



**Humber and North Yorkshire**  
Health and Care Partnership



**Humber and  
North Yorkshire**  
Integrated Care Board (ICB)

# **York Population Health Management Diabetes Project Summary**

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# About this project

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Peter Roderick, Consultant in Public Health and Charlotte Sheridan-Hunter, Commissioning and Transformation Manager, established a multi-disciplinary/agency working group in March 2021 including primary care, the voluntary sector, the CCG and Public Health. Practices within four PCNs in York agreed to participate in the project. The working group initially met monthly to explore engagement methods with identified patients and what interventions are currently available to patients both clinically and within the community.

The objectives of the project are:

- i. Understand more about this cohort and what gaps in care and support / barriers they might face.**
- ii. Improve their confidence to manage their own condition and get support when needed.**
- iii. Identify prevention opportunities (clinical, social) given their age range and deprivation score, and additional support to engage.**

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## **1 Background**

Around 11,000 people in York are living with a diagnosis of diabetes. This equates to 71.3% of the estimated diabetes prevalence, meaning another approximately 3000 people live undiagnosed. This is currently the largest diagnosis gap in the Yorkshire & Humber area.

Diabetes is most often a first condition in York and often leads to other long-term conditions e.g., coronary heart disease, depression, and chronic kidney disease. The most common age range is 65-79. 2.5% of diabetics are from a minority ethnic group with another 10% of the population estimated to have pre-diabetes.

The average person with Type 2 diabetes spends only 4 hours a year with a healthcare professional with the rest spent on self-management.

Supported by Optum, who facilitated action learning sets with over 30 partners and using data from primary and secondary care, mental health and community services, a cohort was identified of 400 patients in York living with type 2 diabetes. This cohort also had risk factors for their disease progressing to further complications or other long-term conditions. Individuals were also in the bottom 50% IMD score and demonstrated minimal engagement with Primary Care in 2019/2020.

## 2 Methodology

With the support of York CVS, it was decided that social prescribers would be best placed to have personalised 'what matters to me' conversations with identified patients. They would use an agreed script to inform discussions and as an opportunity for an asset-based social prescribing interaction with the patient.

The script aimed to capture how confident patients felt managing their diabetes, their personal wellbeing using responses to ONS wellbeing score indicators, and any barriers to good health or access to health care. Social Prescribers were also able to identify any changes in lifestyle that the patient would like support with such as smoking cessation, weight management, reducing alcohol intake and becoming more physically active.

An enhanced DOS was developed for the social prescribers, co-produced with primary care and the Voluntary, Community and Social Enterprise (VCSE) sector, which meant additional clinical information and knowledge of available community support was at hand.

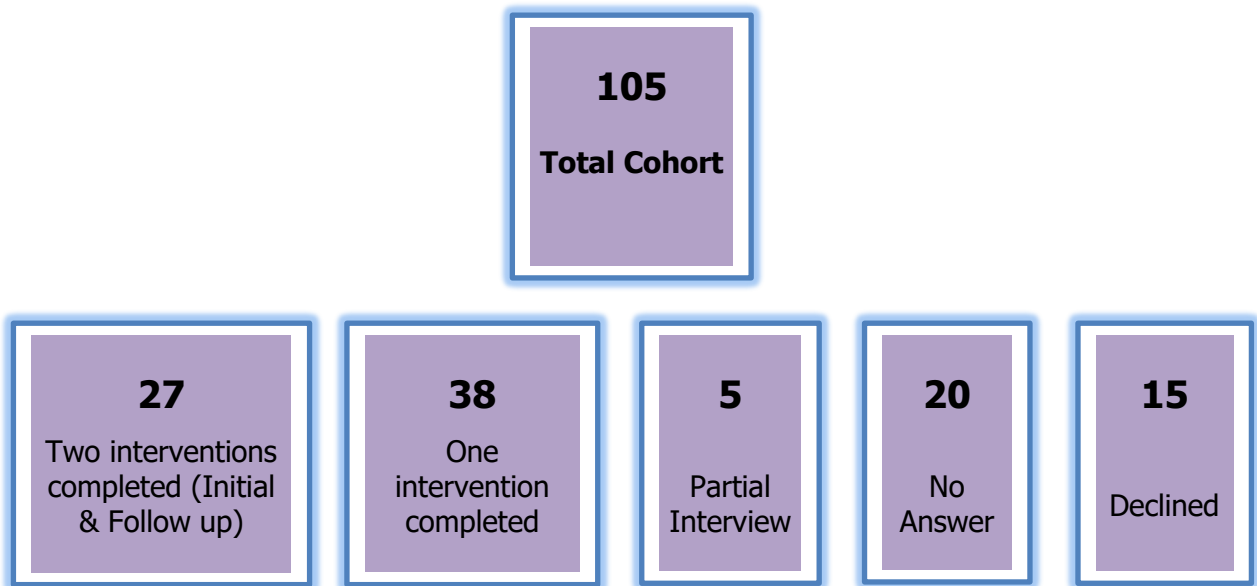
On completing the interview, the social prescriber decided if the interventions offered at the time of the call met the individuals' needs or if further intervention/GP task was required. With the permission of the patient, referrals were made to organisations such as Healthwise, Move Mates, Citizen's Advice and Cruse and they were supported to access the service if needed. They were also able to request a referral via an email to a health trainer, mental health practitioner, or practice nurse.

A follow-up call was scheduled for around six months' time to assess the impact of any interventions or additional support offered. 'Cold calling' resulted in some patients being uncontactable and others opted not to participate in either the first or second interview.

The anticipated outcomes for the project are an improvement in the patient's ONS4 wellbeing score, improvement in their Chronic Self-Efficacy (CSE) scale score and where indicated appropriate referral to lifestyle change programmes and social support.

The project split the patients into two cohorts. Cohort 1 calls took place in May and June 2021 with the follow up calls taking place in November and December. Some follow-up calls were delayed until January due to no answer on the first attempt.

Cohort 2 were contacted between October and December with follow-up calls between April and June 2022.



Fig, 1 Total cohort

### 3 Overall scores

For patients who completed both calls there was a slight improvement in the ONS4, a greater improvement in CSE scores and a larger reduction in anxiety scores. The project did not utilise a methodology which allowed for the control of other variables within the patient's life, so it would not be possible to attribute these improvements solely to the interventions offered; however, it would be reasonable considering the positive follow-up feedback to conclude that these interventions did contribute to improved scores.

Total number of both calls completed = 27			
	1 <sup>st</sup> Call	2 <sup>nd</sup> Call	Final Score
<b>ONS</b>	876	880	<b>+4</b>
<b>CSE</b>	567	589	<b>+22</b>
<b>Anxiety</b>	90	54	<b>-36</b>

Fig, 2 Overall scores summary

Other variables observed that may have affected the outcomes included levels of COVID restrictions and the advent of spring/summer which was observed to have a marked effect on the motivation of participants. The calls in winter were made during another peak of Covid cases/lockdown and Christmas. Around this time, diet, exercise, smoking cessation, reduction in alcohol were generally not a priority.

Overall, the 'cold' calls were well received but on reflection a letter or text with an explanation of the work, maybe including some support options for patients to start to think about, could be beneficial in the future. There could be an option to opt out - but with the link worker number included if they would like to access non-medical support in the future.



## 4 Themes

The largest number of participants expressed an interest in weight management closely followed by increasing physical activity. Several participants indicated that they smoked but the majority were not looking for support to stop.

Another recurrent theme was difficulty with self-care management for those working shifts. These issues ranged from struggling with healthy eating and sedentary shifts to difficulties sleeping.

During the first call, most patients said that they would contact their PN or GP re non-medical management of their condition - though due to clinic and extreme pressures on GP/availability of appointments, a few patients fed back they would not bother as difficult to get an appointment.

On the second call, most patients stated that they would contact the social prescribing team for non-medical support to help manage their diabetes and the practice team if needed to avoid unnecessary GP appointments. They also offered further support if they experienced any further challenges accessing healthcare.





## **5 Care Process and Access**

### **Care Processes**

Participants' records indicated that the majority were missing structured education and retinal screening, but those who were asked about attendance confirmed that they had attended. This further confirms a potential coding or communication issue with both care processes. If a participant indicated that they had missed their annual review a task was sent to the GP or DSN to follow-up.

This also highlights that work on case-finding should be carried out as close to the intervention as possible, as data pulled from clinical systems can quickly become out-dated and interventions offered inappropriately.

### **Access**

Issues around access were also recorded. Some participants highlighted logistical barriers to travelling to centralised blood taking/blood pressure and retinal screening centers. In one instance a social prescriber was able to offer the use of the Social Prescribing Travel Grant to support people to get to appointments if needed.

Other access barriers centred around disability and co-morbidity. Participants who were blind or partially sighted indicated barriers in getting to appointments as well as struggles with testing strips and injections. Individuals with serious mental illness (SMI) such as agoraphobia also struggled with access. A participant with learning disabilities (LD) indicated that weight management programmes were difficult as he was not aware of any of the current LD friendly offer.



## **6 Personalised Care Intervention**

Personalised care underpins the work of the social prescriber. Two case studies that demonstrate the personalised care approach and why social prescribing and the "what matters to me" approach is successful can be found in Appendix 1.

As a result of this personalised approach and not just a conversation limited to diabetes, we found that people were more focused on issues such as stroke rehab, declining/poor health, finances, employment, strain on carers, bereavement support and work-related stress. The social prescriber then facilitated participants to access support within their community. On follow up, participants felt able to address their diabetes management.

The goal was not just to signpost - this contraindicates the York CVS model; all patients who were sent information or had discussed groups were supported, either by us referring them, or the offer of a follow up call - taking them onto our generic social prescribing caseload. This should be something we ensure is recorded in future as many patients were ready for a referral to support on their second call.

Several referrals were to local/community groups and charities - patients seemed more receptive to this lower-level support especially due to lower motivation and increased anxiety going out post-Covid.

The social prescribers have developed close working partnerships with the CYC Health Trainers and Healthwise which has given their team confidence to refer patients to them knowing it will be a positive experience.



## **7 Weight Management Programmes**

Most referrals for participants with a high BMI who indicated that they were ready to lose weight was to the CYC Health Trainers. This was not always the most appropriate referral particularly for those with a BMI over 40.

To increase referral to NHS weight management programmes, knowledge and confidence could be improved within the social prescriber team to encourage them to refer patients if applicable or send a task for GP follow-up.

## **8 Focus for Future Work**

The outcomes of referral to community groups could also be followed up as a way of gaining knowledge around the most effective interventions and to build a case for future investment.

Accessibility to fresh food and education on how to prepare healthy meals could be further explored as this is often identified as a gap within our wider team.

## 9 Proposed Learning & Actions

The amount of time the social prescribers were able to spend talking to patients made a difference in the underlying issues they were able to uncover and signpost or refer to appropriate support. The challenge will be to maintain the obvious benefits that come from bespoke, resource intensive interactions and deliver this at scale by increasing the confidence and upskilling all those who encounter this cohort in both primary care and the community.

### Communications

Develop a patient-friendly explanation of what yearly diabetes reviews are, what to expect and why they are so helpful. Include an outline of options for accessing care processes such as attending the practice by arrangement and any offers for support with travel to centralised venues. Comms can include posters in practices, information on York Place/practice and/or PCN website.

Develop practice communication piece to clarify coding and recording of the Structured Education offer.

### Risk Stratification

Linking levels of clinical and social input to risk stratification –adapting existing risk stratification tools to include social indicators of risk such as isolation and deprivation.

### Retinal Screening

Clarification of retinal screening process and notification of completion recorded in primary care records.

## Appendix 1 – Action Tracker



PHM Diabetes Project  
Action Tracker\_1022.x