Diabetes Health Improvement Project

Project Mission

To identify and address health inequalities among high-risk diabetic patients who DNA'd their review appointments , screening and education programmes. Support with engagement with services to prevent deterioration of diabetes related health and wellbeing. The high-risk patients will include those who are frail, housebound, have mental health conditions, comorbidities and polypharmacy who have a diabetes diagnosis.

Rationale

There are a certain groups of patients who do not engage with health services. They received numerous letters encouraging them as part of the practice recall, but year on year they fail to engage with their practice.

Unfortunately, these patients usually end up with a long term complication of their poorly controlled diabetes .

To prevent this it is important that we look to reduce the barriers patients face.

The Warrington approach

We developed a local program to address health inequalities among high risk diabetic patients who do not engage with services.

The service was divided into two arms:

Home visit and active intervention for those who do not engage with services.

Support for patients who DNA their screening and educational programme

The cohort targeted were diabetic patients who are frail, housebound, have a mental health condition or other comorbidities.

Partners & Stakeholders

The project was a collaboration of **4 PCNs** in Warrington, covering a total of **20 practices** and 160,000 patients.

Project oversight and delivery by the GP Federation, **Quay Healthcare CIC.**

We also worked with our Equiptment and Technology provider, **Roche**, to deliver the COBAS 101 Point of Care Testing HBA1c and Lipid Testing.

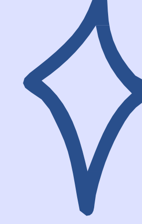
Initial Engagement

- Meeting with individual primary care networks to discuss the project and how useful it would be
- Meeting with practice nurses/diabetic leads to introduce the project
- Meeting with Care Coordinators
- Meeting with Paramedics

> *The project started with one practice, and was then scaled up within the PCN. Once happy with the process, the project was then rolled out to the other three PCNs in the area.*

Training and development

- Point of care testing, use of equiptment (COBAS 101 device)
- Basic foot checks – training delivered by Bridgewater Community FT Podiatrist



Steps involved

1

Identification of at risk groups especially linked to inequalities.

2

Communication with the at risk groups with user friendly means and looking for barriers.

3

Incorporating technology and equipment

4

Active engagement with these groups by making arrangements for people to go out to see them within their environment ,liaising with their practices and

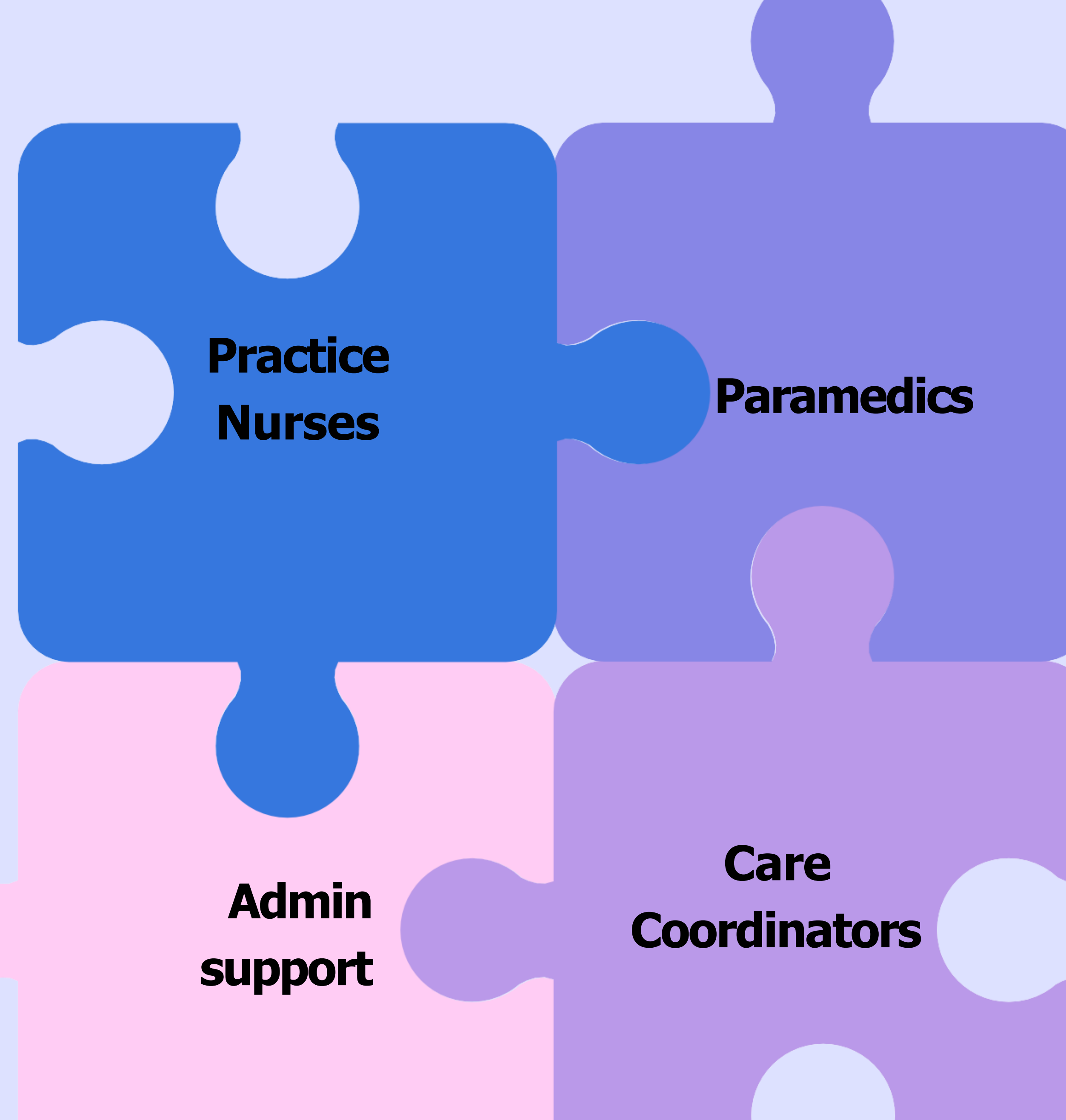
5

Supporting GP practices by working with Quay to help review the difficult to reach patients that have been identified

Who was involved?

Lisae with patients to complete diatbetic review

Proactively contacting patients and arranging date for visit



Visiting patients to do the screening and healthcheck. BP, Weight & Smoking checked too. Completion of diabetic template. Task practice diabetic nurse

Validating data and encouraging patients to take up service offer

Utilising Care Coordinators

Identification

Liaising with the GP lead and the practice nurses within each surgery who specialise in diabetes, to access a diabetes dashboard, or a program of their choice to identify the patients .

Validation

Review patients records and exclude patients that are no longer appropriate to contact

Engagement

Contacting patients and supporting patients to engage with services, by helping to arrange new appointments that had been missed and supporting access to education programme

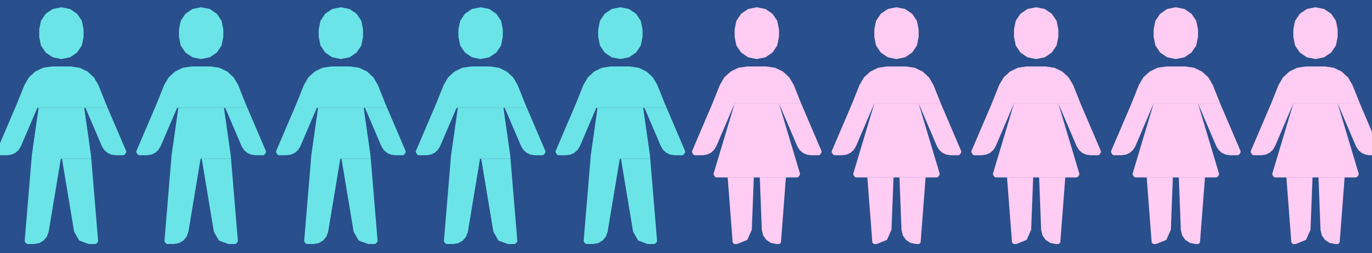
Limitations

- *COVID* – The paramedic service was reassigned in its entirety to the COVID clinics and the home visit of high risk patients which meant the program was not operational then. The care coordinators were reassigned to help with the vaccination hubs
- *Practice engagement* – Inspite of repeated messages some practices did not engage with the service or sent limited information
- *Patient engagement*– These are a group which are very difficult to motivate and have to be repeatedly called to engage
- *Access to services* - No housebound retinopathy service, closest offer nearby optician
- *Staff retention* - Town-wide challenges in recruiting and retaining care coordinators initially.

Uptake

111 patients reviewed

4 PCNs engaged



Male: 52.7% Female: 47.2%

48% of patients seen were over 80 years old

Feedback

"Programme works really well, helpful service, quick turnaround from referring patient to being seen"

Ongoing patient feedback .

Changes to day to day practice

Paramedic team now delivering housebound chronic disease reviews

Programme has become business as usual, practices continue to refer into the paramedic team for screening

Care Coordinators to continue motivating patients to get involved in screening process and support appointment booking for those who are struggling

Thank you

For further information,
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