Adding psychology to the diabetes service 'new patient' pathway: An evaluation

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Key Points

Psychology should be a visible and integrated aspect of the multidisciplinary diabetes care team.
Psychology can be integrated into the annual review system without the need for a specific referral.
Brief psychology assessments can offer reflective space for patients and opportunity for earlier identification of psychosocial support needs.

Abstract

Promotion of psychology as an integrated aspect of the diabetes team has been encouraged, with the aims of: reducing stigma felt by service users accessing this aspect of the MDT, allowing for a biopsychosocial overview of patient care, and timely advising on appropriate signposting and onwards referral where necessary. To this end, a new care pathway was trialled, with psychology appointments offered as the third step in a new nurse and dietitian-led clinic structure.
For a five-month trial period, all new patients (newly diagnosed or new to the service, n=30) were allocated a 30-minute-long remote psychology assessment appointment. The attendance rate was 66.7% and comparable with traditional opt-in psychology appointments. Attendance at psychology appointments was not influenced by diabetes type, however patients were more likely to attend if they were female or of British ethnicity.
The trial suggested that psychology appointments can be integrated into the preliminary assessment and annual review system without the need for specific referral. Such assessments can offer space for patients to reflect on their experience of living with diabetes and the identification of any psychosocial support needs, enabling timely information sharing and referral for support within and beyond the MDT. Further evaluation is necessary to ascertain whether integrated psychological assessments in the usual care pathway can promote better awareness of, and engagement with, psychology whilst patients are under the care of the diabetes team.

Introduction

Bedford Hospital Adult Diabetes Service provides care to people aged 19 and above who are living with type 1 and type 2 diabetes (amongst other diabetes diagnoses). Patients accessing this service are expected to attend a minimum of two appointments per year: an annual review with their medical consultant, and an appointment with the diabetes specialist nurse (DSN) six months later. This exceeds the expectations of the National Institute for Health and Care Excellence (NICE) guidance for diabetes management for adults, which stipulates the need for an annual medical review.[1] Further support is also available from the multidisciplinary team (MDT), including a dietician and clinical psychologist.

The service has promoted psychology as an integrated aspect of the diabetes team to reduce any stigma felt by service users accessing this aspect of the MDT, and to allow for a biopsychosocial overview of patient care and advice on appropriate signposting for MDT staff. It was hoped that psychology could be integrated into the annual review system for brief assessment (during a 30-minute appointment rather than one hour as usual) in order to support recommendations and signposting to appropriate specialties and services within and beyond the MDT. To this end, a new care pathway was trialled, and psychology appointments became the third step in the clinic structure as indicated in Table 1.

Pathway	Appointment offered
Step 1	First appointment – patient sees DSN and dietitian (If patient is newly diagnosed or new to service they will see psychologist at 6 months, if they are returning to the service they see dietitian*)
step 2	At 3 months - patient sees Consultant
Step 3	At 6 months – patient sees either dietitian or psychologist
Step 4	At 12 months – patient sees DSN
…and so on	At 18 months – patient sees Consultant

Table 1: New patient appointment pathway (*decision made due to capacity limitation)

With a commitment to increasing the support available to people living with diabetes and increasing the visibility of psychology as part of the MDT, the team trialled the new pathway. The aim was to ensure that all newly diagnosed patients, and all those newly referred to the service, would meet a psychologist (either virtually, via telephone or face-to-face), be assessed, and could be referred for support where necessary.

Although it was acknowledged that some patients may not need support, these appointments could capture a need for support earlier than was previously possible. Within the previous model of care, not all patients were routinely referred to psychology (due to capacity at 0.6wte across two centres). This meant that patients were required to request referral to psychology, or for need to be suspected and raised with patients by other members of the MDT. It was hoped that having psychological assessment and support as an integrated part of the pathway, offered to all patients, could promote better engagement with psychology whilst patients are under the care of the diabetes team. This report describes attendance and outcome of the trial psychology clinic to inform the allocation of the future psychology provision.

Method

The nurse and dietitian-led new patient clinic contains 4-6 patients per week. For a five-month trial of the new care pathway, all new patients (newly diagnosed or new to the service) were allocated a psychology assessment appointment. This meant that patients needed to opt out of psychology

appointments, rather than request them/opt in. Patients could opt out either by calling the service when they received the appointment letter or by not attending the appointment offered.

Due to limited capacity, patients returning to the service were not referred to the psychologist via this pathway, instead these patients were seen by the dietitian. For those patients known to the service, staff were welcome to consult with the psychologist for a psychological perspective on their presentation or care plan, or about alternative psychological support options available.

Psychology appointments offered were 30 minutes long, with a further 15 minutes allocated to administration (e.g., note keeping and letter writing). Appointment times were structured as follows: 09:00; 09:45; 10:30; 11:15; 14:00; and 14:45. Template outcome letters were created to support efficient summaries and onward referral to the GP, the local Increasing Access to Psychological Therapy (IAPT) Service, and Community Mental Health Team (CMHT), where necessary and appropriate.

Results

The new patient clinic was held on the second and the fourth Tuesday of the month for five-months in 2022. Clinic sizes ranged from one to six patients, with a mode of four patients. Data has been collected on attendance and outcome and is reported below in Figures 1 to 4. In total, 30 appointments were offered. All appointments were offered remotely, either by video call (NHS Attend Anywhere) (73.3%) or telephone (26.7%), based on patient preference.

Of the referrals for this clinic, 56.7% had type 1 diabetes, 36.7% type 2 diabetes, and 6.7% secondary diabetes. The majority of patients were males (73.3%) and the mean age of those referred was 48.7 years (range = 28 – 74 years).

The attendance rate was 66.7% and, as shown in Figure 1, attendance was not influenced by diagnosis. However, patients were more likely to attend if they were female or of British ethnicity (Figures 2 and 3). The attendance rate for those newly diagnosed (n=15) and new to the service (n=15) was identical (66.7%).

Although the majority of patients seen in the clinic did not feel that they had unmet psychosocial needs, and no risk issues related to mental health were identified for these patients, they welcomed information about mental health services available to them. Following a discussion of psychosocial challenges, two patients requested a referral be made for them to access psychological support and one declined a referral for support that was offered. When patients did not attend the assessment appointment, details about how to access support were provided. All letters were copied to the patients GP with the patients consent, as is standard practice within the service (see Figure 4 for a breakdown of appointment outcomes).

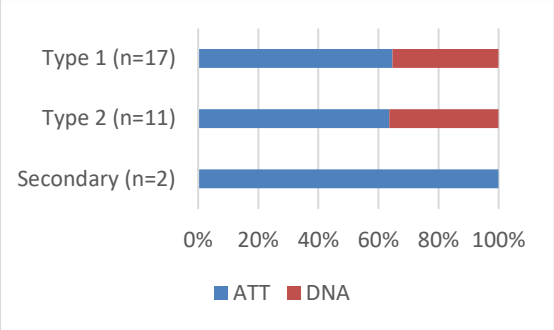

Figure 1: Attendance broken down by diagnosis

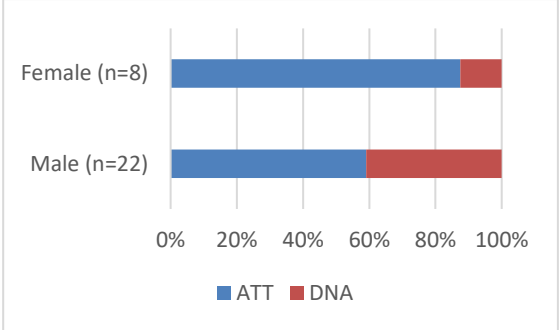

Figure 2: Attendance broken down by gender

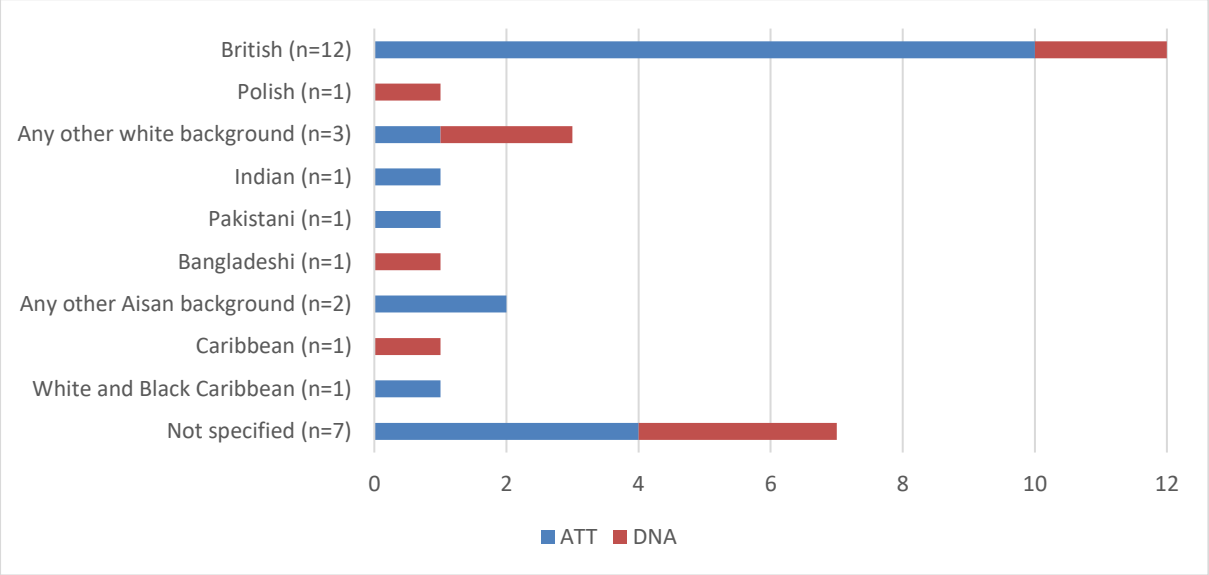

Figure 3: Attendance broken down by ethnicity

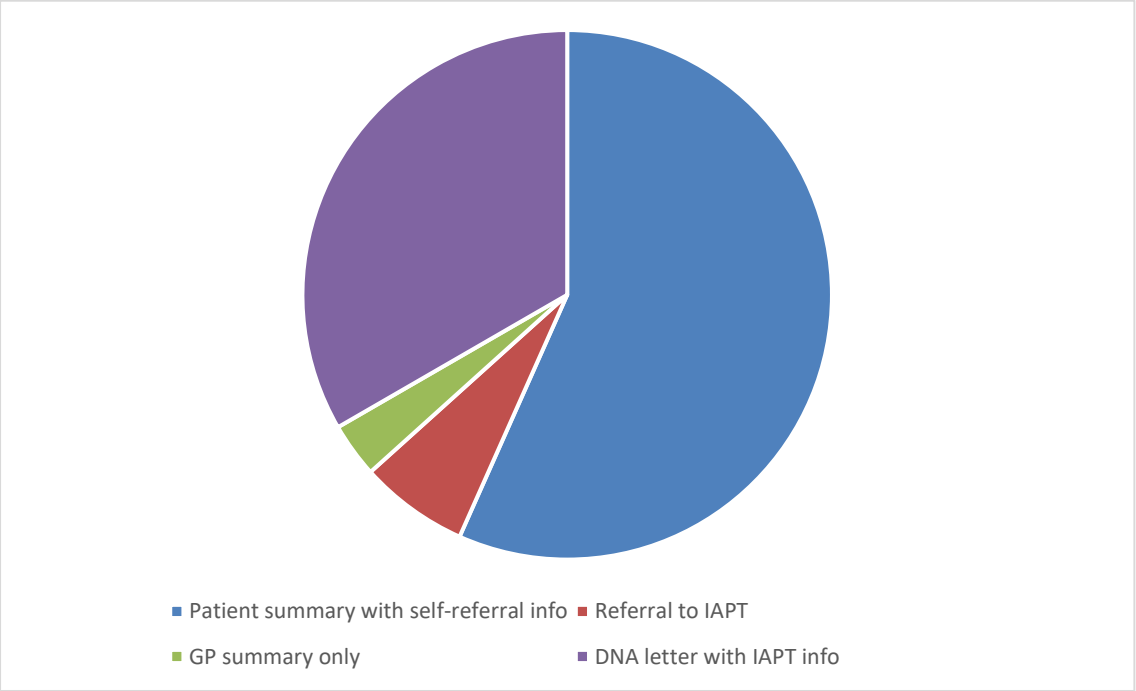

Figure 4: Appointment outcome

Discussion

The addition of a psychology appointment into the new patient pathway gave the diabetes service the opportunity to trial a new way of working and to monitor the uptake and outcome when psychology becomes integrated into the standard care pathway for new patients, rather than patients needing to be actively referred to the psychologist. The aim being to collect data, despite limited allocated time, to support future business cases for increased psychology provision should this way of working prove beneficial for patients and for staff within the service. It is hoped that this service provision can be offered to all patients (not just those new to the service) in the future.

Following referral, attendance at the traditional one-hour-long psychology assessment appointments at Bedford Hospital had been found to be approximately 70%. An attendance rate of 66.7% for brief 30-minute assessments without referral is encouraging, especially as feedback from the MDT suggests that attendance at the first new patient clinic (DSN and dietitian) is around 50%, with the attendance at step 3 dietitian appointments also being around 50%. Unfortunately, irregular or non-attendance of appointments is common in diabetes services, particularly in younger patients[2], along with reports of patient dissatisfaction with adult care-providers.[3,4] Therefore, to inform further service development, it is important to ask questions about the value of these appointments and to seek service user engagement to understand barriers to attendance and how appointment accessibility can be improved. A particular area for attention in this regard is service accessibility and equity considering the multicultural population served by the service.

Attention should also be paid to the differing attendance rates at appointments for males and females. With diabetes being more prevalent in males (2.3 %), than in females (1.4 %)[5], it is expected that a higher proportion of patients referred to the diabetes service would be male, however a disparity is clear in the attendance rate for males when compared to females. A reason for the lower rate of attendance in males could be due to the disproportionate negative psychosocial impact of diabetes on women compared to males[6] but also because men are often less likely than women to seek help from health professionals for physical and mental health problems[7].

Prior to the pandemic, appointments would take place face to face at the hospital. However, in response to the COVID-19 outbreak, and in line with national guidance[8], since March 2020, appointments have been provided virtually (via video consultation or telephone call). Following easing of the restrictions, some face-to-face consultations have resumed when a clinical need has been identified, however attendance in person for these brief review appointments was considered to be unnecessary and likely inconvenient for many. The trial of this new pathway, offered with video or telephone appointments in line with patient preference, found that video appointments were the preferred mode for the majority, although the option of a face-to-face appointment should be provided in future.

Although there is no strong evidence that unmet patient needs were identified more readily during this clinic, with only two referrals being made for psychological support, it is apparent that patients assessing this brief 30-minute assessment were keen to learn more about the support available to them, should they need to access it. This included services such as the local IAPT service's Long-Term Conditions pathway. Sharing this information would enable patients to make a self-referral for

support if necessary in future. Going forward, in order to ensure that patients are aware of the support available to them, the visibility of services, either through discussion at routine appointments or via written service information, is important.

As most people did not feel that they had unmet needs requiring onward referral, it may be helpful for the service to consider a stepped care model, including psychoeducation groups encouraging peer contact and learning, bibliotherapy with an assistant psychologist, referral for diabetes-related support to the local IAPT Long Term Conditions Pathway, or support via an in-house clinical psychologist. It may also be that individual support needs may be more readily identified through the use of standardised questionnaires, such as the Problem Areas in Diabetes (PAID) Scale[9] or Diabetes Distress Scale[10]. Both have been found to be good self-report measures of diabetes distress[11] and can be used as a springboard for initiating dialogue with patients about diabetes-related distress or to monitor the efficacy of support interventions. Using standardised questionnaires to initiate conversation would be helpful in giving patients permission to disclose any concerns or seek support, particularly in the context of a supportive relationship with a clinician who acknowledges and appreciates the complexity of living with diabetes[12]. As is usual practice, referral for unidentified mental health needs prior to diagnosis of diabetes should be made to the IAPT Service, GP and/or the CMHT as appropriate.

With this model of care in mind, the service should remember that "one size does not fit all", and the importance of flexible service provision[13]. Previously patients within this service have spoken about some of the psychological barriers to attending their appointments and the impact diabetes can have on their mental health, emphasising the importance of the whole MDT demonstrating an understanding of mental health in order to provide more tailored person-centred consultations[14]. This is also supported by research identifying patients' desires for professionals to better understand the impacts of living with Diabetes[15] and, more widely, the issues around frontline medical staff not being equipped with adequate mental health and psychological skills training[16].

NICE guidelines,[1] state that diabetes professionals should have *"appropriate skills to identify and provide basic management of non-severe mental health problems in people from different cultural backgrounds".* Therefore, as well as the provision of assessment and psychological intervention for patients who access the diabetes service, a priority for the psychology service within the diabetes centre should also be education to support members of the MDT in tailoring diabetes care as much as possible to the individual psychosocial needs of patients.

Conclusion

Psychology appointments can be integrated into the annual review system for patients living with diabetes. Such assessments can offer opportunities for patients to reflect on their experience of living with diabetes and any psychosocial support needs that they have in relation to diabetes. This can enable timely information sharing and for referrals to be made for support within and beyond the MDT, without patients themselves having to request a referral. Further evaluation is necessary to ascertain whether integrated psychological assessments in the usual care pathway can promote better awareness of and engagement with psychology whilst patients are under the care of the diabetes team.

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