and informs them of their rights, including the Equality Act 2010. It also communicates the diverse student needs, for example regarding diet, to the university services who work to provide healthy and internationally acceptable foods. Students are also helped with the paperwork for airport security and for the 'year abroad' some students enrol for. Finally, the group lunches cater for the food preferences of the diverse cohort.

RESULTS

This programme began in September 2022 and two academic years have been completed. It has led to major improvements for students with diabetes at the university. There is a focus not only on physical health, but also on psychological well-being. The student diabetes clinic has been well attended, as have the group lunches both at this university and the partner university in Poland. HbA1c decreased in the majority of attending patients. None of the patients with type 1 diabetes in the ADAPT support group has needed diabetes-related emergency care. Diabetes education has been provided to students, mainly focused on information about carb counting and dealing with insulin. Students report high satisfaction with the programme. The team has worked with the university Disability Champion and communications team to send out regular emails to all students on campus, including those without diabetes and those with disabilities. Reasonable adjustment plans have been set up for students with diabetes. New diabetes technology awareness has been raised with academic staff and exam invigilators receiving specific training. Senior university management have been supportive of the initiative and provided funding.

USER FEEDBACK

Feedback is being analysed and a PhD student, funded by the Economic and Social Research Council, is researching the experiences of university students with diabetes. Students' feedback was collected anonymously via online surveys. Students are highly satisfied with the support, as measured by clinic attendance, including group lunches.

DISSEMINATION AND SUSTAINABILITY

After the first year of the ADAPT programme, the University of Essex provided £10,000 to implement the programme with collaborators at Jagiellonian University (Krakow, Poland). As a result, medical and academic staff were exchanged, as well as two involved PhD students, and a successful ADAPT group is now established in Poland. A dedicated website https://adapt.diabetes-at-university.info has been set up to help other universities roll out this initiative. The programme was presented at the Diabetes UK Conference (April 2024), the Psychosocial Aspects of Diabetes conference (PSAD) (April, 2024, Germany) and the British Psychological Society Diabetes conference (March, 2024). The Lancet:Diabetes & Endocrinology published on the collaborative work with the Polish university. The presentation at the London BPS conference was awarded best poster and the presentation at the Diabetes UK conference was shortlisted for the Young People Award. Excellent feedback was received at both the Diabetes UK and PSAD conferences, where the team made contact with staff from other UK universities interested in rolling out this programme in the future. The implementation of ADAPT relies on developing good local connections between the NHS primary care, diabetes specialist care and university services. A key factor in success is a willingness to collaborate between services that otherwise work quite differently. The collaboration needs to focus on the shared interest of improving the well-being of students.

JUDGES' COMMENTS:

"Diabetes care and support for university students' is an excellent and sustainable initiative targeting patients at a time in their lives when they need extra support and can fall through the gaps between services. The judges liked that the programme focused on both physical and mental health, and that there was a really good awareness of equality issues. The need was clearly identified, the dissemination was great and the feedback was overwhelmingly positive. A fantastic programme that should be implemented in every university."

FINALIST

IMPROVEMENTS IN DIABETES CARE USING DATA *NEW FOR 2024*

"What gets measured, gets managed!" From negative to positive outlier: quality improvement using PDSA cycles improves performance on NPDA key care processes for Birmingham Children Hospital

by Birmingham Women's and Children's Foundation Trust

SUMMARY

From 2018 to 2021, Birmingham Children's Hospital (BCH) was a negative outlier in the National Paediatric Diabetes Audit's (NPDA) seven key care processes. To address this, BCH adopted a Quality Improvement (QI) initiative using Plan-Do-Study-Act (PDSA) cycles in 2022. The team initially focused on enhancing the annual review clinic, resulting in improved care delivery. By 2023, all clinics were included, integrating data-driven insights and accountability, leading to novel approaches. This data-driven methodology significantly improved the completion of care processes, making BCH an above-average performer by 2023 and anticipated positive outlier in 2024.

INNOVATION

The BCH diabetes team's application of PDSA cycles from 2021 to 2023 serves as an exemplary model for leveraging systematic feedback and key performance indicators (KPIs) to enhance healthcare quality. This approach was initiated after the team was identified as a regional negative outlier in paediatric diabetes care process completions, recording less than 35% annually from 2018 to 2021. The objective was to evolve from a negative outlier to a benchmark of excellence within three years. The core strategy embraced the principle, 'what gets measured, gets managed', focusing on making every patient interaction and data collection opportunity count and driving enhancements in care processes, encompassing HbA1c levels, BMI assessments, blood pressure and other evaluations. In 2021/2022, BCH's attempts to centralise data collection during an annual review clinic fell short. Despite creating patient information leaflets and protocols for data entry, the results were poor due to the absence of regularly measured KPIs and comprehensive attendance, as only 75% of patients attended the annual clinic. The team introduced monthly reporting of KPIs at operational meetings in 2022. This new system clarified the processes each clinician was responsible for and fostered accountability through an accountability board that tracked individual compliance. From 1 April onwards, each clinic became a data collection point, with administrators playing a crucial role in auditing which care processes were completed and by whom. This brought significant improvements, with care process completions rising above the national average. In 2022/2023, BCH developed concise scripts for the team to effectively communicate the importance of blood tests, ensuring better compliance and knowledge among patients and families. Furthermore, phlebotomy was facilitated. Administrative lapses in transferring blood results were rectified. Throughout 2023/2024, the application of monthly KPIs, strategic feedback at operational meetings and accountability leaderboards improved patient care and positioned BCH as a likely positive outlier in the 2024 national rankings for completion of the paediatric diabetes care process.

EQUALITY, DIVERSITY AND VARIATION

The NPDA shows that children and young people from black and Asian ethnic backgrounds have HbA1c levels higher than their white counterparts. The disparities extend across socioeconomic lines. THE BCH cohort consists of more than 60% of this demographic. As a benchmark of excellence in diabetes care, BCH directly addresses these disparities. Regular and thorough screening processes ensure that all children receive consistent, high quality care, regardless of background. This standardised approach minimises variations in treatment that often correlate with ethnic and socioeconomic differences. BCH's focus on data-driven and tailored patient education further enhances equity. BCH effectively communicates the importance of regular screenings and management strategies by understanding and integrating patients' cultural and socioeconomic contexts into care plans. This tailored approach, using interpreters and patient leaflets, overcomes barriers to health literacy. Moreover, BCH's technology and data use ensure no child is left behind, with clinicians aware of, and accountable for, each child's care.

RESULTS

In 2022, the care processes required for paediatric diabetes management were revised nationally, reducing from seven to six. This prompted more focus on the remaining care processes, including HbA1c levels, BMI assessments, blood pressure measurements, thyroid function tests, urinary microalbumin levels and foot examinations. The annual review clinic alone was insufficient, with only 60% of the six key processes completed. By identifying specific KPIs in 2022/23 and establishing a continuous cycle of accountability and reporting, the team saw that 'what gets measured, gets managed'. The compliance leaderboards were particularly effective in driving accountability and behaviour change. Completion of the six processes increased to 79%, making BCH an above-average performer. By 2023, a full year of prior data pinpointed specific periods and processes where compliance waned. Targeted initiatives were launched to address these gaps, such as auditing the transfer of blood test results from the ICE system to Twinkle. Educational initiatives underscored the clinical importance of each care process; these were not merely bureaucratic requirements but crucial for early detection of potential complications and timely intervention. Compliance with these essential processes rose to 85% for 2023/24, which should mean a positive outlier status. Furthermore, 2023/24 had the highest completion rate on every metric except foot check, which was slightly below the previous year's score. The care process performance will join BCH's positive outlier status for mean adjusted HbA1c since 2021.

USER FEEDBACK

In 2022, BCH's diabetes team learned from the fact that it had not consulted the administration team or patients on using the annual review clinic for completing care processes in 2021/22 and shifted to a more inclusive and collaborative approach. The consensus was to transform every clinic visit into an opportunity to complete these processes, beginning each year on 1 April. This gave most patients three or four opportunities to complete the care processes within a year. Furthermore, the team emphasised the need for a clear dashboard outlining the specific data collected at each clinic. They also highlighted the motivational impact of knowing their efforts were being monitored. A crucial pivot was placing the administrator at the centre of this process. Tasked with creating clinic dashboards and auditing compliance, she became a pivotal figure and her real-time insights into compliance patterns and proactive suggestions were invaluable. Her feedback was consistently integrated into operational team meetings to refine processes further. This bottom-up approach revolutionised the project, demonstrating that respecting and integrating feedback from all team members and patients is essential for success. The next goal is to reach 90% compliance. This project exemplifies the power of simplicity in achieving significant improvements in healthcare delivery.

JUDGES' COMMENTS:

"Birmingham Women's and Children's Foundation Trust's project had a clear, methodical approach and a solid set of results. The patient outcomes were impressive and was a whole teach approach, with not just the leads taking it forward."

COMMENDED

IMPROVEMENTS IN DIABETES CARE USING DATA *NEW FOR 2024*

Population health data enable collaboration to improve diabetes care

by CLCH

SUMMARY

The Brent diabetes service worked collaboratively to meet the needs of the local population using data from the Northwest London dashboard and National Audit data. The aims were to improve uptake of structured education for newly diagnosed and ongoing people with Type 2 diabetes and injectable therapy, support care home staff, the clinical pharmacist and people with complex needs, work towards improving national three treatment targets (HbA1c, cholesterol, blood pressure), with an initial focus on HbA1c over 100 mmol/mol to get to an individualised HbA1c target while addressing health inequalities, as well as use of digital continuous glucose monitoring (CGM).

INNOVATION

Data from the Whole Systems Integrated Care (WSIC) dashboard identified that the national three treatment targets and structured education uptake were not met, plus delivery of injectable therapy education varied. Brent diabetes service worked with local communities in primary care, using data to engage GP practices and focusing on HbA1c over 100 mmol/mol to find an individualised HbA1c target. Ambulance callouts at weekends were greater for the frail, elderly and those with complex needs. The WSIC Dashboard data showed approximately 34,500 people living with diabetes and, of these, 13,800 with moderate to severe frailty. About 1,270 had HbA1c over 100 mmol/mol and the percentage of newly diagnosed people who attended structured education was 3.6% within 12 months. The first step was to collate people with type 2 diabetes with HbA1c over 100 mmol/mol at GP practices. The information was disseminated at a diabetes steering group meeting for the Primary Care Network (PCN). The diabetes specialist nurses (DSN) aligned PCNs with joint GP clinics to improve the three treatment targets and support GP staff. Also, focus was placed on uptake of structured education for newly diagnosed and ongoing people with type 2 diabetes, reducing did not attend (DNA) rates, and addressing variability in injectable therapy education delivered in primary care, health literacy and health inequalities. A pilot with the lead for Integrated Neighbourhood Team Development & Transformation Brent Borough Partnership used population health management tools, WSIC data and the EMIS clinical system. This enabled proactive case finding, a review of people with diabetes with complex needs with the DSN Joint GP clinics and a multidisciplinary team (MDT) meeting with other stakeholders, such as Brent Health Matters. A pilot with the Brent Borough Partnership manager and local government identified staff training needs to reduce London Ambulance Service calls and A&E visits for frail, elderly people in care homes. A care home training programme was run for 10 nursing homes, eight residential homes and 37 learning disability/mental health homes. A prescribing pilot with the medicines optimisation team and ICB pharmacist (Brent Borough) developed a business case to measure the quality and cost-effectiveness of oral hypoglycaemic medication, prescribed for people living with type 2 diabetes, was changed to focus on how to improve the quality of prescribing by optimising medication use and deprescribing if not effective at GP practices. The team worked with pharmacist leads to provide education related to deprescribing for clinical pharmacists.

EQUALITY, DIVERSITY AND VARIATION

MDT meetings identified specific needs as people were discussed. Health literacy issues were identified in some groups. The Integrated Neighbourhood Team Development & Transformation Brent Borough Partnership addressed health inequalities at GP practices with DSN team joint clinics. Following mapping of GP practices per Hba1c, a review of 10% of people with HbA1c over 100 mmol demonstrated improved HbA1c of at least 20% reduction or achieved an individualised HbA1c target within six months. Those who did not meet the target received support from Brent Health Matters to address social needs and housing issues, which had an impact on improving their HbA1c. Joint DSN/GP/PCN clinics reviewed people and deprescribed medication where necessary, enabling ongoing cost savings.

RESULTS

The project was carried out collaboratively with stakeholders in primary care and the diabetes service. Structured education for people newly diagnosed with type 2 diabetes increased from 3.6% to 8.2% in six months. When people were enabled to contact the service to book convenient dates, DNA rates improved, reducing from 55% to 7.3%. People on injectable therapy education improved compliance to self-managing and reduced risks related to hypoglycaemia and hypoglycaemia. Also, the use of CGM enabled people to improve their target time in range. Structured education workshops included patient representation and feedback was used to plan and implement changes. Prescribing team and care home staff feedback was positive. An audit on maximising care of people with type 2 diabetes and HbA1c levels over 100 mmol/mol referred to the Central London Community Healthcare (CLCH) Brent diabetes service demonstrated that people had a 64% reduction in HbA1c (20% in three months and 80% in six months, with 20% not achieving a reduction in six months).

USER FEEDBACK

The stakeholders involved were pharmacist leads in primary care, NHS North West London ICB, Integrated Neighbourhood Team, Development & Transformation Brent Borough Partnership, Medicines Management Team, PCN, Brent Health Matters, Complex Patient Management Group, clinical pharmacists, care home staff, carers, GPs/practice staff, endocrinologists and allied health professionals. They collaborated to provide comprehensive diabetes care, address health inequalities, use digital CGM, improve the uptake of diabetes educational sessions while reducing DNA rates, and support care home staff with people who were frail, elderly and with complex needs. Engagement and buy-in were sought at a steering group meeting with CLCH Outer Northwest Division Brent Diabetes team by presenting the mapping of the national three treatment targets. Meetings with the PCN lead mapped a process of joint DSN clinics aligned with MDT meetings. This process enabled complex problems to be reviewed in person with clinicians. Patients were asked for feedback after the joint clinics and educational sessions. GP practice clinicians at joint DSN clinics shared updated EMIS system data. Feedback on the education sessions was obtained after each one. Carers were engaged in the development of injectable therapy sessions and fed back on CGM. The work was presented in a poster at the International Forum London 2024 and at the Transformational meeting with CLCH.

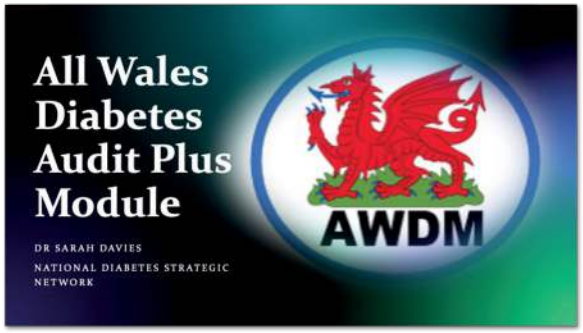
JUDGES' COMMENTS:

“The CLCH work was a big project with big implications across a large community. It was a fantastic example of population health outcomes. The judges liked that it covered diversity with good use of the data.”

HIGHLY COMMENDED

IMPROVEMENTS IN DIABETES CARE USING DATA *NEW FOR 2024*

All Wales Diabetes Audit Plus module
by National Diabetes Strategic Network, Wales



SUMMARY

Clinical prioritisation and a value-based healthcare approach to patient care requires access to accurate, contemporaneous, accessible data. The development of the All Wales Diabetes Audit Plus module enables every practice in Wales to access up-to-date, practice-level data across many aspects of diabetes care, enabling a variety of Quality Improvement work. Cluster and Health Board-level data utilising this platform is driving improvements in care nationwide and the identification and targeting of inequalities in care.

INNOVATION

Prioritisation of care to those most in need and providing care that brings the highest value to the greatest number of people forms a vital part of taking a value-based healthcare lens to health services, which is a focus in NHS Wales. The National Diabetes Audit is a valuable data collection, but differing agreements in data sharing mean that Wales does not have access to timely quarterly reports or practice-level data, as practices in England do. The only access is to annual reports, which are often published a year after collection. This means no access to contemporaneous data to reflect the current situation and practices cannot access their own data for prioritisation of care and quality improvement work. To address this problem, the All Wales Diabetes Audit Plus module was developed. Audit Plus is accessible to all practices across Wales and links directly to electronic patient record systems. It allows standardisation of searches to be available to all practices and data is refreshed daily. It also allows access to anonymised data at a Wales, health board and cluster level, assisting the sharing of good practice, identification of inequity of care and the ability to plan service delivery where it is most needed. Digital Health Care Wales was involved in the design of the module in 2021/22. It is already widely used in Wales for Quality Assurance and Improvement Framework (QUAIF) targets, such as flu vaccinations, so it is familiar to most practices and has all appropriate information governance procedures in place. Data at practice level remains accessible only to individual practices and there is no patient-level data outside of individual practices. The searches within the module reflect the need for care prioritisation. It also has searches related to prescribing and to frailty, with a focus on identifying patients suitable for deprescribing.

EQUALITY, DIVERSITY, VARIATION

The Audit Plus platform is accessible to every practice in Wales, meaning that there is equality of access to the data across the country. The amalgamation of the data down to cluster level allows identification of variations in care. For example, in Cardiff and Vale UHB there is a 19% difference between the best and worst performing cluster in attainment of all care processes. The poorest performing cluster is also the cluster in Cardiff with the highest level of deprivation, highest levels of people of ethnic minority background and highest prevalence of type 2 diabetes. Identifying such inequity has allowed system planning. The Wales Diabetes Strategic Network is using Audit Plus data to produce quarterly reports on performance in completion of the care processes and attainment of treatment targets. These reports are sent to executive leads in each Health Board at a cluster level to initiate discussion and focus on performance in these areas. Having these quarterly reports in a timely fashion is a significant advance on the 12-18 month delay in National Diabetes Audit data annual reports.

RESULTS

Looking at the care process from June 2022 to the present, covering all people with diabetes in Wales, all eight care processes increased from 33% to 42%. Completion of UACR (worst performing care process in Wales): increase from 51% to 58%. The Cardiff and Vale project (June 2022 to present) showed SGLT2i usage in people with type 2 diabetes and heart failure increased from 36% to 60% and SGLT2i usage in people with type 2 diabetes and ACR >30mg/mol increased from 37% to 55%. In terms of impact for people with diabetes, access to extensive, current data allowed the ongoing improvement in care noted here. Completion of care processes has been shown to be associated with reduced complications of diabetes, including amputation and kidney disease.

The data is allowing focus on areas of greatest need, such as the cluster in Cardiff with poorest completion of care processes, improving access to care for those harder-to-reach groups. NICE guidelines support the clear clinical and cost effectiveness of early use of SGLT2is in those at high cardiovascular risk with with type 2 diabetes to reduce cardiovascular events, reduce hospital admissions and reduce progression of CKD to dialysis. The project allows a focus on implementation of these guidelines by identifying those eligible individuals. The development of the project was funded through Digital Health Care Wales provision with no additional cost to the NHS.

USER FEEDBACK

Dr Julia Platts, national clinical lead for diabetes, Wales, stated, "The Audit plus module has been central to improving diabetes services in Wales: it has enabled the monitoring of current essential parameters and targets to share with Health Boards, clusters and practices to request focus and solutions where needed. This has had a direct impact, with improvements seen in most parameters in most areas. It has supported the development of new interventions and solutions in areas such as diabetic kidney disease and will allow direct monitoring of quality improvement projects. It has become a shining example of how data can feed service improvement." Julie Lewis, nurse consultant/ diabetes clinical lead, BCUHB, said, "I use this all the time for HB oversight/ PC education sessions and in clinical practice day to day for QI. One of the key benefits we have experienced at practice level is using the data to manage risk via relatively small QI work. For example, Addressing HbA1c >48 mmol/mol with no diagnosis of diabetes, or improving safety of prescribing in frailty and diabetes, or active recall for individuals with a HbA1c >100mmol/mol, or active recall for individuals with type 1 diabetes to complete all care processes – straightforward task and finish improvement work."

JUDGES' COMMENTS:

"The 'All Wales Diabetes Audit Plus Module' project imposes a high floor, so nobody falls though the net. The judges liked the breadth, national impact and fundamental building blocks. It had real life data that seemed to be updated daily."

WINNER

IMPROVEMENTS IN DIABETES CARE USING DATA *NEW FOR 2024*

Integrated diabetes care for people with advanced CKD : clinical research Programme (Dr Hellena Habte-Asres)

by Royal Free London Foundation Trust

SUMMARY

Dr Hellena Habte-Asres' doctoral study identified care gaps in managing diabetes in people with advanced chronic kidney disease (CKD). She co-led a grant application in October 2022, securing funding to establish a diabetes service at the North Central London's (NCL) Dialysis Unit. A new care model was implemented in NCL's renal satellite unit. This multifaceted approach included self-management education, lifestyle advice, medication optimisation, cardiovascular disease prevention and psychosocial support, resulting in significant metabolic improvements, increased guideline-directed therapies and greater access to diabetes technology.

INNOVATION

In October 2022, Dr Hellena Habte-Asres conducted a comprehensive mapping of diabetes service provision in NCL. This revealed significant gaps in care for people with diabetes and advanced CKD. Multiple interviews were conducted with key stakeholders in diabetes and renal services and routine data was analysed to establish the service needs. The identified need was to enhance diabetes care for individuals with advanced CKD (stages 4 and 5) and those undergoing haemodialysis at a renal satellite unit in NCL. This patient population faces complex health challenges due to the overlapping conditions of diabetes and CKD, requiring specialised care beyond standard diabetes management protocols. The existing service lacked comprehensive integration and expertise in managing both conditions concurrently, leading to suboptimal health outcomes. With grant funding, the new service was implemented in March 2023. The novel diabetes care model was tailored to individuals with advanced kidney disease. This approach involved: deploying a senior diabetes nurse specialist with expertise in kidney disease to enhance the capacity of the existing CKD service; a multifaceted care approach that included self-management education, lifestyle advice, medication optimisation, cardiovascular disease prevention, and psychosocial support, plus data-driven insights, utilising health informatics from both primary and secondary care databases to see the extent to which this population was receiving guideline-directed care. This included analysing the number of people who had completed diabetes care processes at baseline. Additionally, sociodemographic and clinical data were examined to further characterise this population. Incorporating metrics such as the Index of Multiple Deprivation identified significant disparities in access to diabetes care among individuals with advanced kidney disease. These insights were crucial in developing targeted strategies to address these barriers and improve health outcomes for underserved populations. Objectives included improving metabolic outcomes, enhancing use of guideline-directed therapies and increasing access to diabetes technology.

EQUALITY, DIVERSITY AND VARIATION

The insights gained from the data analysis informed the development of targeted strategies to address barriers to care. For example, focusing efforts on identified areas with low completion rates of diabetes care processes. Assigning a senior diabetes nurse specialist with expertise in kidney disease enhanced the capacity of the existing CKD service to provide comprehensive diabetes care. This role was crucial in reaching patients who had previously had limited access to specialised care.

Each patient's care plan was tailored to their specific needs, taking into account their clinical condition, socioeconomic status and personal preferences. The care model incorporated culturally sensitive practices to ensure that patients from diverse backgrounds felt respected and understood. Educational materials and communication strategies were adapted to meet the linguistic and cultural needs of the patient population. The initiative led to significant improvements in metabolic outcomes, including reductions in HbA1c, systolic blood pressure and weight among pre-dialysis patients, and similar improvements in the dialysis population. These outcomes indicated better overall management of diabetes and reduced risk of complications. There was a notable increase in the use of guideline-directed therapies, such as SGLT2 inhibitors and GLP1 receptor agonists, which are known for their cardiovascular and renal protective effects. The project significantly increased the use of continuous glucose monitoring (CGM) among the haemodialysis population, providing real-time glucose data and reducing the frequency of hypoglycaemia episodes. Through self-management education and support, patients gained greater control over their diabetes management, leading to improved health outcomes and quality of life. Identifying and targeting underserved areas, the project ensured that more patients had access to comprehensive diabetes care. This reduced geographical and socioeconomic disparities in service provision. Implementing a standardised care model that combined face-to-face and virtual reviews ensured that all patients received consistent, high-quality care regardless of their location or background. Regular monitoring of clinical outcomes and patient feedback allowed continuous improvement of the care model.

RESULTS

Among pre-dialysis CKD patients, HbA1c levels decreased by an average of -13.0 mmol/mol ($p < 0.001$). In the dialysis population, mean HbA1c levels reduced from 55.3 (±23.2) to 49.6 (±15.1) at the 12-month follow-up ($p < 0.004$). Systolic blood pressure showed a mean reduction of -13.7 mm Hg ($p < 0.0001$) among pre-dialysis patients, and a reduction of 18 mm Hg in the dialysis population. Body weights showed a mean reduction of -2.9 kg ($p < 0.0001$) among pre-dialysis patients. A reduction in serum total cholesterol of 0.2 mmol/L ($p = 0.0001$) was shown in the dialysis population. SGLT2 inhibitor utilisation increased to 62.9% and GLP1 receptor agonist use to 28.4%. CGM utilisation reached 89% among the haemodialysis population. The integration of diabetes and CKD care led to more comprehensive management of both conditions, improving overall patient health. Enhanced self-management education and lifestyle advice empowered patients to manage their conditions more effectively. Increased use of SGLT2 inhibitors, GLP1 receptor agonists, and CGM technology provided patients with cutting-edge diabetes management tools. Improved diabetes management reduced the incidence of acute complications, potentially lowering hospital admission rates. Better control of metabolic parameters and blood pressure helped prevent diabetes-related complications.

Integrating diabetes care into existing renal services optimised resource use and avoided duplication of services. By reducing the need for emergency care and hospital admissions, the initiative contributed to cost savings for the NHS. The project's focus on improving quality of care while minimising costs aligns with the NHS's goals of providing high-quality, cost-effective care.

USER FEEDBACK

The model garnered strong support from both healthcare professionals and patients. Ensuring anonymity in surveys and feedback forms encouraged honest and unbiased responses. Based on feedback, additional materials and workshops focused on nutrition were developed. Addressing concerns about virtual consultations, patients were given the option of virtual or face-to-face consultations.

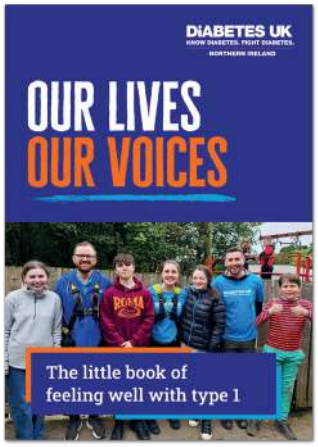
JUDGES' COMMENTS:

"The entry from the Royal Free London Foundation Trust had lots of information and was very well researched. The objectives were clear and it had demonstrable clinical outcomes that could be replicated. This blew the judges away and the improvement in care was fantastic."

HIGHLY COMMENDED

PEER SUPPORT

Our Lives, Our Voices type 1 young person's project
by Diabetes UK Northern Ireland



SUMMARY

The Our Lives Our Voices (OLOV) project was funded through the Empowering Young People Lottery Fund. It aimed to support and empower young people (11-25 years old) in Northern Ireland living with type 1 diabetes through confidence building, peer support, well-being programmes and improving relationships with healthcare professionals (HCPs). OLOV was led by young people, supported by Diabetes UK, and worked in partnership with local mental health organisations, AWARE and Action Mental Health (AMH). Following its success, funding was secured for UK-wide delivery of a similar youth-based project called 'Together Type 1'.

INNOVATION

It has been identified that those between 11-25 years old, and living with type 1 diabetes, are three times more likely to experience psychological problems than those without diabetes because of a gap in information and peer support. At the time of application there were about 1,890 young people in this age group. It was anticipated that the project would reach 569 young people and recruit at least 25 volunteer young leaders. Feedback from young people in this demographic showed that feelings of isolation were significant, demonstrating a need for opportunities to meet more people their age with diabetes. In addition they wanted activities that were geographically dispersed, inclusive and considerate of cultural background to allow a wider circle of community support. OLOV aimed to create a safe space where they could talk, learn and feel part of a community that was accessible when they needed it. The project was designed to empower them to take active roles in managing their condition and find solutions to the wider issues that affect the young diabetes community across Northern Ireland. It focused on improving confidence, developing peer support networks, increasing well-being and improving engagement with HCPs. Similarly, it sought to improve HCPs' interactions with young people. The young people were the best people to identify and develop relevant solutions for the gaps in their care. Over the last five years, OLOV has been led by young people, supported by Diabetes UK Northern Ireland and a dedicated youth coordinator and youth worker. It works in partnership with local mental health organisations AWARE and AMH. It has improved confidence and the emotional well-being of young people and created opportunities to meet other young people with type 1 and access peer support, as well as allowing them to become young leaders. It has also created better relationships with support networks and HCPs delivering diabetes care. OLOV was the blueprint for the subsequent 'Together Type 1' project, a nationwide young person's programme from Diabetes UK.

EQUALITY, DIVERSITY AND VARIATION

A young person's personal, financial and cultural status impact their opportunities to access diabetes support. OLOV needed to create an environment that would be accessible to all, by providing support and activities in various formats. Monthly sessions were held online, allowing the young people access from their homes, work places or elsewhere. The relaxed format of sessions and different days and times allowed them to attend when they could. Tablets were loaned and delivered to those who required them, with the offer made to all of the young people. At project conception, online support was anticipated to be a minor part of outcome delivery. However, in year five, 50% of peer support activities were online. Incredibly, 94% of young people said they had had access to an online support network. Some young people with additional needs found online activities difficult, so OLOV offered face-to-face peer support activities, in-person well-being days and community events. All events were free to the young people and families, with support for transport. Community events were hosted locally so young people felt comfortable. Venues were physically accessible for all and politically neutral, where possible. All support and events had youth input and changes were made based on feedback.

RESULTS

OLOV reached 784 young people and delivered 3,039 interventions through 326 activities. A total of 122 peer-support activities were delivered, connecting 336 young people (13% above target). All young people surveyed said events had provided a peer-support network, improved emotional well-being and provided space to discuss issues related to type 1 diabetes. The project improved well-being by empowering participants to increase their knowledge and skills around their diabetes self-management. Over the course of the project, young people contributed to: a new Northern Ireland-wide insulin pathway; Northern Ireland's Mental Health Strategy Consultation; research at Queen's University Belfast to create an international youth advisory panel investigating the impact of social media on young people with type 1 diabetes; the Diabetes Network for Northern Ireland, including sub-group for foot-care, inpatient care, pregnancy, young adults and patient education; Change Labs – workshops with HCPs designed to improve transition to adult care; one young leader joined the Northern Ireland Advisory Council, plus three young leaders presented to members of the Legislative Assembly at the All-Party Group about the challenges they faced living with type 1 diabetes. OLOV recruited 38 young leaders who delivered 110 activities.

USER FEEDBACK

Two focus groups were held in 2015 and 2016 with young people in Northern Ireland from rural and urban cohorts with different cultural backgrounds, as well as with 107 parents. Four areas of need were identified: confidence building; peer support; well-being, and relationships with HCPs. The project adapted to circumstances and feedback as it progressed.

DISSEMINATION AND SUSTAINABILITY

The project was funded by the National Lottery Community Fund for five years, but it will have a lasting impact. People have remained involved in the wider work of Diabetes UK Northern Ireland and become volunteers for other work. Legacy pieces include the video 'We are Type 1', the 'Belfast Exposed' photography exhibit, plus a well-being resource booklet for young people. Diabetes UK Northern Ireland podcast (Let's Tak Diabetes) had an OLOV takeover for three episodes. It has also laid the groundwork for Together Type 1, which runs for a further five years with funding from the Steve Morgan Foundation to Diabetes UK.

JUDGES' COMMENTS:

The judges liked that Diabetes UK Northern Ireland's work was a whole country-wide peer support programme and that it was funded for a further five years. It had great collaboration with mental health charities and the results demonstrated that individuals are embracing the project. It was just what young people with T1 needed.

WINNER

PEER SUPPORT

Camp for adults with type 1 diabetes
by League of Diabetes by Diathlete registered charity

SUMMARY

The League of Diabetes (LOD) camp for young adults with type 1 diabetes (T1D) transitioning to adult care is a three-day residential event that includes outdoor activities, educational sessions and opportunities to hear stories from others living with T1D. Organised by the Diathlete charity, the camp aims to foster a supportive community. The first camp was held in 2019. In 2024, 50 people were registered and the event partnered with local NHS teams. After the camps, some participants discussed and started diabetes technology and experienced improvement in acceptance and reduced feelings of loneliness.

INNOVATION

Gavin, founder of Diathlete, and his wife Paula, who live with T1D, are passionate about the power of face-to-face opportunities and connections between adults with T1D. The camp's three-day programme combines outdoor activities, such as kayaking, with educational sessions on diabetes management. This fosters teamwork, confidence and trust among participants, while providing practical diabetes management skills. Educational sessions cover topics including exercise management, diabetes technology and mental health. The sessions are interactive and engaging, encouraging participants to share experiences and learn from each other. The camp focuses on young adults transitioning to adult care and addressing their unique psychological and social needs. Peer mentors and camp staff, many of whom have T1D, provide relatable role models and practical advice. By sharing their own experiences, mentors help participants feel understood and supported, reducing feelings of isolation and anxiety. Participants are encouraged to discuss their experiences with different diabetes management technologies and practices around a campfire. All activities are supervised by trained professionals, with healthcare providers on-site to manage any medical issues. Participants receive thorough pre-camp briefings on safety protocols and diabetes management during physical activities. The objectives are to enhance psychological empowerment, increase self-management skills and encourage the adoption of advanced diabetes technologies. Partnerships with NHS teams highlight the camp's effectiveness in improving transitional care strategies, and the initiative has been recommended for integration into regular care practices. This project is unique in its holistic and immersive approach. Unlike virtual appointments or purely educational programmes, the LOD camp addresses the social and psychological needs of young adults with T1D, fostering a supportive community that helps them feel more empowered about diabetes management.

EQUALITY, DIVERSITY AND VARIATION

To ensure those from diverse socioeconomic backgrounds can attend the camp, there is a 'sponsored ticket' option for those who cannot afford the £50 fee. Scholarships and financial aid enable adults from low-income families to attend. Adaptations are made to ensure accessibility for individuals with different levels of physical ability and trained staff assist them. Participants have joined from Europe, the Middle East, Latin America and Africa, where there are no adult peer support events. The needs of participants from different cultural and ethnic backgrounds are addressed by providing specific dietary options and sleeping arrangements. The programme is designed for participants with varying degrees of diabetes management experience and treatments. Culturally sensitive and inclusive educational content is based on consultations with healthcare providers and community leaders from diverse backgrounds, with discussions included on how cultural practices and beliefs may impact diabetes management. Pre-camp assessments to understand the individual needs of each participant enable support and resources to be tailored. A continuous feedback mechanism allows real-time adjustments to ensure the programme meets the needs of all participants.

RESULTS

The first camp for adults with T1D was organised in 2019 at Gilwell Park, with 25 participants from the UK, India, Pakistan, Latin America and Europe. The second camp took place at Aldershot's Runways End Outdoor Centre, attracting 30 participants from the UK, Ireland, Greece, Kuwait and Italy. In 2024 the camp registered 50 participants, mainly from the UK. Participants from Europe, Asia, and Latin America attended to enjoy the programme and to share ideas with their national diabetes charities on developing similar camps. In Latin America, a participant set up a one-day programme, with plans for a three-day residential later in the year. The 2023 camp led to an alliance with the University Hospital of Southampton and Southern Health NHS Trust to allow 10 young people to attend the camp, accompanied by diabetes team staff. Participants felt encouraged to discuss diabetes technology with their diabetes teams. Two participants in 2023 were initially skeptical about insulin pump therapy but, after discussing with others, they decided to try insulin pumps, resulting in improved HbA1c levels and better time in range. Participants also appreciated the opportunity to talk about life with diabetes with other adults, not just their diabetes team. This positively impacted their mental health, technology uptake and engagement with diabetes management. The charity will apply for grants in 2025 to reduce dependence on pharmaceutical and MedTech sponsorships. Forming alliances with hospitals is also a strategic goal, enabling hospital teams to fund the participation of their patients and staff.

USER FEEDBACK

Feedback was collected via MS Forms sent to participants after attending the camp. They reported positive and motivating experiences.

DISSEMINATION AND SUSTAINABILITY

The project has reached adults living with T1D from countries including the UK, Ireland, France, Italy, Kuwait, India, Pakistan, Costa Rica, Chile and Brazil. In 2024 a participant from the Sonia Nabeta Foundation in Uganda planned to shadow the camp. The project will be replicated in different parts of the UK, such as Northern Ireland, where an NHS team is interested in collaborating. The charity wants to collaborate with NHS teams and organisations to increase reach and impact. The camp aims to enhance patient experience by using game-based learning techniques to educate about T1D. These techniques have engaged participants and improved their understanding of diabetes management. Diathlete plans to multiply volunteer teams to develop more camps. Diathlete (LOD) will publish a guidebook on delivering game-based learning techniques for T1D education. It will include the camp strategy and will be supported by a consultancy programme to assist other organisations and hospitals in implementing the initiative. This structured approach will make it relatively straightforward for other services to adopt and implement the adult camp model.

JUDGES' COMMENTS:

"Diathlete's work was fresh and new. It had excellent innovation and was immersive, with strong equality and diversity elements. It was also brilliant to see the programme was picked up by young adults, a tough group to reach. Overall, well thought through, well put together and the judges loved it!"

FINALIST

PEER SUPPORT

Podding Peer Support
by Podding Peer Support

SUMMARY

Podding Peer Support began in February 2023 as a way for people who were using, or interested in, Omnipod, and living in Leicester, Leicestershire and Rutland, to connect and support one another. The community has an active WhatsApp group called 'The Omnipod Squad', with over 50 members. It also meets monthly online and in person, benefitting individual users and the local hospital diabetes team. Its success has engendered plans to set up and run other local insulin pump-specific peer support groups.

INNOVATION

On average, people with type 1 diabetes spend just an hour each year with a healthcare professional. The rest of the time they must self-manage their condition. Peer support has been highlighted as one of the key pillars to enable successful self-management. Podding Peer Support began following a conversation in January 2023 between the University Hospitals of Leicester NHS Trust Diabetes service lead and the group's co-lead. People using Omnipod had shown interest in connecting with other people using the technology. In February 2023 the first meet-up was held with five Podders. Since then, the group has grown to over 50 members using or interested in Omnipod. The Omnipod Squad WhatsApp group hosts individuals between the ages of early-20s to mid-70s. The group was initially for people using Omnipod Dash in manual mode, as well as those utilising the technology as a do-it-yourself closed loop system. However, following the change to NICE guidance in relation to the rollout of hybrid closed loop therapy in type 1 diabetes, there has been a substantial increase in people joining who are using Omnipod 5. This support group has not only benefitted those living with type 1 diabetes, but also the local hospital diabetes team, who have highlighted its importance as a way for people to support each other, especially out of hours and at weekends. The group adheres to recommendations set out by ABCD-DTN Best Practice Guidance for hybrid closed loop therapy about how hospital type 1 diabetes services should have a peer support group/intervention. The group is run on a voluntary basis and does not provide specific medical advice.

EQUALITY, DIVERSITY AND VARIATION

A key value is ensuring that people have equal opportunities to get involved, while considering different backgrounds, cultures and needs. A female Podder with a South Asian background who came to one of the group's meet-ups said that her family had advised her to keep her condition hidden. This was the first time she had connected with other people living with type 1 diabetes and she found the experience "amazing". Podding Peer Support has a majority of White British people. The co-leads are trying to raise awareness to encourage people from different backgrounds to join, including by celebrating members' involvement through the Podding Peer Support website and discussion on a podcast. The group promotes equality, diversity and variation through its interactions via the private WhatsApp group and monthly meet-ups. Each member is given an opportunity to discuss and share their experiences. Each face-to-face and online meet-up has a theme to help focus the conversation, such as hypos, physical activity, mental health, carbohydrate counting, holidays and travel or stigma. Some meet-ups have featured healthcare professionals from the diabetes team, such as a senior diabetes dietitian who did a question-and-answer session about carbohydrate counting.

RESULTS

Since the group began, it has provided over 18 hours of live meet-up support and over 12,000 hours of live WhatsApp support. To understand its impact during the first 12 months, members (n=24) were invited to complete a knowledge and confidence questionnaire (K&C) and Problem Areas in Diabetes (PAID) scale questionnaire upon joining the group. At month 12, those (n=22) who had been part of the group for at least one month repeated the initial K&C and PAID scale to identify any changes, plus an evaluation questionnaire. In addition, 14-day continuous glucose monitoring (CGM) data (via LibreView and Dexcom Clarity) was obtained following written consent from each participant. This data was used to compare pre-participation values to those obtained at least one month following initial participation in the group. An increase in knowledge and confidence and positive trend benefits were noted in the CGM data. A total of 85% of members rated the group as 'very helpful' or 'extremely helpful' to their self-management. This is further supported by an increase in hypoglycaemic awareness for 23% of the members. Surprisingly there was a substantial increase in Diabetes Distress scores, by 21.5%, but 82% rated the group 'very helpful' or 'extremely helpful' to their psychological wellbeing. These findings could have been impacted by things like the length of time someone had been part of the group, and whether someone had changed their treatment method (eg. moving from open loop to closed loop using Hybrid or DIY). This is an important point, as over 50% of members stated that they had been using their current method of treatment for less than one year.

USER FEEDBACK

There has been much positive feedback about the group from stakeholders and participants. On World Diabetes Day four Podding Peer Support members took part in an Eden Chats podcast episode to talk about the importance of peer support and the impact that the group has had on their own lives.

DISSEMINATION AND SUSTAINABILITY

Since the group started, a key part of its success has been the relationship with the hospital diabetes team. They email all of the Podders living in Leicester, Leicestershire and Rutland each month, prior to each meet-up, enabling all local people using the technology to hear about the group, while complying with GDPR. Awareness about the group is also raised via Diabetes UK's group search engine. Also the group launched its website: www.podding.co.uk on World Diabetes Day in 2023. The group has been running for over 500 days now, growing in numbers and reputation. It is hoped that other insulin pump-specific groups will be developed within the service. To maintain sustainability, in April 2024 another Podder became co-lead, which reduced pressure on the other lead and introduced new ideas.

JUDGES' COMMENTS:

"Podding Peer Support' was a great idea, run by volunteers. It was fantastic that the patients are the ones providing peer support, so addressing issues in a way that is understood by all concerned."

FINALIST

PEER SUPPORT

The Highs & Lows support group

by University Hospitals of Leicester Children's Diabetes Team

SUMMARY

The Highs and Lows Support Group came about following reports that many patients and families looked after by the paediatric diabetes team at University Hospitals of Leicester did not know anyone else who understood the burden of diabetes. The group helps them feel supported, included and understood. A wide range of events is organised, such as bowling, soft play, mini golf and picnics. The impact has been positive, with parents gaining compassion and understanding from other parents, and the children enjoying meeting others with diabetes. It also helps to show young people and families diabetes technology in a fun, social environment away from clinical care.

INNOVATION

Some children and parents see the clinic as a threatening environment. They are reluctant to open up to or engage with the diabetes nurses and doctors. Many children/young people (CYP) are the only student in their school with diabetes, or the only one in the family. The support group offers a safe space in a non-clinical setting where they can meet others who understand life with diabetes. It is a place where they can be themselves, talk and share problems without the worry of getting things wrong. Many siblings of children with diabetes also find living with diabetes difficult, which often goes unrecognised. The support group gives them 'time out' from being the sibling of a child with diabetes. Again, they can meet others and share experiences, or just make new friends and have fun. The parents also meet and socialise, make new friends and discuss and share their lives with diabetes. The group also improves partnerships between the CYP, parents, careers and the diabetes team, helping to remove boundaries found in a clinic environment. This enables better interactions and improved information sharing. Now, in the clinic, some of the CYP, parents and careers are less apprehensive about being there and feel more at ease with the diabetes team. Some seem more accepting of their diabetes and clearly support one another. It is too early to say if there has been a positive effect on glycaemic control. Once established, the parents and carers will be able to support this venture themselves, with minimal support from the professional team.

EQUALITY, DIVERSITY AND VARIATION

Issues relating to equality and diversity have been addressed by ensuring all families (n = 415) are informed of the diabetes support group at outpatient appointments and via social media platforms. Clear written and verbal information about upcoming events is also provided. The group provides an environment where families' voices can be heard and concerns addressed. As those from deprived backgrounds may not be able to afford activities like bowling, laser tag and trampolining, fully funded places are offered for all CYP with type 1 diabetes. Activities that do not require substantial funding, such as picnics in the park, are offered to ensure annual budgets can be spent appropriately. Event locations are chosen to be easily accessible via public transport. To cater for the 1-16 years age range, different activities are held, ranging from soft play and trampolining to laser tag and bowling.

RESULTS

The Highs and Lows support group has been established since May 2022, hosting quarterly events each year. In the past year, events included a family picnic in Abbey Park, laser tag, a Christmas party, bowling and BOOST trampolining. Approximately 130 families benefit from funded places at these events. As a way of supporting young people and families, the group is included in diabetes annual review clinics when discussing emotional well-being – a frequent point of discussion, considering diabetes burnout. The positive feedback from the support group has been overwhelming and attendance at the events continues to grow. Families have made financial contributions to the group to ensure it can continue to thrive. In addition, providing this group has reduced phone calls, saving staff time. Families are supporting each other and meeting up outside of group activities.

USER FEEDBACK

The feedback from families has been very positive, via text messages, cards and in person. The diabetes team has enjoyed getting to know the CYP and their families/carers in a non-clinical, relaxed environment. The overwhelming benefit of this support group was reflected in families asking when the next event would be, wanting to get involved and reporting the benefits to not only their children but to them as parents. Many CYP shared phone numbers and developed long-term, meaningful friendships. Parents are now involved in organising events along with the diabetes team. Support from the children's hospital charity and diabetes UK has funded the project.

DISSEMINATION AND SUSTAINABILITY

The Highs and Lows support group was established for families looked after by the paediatric diabetes team at University Hospitals of Leicester, supported by Diabetes UK, who provided a template of how to establish a family support group. The aim is to reach as many families as possible in the service, and ensure that all activities remain free for the CYP with diabetes. Given the limited provision of paediatric psychology services within the team, it is hoped that the peer support group will serve as an alternative service to help remind families they are not alone in the difficulties they face, and that diabetes can also bring new connections, friendships and enjoyable times for CYP.

JUDGES' COMMENTS:

"The Highs & Lows Support Group' was a strong project with powerful user feedback. The judges liked that this supported children and their families, with regular events that included the wider family of patients."