London's diabetes care pathway: Commissioning recommendations for psychological support

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Strategic Clinical Networks

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Acknowledgements

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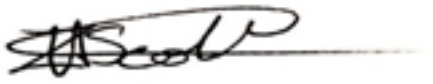
Foreword | Zoe Scott

Having lived with Type 1 diabetes since the age of six, along with the physical symptoms of the condition, I have experienced its emotional and psychological effects often with detrimental consequences. Having suffered post-traumatic stress, depression and anxiety all related to diabetes, I used insulin in a suicide attempt, as diabetes provides an easy way to attempt suicide due to being able to access large amounts of insulin. The correlation between my mental wellbeing and having diabetes has often confused the healthcare professionals I come into contact with, as I was often being told that my anxiety could not be related to diabetes due to the length of time I have had the condition and telling me that I wasn't depressed. Every person may end up with anxiety or depression no matter how long ago they were diagnosed due to certain life events, early stages of complications, changing regimes or just simply growing up. I have also had a period of time on an acute mental health unit which highlighted a lack of knowledge surrounding diabetes care and the risks to service users safety in regards to all diabetes treatment (eg blood sugar control, insulin control and general lack of understanding of an insulin pump).

During a diabetes review the focus is on the HbA1c result and not the emotional and psychological reasons behind it. Rarely does a patient who is seen as "non-compliant" get asked what is actually going on behind the scenes. There will be reasons why they don't comply, these may include feeling that they are not "normal", issues surrounding weight with manipulation of regimes to help lose weight and bullying because they don't have the same freedom as their friends.

I set up Hedgie Pricks Diabetes to provide a way to campaign for better access and resources for psychological support for people with diabetes. We provide signposting to resources where patients can self-refer to or are able to ask their diabetes team or GP for a referral. We provide inspiring events for young people with diabetes to show them that although diabetes makes them different and they may often feel alone in their teenage years, by keeping good control they will be able to secure a healthy future where their dreams can become reality. These events also try to improve the compliance of patients to help prevent complications, enhance quality of life and minimise the huge cost of treating such complications for the NHS.

So I am pleased to support the work being developed by the London Mental Health Strategic Clinical Network, in conjunction with Diabetes UK, in particular the resource pack for commissioners and providers in improving access to psychological services and support for people with diabetes. Finding a way to provide easy access or referral for people with diabetes, including family members and their carers, to psychological interventions which can enable them to improve compliance, general wellbeing and overall control is vital. Diabetes care should be person centred -- remembering that everyone is different as are their needs. I hope this venture will facilitate achievement of this goal.



Zoe Scott
Founder
Hedgie Pricks Diabetes

Foreword | Dr Steven Reid

Diabetes care should be patient centred care. Zoe's point seems self-evident and few would argue with it. Yet the way we organise health and social care often fails to achieve that goal.

We know that the body and mind are inextricably linked. Long term conditions are commonly associated with emotional and psychological problems that can have a significant negative impact on outcomes. Mental health problems such as depression and anxiety also lead to increased costs. We need to address this in a time of scarce resources.

The focus of this guidance is on people living with diabetes. We chose diabetes as an example of a long term condition where there is good evidence that psychological interventions can not only have benefits for your emotional state, but also your physical health through improved control of your blood sugar. The management of diabetes in people with serious mental illness is a closely related and important issue but is not discussed in depth here; there is much work going on elsewhere.

When we set out to produce this guidance it soon became apparent that if we want to bring body and mind back together we need to rethink how we design and provide our services. You will find here examples of people using innovative methods to develop integrated models of care across the capital. London has a youthful population that is more transient and ethnically diverse than anywhere else in the UK. This presents some challenges but also highlights one of the capital's greatest assets: its people.

We need to move beyond traditional models that focus on professional and patient. We need to understand the needs of carers and families. We need to focus on what is important to the individual, which brings us back to Zoe's point: diabetes care should be patient centred care.

Dr Steven Reid
Clinical Director
Psychological Medicine
Central and North West London NHS Foundation Trust

Foreword | Dr Matthew Patrick

In setting up London's Mental Health Strategic Clinical Network, it was clear that something different was needed; something that represented more directly the different narratives that exist around mental health and illness.

Indeed we are, in many ways, at a moment of real possibility in relation to mental health. Increasingly, a body of ideas is being shared that together represent a coherent direction of travel: Care and support moving further out of hospital towards home; moving from prescription to partnership in working with empowered citizens and patients; seeing the development of resilience and health promoting communities as key ingredients for real population health; working towards holistic approaches that bridge the mind-body divide that we have artificially created.

I think that the work that has been done to prepare this guide shows that healthcare professionals and people with diabetes share the same view that now is the time to address the link between physical and mental health, and that staff and service users alike can benefit for learning more about this key link. As one participant in the co-production workshop so eloquently put it, *'I have different body parts in different places'.*

> "I have different body parts in different places."
>
> -- Event participant

It is time now for us to take up the challenge of reuniting mind and body, working to see and to support whole people. There is a wealth of knowledge here that I hope inspires you to make changes in your own area.

Dr Matthew Patrick
Clinical Director, London Mental Health Strategic Clinical Network
Chief Executive, South London and the Maudsley NHS Trust

Executive summary

This guide provides recommendations for commissioners when providing emotional and psychological support on the diabetes care pathway. The report has been shaped from information gathered from discussions with professionals and people with lived experience and surveys identifying local provision in London.

Recommendations: How to make a change

These recommendations are designed to help commissioners and others to develop improvements to psychological and emotional care provision in London:

Access to services

» Provide a **range of interventions** according to need and severity, flexible to changing needs over time (see the pyramid model on page 10 for a framework).
» **Universal access** - make services readily available.
» Be **proactive in supporting specific groups** - young people at transition, black and minority ethnic groups, people with severe and enduring mental illness, people with learning and sensory disabilities, family and carers.

Service design

» **Co-produce** – recognising that people with diabetes are experts in their own condition and are best placed to inform how services can be improved.
» Provide **timely, effective and safe care** in accordance with NICE Quality Standards
» Provide **individualised packages of care** - promoting emotional wellbeing and involving social care and the third sector, and not limited to people with criteria-based psychiatric disorders.
» **Promote self-management** to increase mental health awareness at diagnosis, resilience and self-management.

Training, education and raising awareness

» Provide psychological **screening** when undertaking reviews in diabetes services
» **Train diabetes health professionals** in identifying and providing support for psychological and emotional problems
» **Educate staff in services providing psychological and emotional support** for people with diabetes to have expertise in diabetes care

Evidence and working models show that care and outcomes for people with diabetes who need psychological or emotional support can improve, benefiting them and the service. The next stage of this work will be to look at how this learning transfers to other long term conditions.

Introduction

People living with diabetes (Types 1 and 2) experience disproportionately high rates of mental health problems, with 41 per cent reporting poor psychological wellbeing[1].

Depression and anxiety are the most common diagnoses but a range of other difficulties are encountered, from problems adjusting or coping with the diagnosis to phobias, eating disorders and sexual dysfunction[2, 3, 4, 5].

A number of factors associated with living with a long term condition -- and specifically, diabetes -- may affect psychological wellbeing:

- Acceptance of the diagnosis
- Adjustment of lifestyle to self-care
- Living with symptoms and progression of diabetes
- Prospect of complications

In addition diabetes, in contrast to cardiovascular disease and lung disease, is a long term condition that has a significant impact on young people, particularly in the transition through adolescence. Young people may struggle with the increase in responsibility for their own self-management and the transition is associated with an increased risk of poor glycaemic control[6].

The consequences of psychological morbidity in diabetes are significant. Impaired psychological well-being is associated with poorer self-management, suboptimal glycaemic control and an increased risk of diabetic complications[7, 8, 9].

In addition to the impact on quality of life, several population studies have shown a 1.5-fold increased risk of mortality in people with co-morbid diabetes and depression compared with diabetes alone[10,11].

Co-morbid depression is also associated with a 50 to 75 per cent increase in healthcare costs, an estimate which does not include the wider costs associated with unemployment and sickness absence[12, 13]. A King's Fund report estimates that for every £8 spent on long term conditions, £1 is linked to poor psychological wellbeing[14].

There is an expanding evidence base demonstrating the benefit of a range of interventions that support psychological wellbeing and reduce psychological morbidity for people with diabetes[15, 16, 17, 18, 19].

Structured patient education about diabetes can promote self-management, and motivational interviewing is an effective means of identifying and reinforcing the benefits of lifestyle change. Specific interventions, medication and psychological treatments, are indicated for disorders such as depression and anxiety. The collaborative care model largely used in the United States comprises systematic screening and treatment of depression in diabetes and has been shown to reduce glycosylated haemoglobin as well as co-morbid depressed mood[20, 21].

The same benefits (a reduction in psychological distress and improved glycaemic control) have been demonstrated with cognitive behavioural therapy in type 1 diabetes[22].

Type 2 diabetes is a particular challenge for people living with serious mental illness, such as schizophrenia and bipolar disorder. They have two to three times the risk of developing diabetes compared to the rest of the population -- and this contributes significantly to a 20 year gap in life expectancy. Lifestyle factors are important, but there is also a specific association with antipsychotic medication[23].

> "The provision of information, education, and psychological support that facilitates self-management is the cornerstone of diabetes care."
>
> *National Service Framework for Diabetes (Department of Health, 2001)*

Although not the focus of this guidance, there are significant inequalities in the provision of physical healthcare for people with serious mental illness and diabetes. They have fewer physical health checks and often their physical health needs are ignored or seen as a manifestation of mental illness. Following campaigns by Rethink and the Royal College of Psychiatrists as well as the publication of new NICE guidance, there are now a range of initiatives underway to improve physical healthcare in this group by monitoring and acting on risk factors for heart disease and diabetes. A notable example is the introduction for 2014/15 of a new national indicator (CQUIN) for improving physical healthcare to reduce premature mortality in people with serious mental illness[24].

Introduction

The local picture: diabetes care in London

There are more than 350,000 people diagnosed with diabetes in London[25]. An ageing population and lifestyles predisposed to obesity mean that this figure will grow. It is estimated that there are at least 100,000 people with diabetes who remain undiagnosed bringing the estimated prevalence of diabetes in London up to 7.5 per cent[25].

A number of factors make the management of diabetes in the capital a particular challenge. A young and more transient population makes service delivery and establishing care pathways difficult.

London's ethnic diversity is also important; Type 2 diabetes is up to six times more likely in people of South Asian descent and up to three times more likely in African and African-Caribbean people[26]. It tends to present at a younger age in black and minority ethnic groups, and these groups have a higher risk of developing diabetes-related complications. Provision of diabetes care across the capital is often fragmented with a lack of coordination between primary care, community and hospital services and more widely between health and social care. These factors do have an impact on outcomes. London has the highest percentage of deaths in England attributable to diabetes for people aged 20-79 years, and diabetes accounts for almost 12 per cent of all premature deaths in the capital[25].

Fragmented care is also reflected in access to emotional and psychological support. The limited provision of psychological support for people with diabetes was highlighted in the national survey commissioned by Diabetes UK for the 2008 report, *Minding the Gap*[27].

The survey, covering all diabetes services in the UK, looked at the level and type of support available. The data found that 85 per cent of people with diabetes in the UK either have no defined access to psychological support and care, or at best, access to local generic mental health services with little or no useful knowledge of diabetes and its challenges. For services to be effective, assessment and treatment needs to be provided in the context of the particular issues faced by people with diabetes.

The pyramid of psychological problems (*see next page*) was developed as a framework for the survey in order to support respondents in identifying the severity and complexity of psychological difficulties in this patient group; as the severity increases, the prevalence reduces. It has subsequently served as an evidence-based framework for commissioners in assessing local community needs and planning services.

Purpose of this guide

The purpose of this guide is to support the development of accessible, consistent and effective psychological support for diabetes care pathways across London.

It should be of value to CCGs, as well as healthcare providers, in describing best practice services and 'what good looks like'. To this end, we have included the Commissioning Support and Implementing Best Practice Factsheet: Diabetes and Mental Health (Appendix F). We also hope that it will be helpful for patients, families and carers as a guide to accessible services across London.

The guidance and the recommendations that follow have been informed by three strands of work:

Firstly, this guide has been developed in partnership with Diabetes UK and a number of patients, family members and carers, all of whom contributed to a co-production workshop that identified gaps in provision and what is needed to improve the services we provide for people living with diabetes.

Secondly, a survey of both commissioners and service providers has helped to map current provision across London.

Thirdly, by recognising local examples of innovation and good practice we have developed a directory of case studies of service models.

Above: Pyramid of psychological problems (Adapted from *Minding the gap: A report for Diabetes UK*)[27]

What works, what doesn't: A co-production workshop

Given that co-production is now acknowledged as essential to effective commissioning and service development it is surprising that its application in the context of managing long term conditions is relatively recent.

Co-production means:
"…delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. Where activities are co-produced in this way, both services and neighbourhoods become far more effective agents of change"

The challenge of co-production: How equal partnerships between professionals and the public are crucial to improving public services (Boyle, D, and Harris, M. 2009)
NESTA, London

The effective management of long term conditions is largely dependent on how people care for themselves, rather than on interventions delivered by professionals. Given that only an individual can know his or her own priorities and preferences for care to be effective, it has to be shaped around these.

This guidance has been informed by a co-production workshop held in June 2014. The event was supported by the London Mental Health Strategic Clinical Network and Diabetes UK. Commissioners and healthcare professionals came together with patients and carers to share knowledge, review areas for improvement and consider how we can develop better models for emotional and psychological support. Participants (listed in Appendix F) were asked to focus on three questions:

- **What has been good** about the services you have experienced?
- **What is missing** from available services that could make a difference?
- **What are the essential components** required to provide an excellent service?

Key themes

Five key themes emerged from the discussions:
- Education and awareness for healthcare professionals
- Access to information for patients and carers
- Service provision
- Wrapping services around individuals
- Support for families and carers

Each theme follows below, with comments from participants.

Education and awareness for healthcare professionals

Healthcare professionals working with people with diabetes should have training and support to enable them to recognise the impact that emotional and psychological problems can have on patients and their self-management. Healthcare professionals should be able to ask sensitive questions, identify and provide care for the emotional and psychological needs of patients with diabetes to an appropriate level.

"Educating the healthcare professional about the connection between physical and mental health is essential."
-- Event participant

It was also particularly important that professionals providing psychological care should have specific knowledge and experience of working in the area of diabetes.

Comments from participants:
- Nurses and other healthcare professionals who understand the 'managing the self' should help with diabetes care
- GPs may not have asked the screening questions for depression
- Unawareness of social impact which impacts on health
- Understand that social links relate to how people manage their care
- Educating the healthcare professional about the connection between physical and mental health
- Training for doctors and nurses to understand diabetes
- Recognition of the stigma of diabetes and depression
- Educating diabetic nurses so they feel comfortable about asking sensitive questions (eg suicide risk)
- Knowing the psychological impact and the issues that arise (both for patients and professionals)
- Ensure psychological support at diagnosis; emotional impact seems not a priority for focus
- Psychological understanding across professions
- Diabetes knowledge for mental health team; a basic understanding of both for all staff
- Mental health awareness training for all clinicians and healthcare professionals
- Organisation should be psychologically minded -- not just staff but at system level

Access to information for patients and carers

The emotional and psychological aspects of living with diabetes should be introduced at diagnosis as part of self management. This would help to normalise the experience of talking about psychological needs and signal that emotional wellbeing is *everybody's business*.

Positive action should be taken by healthcare professionals to share information and signpost patients and carers to support available locally. Access to information about the emotional and psychological aspects of diabetes, guidance in self help, and local support services, including third sector organisations (eg Diabetes UK) should be readily available through a range of channels: leaflets, social media and the internet.

Comments from participants:

- A psychological service in a locale, but service users appear not to have knowledge about it
- Service users must be informed about the psychological aspect of the illness
- Provide insightful information
  - From people with diabetes
  - Self help information/books (eg *Diabetes and wellbeing: Managing the psychological and emotional challenges of diabetes Types 1 and 2* [28])
- Telling people at diagnosis about Diabetes UK
- Promoting psychological services by way of adverts (on a bus, for example).
- Service maps for both healthcare professionals and service users depicting local services
- Using trusted websites to link to what exists

Service provision

Service development should be needs-led, and people with diabetes and carers should be involved in service design. Flexibility and timeliness are both essential elements for good psychological support services as is the ability to self refer. Commissioned services need to be sustainable rather than time-limited initiatives.

Particular attention should be paid to the needs of patients in the transition from children's to adult's services.

The prevalence of diabetes is significantly higher in black and minority ethnic groups so services need to be culturally responsive.

"Some services are very good but we have limited access or referral."
-- Event participant

"'Provide a range of psychological options not just cognitive behavioural therapy (CBT)."
-- Event participant

The use of peer support may be especially valuable in working with groups who traditionally have limited engagement with services.

Comments from participants:

» Access to psychological/well-being services would improve self care, reducing costs in future
» Some services are very good but have limited access or referral
» Inconsistency in services
» Ensure self referral to all aspects of diabetes care, especially psychological care
» Access to support groups
» Include patients in service design/pathway design
» Local peer support groups
» Easy access to the services provided
» Prepare all service users, particularly the young population, about the transitional phases in life
» Create sustainable service provision (*When does a pilot stop being a pilot?*)
» Flexibility of services; person-centred service provision
» Awareness that BME groups have higher prevalence of diabetes and mental health problems
» Provide a range of psychological options, not just CBT
» Timely access
» Transition services (eg 16 to 25 years)

Services should 'wrap around' individuals

The divide between mental and physical health services, including commissioning, leads to fragmented care. Emotional and psychological support for people with diabetes should be embedded in each step of the diabetes care pathway and not as a stand-alone service.

Integrated care could include patients and their carers through the use of shared care plans and patient-held care records, allowing for improved information sharing. Integrated care should not just involve physical and mental healthcare but also social care.

Comments from participants:

» Self management is improved when areas are well managed and coordinated, but frustrating if not. Many times psychological management is not included
» All care should be in one place but it's a struggle to achieve
» 'I have different body parts in different places'
» Even services in the same trust may not be linked up
» Need a holistic understanding by mental health and physical health professionals
  - Not targets and tick boxes
  - Person-centred care, adjusted to changes in health and management
» Integrate mental health services and psychologists within the diabetes team
» Make use of multi-disciplinary clinics
» Full integration with social care

Support for families and carers

Families and carers are important members of the diabetes team and their experience should be recognised. Participants reported their observations of the psychological impact on the family and carers for people living with diabetes, including younger people.

Services should ensure that families and carers have access to psychological support.

Comments from participants:

» Network events are helpful for patients and carers to learn and share with others
» More support for carers, particularly younger people
» Acknowledge the impact on families and help them feel understood
» Recognise the impact on carers; including the help or assistance they receive (including offers of psychological support)
» Social support for people who have lost their carer or partner
» Diabetic support groups

"There is no psychological support at diagnosis; emotional impact seems to not be a priority or focus."

-- Event participant

What is available: mapping services in London

In producing this guidance, it became clear that there are a number of models of good practice for providing psychological support but across London the overall picture is highly variable.

The range of services provided includes specialist clinicians or teams integrated with diabetes services, those with specific provision for long term conditions including IAPT (Improving Access to Psychological Therapies), and generic mental health services.

To understand the pattern of service provision, two surveys were undertaken. The first survey asked the GP mental health leads of the 32 London CCGs what they thought was available in their locality. The second survey explored IAPT support for diabetes.

Survey of CCG mental health leads

Questions were developed to ensure responses would provide an understanding of the current level of service provided (Appendix D).

The survey, distributed in January 2014, was shared electronically to minimise error and reduce the potential for respondents to omit questions.

Twenty-seven responses, representing 28 CCGs, were received. Whilst the survey relies on self-reporting which could lead to potential errors (due to a lack of in-depth understanding of current provision or over-optimistic responses, for example) a second survey offered triangulation of the data, both in the data received and the perceptions of commissioners of services available.

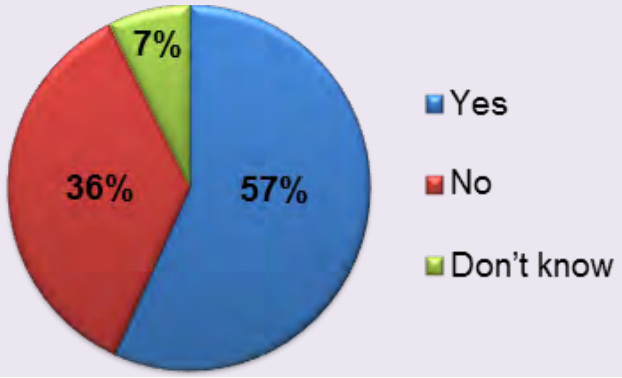
Summary of key findings

Of those responding, almost 60 per cent reported that specific psychological services were available for people with diabetes. Two-thirds of those services are general adult mental health services rather than specialist services either associated with or integrated in the diabetes care pathway.

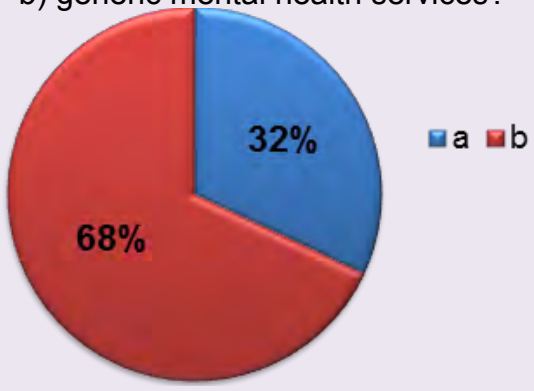
The remaining one-third are integrated services that use a range of models, including specialist psychology and/or psychiatry, as part of the diabetes multidisciplinary team, liaison psychiatry or clinical health psychology associated with diabetic teams, and IAPT services (see below).

Some services also provide social care, helping with housing, debt, and employment issues. Examples of these services are described in the case study directory (Appendix A). Respondents reported waiting times of up to one month (47 per cent) or up to three months (18 per cent) for all psychological services. Thirty-two per cent did not know the waiting times, and one service reported waiting times of less than one month.

Are there specific psychological services provided for people with diabetes type 1 and 2 who have psychological problems in your area?



Are these services: a) dedicated for people with diabetes type 1 and 2 OR b) generic mental health services?



Only a minority of respondents (14 per cent) reported the use of protocols in primary care to guide referrals for psychological support, although nearly 80 per cent reported the routine screening of patients with diabetes for anxiety and depression.

However, now that the use of a two question screening for depression tool (PHQ-2)[29] in diabetes is no longer a Quality and Outcome Framework (QOF) requirement, this may change. The majority of services are for adults only, with two services providing access for children and young people. However, many respondents reported that children could access psychological services through local paediatric diabetes teams.

3 Dimensions of Care for Diabetes

3 Dimensions of Care For Diabetes (3DFD) integrates medical, psychological and social care for patients with persistent suboptimal glycaemic control to improve glycaemic control, reduce psychological distress, improve quality of care and patient-reported outcomes and to reduce short and long term health service use costs.

The care pathway is embedded in the community and hospital diabetes services and interventions include medical review of diabetes status, brief focused psychological treatments, optimising psychotropic medication and interventions targeting social problems (such as poor housing, debt management, literacy, occupational rehabilitation).

The team have found improvements in glycaemic control, psychological status and health service use including a mean reduction in HbA1c of 17mmol/mol. The team noted a significant decrease in unscheduled care reflected by fewer AandE attendances and acute inpatient diabetes admissions, and this included readmissions. Preliminary analyses indicate that there will be an annual saving of £102,000 per 100 patients per year, based on the reduction in HbA1c from the first pilot.

Survey of IAPT provision

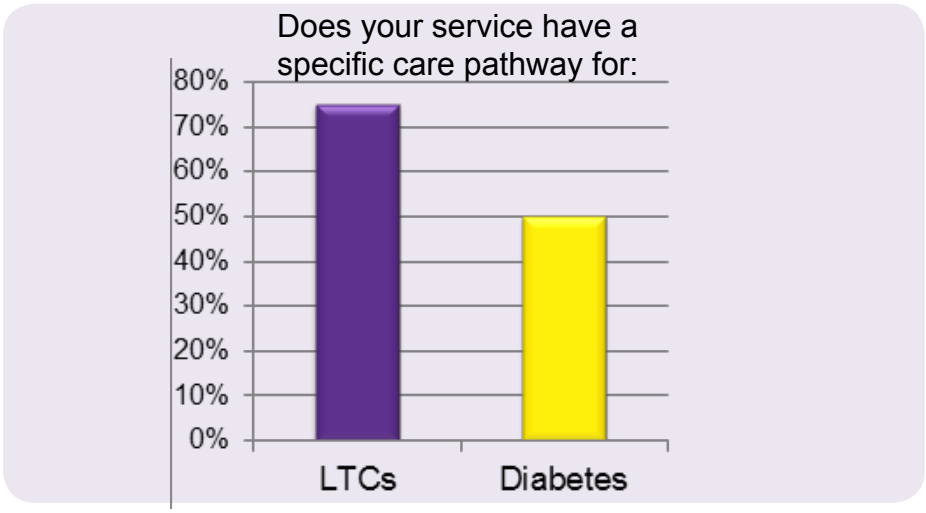
IAPT services were originally tasked with treating anxiety and depression in adults through a stepped care approach based on NICE guidelines. IAPT services typically offer access to guided self help interventions as a first line before the use of NICE approved therapies (primarily CBT) depending on need and past experience of treatment. The government's mental health outcomes strategy *No Health Without Mental Health*[30] gave new responsibilities to IAPT for supporting the psychological needs of people with long term conditions.

Five IAPT services were selected to become pathfinder sites piloting the development of stepped care pathways for long term conditions (LTC) including diabetes. Evaluation of these sites is currently underway and other services have opted to develop LTC pathways without having pathfinder status.

A questionnaire survey was developed using the same method as the CCG survey to explore IAPT support for diabetes (Appendix G). The questionnaire was sent to the localities that provide IAPT services. Twenty-four responses were received.

Summary of key findings

Forty-two per cent of the respondents were either selected pathfinder sites for long term conditions or were developing their own pilots. However, 75 per cent of respondents reported that they were providing specific care pathways for long term conditions, and 50 per cent were providing care pathways for diabetes. Thirty per cent of the services reported having clinical health psychologists with expertise in long term conditions and 25 per cent with expertise in diabetes.



In those IAPT services providing care pathways for diabetes there is significant variation in the range of interventions that they are able to provide beyond treatments for anxiety and depression. Three-quarters of this group provided guidance for self management of diabetes, 71 per cent provided treatment for injection-related anxieties, 46 per cent for fear of hypoglycaemia, 55 per cent for problems coping with the diagnosis of diabetes, and 34 per cent for eating disorders.

The IAPT services that are providing interventions for long term conditions typically include provision for diabetes along with lung disease, cardiovascular disease and chronic pain.

A range of treatment approaches (mindfulness, cognitive analytic therapy, in addition to cognitive behaviour therapy) and settings (individual, group etc) are provided and services commonly reported trying to enhance care through education of patient groups, practice nurses, and GPs. Another common theme was the submission of business cases for piloting of new models of care.

As expected, we found considerable variation in service provision across the capital. What the surveys also show is that local providers have developed a wide range of clinical models to address a recognised need.

Many of the services identified have been established as pilots with time-limited funding. The challenge will be in answering the question *When does a pilot stop being a pilot?*

IAPT pathfinders

In 2007 primary care trusts across England were invited to submit expressions of interest in joining the Improving Access to Psychological Therapies (IAPT) programme as pathfinder pilot sites.

The Pathfinder programme aimed to discover how IAPT services could in future meet the needs of the whole population by expanding the model of care. Pathfinders aimed to identify positive benefits and address specific barriers to improving access to psychological therapies for particular sections of the community relevant to local population.

The Diabetes Wellbeing Service: *A Space to Think*

The project provided a short-term psychological intervention for people with poorly controlled type 1 or type 2 diabetes. Patients received a cognitive behavioural therapy-based intervention (one to 16 sessions at a frequency that suited the individual, with an average of eight sessions).

The input of a clinical psychologist provided the space for patients to engage in the practical problem solving of the complexities of managing diabetes, unlike the traditional medical setting, in which there may simply not the time or opportunity to do so.

The results demonstrated the impact of psychology treatment on the medical management of diabetes through reduced HbA1c. All patients achieved a HbA1c reduction, with a mean reduction in HbA1c of 12 mmol/mol, range between 1-41 mmol/mol.

Preliminary analysis indicates there will be an annual saving of £57,266 for the 50 patients seen by the service next year. If all Hillingdon diabetes patients who had been admitted last year were seen by the service, there is an estimated saving of £551,224 per year on admissions for avoidable complications.

Commissioning recommendations for psychological support

The following recommendations are designed to guide commissioners in the commissioning of psychological services and service improvement. They should also be a useful resource for providers and practitioners.

They have been drawn together from surveys, a co-production workshop and discussions with people living with diabetes and healthcare professionals.

Access to services

1 **People with diabetes should have access to a range of interventions for emotional and psychological problems according to need and severity.** The pyramid model of psychological problems provides a framework for the organisation of provision. It should also be recognised that level of need and severity is likely to change with time, personal circumstances, and the effects of diabetes.

2 **Universal access for people with diabetes to emotional and psychological support should be readily available regardless of post code.** Service development should be coordinated to allow for commissioning in partnership across geographical boundaries where that may be of benefit.

3 **Specific groups should be proactively supported.** Services must be proactive in enabling emotional and psychological access to these groups:

- Young people at the stage of transition from children's to adult's services
- Black and minority ethnic groups
- People with severe and enduring mental illness
- People with learning disabilities
- People with sensory impairments
- Families and carers

Service design

4 **Co-production by people with diabetes and mental health problems, as well as their carers/families should be integral to service development.** Co-production acknowledges that people with diabetes have a degree of expertise that is best placed to inform how services can be improved. This process enables people to support each other and fosters the development of resilient communities.

5 **Commissioners should ensure that services provide timely, effective and safe care in accordance with the NICE quality standards for diabetes**, which outline the provision required in developing appropriate services for people with diabetes. Outcomes should take account of patient experience and align with the NHS Outcomes Framework.

6 **Individual packages of care should be developed to 'wrap around' individuals and their carers promoting emotional wellbeing and involving social care and the third sector.** They should not be limited to people with criteria-based psychiatric disorders but should include provision for problems adjusting to diagnosis, general coping difficulties and lifestyle changes.

7 **Promoting self-management should be encouraged and commissioning should support the development of services that promote mental health awareness at diagnosis, resilience and self-management.** Self-management has the potential to improve health outcomes and patient experience and includes the use of expert patient programmes, peer support, and social media.

Training, education and raising awareness

8 **Screening tools should be used to improve the recognition of psychological and emotional problems** should be included as part of the review of care for people with diabetes in the community and hospital-based diabetes services.

9 **Staff and organisations providing care for people with diabetes should have training and education that enables them to identify emotional problems and provide psychological support** at an appropriate level. The aim being to ensure that emotional wellbeing is considered everyone's business.

10 **Specific expertise in the area of diabetes should be acknowledged** to ensure services providing emotional and psychological support have sufficient knowledge to support people with diabetes. Experience and shared knowledge of diabetes management is essential for an appropriate understanding of issues facing people living with diabetes.

Next steps

The evidence presented here shows that the provision of effective psychological support on the diabetes care pathway continues to present a challenge. And yet the costs both in terms of health outcomes and NHS spend mean that this is a challenge we must meet. There are models that have been developed to provide well-coordinated care for people with diabetes who have psychological and social needs. This guidance and these recommendations provide tools to ensure that these models of care are accessible to all. From here we need to consider how this approach will transfer to other long term conditions.

Appendix A: Case study directory

A selection of case studies as featured in the London Mental Health Strategic Clinical Network publication, A commissioner's guide to primary care mental health (July 2014)

No	Tags	Title	Description	Location	Contact name(s)	Contact details
1	Long term conditions, diabetes, outcomes, self management	3 Dimensions for Diabetes (3DFD)	3DFD provides a 'wrap-around' service which allows all the needs of the patient to be met by 1 service which is integrated fully with the diabetes team. The service is clinically considered part of the diabetes team and allows for better outcomes where patients can receive diabetes, psychological and social care. The model for 3DFD came from the difficulties experienced in trying to work across these sectors on behalf of patients. The model of intensive case management with the extended multidisciplinary team, including the patient as a member of the team, has been successful and cost effective. The cross-fertilisation of skills sets within the team has been a key part of the success.	King's College Hospital NHS Foundation Trust	Dr Anne Doherty, Consultant Liaison Psychiatrist, Kings College Hospital NHS Foundation Trust Prof Khalida Ismail, Honorary Consultant Psychiatrist, Kings College Hospital NHS Foundation Trust	annedoherty1@nhs.net khalida.ismail@nhs.net www.londondiabetes.nhs.uk/services-and-referrals/3dfd-project.aspx
2	Long term conditions, diabetes, self management	*A space to think*: Diabetes wellbeing programme	The Diabetes Wellbeing Service supports patients with the 'non-medical' challenges of managing their condition. Referral is not founded on criteria-based mental health diagnoses, 'poorly controlled diabetes' (type 1 or 2) is the criteria for accessing the service. Patients are offered session(s) with a clinical psychologist that aim to identify what is getting in the way of being able to implement medical advice, and develop an action plan and strategies to support. Outcomes have demonstrated significant reductions in HbA1c and improvements in psychological wellbeing.	Hillingdon Hospital NHS Trust	Dr Jen Nash, Clinical Psychologist, Hillingdon Hospital NHS Trust Dr Simon Dupont, Clinical Psychologist, Hillingdon Hospital NHS Trust	jen.nash@nhs.net simon.dupont@nhs.net
3	Practice nurse training, integration, education, nurse educators, action learning, primary care	Bespoke mental health and wellbeing training package for practice nurses	To develop a bespoke mental health and wellbeing package for practice nurses. To ensure health professionals understand the patients mental, physical, emotional, spiritual and social needs therefore can respond appropriately and effectively. To create a community of nurse educators engaged with improving the capability for mental health in primary care and to improve integration between primary and secondary care for mental health patients.	Health Education North Central East London	Dr Sheila Hardy, Education Fellow, UCLPartners	Sheila.hardy@uclpartners.com

Appendix A: Case Study Directory

4	User-led support, diabetes, self management	Hedgie Pricks Diabetes	Hedgie Pricks Diabetes was set up to highlight the life of people living with diabetes. Aim to gain greater awareness of the psychological, emotional and social sides of living with condition, especially depression, diabetes burnout and anxiety problems. Longer term the aim is to continue to spread the work about the emotional/ psychosocial impact of living with diabetes, to create a network/ information section of known psychologists and counsellors who specialise in diabetes, to create diabetes camps, that really help inspire teenagers and young adults to care for their diabetes and take control.	Essex	Zoe Scott, Founder, Hedgie Pricks Diabetes	hedgiepricksdiabetes@gmail.com www.hedgiepricksdiabetes.org.uk/about
5	Long term conditions, co-morbidity, resilience, early intervention, self management, crisis prevention	Mind – service transformation programme	Three year programme ending March 2016 and funded by DoH. Set up early intervention wellbeing sessions to support people with long term physical conditions to become resilient and therefore less likely to develop co-morbid mental health problems. An additional outcome of this work will be that people are better able to manage their LTC and will use crisis care less frequently.	Local Minds in Birmingham and Manchester	Mel Harakis, Service Development Manager, local mind	m.harakis@mind.org.uk
6	Long term conditions, COPD, diabetes, CHD, pain, chronic fatigue, self- management, stepped care, IAPT	Barking and Dagenham IAPT	Barking and Dagenham IAPT provide support for people with diabetes in partnership with the Clinical Health Psychological Service for Barking and Dagenham. This service employs a psychologist specialising in diabetes, embedded within the diabetes team. The psychologist works with patients post-diagnosis to support them and their families and runs a 'Mood and Food' group. The diabetes psychologist is also able to provide consultation, advice and supervision for the IAPT and secondary care psychological staff, as well as for the physical healthcare team.	Barking and Dagenham	Julie Wilson, IAPT Lead	Julie.wilson@nelft.nhs.uk

APPENDIX A: CASE STUDY DIRECTORY

A selection of case studies as featured in the London Mental Health Strategic Clinical Network publication, A commissioner's guide to primary care mental health (July 2014)						
No	Tags	Title	Description	Location	Contact name(s)	Contact details
7	Long term conditions, CBT, staff training, diabetes	Jubilee Health Centre	Won funding from the Health Education and Training Council to run training on low-level CBT approaches for GPs and nurse practice staff supporting patients with long term health conditions. Have a pathway at Step 2 and 3 specifically for patients with LTCs. Also have a specific protocol at Step 3 for treating patients with diabetes referred via our general LTC pathway.	Merton and Sutton	Steve Sheward, IAPT Lead	steve.sheward@swlstg-tr.nhs.uk
8	Long term conditions, IAPT, diabetes, self management, physical health, co-morbidity	St Charles Centre for Health and Wellbeing	Pilot looks to meet the needs of individuals with LTCs within IAPT. In the early stages of service development and have not officially launched. We will accept self and other service referrals (as well as GP). Made initial links with the community type 2 diabetes service and aim to see people within a CBT group as well as individually. Currently looking at general groups for mood and self-management. Could offer basic phobia work individually. Therapy for more complex cases (eating disorders, etc) are not in place yet.	Kensington and Chelsea	Jo Ashcroft, Clinical Health Psychologist	j.ashcroft@nhs.net
9	Education, early indicators, risks, common mental health, personality disorders, MUS, PTSD, alcohol problems, stigma, suicide, signposting	Education and training for frontline staff in Camden	To provide specific and targeted education, awareness and skills training across primary and secondary care among health professionals. Aimed to help early recognition of indications and risk factors for common mental health disorders, personality disorders, PTSD and medically unexplained symptoms. Includes the development of awareness and skills training for frontline staff, local communities and others to improve engagement, reduce stigma, and support earlier recognition of mental health problems and suicide risk and signposting to effective support. Also improves support for GPs in identifying and treating people with alcohol problems within primary care, including training for the RCGP certificate in the management of alcohol problems.	Camden CCG	Alex Warner, Mental Health GP Lead, Camden CCG	a.warner@nhs.net

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A selection of case studies as featured in the London Mental Health Strategic Clinical Network publication, A commissioner's guide to primary care mental health (July 2014)						
No	Tags	Title	Description	Location	Contact name(s)	Contact details
10	Long term conditions, diabetes, outcomes, self-management	Compass Wellbeing	Compass Wellbeing is primarily a service that helps people with anxiety and depression, formerly known as the Tower Hamlets Primary Care Psychology and Counselling Service; we provide psychological therapies to General Practice and the local community. We have a specialist Diabetes Psychologist working in the Diabetes team at a secondary care level. There is also a Disability and Health Counselling team who see clients with co-morbid physical and mental health conditions in primary care . This team is part of Compass Wellbeing which delivers psychological therapies to Primary Care (including IAPT). The Disability and Health Counselling Team work across a wide range of disabilities and health conditions including sensory impairments.	Tower Hamlets	Maria Casey, Clinical Director	maria.casey3@nhs.net
11	Long term conditions, anxiety, depression, CBT, self-management, online tool	IAPT – Greenwich Time to Talk	Greenwich Time to Talk provides psychological treatment for people aged 18 and above living in the borough of Greenwich with common concerns such as anxiety or depression. Treatment is based on cognitive behavioural psychotherapy (CBT) and counseling. Involves guided self-help and talking therapy. This service does not prescribe medication. Specialist support is provided over the phone along with stress control classes and online computer programmes to help develop skills needed to make positive changes. GP referral is not needed, can self-refer.	Greenwich	Katy Grazebrook, IAPT Clinical Lead and Consultant Clinical Psychologist, Greenwich Time to Talk	Katy.Grazebrook@oxleas.nhs.uk
12	Long term conditions	Primary care psychology	Have a specific care pathways for anyone either referred from a medical specialism - diabetes, cardiac, sickle cell, gastro etc. If a GP or self-referral is identified as having a significant health concern they would go through the pathway. Case is reviewed by senior health psychologist - standard or adapted telephone screen takes place - usually they would then be treated by either clinical health psychologist, CBT therapist with additional support and training, or more rarely a PWP. Also support education groups in diabetes, cardiac rehab and pulmonary rehab. There is a number of senior psychologists with backgrounds in clinical health psychology.	Homerton University Hospital NHS Foundation Trust	James Gray, Consultant Clinical Psychologist for Long term conditions	James.Gray@homerton.nhs.uk

APPENDIX A: CASE STUDY DIRECTORY

A selection of case studies as featured in the London Mental Health Strategic Clinical Network publication, A commissioner's guide to primary care mental health (July 2014)						
No	Tags	Title	Description	Location	Contact name(s)	Contact details
13	Education, first aid, discrimination, self management	Mental Health First Aid Lite (MHFA Lite)	Provision of mental health first aid training to GP receptionists across Hackney. 3 hour session aiming to enable participants to gain a wider understanding of some of the issues surrounding mental health, work more effectively with people living with mental health problems, identify the discrimination surrounding mental health problems, define mental health and some mental health problems, relate to others' experiences, help support people with mental health problems to look after their own mental health.	City and Hackney CCG	Teresa McInerney, General Manager, City and Hackney CCG	Tmcinerney1@nhs.net
14	Service, diabetes, COPD, psychological interventions	Newham Primary Care Psychological Services	We are a pathfinder site and currently focusing on 2 LTCs: diabetes and COPD. Looking at the effectiveness of group and individual high intensity psychological interventions. The Pathfinder 1 project focuses on the effectiveness of LI interventions in LTCs and MUS. Our service integrates LI and HI interventions. Offer a package of care case managed by a HI staff member (usually a clinical psychologist) who proposes a programme of intervention based on clinical presentation, client choice, language factors etc. Offer a variety of interventions which have been designed with people with diabetes although non-diabetics also access this intervention. Also offer a stepped care pain intervention, graded exercise therapy, memory and wellbeing, coping with chemotherapy, breathlessness and COPD and a specific intervention for people with stroke.	East London Foundation NHS Trust	Tomas Campbell, IAPT Lead, East London Foundation NHS Trust	tomas.campbell@eastlondon.nhs.uk
15	IAPT, NICE treatments stepped care model. Outreach	Back on Track: Hammersmith and Fulham IAPT Service	One of the clinical psychologists from the IAPT team provides an outreach session on the links between diabetes and common mental health conditions as part of the expert patient group programme at a local hospital. Treatment pathways to and from this programme have been created. In-house we use the pathfinder diabetes self management programme usually delivered by step-2 clinicians.	Hammersmith and Fulham	Brett Grellier, LTC lead, HandF IAPT	Brett.grellier@nhs.net

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A selection of case studies as featured in the London Mental Health Strategic Clinical Network publication, A commissioner's guide to primary care mental health (July 2014)						
No	Tags	Title	Description	Location	Contact name(s)	Contact details
16	Long term conditions, COPD, diabetes, CHD, MUS, self-help. Self-referrals. Training	iCope Camden Psychological Therapies Service	As a pathfinder site, specialist health psychologists are employed as part of the IAPT team to provide training, consultation and supervision for IAPT and LI staff. A web-based portal has been developed for staff. This includes regular clinics for diabetes, COPD and heart failure. The team work with primary care to encourage more long term conditions referrals and have developed a targeted leaflet to help with self- referrals. Primary care pilots are being developed with specific practices. Future plans involve working with UCL to implement a web-site for supporting people with diabetes in primary care.	Camden	Judy Leibowitz, Consultant Clinical Psychologist, Clinical Lead	Judy.leibowitz@candi.nhs.uk
17	Education, RCGP, GP leaders, bio-psychosocial approach, emotional health	Primhe RCGP and University accredited diplomas in Primary care mental health	To validate education in mental health that is relevant to Primary Care, giving the workforce an understanding of and the skills required to improve outcomes. The Primary Care Mental Health and Education training is values based and through case studies identifies the social determinants of mental health and why a bio-psychosocial approach is most effective for patient outcomes.	RCGP and Stafford University	Ian Walton, IAPT lead, Sandwell and Birmingham CCG	mentalhealthdiploma@gmail.com
18	Social Prescribing, LTCs, behavior change, social well-being, link worker	Ways to Wellness: Social prescribing for people with long term conditions in Newcastle West CCG	Project aims to develop a single cohesive approach to social prescribing in primary care to improve the quality of life for vulnerable adults with a range of long term conditions and mental health issues. Supports GPs to refer and encourage people to take up activities instead or alongside medical prescription. Promotion of non-traditional service provision as complementary to traditional commissioned services.	Newcastle Bridges CCG	Sandra King, Project Director, Ways to Wellness	sandra.king@vonne.org.uk
19	IAPT, NICE, stepped care, peer support, self help, Learn2b	Changing Minds Education Centre	The service is a practice based initiative with an early intervention and recovery focus. Initially centered on primary care medication but expanded to look at new ways of working and new roles such as graduate workers and community nurses trained in mental health. Service includes peer support and parent support service.	Northamptonshire	Jane Shears	j.shears@nhs.net www.changingmindscentre.co.uk

APPENDIX A: CASE STUDY DIRECTORY

A selection of case studies as featured in the London Mental Health Strategic Clinical Network publication, A commissioner's guide to primary care mental health (July 2014)						
No	Tags	Title	Description	Location	Contact name(s)	Contact details
20	Navigator, discharge, recovery, transition, depot, stigma, social isolation, inclusion, physical health	"Evolve" – Mental Health Long Term Conditions Navigator Service	The Mental Health Long Term Conditions Project 'Evolve' is part of CREST Waltham Forest a local voluntary sector charity, commissioned to provide 4 navigators and a team leader in April 2012. The aim of the scheme is to support adult service users with a severe mental illness in their discharge from secondary to primary care and ensure service users attend appointment - GPs/Practice Nurses to monitor mental and physical health. The scheme uses a person-centred recovery focus, to support clients to reduce any social isolation they may be experiencing by an increased access to a variety of local opportunities/ services.	Waltham Forest CCG	Chris O Sullivan, Evolve Team Leader, CREST Waltham Forest Paulette Lawrence, Mental health GP Lead, Waltham Forest CCG Chris Soltysiak, Associate Director of Strategic Commissioning, Waltham Forest CCG	chris.osullivan@crestwf.org.uk
21	SMI and diabetes, co-morbidity, schizophrenia, self-management, compliance, education	Programme of Education in Diabetes for Care Coordinators	To improve both self-care of patients with SMI and diabetes and the uptake of the 9 diabetes care processes. Aim was to develop and deliver an education intervention to provide mental health care coordinators with knowledge and required care processes to manage Type 2 diabetes. Programme also addresses proportion of people with schizophrenia and diabetes who attend for annual review of their diabetes, have a care plan and access the 9 care processes of diabetes care.	Lewisham CCG	Hilary Entwistle, Mental health Clinical Director, Lewisham CCG Dr Charles Gostling, Diabetes Clinical Lead (Lewisham CCG) and Clinical Director Diabetes GPWSI, Health innovation network South London	hilary.entwistle@nhs.net Charles.gostling@nhs.net
22	Integration, care planning, co-morbidities, coordination, contracting, CQUIN, GP led, service user engagement	Tower Hamlets Mental Health in Integrated Care	The development of a coherent mental health offer to improve the identification of mental health problems in patients with multiple co-morbidities, improving care planning; improving patient experience; reducing emergency admissions to hospital, reducing length of stay and reducing admissions to care homes. Developing recovery orientated primary care mental health services to support discharge from secondary care.	Tower Hamlets CCG	Richard Fradgley, Director of Mental Health and Joint Commissioning, Tower Hamlets CCG	Richard.Fradgley@towerhamletsccg.nhs.uk

APPENDIX A: CASE STUDY DIRECTORY

A selection of case studies as featured in the London Mental Health Strategic Clinical Network publication, A commissioner's guide to primary care mental health (July 2014)						
No	Tags	Title	Description	Location	Contact name(s)	Contact details
23	Leadership training, informatics, commissioning, primary care, outcomes	Mental Health CCG Leadership Programme	A CCG Leadership Programme was developed for GP mental health leads from across London. The programme was based on a competency based leadership model, aimed at creating a knowledge-based leadership programme. It brought together service users and carers, academic experts to discuss the evidence base around mental health informatics, primary care and mental health commissioning experience, and the clinical expertise of primary care and secondary care providers. This would equip leads to achieve excellent mental health outcomes for patients through effective commissioning and local delivery. The alumni group formed the Mental health CCG Network which continues to meet.	NHS London, Lucent Management	Geraldine Strathdee, National Clinical Director for mental health, NHS England Glen Monk, Managing Director, Lucent Management	Geraldine.strathdee@nhs.net glen.monks@lucent.org.uk

Appendix B: Case study detail | 3 Dimensions of Care for Diabetes

Aims

3 Dimensions of Care For Diabetes (3DFD) integrates medical, psychological and social care for patients with persistent suboptimal glycaemic control (HbA1c ≥75mmol/mol IFCC; ≥9% DCCT), and aims to improve glycaemic control, reduce psychological distress, improve quality of care and patient-reported outcomes and to reduce short and long term health service use costs.

Rationale

Many people with persistent suboptimal diabetes control also have psychological and social problems which interfere with their ability to self-manage their diabetes. Until these difficulties are addressed, this group of patients struggle to attain optimal glycaemic control.

Research also indicated that where people have depression alongside diabetes the costs are higher and that treating depression in diabetes could result in significant savings[31].

Development

The care pathway is embedded in the community and hospital diabetes services. GPs refer directly or via the community teams for intensive diabetes management after completing a simple referral form allowing identification of psychological and/or social problems and poor glycaemic control. The interventions include medical review of diabetes status, brief focused psychological treatments, optimising psychotropic medication and interventions targeting social problems (such as poor housing, debt management, literacy, occupational rehabilitation). It integrates psychosocial care with diabetes care by patient-led case conferences, addressing barriers to diabetes self-care, risk assessments and patient safety. Once the patient has made progress, 3DFD supports the return of the patient to routine diabetes care.

Outcomes

3DFD has completed two consecutive pilot phases during which the components of the service has been refined and effectiveness demonstrated. In both pilots the team have found improvements in glycaemic control, psychological status and health service use and that this provides the best possible model of care for those patients with persistent poor diabetes control. The team have produced outcomes which compare favourably with new anti-diabetic medications to the market and to the outcomes of the local intermediate teams, with a mean reduction in HbA1c of 17mmol/mol.

The full economic evaluation is in progress for the first 100 patients. Preliminary analyses indicate that there will be an annual saving of £102,000 per 100 patients per year, based on the reduction in HbA1c from the first pilot.

Other results include:

- Significant decrease in unscheduled care reflected by fewer AandE attendances and acute inpatient diabetes admissions, and this included readmissions.
- Less than 10 per cent of patients from phase 1 were referred back into phase 2, and this demonstrates that the model of integrating patients back into ‘routine care ‘ has been successful with a low relapse rate.
- 3DFD has effectively addressed inequalities in access to psychological and social health care: the team have been successful in engaging a high proportion of men, ethnic minorities (high African/ Caribbean population in two boroughs), in areas of higher deprivation. Also high uptake in tier 2 who usually would not have access to diabetes specific mental health care.

Contact

Dr Anne Doherty, Consultant Liaison Psychiatrist, 3 Dimensions of Care for Diabetes service, King’s College Hospital NHS Foundation Trust
annedoherty1@nhs.net

APPENDIX B: CASE STUDY DETAIL | A SPACE TO THINK

Aims

A Space to Think is an innovations fund project that offers a 'non-medical' space to patients who are struggling to manage their condition. Short- term psychological intervention was provided to individuals with type 1 or type 2, with a HbA1c > 75mmol/mol with the aim of reducing HbA1c, improving psychological wellbeing and reducing health service use costs.

Rationale

The service was established in recognition that psychological and social factors interfere with the individual's ability to prioritise their diabetes self-care. Evidence suggests that offering psychological intervention in people with diabetes leads to improvements in health-related outcomes, psychological wellbeing and reduces healthcare costs[32]. The input of a clinical psychologist provided the space to engage in the practical problem solving of the complexities of managing diabetes, that this is simply not the time, opportunity, or skill-set to facilitate, within the traditional medical setting.

Development

Patients received a cognitive behavioural therapy based intervention. The number of sessions ranged from one to 16, with an average of eight sessions. Typical issues worked with:

- Problem solving challenges of diabetes in the context of competing life priorities
- Acceptance and integration of diabetes into the individuals identity
- Low mood or depression affecting diabetes self-care
- Anxiety (needle phobia, fear of hypoglycaemia, fear of complications)
- Eating issues (eg emotional or binge eating)
- Assertiveness skills (eg to set boundaries with others to enable health needs to be prioritised)
- 'Myth-busting' (eg confusion about differences between type 1 and type 2)
- Unhelpful narratives (eg '*My dad died of diabetes so what's the point in trying?*')

The clinical psychologist attended primary care multidisciplinary group meetings in the locality. The aim was to educate primary care clinicians about psychological issues in diabetes patients and their management in primary care and to facilitate referrals to the service. Patients admitted with diabetic ketoacidosis (DKA) were proactively targeted as this group are often repeat users of unscheduled care.

Outcomes

A mean reduction in HbA1c of 12 mmol/mol has been achieved to date (range 1- 51 mmol/mol). Improvements in psychological wellbeing have also been demonstrated through reductions in scores on the PHQ-9, GAD-7 and Diabetes Distress scales.

Anticipated cost savings: financial analysis showed that 25 of the 50 patients involved in the pilot have been in secondary care over the last year for 83 episodes at a cost of £105, 609. Of these secondary care episodes, 49 episodes totalling £62,788 were for diabetes-specific avoidable complications. Using Stratton[33] epidemiological modelling of improvements in health associated with reduced HbA1c we could expect a saving of £57,266 for these 50 patients next year. Further, given that psychological interventions equips patients with long term self-management skills, it is reasonable to predict savings related to avoidable admissions to continue over the lifetime of the patient.

If all patients with diabetes in Hillingdon who had been admitted last year were seen by the service and achieved a reduction in HbA1c of 10mmol/mol, we would expect this to lead to an expected cost saving of £551,224 per year on admissions for avoidable complications.

Patient feedback has been excellent. Patients have reported a 'non-medical' space to think about diabetes as invaluable in integrating the self-management and emotional demands of the condition. The service is a Finalist in the 'Best CCG Initiative' in the 2014 Quality in Care Awards.

Contact

Dr Jen Nash and Dr Simon Dupont, Clinical Psychologists, The Hillingdon Hospital
jen.nash@nhs.net | simon.dupont@nhs.net

APPENDIX C: PSYCHOLOGICAL ACCESS FOR DIABETES IN LONDON

Note:
Responses from CCG and IAPT questionnaires were used to populate this map.

For the most up to date service development, clinicians and members of the public are advised to contact their local IAPT service.

Access to psychological support

- Specific to diabetes
- Specific to long term conditions including diabetes
- Specific to long term conditions including diabetes and children AND young people
- Generic mental health services
- Generic mental health services including diabetes
- Generic mental health services including diabetes AND children and young people

APPENDIX D: CCG SURVEY TABLE

Area	In your area, are there specific psychological services provided for people with diabetes type I and II who have psychological problems?	Are these services		In relation to the previous question, who are these services available for				If you have access to specific psychological services what is the approximate waiting time for routine referrals	Do you use protocols or guidelines for referral to psychological services for patients with diabetes type I and II	Are diabetic patients (type I and type II) routinely screened in primary care or community services?		In your area, are you aware of any mental health professionals working as integrated members of the community or hospital diabetes team?
		dedicated for people with diabetes type I and II	generic mental health services?	Adult diabetes		Children and young adults diabetes type I and II				Anxiety and depression	Other mental health problems	
				Type I	Type II	Type I	Type II					
NWL												
Harrow	✓		✓	✓	✓			Up to 3 months	x	✓	✓	x
Ealing	x		✓							✓		✓
Brent												
Hammersmith and Fulham	✓	✓		✓	✓				✓		✓	✓
Central London												
Kensington & Chelsea												
Hounslow	x		✓						x	✓		✓
Hillingdon	✓	✓		✓	✓			Up to 1 month	✓	x	x	✓
NCL												
Barnet												
Enfield	x		✓					Up to 1 month	x	✓		✓
Haringey	x		✓						x	✓		
Camden	✓	✓		✓	✓	✓		Up to 1 month	x	✓	✓	✓
Islington	✓		✓	✓				Up to 1 month	x		✓	✓
ONEL												
Waltham Forest	✓	x	✓	✓	✓			Up to 1 month	x	✓	x	x
Redbridge	x		✓	✓	✓				x	✓		x
Barking & Dagenham	✓	✓		✓	✓				x	✓		x
Havering	x		✓	✓	✓	✓	✓		x	x	x	x
INEL												
City & Hackney	✓		✓	✓	✓			Up to 1 month	x		✓	✓
Tower Hamlets	✓	✓	✓	✓	✓			Up to 3 months	x	✓	✓	✓
Newham	✓	✓		✓	✓	✓	✓	Up to 1 month	x	✓	✓	x
SWL												
Richmond	✓		✓					Up to 1 month	✓	✓		x
Wandsworth	✓		✓					Up to 1 month	x	✓		x
Kingston	✓		✓					Up to 1 month	x	✓		x
Merton	✓		✓					Up to 1 month	x	✓		x
Sutton	✓		✓					Up to 1 month	x	✓		x
Croydon	x		✓					< 1 month		✓		x
SEL												
Lambeth	x	✓								✓		x
Southwark	✓	✓		✓	✓			Up to 3 months	✓	✓		✓
Lewisham	x		✓	✓	✓			Up to 3 months	x	✓		x
Greenwich	x	✓			✓			Up to 3 months	x	✓		x
Bexley	x		✓						x	x	x	x
Bromley	x		✓	✓	✓			Up to 1 month	x	✓		x

APPENDIX E: IAPT SURVEY TABLE

Area	Name of service	Current Referral Method	Is your IAPT service a pathfinder or pilot for LTCs			Does your service have a specific care pathway for:		Does your service have any specialist health psychologists with expertise in:		Is your service able to provide interventions for LTCs and diabetes other than anxiety and depression? E.g.:				
NWL			**Pathfinder**	**LTCs**	**Pilot**	**LTCs**	**Diabetes**	**LTCs**	**Diabetes**	**Improved self-management**	**Injection-related anxieties**	**Fear of hypoglycaemia**	**Eating disorders**	**Problems coping with diagnosis**
Harrow	Harrow Psychology Services (IAPT)	GP												
Ealing	Ealing Mental Health and Wellbeing Service	GP,Other,Self-referral												
Brent	Brent Psychological Service (IAPT)	GP	x	x	x	x	x	x	x	x	x	x	x	x
Hammersmith and Fulham	Back On Track Hammersmith & Fulham	GP,Self-referral, Other	x	✓	x	✓	✓	x	x	✓	✓	✓	✓	✓
Central London	North Westminster Centre for Psychological Wellbeing Westminster Centre for Psychological Wellbeing	GP, self-referral	x	x	x	x	x	x	x	x	x	x	x	x
Kensington & Chelsea	Kensington and Chelsea Psychological Services (IAPT)	GP, Other	x	✓	✓	✓	✓	✓	✓	✓	✓	x	x	x
Hounslow	Hounslow IAPT	GP	x	x	x	x	x	x	x	x	x	x	x	x
Hillingdon	Hillingdon Wellbeing Services (IAPT)	GP												
NCL														
Barnet	Barnet Psychological Therapy Services (IAPT)	GP, self-referral	✓	✓		✓	✓	✓	x	✓	✓	✓	x	✓
Enfield	Enfield Psychological Therapy Services (IAPT)	GP, self-referral												
Haringey	Haringey West IAPT Team Haringey East IAPT Team Haringey Central IAPT Team	GP,Self-referral												
Camden	iCope Camden Psychological Therapies Service	GP,Self-referral	✓	✓	✓	✓	✓	✓	✓	✓	✓			
Islington	iCope Islington Psychological Therapies Service	GP,Other,Self-referral	✓	✓	✓	✓				✓	✓			
ONEL														
Waltham Forest	Waltham Forest IAPT Solutions	GP,Self-referral	x	x	x	✓	x	x	x	✓	✓	✓	x	✓
Redbridge & Havering	Redbridge and Havering IAPT	GP, self-referral	x	x	x	x	x	x	x	x	x	x	x	x
Barking & Dagenham	Barking & Dagenham IAPT	GP, self-referral	x	x	x	✓	✓	✓	✓	✓	✓	✓	✓	✓
INEL														
City & Hackney	City and Hackney Psychological Therapies Service	GP	x	x	x	✓	✓	✓	✓	✓	✓	✓	✓	✓
Tower Hamlets	Tower Hamlets Primary Care Psychology Service	GP, Self-referral, Other	x	x	x	✓	✓	✓	✓	✓	✓	✓	✓	✓
Newham	Newham Psychological Services	GP, self-referral	✓	✓	x	✓	✓	✓	✓	✓	✓	✓	✓	✓

APPENDIX E: IAPT SURVEY TABLE

Area	Name of service	Current Referral Method	Is your IAPT service a pathfinder or pilot for LTCs			Does your service have a specific care pathway for:		Does your service have any specialist health psychologists with expertise in:		Is your service able to provide interventions for LTCs and diabetes other than anxiety and depression? E.g.:				
SWL														
Richmond	Richmond Wellbeing Service	GP, self-referral	x	x	x	✓	x	x	x	✓	✓	✓	x	✓
Wandsworth	Wandsworth Psychological Therapies and Wellbeing	GP,Self-referral	x	x	x	✓	x	x	x	✓	✓	✓	✓	✓
Kingston	Kingston Wellbeing Service (IAPT)	GP, CMHT, Self, Other	x	x	x	✓	x	x	x	✓	✓	✓	✓	✓
Merton	Sutton and Merton Psychological Therapies	GP,Self-referral												
Sutton	Sutton and Merton Psychological Therapies	GP,Self-referral	x	✓	x	✓	x	x	x	x	x	x	x	x
Croydon	Croydon Psychological Therapies and Wellbeing Service (IAPT)	GP,Self-referral	x	✓	✓	✓	✓	x	x	✓	✓	✓	x	✓
SEL														
Lambeth	Lambeth Psychological Therapies (IAPT)	GP,Self-referral	x	x	x	✓	✓	x	x	✓	x	x	x	x
Southwark	Southwark Psychological Therapies North Service Southwark Psychological Therapies South Service	GP,Self-referral	✓	✓	x	✓	✓	x	x	✓	✓	x	✓	✓
Lewisham	Lewisham Psychological Therapies Service (IAPT)	GP, Self-referral	x	x	x	x	x	x	x	✓	✓	x	x	✓
Greenwich	Greenwich Time To Talk	GP,Self-referral	x	x	x	x	✓	x	x	✓	✓	x	x	x
Bexley	Being Well in Bexley	GP, Self-referral												
Bromley	Bromley Working for Wellbeing	GP	x	✓	x	✓	x	x	x	x	x	x	x	x

APPENDIX F: DIABETES FACT SHEET

High Impact Strategic Mental Health Training and Education Programme
Integrating physical and mental health care pathways

Improving services, implementing best practice and informing mental health commissioning

Commissioning Support and Implementing Best Practice Factsheet: Diabetes and Mental Health

(March 2013)

Mental health problems are common in people with diabetes and interfere with their ability to self-manage. Mental health problems are often under-recognised and undertreated, leading to increased risk of complications of diabetes, earlier mortality, reduced quality of life and increased societal and individual costs.

What mental health conditions are associated with diabetes?

Any mental health condition may be associated with diabetes. Generally, any condition which impairs the individual's ability to engage in self-care is likely to have an effect on the management of diabetes, and as a result people with diagnoses of psychosis, cognitive impairment, substance abuse, etc. may experience difficulties. However, there are certain conditions which have a particular relationship with diabetes:

Depression

One in 10 people with diabetes suffer from clinical depression which is twice as high as the general population. It is a common mental disorder characterised by pervasive low mood, poor energy, loss of interest in everyday life, suicidal thoughts and reduced motivation. In depression, this combination of negative thoughts with poor energy and motivation may make it very difficult for the patient to prioritise or optimise their diabetes self-care.

In addition, fluctuations in glucose levels may have a direct biological effect on the mood, and further exacerbate any depressive symptoms, as may and diabetes-related neurovascular changes.

Anxiety

The anxiety presentations which have the most significant effect on diabetes are:

- **Injection-related anxieties or needle phobia** - This may present as a phobic avoidance of needles with consequences for adherence to insulin or GLP-1 medications, and for monitoring of blood glucose.
- **Fear of hypoglycaemia** - This may present with the patient maintaining high blood glucose levels in an effort to avoid the risk of hypoglycaemia.
- **Fear of complications**, which paradoxically may lead to avoidance of self-care.

Eating disorders

Eating disorders such as anorexia nervosa and bulimia nervosa may hinder the patient's ability to manage their diabetes in a number of ways. The dysfunctional eating patterns seen characteristically in eating disorders (bingeing, purging, laxative/diuretic abuse, excessive exercise) may cause dramatic fluctuations in blood glucose and predispose towards complications. Intentional omission of insulin is particularly linked with poorer health outcomes and at least a third of young women with type 1 diabetes will admit to this behaviour to avoid weight gain. Patients with eating disorders and diabetes are three times more likely to die earlier than patients with diabetes alone. Many patients struggle to accept the diagnosis until much later.

Authors:
Anne Doherty, Consultant Liaison Psychiatrist, King's College Hospital NHS Foundation Trust
Khalida Ismail, Professor of Psychiatry and Medicine, Institute of Psychiatry, King's College London

Problems adjusting to or coping with diagnosis
Some people may find it difficult to accept their diagnosis, and all the implications that a diagnosis of diabetes entails for lifestyle and health. This may manifest in a number of ways. Some people may cope by a state of denial, avoiding all reminders of their diagnosis – including insulin, glucose monitoring and medications etc. leading to poor adherence. Some people may feel overwhelmed with the relentless nature of their self-care and experience of "burn-out" at different stages in their lives.

Common psychological presentations in diabetes

At diagnosis
When an individual receives a diagnosis of diabetes, some patients may experience a period of adjustment which may include denial, depressive symptoms, guilt and self-blame and role transition with having to learn dietary restriction, blood glucose monitoring and taking insulin and/or medications.

Unscheduled care
People with diabetes are more at risk of requiring an inpatient admission. This may be for hypoglycaemic episodes, DKA or for complications of diabetes, as well as for non-diabetes related conditions, which diabetes however may reduce the speed at which the patient recovers. In particular, if admitted with poor glycaemic control, it is always important to exclude psychological and social factors such as eating disorder, abuse in the home, school refusal.

Suboptimal glycaemic control
Despite the patient's and the doctors best endeavours, the patient may continue to struggle with effective self-care and if the patient has persistent suboptimal glycaemic control, it is important at this stage to exclude common mental health problems such as depression, diabetes related anxieties and health beliefs and eating disorders. The routine annual reviews are a good point where mental health problems can be identified. If a patient has poor glycaemic control, commence by assessing whether the patient is struggling adhering to their multiple self-care tasks. If they appear to be having difficulties, it is worth considering if there may be a psychological reason for this or if there is any evidence of mental illness.

Onset of complications
Developing a complication is a life event, often involving increased disability, dependency and pain, and as such is vulnerable to the onset or relapse of depression and problems coping.

Mental health interventions to improve glycaemic control

- **Cognitive behavioural therapy (CBT)** - Diabetes-focused CBT techniques can help improve glycaemic control in type 1 diabetes.
- **Motivational interviewing** is a consulting style that is suited to supporting lifestyle changes in people with type 2 diabetes.
- **Collaborative care models** - This is where a nurse case manager integrates the management of depression, diabetes and other cardiovascular risk factors by focusing on guideline based treating to target each condition using basic psychological techniques such as problem solving and use of antidepressants for depression.
- **Case management** - Complex patients with multiple medical, psychological (such as severe depression, psychosis, eating disorders, resistant anxiety, personality disorders, etc) and social problems benefit from care from an intensive multidisciplinary team (ideally embedded in the community specialist diabetes clinics) which integrates liaison psychiatry and social welfare input with diabetes care.

Training and service development

1. Introduce red flag monitoring

It is important for all clinicians to have a high index of suspicion of psychological problems, particularly where patients are struggling to manage their diabetes. Certain symptoms or characteristics should be seen as red flags and prompt further investigation:

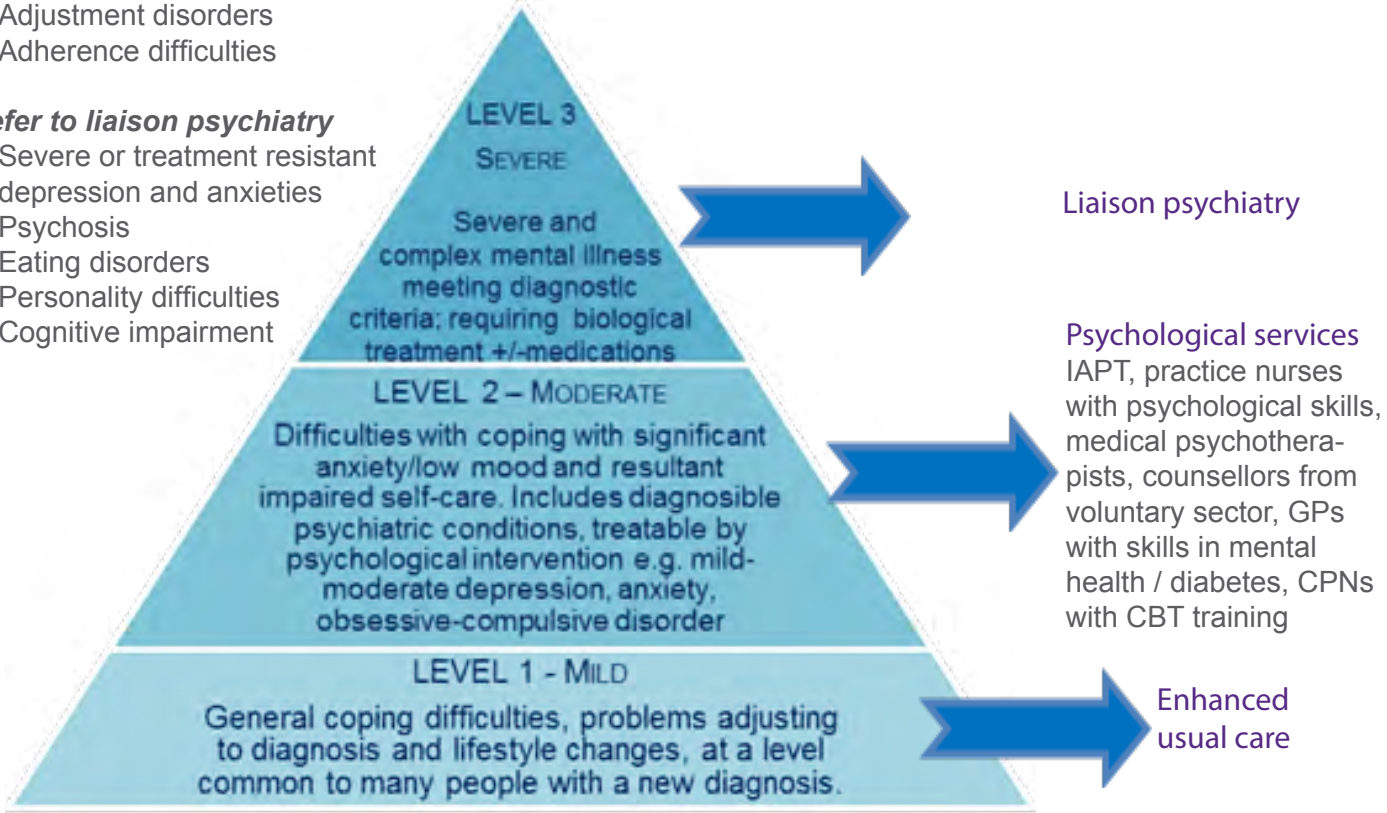
» Evidence of depressed mood
» Low BMI: This may indicate an eating disorder
» Reluctance to start insulin therapy: May indicate needle phobia or fear of insulin
» Persistent suboptimal glycaemic control
» Recurrent admissions (e.g. DKA)
» Difficulties at transition to adult services

2. Training

» Recognition: this requires learning how to do a depression assessment efficiently in a short time frame. E-learning modules are available for primary care staff to acquire these skills http://slondonhiec.org.uk
» Training in adherence enhancement using techniques such as information giving and motivational interviewing.
» Developing pathways for psychological care for the person of diabetes:

Refer to psychological services *(depending on local service availability: IAPT, practice nurses with enhanced psychological skills, medical psychotherapists, counsellors from the voluntary sector, GPs with skills in mental health or diabetes, CPNs with CBT training etc).*
» Mild-moderate depression
» Anxiety disorders, especially needle phobia, fear of hypoglycaemia
» Adjustment disorders
» Adherence difficulties

Refer to liaison psychiatry
» Severe or treatment resistant depression and anxieties
» Psychosis
» Eating disorders
» Personality difficulties
» Cognitive impairment



Above: Pyramid of psychological problems: Adapted from Minding the Gap; A Report for Diabetes UK (Trigwell et al 2008)

APPENDIX F: DIABETES FACT SHEET

For commissioners and providers sharing good practice:

How will you use this information?

» What key commissioning questions does this factsheet help address?
» What key messages will you now disseminate to commissioners and providers?
» What decisions and actions are you likely to make having read this key factsheet?
» What else could we do to make this factsheet useful to you?

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APPENDIX G: CO-PRODUCTION DELEGATE LIST

Name		Organisation
Ash	Ali	Diabetes UK
Amanda	Bailey	Central and North West London NHS Foundation Trust
Tricia	Burman	Bromley Diabetes UK
Natasha	Collett	Bexley Health Limited
Neil	Collins	Diabetes UK
Olivia	Djouadi	Diabetes UK
Anne	Doherty	Kings College Hospital
Graham	Durtnal	Diabetes UK
Jenny	Fisher	Oxleas NHS Foundation Trust
Helen	Gibson	Camden Diabetes Integrated Practice Unit
James	Gray	Homerton University Hospital NHS Fundation Trust
Lise	Hertel	NHS Newham CCG
Stefan	Holzer	Central London NHS Foundation Trust
Claire	Kearns	DWED
Charlie	Kennedy	Diabetes UK
Mark	Knight	3DFD Thames Reach
Marilyn	Lister	Diabetes UK
Laura	Mazzotti	Greenwich LTC Team, Oxleas NHS Foundation Trust
Jen	Nash	Central and North West London NHS Foundation Trust
Patrick	Nyagol	Croydon Diabetes UK
Rebecca	Owen	Camden Diabetes Integrated Practice Unit
Alan	Partington	Diabetes UK Lewisham Voluntary Group
Jacky	Percy	Diabetes UK Lewisham Voluntary Group
Catherine	Perry	3DFD Thames Reach
Duncan	Peterkin	Diabetes UK
Steve	Reid	Central and North West London NHS Foundation Trust
Roz	Rosenblatt	Diabetes UK
Vivienne	Ruddock	Diabetes UK
Farhana	Sarker	Oxleas NHS Foundation Trust
Zoe	Scott	Hedgie Pricks Diabetes
Anne	Scott	Hedgie Pricks Diabetes
David	Sims-Baker	Diabetes UK
Stephanie	Singham	Guy's and St Thomas' NHS Foundation Trust
Syena	Skinner	Central and North West London NHS Foundation Trust
Laura	Spratling	Health Innovation Network South London
Lynda	Stewart	Diabetes UK
Aoife	Twohig-Donfield	DWED
Julia	Tyson	Diabetes UK

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About the Strategic Clinical Networks

The London Strategic Clinical Networks bring stakeholders -- providers, commissioners and patients -- together to create alignment around programmes of transformational work that will improve care.

The networks play a key role in the new commissioning system by providing clinical advice and leadership to support local decision making. Working across the boundaries of commissioning and provision, they provide a vehicle for improvement where a single organisation, team or solution could not.

Established in 2013, the networks serve in key areas of major healthcare challenge where a whole system, integrated approach is required: Cardiovascular (including cardiac, stroke, renal and diabetes); Maternity and Children's Services; and Mental Health, Dementia and Neuroscience.

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