

A top-down view of a wooden desk. In the top left corner, a silver laptop is partially visible with a spiral-bound notebook resting on it. Next to the laptop is a small, round, light-colored pot containing a green succulent plant. In the bottom left corner, there is a white ceramic mug filled with dark coffee. Two black pens are scattered on the desk: one is lying horizontally above the coffee mug, and the other is lying diagonally below it. The background is the natural wood grain of the desk.

Diabetes annual check Project debrief

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Key themes and best practice from HCP interviews



Best practice themes from HCP interviews

- The practices we spoke to (who are doing well re growing the base of diabetes patients and driving compliance with checks), all demonstrate some pretty common themes (all were based in communities with high levels of deprivation and really diverse populations):
- They all had a commitment (“annoyingly passionate about this”) to do the right things by their patients (and practice – though doing the first guaranteed the second was looked after). Every practice had advocates for diabetes (one GP while the other 3 weren’t interested)
- All had developed (specialist) talent to focus on diabetes (from retraining receptionists in lockdown, to upskilling health support workers). They had no cynicism or pre-conceived ideas
- These HCPs were positioned as expert and specialist and had built strong bonds/trust with patients (“they trust Michelle”)
- They’re empathetic, going the extra mile to make life easier (not the “3 strikes and you’re out” rule)



Best practice themes from HCP interviews

- All have removed duplication and use common sense to make things easier for patients (“you’re here now, let’s quickly do your bloods” / “we talked about smoking last week” / “you’re BMI won’t have changed since last month so we don’t need to bother with that”)
- They had joined up processes and clear roles within the patient journey (secretary does the admin, HCA does the tests, nurse does the follow ups)
- They were flexible and resourceful (not bound by process – extended hours, doing urine tests on the day etc)
- They use psychology and flattery rather than coercion (“you’ve done 5/7, let’s talk about the other 2”)
- They always follow up on tests, no matter what’s changed, or not
- They capture contact capabilities/preferences, update them, and ask questions re lifestyle limitations etc
- They use common sense to work their way round problems (can’t write letters in Pakistani, but can ask who speaks English in the household, or who could sit with you and watch a youtube video)



Best practice themes from HCP interviews

- They use common sense to work their way round problems...
 - ...can't write letters in Pakistani, but can ask who speaks English in the household, or who could sit with you and watch a youtube video)
 - ...remove complexity from letters for people who struggle to read long winded English (“come at 12, ask for Rebecca”)
- They build a sense of community around the issues that matter most to diabetes patients (run diet and lifestyle talks upstairs with PCN)



There's an opportunity/need to encourage sharing of best practice

- HCPs don't see a huge amount of content that's helping them engage diabetes patients better – best practice principles usually come from someone grabbing hold of diabetes and showing initiative
- Where things are working well, it's usually down to the resourcefulness of practice leaders/boards, or specific individuals
- But none of this is shared

Opportunity: create a forum/social platform where great ideas can be discussed and shared across the region?

Hero the people and practices that are making a real difference



Overview of big themes from the patient groups and interviews



An overview of big themes

- There are deeply rooted and quite complex issues around perceptions of the state of the NHS
- Some additional cynicism towards GPs is evident
- There's a sense that type-2 diabetes is somehow an inferior disease and patients are less worthy
- A pretty deep-rooted belief that they "know" their illness and that self-care (diet/exercise) is effective
- Some checks have the ability to break through their resistance and default to self-care
- Duplication and a lack of "efficiency" really winds people up
- A sense that the checks are hard work and a box ticking exercise, rather than a patient centric one
- There's a sense that nothing would change in terms of outcomes even if you attended the check
- Diet aside, there's a massive knowledge gap re what can be done other than/before drugs and insulin
- We heard loads of horror stories around Metformin and these reinforce resistance to checks



An overview of big themes

- Some diabetes patients feel quite isolated and unsupported with their condition
- Covid exacerbating this situation and reinforced the focus on self-sufficiency and self-care
- Many patients experienced poor care or treatment in their early experiences
- If you can build rapport early, and with the right person, the rewards are huge
- But there's a general (and unhelpful) lack of awareness re what's available in terms of support beyond the GP
- Lack of flexibility in the system and asking them to take the strain can be a real deal breaker
- Everyone has different contact preferences and time commitments but these aren't captured in the majority of cases
- Communication currently has a perfunctory tone rather than a personalised one
- Language is a barrier in some communities, but little common sense is used to work around this



Expanding on the themes and opportunities



There are deeply rooted and quite complex issues around perceptions of the state of the NHS

- There's a consistent belief that the NHS/GP system is broken and that you'd be banging your head against a brick wall trying to get seen
- The whole "call at 8/wait in a queue/get through to find out that all the available appointments have gone" thing is a recurrent theme
- Within the context of diabetes/annual checks, this is reinforced by some who've either had annual check appointments cancelled or been unable to get one in the first place

Opportunity: it's hard to counter these perceptions as there's so much noise in this space and most people have first-hand experience of such issues

Within the context of diabetes and annual checks, there may be some initiatives or interventions which could have some effect... for example, reply to a text for an automatic appointment went down quite well as an idea and undoubtedly removes a perceived barrier



Some additional cynicism towards GPs is evident

- The GP is often seen as the busiest and least compassionate person in the practice and people have often had first-hand experience to support this (standoffish GPs, having the condition belittled etc)
- There's a belief that old school GPs, who were there to provide advice and support, are a thing of the past and that this has given way to a very transactional approach, driven by ruthless efficiency... there's even a sense that they're motivated more by commercial concerns than care giving
- It might be harder to counter these perceptions, than to leverage the other (more credible) providers of support within the practices

Opportunity: here the broader service providers within the practice.

Anything we could do to humanise things is going to help against this backdrop – knowing that there's specialist diabetes nurses or NHS dieticians who are ready to talk and help, can be a bit of a game changer for patients – it immediately dials up the fact that the tests and support are motivated by care rather than a calendar commitment



There's a sense that type-2 diabetes is somehow an inferior disease and patients are less worthy

- This is the biggest single barrier within the whole piece – 80% or 90% of all patients take this view, across all demographic, and most ethnic groups
- People feel well and are able to get on with their lives relatively unencumbered by their diagnosis – typically they've adapted their lifestyles (diet and exercise), though some struggle with the motivation or commitment, and a minority do need more “medical” intervention
- Because they feel well (and many have relatives/friends with what they see as more “serious” conditions – whether that's type-1 diabetes or cancer) they feel embarrassed/guilty taking up space in a system that's under so much pressure

Opportunity: there's a need to challenge their perceptions that type-2 diabetes isn't a “proper” ailment and that somehow their needs aren't important in the grand scheme of things



A pretty deep-rooted belief that they “know” their illness and that self-care (diet/exercise) is effective

- The vast majority are almost blindly committed to self-managing their condition. They think they know everything they need to know (through Google and friends) and that diet/exercise are all that's required (and that if they do engage, the only “value” GPs can add is to put them on Metformin, or worse still, insulin)
- There's a really consistent view that there's no need to engage with healthcare until your (self-diagnosed) symptoms change (clearly dangerous but very prevalent)... for many, it's about a perception that they don't need a doctor rather than they don't trust a doctor

Opportunity: We need to challenge the perception that people can self-manage. They don't know what they don't know and positioning the annual check as a safety net/early warning mechanism would be of value

We could/should talk about how complex it is, challenge the perception that it's easy to self-manage and/or just comes down to living/eating healthier. Unless we counter these perceptions, people are always going to opt for self-care until something drastic (and visible) happens. And bust the myths around it being a straightforward disease to monitor and treat



Some checks have the ability to break through their resistance and their defaults to self-care

- For most, the checks seem unnecessarily complex and it's often seen to duplicate things that are done at other times during the year. Similarly, some of the tests are seen to be things you can keep on top of yourself (BMI = proxy for weight management etc)
- Being specific about the number (6, 7, 8 or 9) is problematic because different practices are managing this in different ways and it just reinforces a sense that it's hassle (rather than comprehensive)
- But people show a greater likelihood of engaging around some of the tests that are less "routine" and less obviously easy to manage for yourself... they definitely feel more exposed (in terms of their knowledge and confidence) when we talk about tests on eyes and feet (and what the implications might be of these tests/changes in these areas)

Opportunity: Rather than leading on the comprehensive nature of the check and/or a specific number of tests, would we be better isolating 2 or 3 "hero" tests – the eye, kidney function and foot tests (the ones that people see more value in because it's harder to self-diagnose in these areas and these are the tests which are way less likely to have been carried out during the course of the year)



Duplication and a lack of “efficiency” really winds people up

- It really winds people up if things are duplicated – a waste of their time and valuable NHS resource
- It’s a must to show that the system is joined up – so if people have had 4 of the tests throughout the year, don’t ask them to repeat...
- ...we’ll only do the tests you need (people often have blood pressure, BMI etc taken throughout the year and get annoyed when they have to have these tests again).

Opportunity: join the dots and show that we’re on the patient’s side – making life easier for them, and easing pressure on the system



A sense that the checks are hard work and a box ticking exercise, rather than a patient centric one

- They think the checks and the communication around them are just box-ticking exercises... “they send them out, maybe follow up with a reminder and then they’ve done their job, and probably got paid for keeping their end of the bargain”
- So they see no empathy and believe that none of the activity is motivated by care or compassion
- They feel like they’re being transacted for the GP practice coffers rather than engaged as diabetes patient

Opportunity: Personalising things has huge value – we know the tests are inconsistent (some have 7, 8 or 9) but that could be turned into an opportunity...

And the fewer tests we have, the more time it frees up to engage the patient in chats around how they can better manage the condition/what we can do to help (this is of huge value – gives us an opportunity to build rapport with patients)



There's a sense that nothing would change in terms of outcomes even if you attended the check

- Loads of people just don't see the value in the annual check – “what's the point?”
- They don't see what they could be told that they don't already know and they don't think there's much that could happen in the space between self-management and being put on drugs
- And many people who attended their first annual check received no feedback and nothing changed as a result (confirmed by HCPs). So (in their eyes) what was the point – word spreads quickly around stuff like this?

Opportunity: we need to disrupt and challenge their default beliefs, talk up WHY people need to attend tests and tell them/prove to them that we'll ACT upon what we identify (they'll get feedback etc) to counter the perception that they've more to lose than gain by attending tests right now

We need to remind people why having the check matters and echo what we heard from some of the GPs – there's loads we can do to help you stay on top of diabetes



Diet aside, there's a massive knowledge gap re what can be done other than/before drugs and insulin

- Most don't really think the practices (or annual checks) will have any value in terms of diet and healthy living (there are no references to this – BMI aside) advice
- The fear of being put on drugs reinforces this sense that you're better off managing things yourself until you lose the ability to so

Opportunity: Maybe we need to fill the space between self-management and going on drugs? What could happen, and what would the NHS be able to do for you as a result?

Is there an opportunity to make advice around diet and exercise a bigger focal area within the annual check (even if it's talked about in the context of a chat, more than a check?)



We heard loads of horror stories around Metformin and these reinforce resistance to checks

- Metformin is mentioned loads and pretty much no-one had a good experience – some of the stories they tell are horrific and only the most committed are seeing it through
- But many are self-prescribing the dose (one respondent has sickness and diarrhoea constantly and cramps which keep him off work, he's cut his intake down from 4 tablets a day down to 2 to see if he can keep going)
- Word spreads around these issues and it reinforces the perspective that you should put off any “medical” intervention should be put off for as long as possible (because they think that medicine is the most likely outcome beyond managing your diet and lifestyle)

Opportunity: talk up other options and the role the practices can play in helping people manage conditions without reverting to drugs and/or any other drugs that are available, or how to take Metformin in “safe” ways



Some diabetes patients feels quite isolated and unsupported with their condition

- People talk about feeling very alone and feeling quite exposed within the system (it's you and a doctor, who will often be perceived to be going through the motions). Challenging these perceptions is necessary to open peoples' minds to communication
- So, there could be an opportunity to build more of a sense of community among type-2 patients and creating such communities maybe opens up options for different comms channels (social/forums) and tone

Opportunity: anything we can do to create a sense of community around diabetes could be of real value (diet and lifestyle classes on-site)

Could we have "buddy networks" or days/weeks where we have a greater focus on diabetes, maybe bringing this to life through local communities?



Covid exacerbating this situation and reinforced the focus on self-sufficiency and self-care

- There's still a fairly big hangover from the pandemic (the perception was that people with diabetes were marginalised and forced to fend for themselves)
- Which created a degree of comfort (danger?) with self-diagnosis and management, which is going unchallenged

Opportunity: establish and communicate post-covid conventions – create a new normal for diabetes treatment and surprise patients, rather than letting them default to exaggerated and untrue views around self-care



Many patients experienced poor care or treatment in their early experiences

- We saw classic proof of the adage that you don't get a second chance to make a first impression
- Many of our (under 50) respondents have been diagnosed when the system was under its greatest pressure and delivery was poor
- This is compounded by some people who'd attended annual tests early into their diagnosis (because they hadn't yet formed unhelpful views around coping and treating) but very little happened as a result of having the tests/checks (eg, no follow-up) so they create a value equation where the efforts far outweigh the potential gains

Opportunity: the point of highest engagement is undoubtedly when they're first diagnosed and it's when they're most open to advice and support

Is this the point when we should be showcasing the broader support network available through practices and connecting them to the people who are specialist, compassionate, empathetic etc?



If you can build rapport early, and with the right person, the rewards are huge

- We heard from both patients and HCPs that if you can build rapport and understanding early in the process, it can embed much more useful attitudes
- The best practices appoint diabetes “leads” (or train them) and use these to own and manage the entire process (from sending out reminders/doing calls, to providing support and advice)
- It’s really helpful to position the appointment as a chat as much as a check – this would challenge the perception that the NHS is just going through the motions and that nothing is likely to change as a result of attending the check

Opportunity: dialling up the human element is useful (a chat as much as a check) as it builds empathy and rapport between HCP and patient and any communication/reminders coming from named individuals/diabetes leads, is way more likely to result in engagement and attendance



But there's a general (and unhelpful) lack of awareness re what's available in terms of support beyond the GP

- They're currently getting all the "useful" advice from google or other patients
- There's clearly a barrier in terms of GPs for many people – but the broader support network that's available really surprised people. If they feel supported and understood, the annual check becomes a different proposition altogether
- And feeling understood requires us to display an understanding of the realities of their lives and the challenges they face in the day to day

Opportunity: The earlier they could be introduced to dieticians or a specialist diabetes nurse, the better

Could we provide practical advice around healthy eating and meal prep on a budget / during the cost-of-living crisis? The current language and advice within this space is scoffed at (soup and shake diet feels very middle class and patronising)



Lack of flexibility in the system and asking them to take the strain can be a real deal breaker

- There's little perceived flexibility re scheduling of checks and managing the patient workload around them – so for people on zero-hour contracts it becomes an impossible burden to attend
- Extending hours is a big win – we're dealing with a lot of people on zero-hour contracts and even opening the surgery for 2 hours in the morning or 2 hours in the evening has a big impact

Opportunity: extending hours (having diabetes clinics in the mornings or evenings) builds empathy and breaks through some of these engrained perceptions and anything that takes the annual checks out of the “NHS machine” would help (this involves making it more personal and less clinical – so calls from diabetes nurses etc)

Maybe a bridge too far, but anything that sees us meeting them in their world rather than expecting them to meet them in ours would make a massive difference (checks or engagement in community settings etc)



Everyone has different contact preferences and time commitments but these aren't captured

- There is no “one-size-fits-all” from a messaging and medium perspective... there are people with landline only, people who don't use smartphones, people who can't read (complex) written English
- As well as lifestyle limitations (from hairdressers who can't answer the phone during the day, to people on zero hour contracts who can't leave work without it costing them)

Opportunity: capture contact preferences and work/time restrictions right at the start of the process. This would be a massive win and it shows that we empathise with the patient, as well as challenging perceptions that they're being processed

And show flexibility (send out links to videos to watch, is there anyone in the house who speaks English, anyone who can use YouTube)



Communication currently has a perfunctory tone rather than a personalised one

- At best it smacks of cold efficiency, at worst a complete lack of care
- It should reflect empathy... the more we develop 1-2-1 relationships with experienced and committed diabetes specialists, the better
- Even sharing the information that many practices have diabetes specialist nurses was powerful and people are far more likely to attend checks if they're treated as individuals and talked to with empathy.
- If we can break out of the white coat ghetto and build relationships with people, they're far more likely to respond and engage with the annual testing regime

Opportunity: personalisation is everything and is really powerful in countering the recurrent perception that the annual checks and communication around them are process driven (tick box) rather than motivated by care and compassion – human contact is the ideal for the majority but even when it comes to texting or writing letters, showing evidence of care/empathy is of huge value



Communication has a perfunctory tone rather than a personalised one

- The reality is that loads of patients can't recall any of the communication. If texts land when you're busy, it gets consigned to history, letters which feel official and perfunctory reinforce negativity
- There's no doubt that personal calls (ideally from someone with empathy and/or someone who's built a relationship with the patient and/or someone who's seen to have expertise specific to diabetes) beat letters and texts (they also overcome any issues around literacy and language)
- But if we are going to write letters, injecting a sense of care and compassion will help – less like a letter from the tax man and more like a note from a care provider, both in tone and look (these things were directly and spontaneously suggested by patients)

Opportunity: it feels like there's an opportunity to enhance messaging, but there's also a risk of focusing only on this area and not challenging some of the perceptions and behaviours that sit further back in the journey



Language is a barrier in some communities, but little common sense is used to work around this

- That's not to say that language isn't an issue – we need to make sure that messaging is personalised where appropriate (some of the GPs in areas with lots of patients in ethnic minority groups state we need to do more re translations and/or making the contact more personal)
- Inaccurate records are a bigger barriers (no mobile/smartphone/only a landline etc) than language in a lot of cases
- There's undoubtedly a need to respect and accommodate issues around language and culture/faith and there will be gains to be made from approaches in these areas
- But the real barriers to engagement feel more profound – tailoring reminders and messaging will be the icing on the cake, not the big win

Opportunity: do more around translations etc, but it feels like it boils down more to initiative, thinking creatively, showing empathy

And HCPs sharing “hints and hacks” will spread the word quickly



Summary of focus areas



Key focus areas

- Encouraging the development of specialist and committed support for diabetes patients in every practice
- Sharing best practice across the region
- Take advantage of the earliest engagement opportunities, before unhelpful norms and defaults kick in
- Build empathy into the process at early stages
- Remove duplication and inefficiency in testing regimes – create time for a chat, as well as scheduling checks
- Hero the tests that break the cycle of “knowledge” and self-reliance
- Try to add value in the areas that are relevant to more patients (useful, realistic dietary advice that’s fit for purpose – COL crisis etc)
- Elevate type-2 diabetes as a serious (but manageable – by the experts) condition
- Clarify the space/journey between healthy eating and reliance on Metformin/insulin dependency



Key focus areas

- Personalise communication and build a rapport, ideally with the teams specifically relevant to and passionate about diabetes
- Capture contact preferences and lifestyle characteristics (living arrangements, support network, work commitments etc) early
- Revisit and update these preferences and commitments annually – as well as contact details/phone numbers/changes in support network
- Build more flexibility (spontaneity/common sense) into testing regimes
- Meet them in their world rather than asking them to meet you in theirs (extended hours, build a sense of community, community-based engagement and messaging, home visits etc)
- Tailor messaging (and medium) to life stages, ethnicity, religion/faith etc – much easier when rapport established
- Never a “3 strikes and you’re out” mentality/approach – flattery and positivity beats being told off and negativity
- If people attend checks, always follow up – whether anything’s changed or not – with a clear plan of action



Any questions?

