NHS
Coventry and Warwickshire

Sowe Valley PCN are taking a Population Health Management (PHM) approach to support patients with Type 2 diabetes. They were among the four PCNs that participated in the national Population Health Development Programme in which they identified a population cohort to develop targeted interventions and evaluation plans.

The PCN has continued to build upon their progress from the programme to design a proactive, personalised and preventative model of care to support patients with Type 2 diabetes.

Why change was needed?

Sowe Valley is a large population with two significant bands of deprivation and a reasonably high recorded percentage of people from a BAME background. In comparison to other PCNs within the ICS, there is a highly documented history of smoking and medium-high levels of social vulnerability. This population is considered to be at a higher risk of Type 2 diabetes and a proactive care approach was needed to identify and design interventions to support these patients.

What we did

Health and social care professionals selected a cohort of 170 people with Type 2 diabetes between the ages of 20-39 with a BMI greater than 30.

Clinicians took a population health management approach to better understand people's experiences with accessing services currently offered in the area. This involved taking into account the wider determinants of health, such as people's social structure in terms of work, family, exercise, shopping and cooking habits.

One of the key aims of the programme is to provide patients with a more integrated approach that supports them to self-manage their health and wellbeing. For example, the diabetes project has supported one patient to self-manage her diabetes by providing her with a personalised clear plan and guidance from a Diabetic Nurse.

The patient entered the Diabetes Support project in June 2023, and was referred to a Diabetic Nurse for a rounded personalised support plan. The patient is now confident in managing her condition and was extremely thankful and expressed how her confidence has increased. The patient also expressed her joy at losing weight in this short amount of time. The patient continues to be monitored by a Care Coordinator for any further support to address the wider determinants of health impacting their diabetes.

Overall, the approach has been successful with supporting patients with Type 2 diabetes. We've seen excellent engagement from the selected cohort and an increase in their knowledge of what services available to support them. Work continues to scale out the interventions.

Who we worked with

The programme was a collaborative approach between:

- Coventry and Warwickshire Integrated Care Board
- Sowe Valley PCN leadership team
- Social prescribing team
- Long-term conditions leadership team for Coventry place
- University Hospital Coventry and Warwickshire - Specialist diabetes team
- Coventry and Warwickshire Partnership Trust - Community diabetes team and PCN based Community psychiatric nurse
- Compassionate communities
- PCN – Dietetics, Pharmacist and Health and well-being coach (PH)
- Innovation roles – psychology doctorate students