

ENTRY FORM

SECTION ONE - CATEGORY

Please put a cross in the box beside the category you wish to enter:

Best type 2 diabetes prevention initiative	
Best screening/early detection initiative	
Best initiative supporting self-care	
Best integrated care initiative	X
Best emergency/in-patient care initiative	
Best initiative managing complications associated with diabetes	
Best safe care of patients initiative	
Clinical service redesign	
NHS Team of the Year working in diabetes	
Community initiative of the year	x
Industry-led initiative of the year	
Partnership working of the year	

Note: Please complete a separate form for each entry and category you wish to enter

SECTION TWO – YOUR DETAILS

Title:	Dr
First name:	Carol
Surname:	Gayle
Job title:	Consultant Diabetologist
Hospital/trust/company/organisation:	King's College Hospital NHS Foundation Trust
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SECTION THREE – ADDITIONAL CONTRIBUTORS

If entering a team/partnership category, or if there are other individuals to recognise, please list them here:

Additional contributor one:	Dr Khalida Ismail, Consultant Psychiatrist (Co-project lead)
Additional contributor two:	Ms Lauralee Pryce, Community Support Worker, ThamesReach
Additional contributor three:	Dr Nicola Archer, DClinPsych, clinical psychologist

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Additional contributor four:	Dr Kitty Morgan-Jones, PhD, psychotherapist, HearSay Charitable Trust
Additional contributor five:	Ms Oxana Brigden, Project Officer

SECTION FOUR – YOUR ENTRY

Once you have completed this form, you may submit your application online by uploading this form when prompted.

Background/origin of the project:

Briefly provide the background to the initiative and explain why it was undertaken. From this the judges should be able to understand why there was a need for the initiative. Also state the month and year when it started.

The 3DFD (**3 Dimensions of Care For Diabetes**) Programme is a model that integrates medical, social and psychological care with the aim of improving diabetes control in complex cases who are most at risk of worse biomedical outcomes. Our innovation is new in that it recognises that social factors influence diabetes control and it is radical in that its aim is to improve the social environment so that the person with diabetes may become more confident in managing their diabetes. This project was funded to be set up in the borough of Southwark by the NHS London Regional Innovations Funding Scheme in February 2010 and began in August 2010. To our knowledge, 3DFD is the first to fully integrate medical, psychological and social care for adults with diabetes.

Type 2 diabetes tends to cluster in areas associated with high levels of socio-economic deprivation, multi-ethnic populations and psychiatric morbidity such as depression, anxiety, eating disorders and psychosis. Yet current models of diabetes care are Cartesian in that they separate the mind from the body and even more from the social context. Psychological and social factors interfere with the individual's ability to prioritise their diabetes self-care in both type 1 and type 2 diabetes. There may also be substantial psychological and social consequences of living with diabetes such as guilt, stigma and financial and occupational worries. There is increasing recognition of the importance of integrating social and health care (Health and Social Care Act 2008). While there has been some progress in integrating psychological care for adults with diabetes (Diabetes UK & NHS Diabetes: Emotional and Psychological Support and Care in Diabetes Report 2010), there has been no progress in integrating their social needs.

Healthcare for London, A Framework for Action (2007) emphasised the importance of partnership working across the NHS, London boroughs, the Mayor's office, voluntary and private sector and higher education to address London's health inequalities and improve healthcare outcomes. The Diabetes Guide for London () emphasised that the model of care requires integration at multiple levels. This includes individual patients being involved in care planning; care pathways; integrated diabetes teams across primary and secondary care; social marketing; community specialist clinics. This model is being increasingly adapted across the UK.

In 2003, the Diabetes Centre, King's College Hospital, integrated a liaison psychiatrist into their main service. We adapted the Care Programme Approach which is the UK system of delivering community services to those with mental illness. Our audit (2009) found that attendance to the liaison psychiatry service integrated into the diabetes clinic was associated with improved glycaemic control for people with complex diabetes compared to those who did not attend (mean difference in change between the two groups from referral to follow up in HbA1c -1.90%). It was shortlisted for the Clinical Audits Award, King's College Hospital in 2009.

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The process evaluation of the audit recognised that when psychological and social care was integrated with diabetes care for those with multiple health and social problems, this led to an improvement in biomedical outcomes. For instance, by early and rapid facilitation of housing, managing debt or childcare, a case worker can reduce the social drivers contributing to a person's difficulty in prioritising diabetes.

Qualitative analysis from a third sector charity, HearSay Charitable Trust (www.hearsay-trust.org.uk), which provides rehabilitation counseling for people challenged by a disabling event or long-term condition, in achieving a better quality of emotional life and reducing stress found a wide range of themes in people with diabetes. These included denial and acceptance of diabetes, fears around insulin and oral diabetes agents, the traumatic stress of developing complications, peer pressure from friends and expressed emotions from families as well as everyday life such as bereavements, carer roles, marital strife and social isolation.

We selected Southwark as it has a highly deprived, young, multi-ethnic population with high rates of diabetes. It also had successful collaborations with Thamesreach which is a highly active third sector organisation providing community case work support on a range of social problems. Our model places the person with diabetes at the centre of their own care by bringing a team of cross-sector care providers to that individual.

Objectives:

Explain what you hoped to achieve with the project, including what you wanted success to look like. This will help the judges determine whether you were successful.

The main objective of 3DfD (**3 Dimensions of Care For Diabetes**) is to deliver a community based model that integrates medical, social and psychological care to improve glycaemic control and other biomedical outcomes in complex cases.

Our secondary objectives were:

1. To specifically address health inequalities by targeting the hard-to-reach individuals with diabetes. We will achieve this by improving their access to preventative health care, reduce use of unscheduled care (including out-of-hours general medical services; A&E admissions; walk-ins to diabetes centres)
2. To improve psychological status: improvement in generic quality of life and diabetes specific psychological functioning measured by Diabetes Distress Scale.
3. To improve social functioning: each patient in 3DFD will have had a formal needs assessment and appropriate activation of plan within national guidelines with documented use of both voluntary sector and statutory resources.
4. To improve the quality of care while making efficiency savings by identifying current components of current service provision which can be decommissioned

The inclusion criteria were i) adult resident of Southwark; ii) to have persistent (>6 months) poor glycaemic control; iii) significant psychological and/or social issues by referrer.

The exclusion criteria were i) severe mental illness such as schizophrenia, bipolar disorder; ii) registered with a community mental health team; iii) known learning

disability.

Execution/implementation:

Use this section to demonstrate what you did. You can outline any methodology, analysis, monitoring, communication, staff and patient participation, and your overall approach in implementing the project. Judges will be looking to understand how you went about achieving your objectives.

We had 6 months from receiving the funding award to the initiation of the service. As 3DFD was a new service rather than a reorganization of an established service we (Dr Gayle and Dr Ismail) led its implementation as follows:

1. Staff and patient participation: the service was presented to the clinical team and each of the four levels of within King's College Hospital (the clinical team, department managers, divisional manager, and the Chief Executive office) to receive critical feedback and to ensure joint working within the organization vertically and horizontally. As the patients are hard to reach, patient participation was in the form of delivering the service to them and adapting it to the needs and wishes of the patient.

2. Workforce planning: 3DFD was led by a consultant diabetologist and consultant liaison psychiatrist. We developed job descriptions, advertised and appointed project officer (Ms Oxana Brigden), clinical psychologist (Dr Nicola Archer), Project Worker seconded from SouthwarkReach (Ms Lauralee Pryce). Dr Kitty Morgan-Jones (PhD) came from HearSay Charitable Trust to work systematically with individuals and families. Team members attended accredited courses on introduction to diabetes, statistics and motivational interviewing.

3. Infrastructure: the service was originally designed to be implemented in the community at the polyclinic level. Changes in government policy led to a halt in polyclinics in Southwark. We revised the service to delivered at both the community and hospital level. We negotiated 4 days of outpatient rooms in an organization extremely pressed for clinical space. These clinical sessions were to deliver psychological treatments, case work and to multidisciplinary team sessions and case conferences.

4. NHS e-technologies: We worked with IT departments to embed the service in the hospital's electronic patient records system. This involved a) an electronic referral form and b) implementing an appointments system also allowing data to be collected for service evaluation (including costs) and auditing.

5. Model of care: we developed a pathway to guide ourselves and to inform the patient:

Step 1: Referral from GP or hospital

Step 2: Individualised tailored working with the patient to address the medical, psychological and social needs according to those identified as a priority for the individual with the aim of supporting their diabetes care.

Step 3: Patient led case conference: patient defines the agenda and the help s/he needs from 3DFD. This usually takes place at 3-6 months into treatment

Step 4: Individualised working with any revised goals continues.

6. Marketing: We circulated patient and professional leaflets (please see supporting information), networking to Southwark Primary Based Commissioning consortia (Dr Gayle has a community diabetes role) and visited individual surgeries. We also created an open access webpage on the regional diabetes website.

(www.londondiabetes.nhs.uk/content.aspx?pageid=100382). We have also promoted our service within the Southwark Improving Access to Psychological Therapies.

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7. Data collection and evaluation: We applied for clinical governance approval for audit and clinical effectiveness; We adapted the Plan-Do-Study-Act cycle methodology on a 3 monthly cycle to conduct an interim process evaluation of 3DFD to identify weakness, and build on strengths. Psychological, social, health economics and biomedical data collection was collected at baseline and 12 months plus quarterly HbA1c.

8. Independent monitoring: We have a steering committee represented by the Kings Health Partners Health Innovations and Education Cluster (HIEC), Southwark Primary Care Trust/GP Commissioners), Southwark Patient Participation Group to receive feedback and give guidance and advice and steer any problem solving. Martin Knapp, Professor of Mental Health Economics, King's College London was an observer.

Results :

Describe the outcome(s) of the project. In particular demonstrate the impact on staff and patient outcomes, against the original objectives.

Quantitative analysis:

We have conducted analyses on the first 32 patients who have completed 3DFD or in full progress. The characteristics of this group are summarised in the table below:

Characteristics		Mean (SD)/Proportion (%)
Mean age, years		43.5 (12.9)
Gender, n (%)	Male	19 (59)
	Female	13 (41)
Ethnicity, n (%)	White	10 (31)
	African/Caribbean	20 (63)
	South Asian and other	2 (6)
Type of diabetes, n (%)	Type 1	14 (45.2)
	Type 2	17 (54.8)
Mean (SD) duration of diabetes, years		9.7 (8.2)
Mean (SD) % HbA1c		11.1 (2.29)
Employment, n (%)	Fulltime/Part-time	11 (39)
	Unemployed/sick/medically retired	16 (57)
	Retired	1 (4)
Did not attend (DNA) rate in the previous year, n (%)		3 (31)
Patient Health Questionnaire-9 (depression caseness), n (%)		12 (70)
Diabetes Distress Scale (clinically significant distress) n (%)		12 (80)

The group of patients was representative of the hard to reach people with diabetes in keeping with our main objective. Interestingly more men entered the service, the patients

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were more likely to be from ethnic minority backgrounds and unemployed. On average they had had diabetes for 10 years, the majority had type 2 diabetes and extremely poor glycaemic control. The DNA rate was well above the national average which is 18%. Nearly everybody was suffering from depression. On the Diabetes Distress Scale, the most highly rated distress subtypes were 'Emotional Burden' (feeling overwhelmed by diabetes) and 'Regimen Distress' (concerns about managing day-to-day diabetes care).

At the first 3 month evaluation, we observed clinically significant reductions in glycaemic control: mean change in HbA1c from baseline to 3 months in those for whom data was complete was -0.9 (95% confidence interval -1.67 to -0.09, $p=0.03$) and this was statistically significant. The DNA rate fell to 19% and thus closer to the national average.

The following qualitative findings were observed:

1. There were high levels of severe unmet need such as marked poverty, high debt, profound social isolation, undiagnosed psychosis.
2. There were high levels of risk to self and others such as active suicidal ideation and self harm, child protection, domestic violence, eating disorder. For instance, 43% receiving clinical psychology reported a past history of suicide attempt mostly involving intentional insulin overdose.
3. High levels of other co-morbidities such as rheumatoid arthritis, undiagnosed TB, diabetes complications such as painful neuropathy,

Evaluation:

Explain how you measured the success of your project.

We have addressed this section in a series of questions and answers:

1. Was the model accepted by stakeholders?

The stakeholders were local GPs, the hospital diabetes teams, hospital managers, patients, third sector providers. The stakeholders had increased awareness of the multi-factorial nature of poorly controlled diabetes. We succeeded in setting up a functional unit within 6 months. This demonstrates that the concept of the 3DFD model was accepted by the stakeholders and that there was a collective ownership of the project amongst the hospital and community teams. This is despite radical government policy changes related to GP commissioning of health care.

2. Can the 3DFD model be diffused?

The project was implemented in one PCT. One of the essential component of the intervention was to include community workers from the third sector who by definition and experience know their own community the best. Within weeks of launching 3DFD we received referrals from neighbouring PCTs (Lambeth and Lewisham) indicating the potential to diffuse the project who may have their own community workers. Plans are afoot to embed 3DFD within other King's Health Partner organisations such as Guy's and St Thomas' Hospital.

3. Is the model sustainable?

3DFD has been 'adopted' by the Diabetes Modernisation Initiative which is a £4.5 million project funded by Guy's and St Thomas' Charity to radically reorganise and redesign diabetes services across primary and secondary care in Lambeth and Southwark. The Initiative will test the project into a community locality clinic. This Initiative may decommission components of the traditional diabetes services to commission 3DFD.

4. Has the model led to quality improvement?

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It is well recognised that any reduction in glycaemic control towards optimal levels is associated with decreased risk of diabetes complications and disability in the medium and long term. These are associated with reduced individual and societal health costs.

5. Did we reach the hard-to-reach people with diabetes?

We clearly succeeded in reaching those considered hard to reach. In particular we are pleased to report that people from ethnic minority backgrounds and social deprivation do engage pro-actively with the service and perceive it to be of value (please see supporting information-patient testimonials on the video-weblink).

6. Did 3DFD succeed in a genuine integration?

We have clearly demonstrated integration across professional disciplines, organisations, sectors and policies to create a service that is flexible boundaries.

7. Patient satisfaction: the patient led case conferences have been a resounding success. One patient fed back 'Just knowing that someone cared, and was going to help me, helped me to take better care of my diabetes'. The fact that we had volunteers keen to share their story on video reflected patient satisfaction.

Feedback:

Provide at least one quote from a customer/clinician/commissioner/patient confirming the impact/effectiveness of your initiative. All referee details will be kept confidential.

Referee details:

Name:	Ms Sharon Hogan
Position:	Patient
Organisation:	358a Upland Road, London, SE22 0DP
Email:	Mobile: 07539 722699

'It was good to get everyone altogether at the meeting, for all different parts of my care. It was different from how things were done before. you didn't have to wait for people to get back to you when you ask a question-you could get an answer back straightaway.'

Learnings:

One of the main aims of QiC is to enable learning and sharing of initiatives across the four nations for the benefit of diabetes patients. Use this section to outline any learnings that can be taken from the project and/or challenges faced along the way, that could be transferred to other teams and organisations in the field of diabetes care.

1. Setting up cross-sector teams: Care providers are used to working according to their own professional training and experience, the values of the sector they come from and the work culture of their organization. In assembling a team from clinical psychology, acute medicine, third sector, psychotherapy one needs to take account of all of these variations. We learnt in real time that this required patience, tolerance, respect, willingness to learn and share one's own knowledge, joint training for team members, developing a common goal. The sum of the skills of the team is greater than the sum of the individuals. A learning point is that in the formation of cross sector team, the leads should be aware of the risks and be explicit in managing this journey. Strong and positive leadership by the project leads was maintained by weekly team meetings which ensured we grouped at least once a week.

2. Diplomacy: It is not enough that the idea is a good one and that opinion leaders and key players approve of it. A learning point is the need for constant and clear

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communication streams at multiple levels across the sector boundaries, across organisations and across policies. This is especially crucial in the current climate with economic and political uncertainties regarding commissioning and loss of local government funding for our third sector partners, ThamesReach (www.thamesreach.org.uk) and HearSay Charitable Trust.

3. Professional ignorance ('Where ignorance is bliss, 'tis folly to be wise' by Thomas Gray): In the original planning we had funding for a full-time social worker and only sessional time from the third sector support worker. We learnt very quickly our definition of social care was wrong and the social care workforce planning needed to be reversed. Our learning point is that for an innovation to be successful, there is a need for scoping, being open-minded, listening and reflecting and being ready and responsive to making rapid changes.

4. Applying the iterative process: we learnt that having an explicit interim process evaluation using models such as the Plan-Do-Study-Act cycle is invaluable to improving the quality in care while continuing to deliver the service.

5. The value of patient centred care: we learnt a huge amount from observing the patient experience and this became one of the main drivers of 3DFD team. Many services are at risk of paying lip service to the wishes and needs of patients-please see Natalie's testimonial. By letting the patient lead the case conference and other aspects of their care, it allowed us to acquire an in depth learning of their difficulties and this improved the patient-care provider alliance. It allowed the patient to return to, and engage with mainstream services as they improved.

6. Hard-to-reach are not so hard-to-reach: organisational perceptions about this group can be explicitly challenged and we found that this patient group's perception of our services are an important factor that influences their engagement.

Innovation:

If applicable, explain what makes your initiative innovative or pioneering, and describe the impact of your initiative relative to the resources you used.

The key components of the innovation were as follows:

1. We created an integrated model across sectors that deliberately targeted many of the most hard-to-reach individuals in an area of severe social deprivation and marked health inequalities. The team was designed to provide care centred around the patient's needs and wishes, while at the same time keeping in mind the need for quality in care and efficiencies. The unique feature of the team is that we integrated the medical, social and psychological care into one team.

2. The community support worker from the third sector (Thamesreach). The support worker is a member of the team but works in the community, that is, the patient's home, cafes and public spaces. She gives the team and its patients practical back up in the following areas: claiming benefits, appeals for unjust dismissal, developing self confidence and life skills and putting patients in touch with special services. She prepares patients for the patient led case conference and escorts on behavioural experiments such as going swimming.

3. Range of psychological care: where psychological care is available in diabetes

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settings, this is usually limited to one type of treatment such as cognitive behaviour therapy, counselling. In 3DFD, by utilising the resources in the different sectors we were able to offer a wide range of psychological treatments. These included CBT, motivational interviewing, systematic therapies, group therapy, psychiatric care, psychotropic medication such as antidepressants under one umbrella.

4. Patient-led case conference: we developed a template agenda (please see supporting documents) for patients to use as they wished, to list their hopes and plans for diabetes, their barriers, and need for further information from the team. For every patient, this was the first time the patient had put their story across. Considering the high levels of social, economic and educational deprivation and lack of experience in having an equal voice vis-a-vis health care experts, this was a powerful tool to increase the patient's self esteem and diabetes self care.

5. Cross-fertilisation of professionalism: the strength of this innovation is the bringing together the different knowledge, skills and experience of working with people with long term conditions. This led to continuing professional development.

6. Built in quality improvement and efficiency: most new services tend to become additional to current services rather than in lieu or part of a redesign or decommissioning. We deliberately designed this project with diffusion and sustainability in mind from the outset. This includes identifying components of current service that could be decommissioned or moving 3DFD into the community. By including a project officer this allowed the administration and data collection to be done independent of delivery of care.

7. Academic Health Sciences Centre: We used the infrastructure of the King's Health Partners to bring together academics, clinicians and educators to develop the evidence base for the model (literature review, scoping) and define the standard of data collection. The joint working between the project leads, Dr Khalida Ismail who is a psychiatric epidemiologist and an NHS liaison psychiatrist and Dr Carol Gayle who is a community diabetologist with expertise in community and strategic development, is an innovative use of academic and clinical expertise from different branches of medicine.

SECTION FIVE – SUMMARY OF ENTRY

Provide a short summary of your full entry (max. 250 words). Please note that this may be reproduced by the Qic organisers if your entry is shortlisted, to promote the Qic finalists, including in print and online.

Brief summary:

Many people with persistent poorly controlled diabetes also have additional psychological and social problems which impinge on their ability to effectively manage their diabetes care. 3DFD (**3 Dimensions of Care For Diabetes**) is a service that fully integrates medical, psychological and social care for this group of patients. The overall aim is to improve diabetes control, quality of life and quality in care with associated cost efficiencies. The key innovations of 3DFD are first, a community support worker addresses the social problems; second that a range of psychological treatments are offered to reduce diabetes related distress; third, it is patient-driven service with patient led case conferences; and fourth, there is increased attention to their medical and diabetes education needs. The model is specifically designed to target those considered

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hard-to-reach in the diabetes setting, such as non-attenders, those with frequent unscheduled visits, psychological problems and significant social deprivation. We found that within the first 3 months of a 3DFD intervention, on average patients achieved clinically significant reductions in glycaemic control in the region of 1% in the HbA1c. The 3DFD is a team with flexible boundaries moving seamlessly between hospital, primary care and the community. The level of patient satisfaction has been unanimous and this has been substantiated with patient testimonials. Our model has been adopted for its sustainability potential by the Guy's and St Thomas' Diabetes Modernisation Initiative which is radically re-designing services for all people with diabetes in Lambeth and Southwark.