Transforming Conversations about Type 2 Diabetes

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INNOVATION SCHOOL THE GLASGOW SCHOOL OF ART
DIGITAL HEALTH & CARE INSTITUTE

Project Summary →

NHS Lanarkshire / Digital Health and Care Institute
Led by The Glasgow School of Art (GSA)

Transforming Conversations about Type 2 Diabetes

The project employed a participatory design approach to redesign the diagnosis experience for people living with type 2 diabetes. Through scoping workshops, in-depth interviews with diabetes specialists, practice nurses and people living with type 2 diabetes we mapped the current experience. A co-design workshop with practice nurses and specialist staff generated a new model of care for diagnosis, which was developed with input from people living with type 2 diabetes.

Participants:

- 4 People living with type 2 diabetes
- 10 Practice Nurses
- 4 Diabetes Specialists nurse/ dietitians/ podiatrist
- 2 hospitals, 1 health centre — Clinic attendees

Methods:

- Scoping workshop
- Pop-up engagement
- In-depth interview
- Co-design workshop

Fourteen Interviews
+ Five Pop-ups
+ One Co-Design Workshop
+ One Scoping Workshop

Design Research Team:
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Cate Green

Outputs:

x2 x1 x7 x1

- 2 Reports
- 1 Video
- 7 Current service maps
- 1 prototype

Locations:

- University Hospital Hairmyres
- University Hospital Monklands
- Hunter Health Centre
- Carluke Health Centre

* Interview locations not included to maintain anonymity

2017-2019

- 15 Hours Interview time
- 12 Hours Pop-up engagement time
- 3 Hours Co-Design workshop time
- 3 Hours Scoping workshop time

Type 2 Diabetes

Diagnosis

Structured Education

New Concepts Developed:

1. New forms of support for practice nurses including training, shadowing, specialist input and peer support.
2. A new diagnosis visual tool that structures the conversation and supports shared decision making to produce an individual care plan driven by what matters to the person.
3. A new group education appointment within 6-9 weeks of diagnosis to ensure early access to specialist input, and increase uptake of structured education in Lanarkshire.

Background

As part of a programme of work commissioned by the Scottish Government, the Digital Health and Care Institute formed a strategic partnership with NHS Lanarkshire to collaborate on health and care service transformation. Diabetes was identified as a key area of need. Through scoping activities with the NHS Lanarkshire Diabetes Service, services for type 2 diabetes were identified as the focus for innovation and redesign activities.

A number of specific challenges were identified relating to care across the interface of secondary and primary care, including the need for more support for primary care staff to improve the consistency of care. The findings of our previous research with people living with long-term conditions also pointed to the importance of the diagnosis conversation in engaging people early in self management.

Aim

The overall aim was to **explore person-centred approaches to diabetes care in Lanarkshire and create a roadmap for future care, working together with those delivering the services and those receiving care**.

Two focus areas were identified based on our early scoping work:

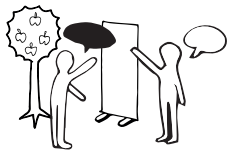
1. **How might we innovate conversations at diagnosis?**
2. **How might we innovate care across the interface between primary and secondary care?**

By focusing on the conversation between the primary care health professional and the person newly diagnosed with type 2 diabetes, we aimed to understand how secondary care and primary care staff could work more collaboratively to improve self management in the community. Through mapping current care experiences and identifying aspirations for future care, we aimed to identify opportunities to redesign the type 2 diabetes diagnosis conversation to support early engagement.

What We Did

Interviews with four specialist staff and two primary care staff working in NHS Lanarkshire, using a visual tool capturing their perspective of the primary and secondary care system.

Interviews with four people living with type 2 diabetes in Lanarkshire, using a visual tool mapping the participant's experience of the current service, any challenges, and ideas for how things could be improved, with a particular focus on their experience of diagnosis.



Pop-up engagement at the diabetes clinics at two hospitals in Lanarkshire for two half-day engagement sessions, talking to people living with type 2 diabetes who receive specialist care to gather their feedback on how to improve the diagnosis experience based on critical reflections of their own care journey.

A co-design workshop with eight practice nurses and two diabetes specialists, focusing on three opportunity areas to innovate the experience of diagnosis and ways of working across the primary and secondary care interface.

Three pop-ups in clinic entrance areas and three interviews with people living with type 2 diabetes to test the emerging concepts. We visualised the new care scenarios and printed them on large boards to gather feedback.

Insights

Across Lanarkshire there are **variations in diabetes pathways and the support available to practice nurses**, including the time available for diagnosis conversations (10-30 mins). There was appetite for **training sessions** led by specialist diabetes staff, but practice nurses cautioned that they are often forced to do this **in their own time**.

A wealth of information is given in the diagnosis appointment, which can be **overwhelming** and make it **difficult to navigate** the different appointments in the period after diagnosis. **Explaining the long-term consequences of diabetes can be challenging**, but it is vital that people understand. Some practice nurses use a 'cheat sheet' as a reminder of the many things they need to cover. **Visual aids** can be powerful tools to **support people to engage and understand**.

Early education and peer support were found to be **important for engaging people in self management**. Some people told us they would like **more specialist input early on in** their journey.

Opportunities

Three clear opportunities to innovate the experience of diagnosis and ways of working across the primary and secondary care interface emerged. These were explored in the co-design session with primary care and specialist staff:

1. **How do we create the ideal diagnosis conversation – who, what, where, when, how?**
2. **How do we increase early uptake of structured education following diagnosis?**
3. **How do we support primary care staff in their conversations with people living with type 2 diabetes?**

Concepts emerged for a new visual tool to support the diagnosis conversation, a new diagnosis group education appointment, and new ways of working across primary and secondary care to support practice nurses to deliver person-centred care. These concepts together form **a new diagnosis experience**.

Support for Practice Nurses

Practice nurses highlighted the need for practice staff across Lanarkshire to share type 2 diagnosis resources and working practices, and receive training from specialist staff. They felt this should include the wider GP team to ensure consistency and support for the practice nurses at a local level.

They suggested that attending the new diagnosis specialist group appointment (see next page) could be a great way to learn about new developments and the benefits of structured education so they can promote this to their patients.

For new practice nurses, shadowing more experienced nurses and having specialists observe some of their diagnosis appointments and give feedback would ensure they felt confident in the quality of their care.

In response to challenges in communication between primary and specialist care, they suggested creating a network and email list to disseminate messages and updates.

New ways of working

Trained practice nurses at the forefront of type 2 diabetes diagnosis and care in the community

Diagnosis Conversation Tool

A new paper-based tool structures and records the conversation between the practice nurse and the newly diagnosed person. It uses icons printed as stickers which can be added to the visual pathway to produce a personalised care plan. The practice nurse can explain the options, and make shared-decisions aligned to what matters to the person. It also prompts the practice nurse to cover key information about the services available. The visual facilitates a conversation about screening and self management to avoid complications. The plan can be digitised for the practice nurse's records and given to the person as a reminder of what was discussed.

Person-centred care plan at diagnosis

Supporting consistent information and person-centred care plan at diagnosis

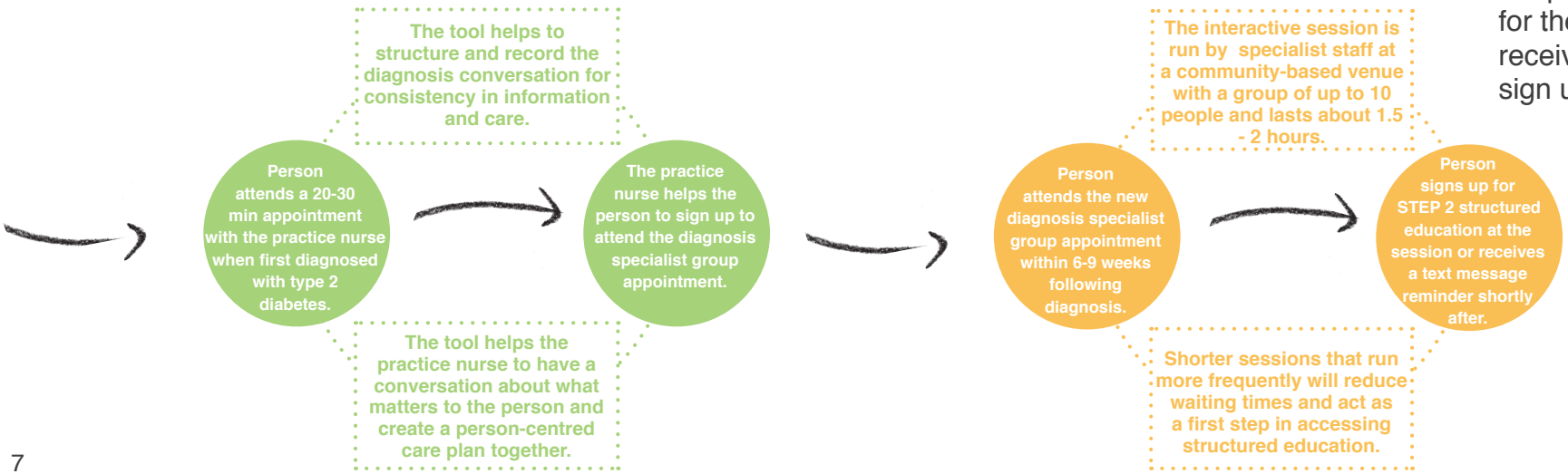
Diagnosis Specialist Group Appointment

Early support for self management

Providing information and support on diet, exercise and self management soon after diagnosis

A new group education appointment within 6-9 weeks of diagnosis was suggested as a way to ensure early access to specialist input, and increase uptake of the full structured education programme. This would be an alternative to the current 1:1 appointment with the specialist dietitian – by seeing patients in small groups the dietitians felt this would make a more efficient use of their time. Specialist diabetes educators advised that this session should last around two hours, and include some interactive activities based on the principles of adult learning. The sessions could be scheduled for regular days and times in a range of different accessible community locations to increase availability and reduce waiting times. At the session, the person could choose to sign up for the full structured education or to receive a text message reminder to sign up at a later date.

The New Diagnosis Experience



Conclusion

The new diagnosis experience presented here aligns with ongoing developments in NHS Lanarkshire and key priorities set out in diabetes policy at a national level.

Our full report sets out next steps for NHS Lanarkshire to implement the new diabetes diagnosis experience, presenting a roadmap to the 'near' future service, alongside a medium-term future vision of care enabled by new digital services. In the short term this outlines a process for collaboratively developing the conversation tool with practice nurses across Lanarkshire. In the longer term this includes exploring how the digitised individual care plan can be developed to facilitate ongoing care and self management.

The Diabetes Team in Lanarkshire have already begun to develop new models of communication and shared resources to support practice nurses. They are also developing their structured education programme and exploring opportunities to develop the new diagnosis specialist group appointment.

Further Information

To see the full report including insights on the current experience, roadmap for the future service, and the project video please visit:

www.futurehealthandwellbeing.org/t2diabetes

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Thank You

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