Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Cefnogi pobl sydd â chyflyrau cronig

This response was submitted to the Health and Social Care Committee consultation on supporting people with chronic conditions.

CC18: Ymateb gan: | Response from: Hywel Dda University Health Board

Hywel Dda UHB response to Supporting people with chronic conditions consultation

May 2023

Introduction

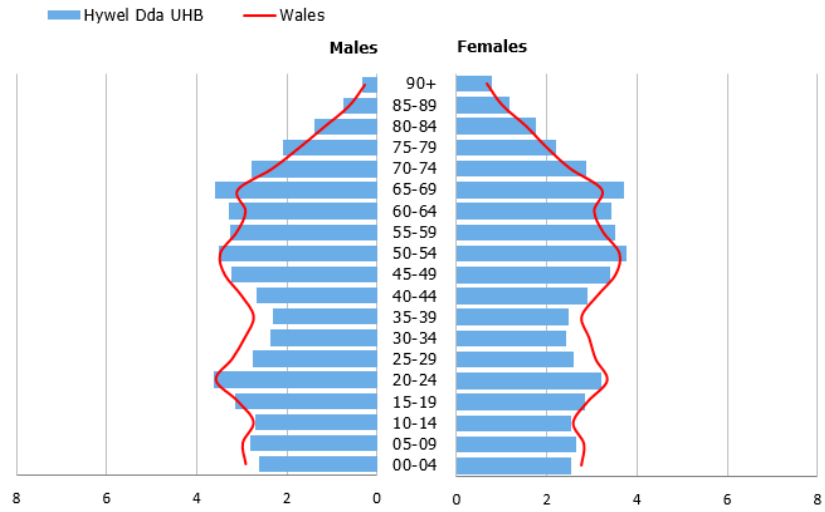
Hywel Dda University Health Board consists of the three Local Authority areas of Carmarthenshire, Ceredigion and Pembrokeshire and has a total population of 374,600 people (Public Health Wales website, accessed 2019, based on Mid-year population Estimates (MYE) from the Office of National Statistics (ONS).

Generally, Hywel Dda has an older population than the rest of Wales with 9.8% of Hywel Dda residents aged over 75, compared to the Welsh average of 8.6%. It is estimated that 59% of Hywel Dda adults are overweight or obese (above all Wales average of 57%) but only 23% of Hywel Dda residents smoke compared to 24% across Wales. It is self-reported that 40% of the adult population of Hywel Dda drink above the alcohol guidelines compared to 45% for all-Wales and this is one of many statistics which will be analysed in more detail later in this needs assessment. Other indicators are presented in Table 1. Summary Statistics Description of Hywel Dda University Health Board's population (Public Health Wales, 2019)

Hywel Dda HB	
Total population	374,600
% aged 75 and over	9.8%
Life expectancy at birth - males	77.5 years
Life expectancy at birth - females	82.0 years
% overweight or obese adults	59%
% adults who smoke	23%
% adults drinking above guidelines	40%
MMR uptake	92.2%
Live births per 1000 women aged 15-44	57.9
Emergency hospital admissions (European age standardised rate per 1,000 population)	59.4

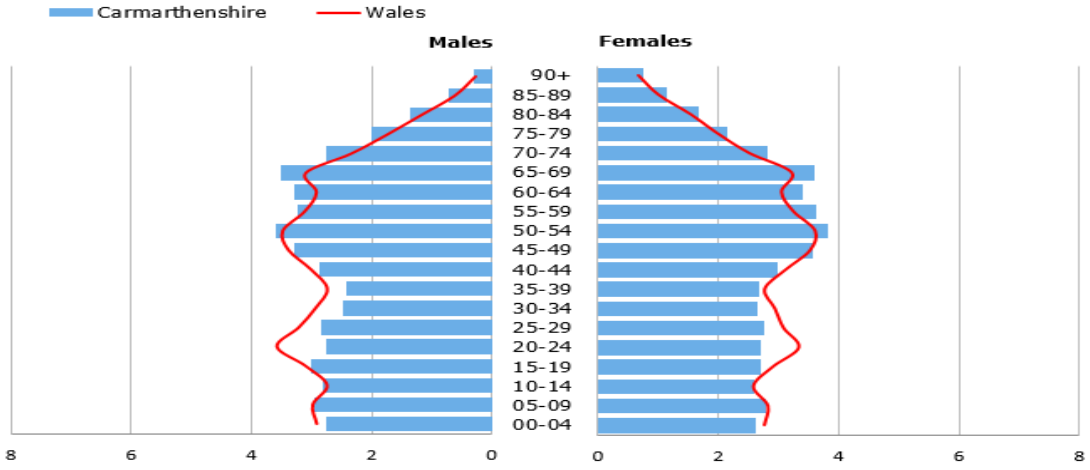
Figure 1 shows that the age distribution across Hywel Dda generally reflects that seen across the rest of Wales but with fewer adult males and females aged between 25 and 49 and more adults aged 55+.

Figure 1. *Percentage of population by age and sex, Hywel Dda University Health Board, 2015 (Public Health Wales Observatory)*



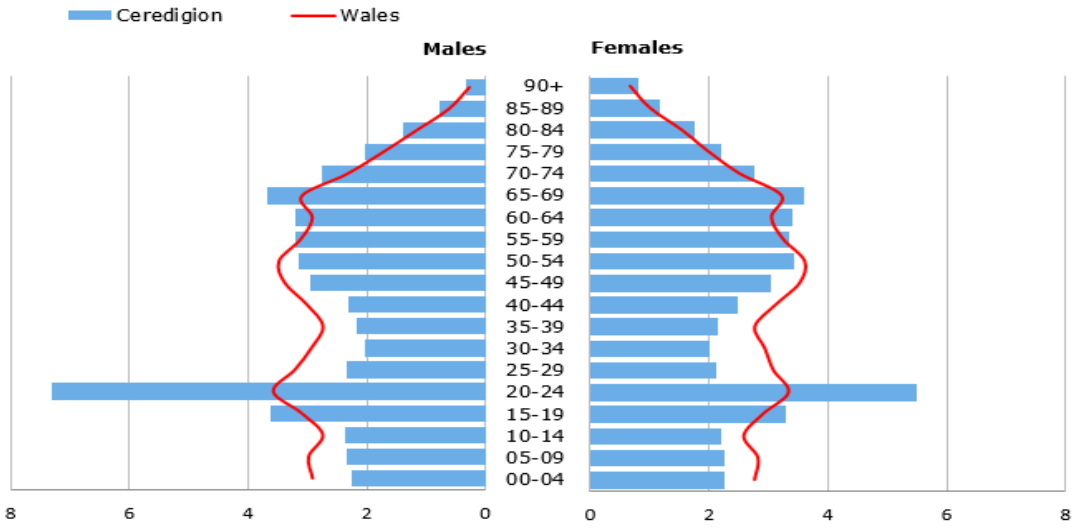
According to the National Census (2011) Carmarthenshire has a population of around 186,500 people. Whilst much of Carmarthenshire would be considered a rural county, there are also major town such as Carmarthen, Ammanford and Llanelli. Some of the wards in Llanelli are statistically amongst the most deprived in Wales. The population pyramid for Carmarthen (Figure 2) mirrors that for Hywel Dda with a population generally older than the Welsh mean.

Figure 2. *Percentage of population by age and sex, Carmarthenshire, 2015 (Public Health Wales Observatory)*



Ceredigion has a population of 75,900 (National Census, 2011) and is a very rural county with over fifty miles of coastline. Its major towns are Aberystwyth, Aberaeron, Cardigan and Lampeter. Aberystwyth University is within the county as well as Lampeter hosting part of University of Wales, Trinity St David. These two academic institutions have a massive impact upon the population pyramid for Ceredigion as demonstrated in Figure 3. There is a spike in those aged 15 to 24 whilst the rest of the younger population is much lower than the all-Wales average. Like the rest of Hywel Dda, Ceredigion has a greater proportion of people aged 55+.

Figure 3. *Percentage of population by age and sex, Ceredigion, 2015 (Public Health Wales Observatory)*



According to the National Census (2011), Pembrokeshire has a population of just over 122,000 and is generally considered to be a rural county whose major towns such as Tenby, St David's, Saundersfoot and Pembroke are major tourist destinations in the summer months. However, much like Carmarthenshire, there are pockets of deprivation especially in towns such as Milford Haven, Pembroke Dock and Haverfordwest. The population pyramid (Figure 4) reflects the general trends seen across all of Hywel Dda.

Figure 4. *Percentage of population by age and sex, Pembrokeshire, 2015 (Public Health Wales Observatory)*

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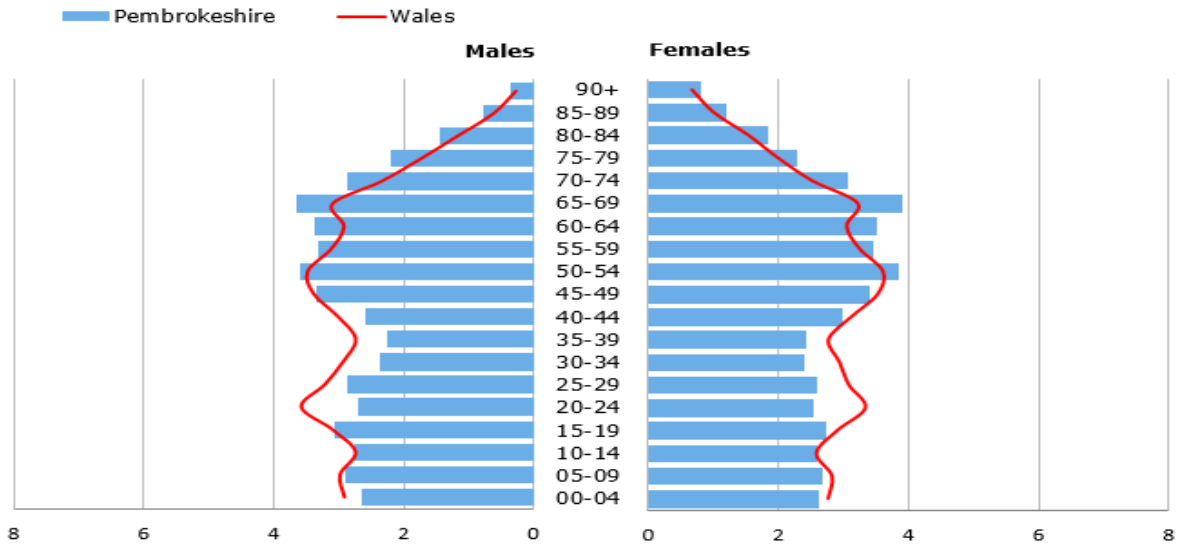
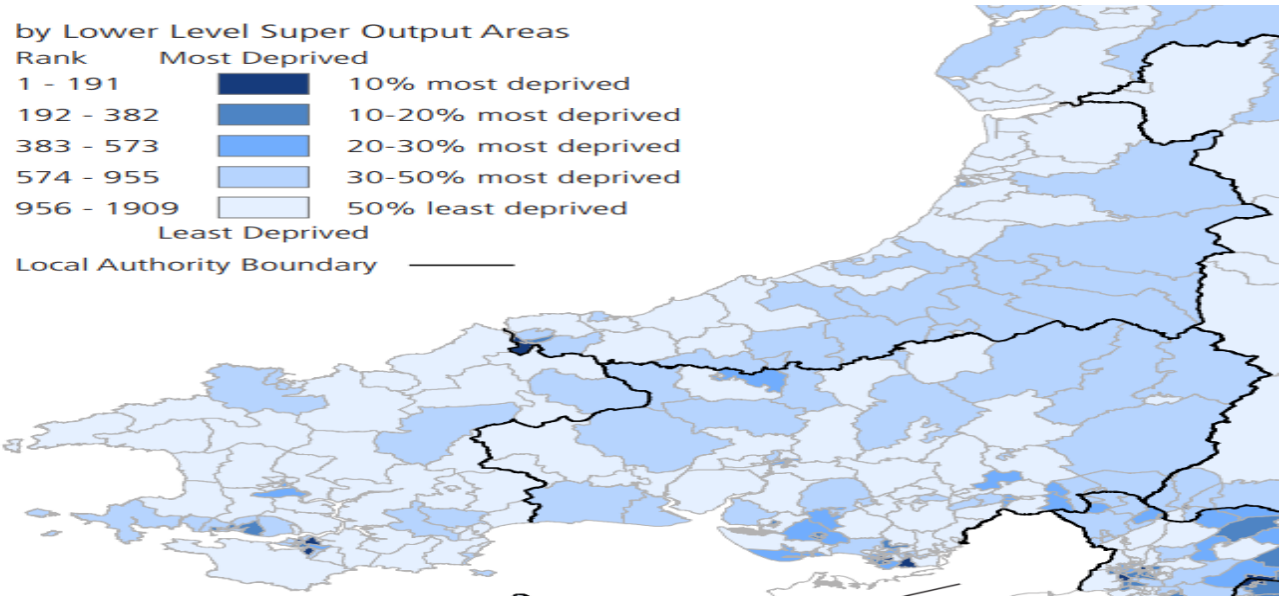


The map opposite shows Hywel Dda by Lower Super Output Area and by the Welsh Indices of Multiple Deprivation.

The Welsh Index of Multiple Deprivation (WIMD) is the Welsh Government's official measure of relative deprivation for small areas in Wales. It identifies areas with the highest concentrations of several different types of deprivation. WIMD ranks all small areas in Wales from 1 (most deprived) to 1,909 (least deprived). It is a National Statistic produced by statisticians at the Welsh Government. Small areas are Census geographies called Lower-layer Super Output Areas (LSOAs).

Hywel Dda generally displays areas within the two least most deprived levels of deprivation but there are towns (Llanelli, Cardigan, Pembroke Dock, Milford Haven) which fall within the most deprived areas of Wales.



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Due to the geography of Hywel Dda it is important to note that rural areas are often socially or service deprived even when their overall categorisation is within the 50% least deprived category.

General Lifestyle Data (by GP Cluster)

Estimated prevalence of lifestyle behaviours, counts and percentage, all persons aged 16+, Wales, Hywel Dda UHB GP Clusters, 2016-18

			Count	Prevalence				
Health Board	GP Cluster Code	GP Cluster Name	GP cluster population aged 16+	Smoking	Drinking above guidelines	Working age adults of healthy weight	Meeting physical activity guidelines	Consuming 5 a day
Hywel Dda UHB	CC201	Amman/Gwendraeth	49,309	19.4	18.9	37.9	50.8	22.4
Hywel Dda UHB	CC202	Llanelli	50,309	20.8	18.2	37.2	50.6	22.0
Hywel Dda UHB	CC203	North Ceredigion	39,658	15.5	19.9	45.4	57.2	24.6
Hywel Dda UHB	CC204	North Pembrokeshire	53,924	18.1	19.1	38.9	52.1	23.6
Hywel Dda UHB	CC205	South Ceredigion	40,927	17.2	19.5	37.9	51.7	22.7
Hywel Dda UHB	CC206	South Pembrokeshire	45,445	17.7	19.3	38.7	51.8	23.6
Hywel Dda UHB	CC207	Taf / Tywi	48,763	17.1	19.6	39.5	52.8	23.9
Hywel Dda UHB			328,335	18.1	19.2	39.3	52.3	23.2
Wales			2,642,152	19.2	18.9	39.1	52.8	23.4

Life Expectancy

Male and female life expectancy has only increased by 0.2 years and 0.1 years respectively since 2010-12. Prior to this, the increases had been 2.6 years and 2 years respectively between 2001-03 and 2010-12.

The all-cause mortality rate for Wales decreased by almost 20% between 2002 and 2011, however there has been very little change since 2011.

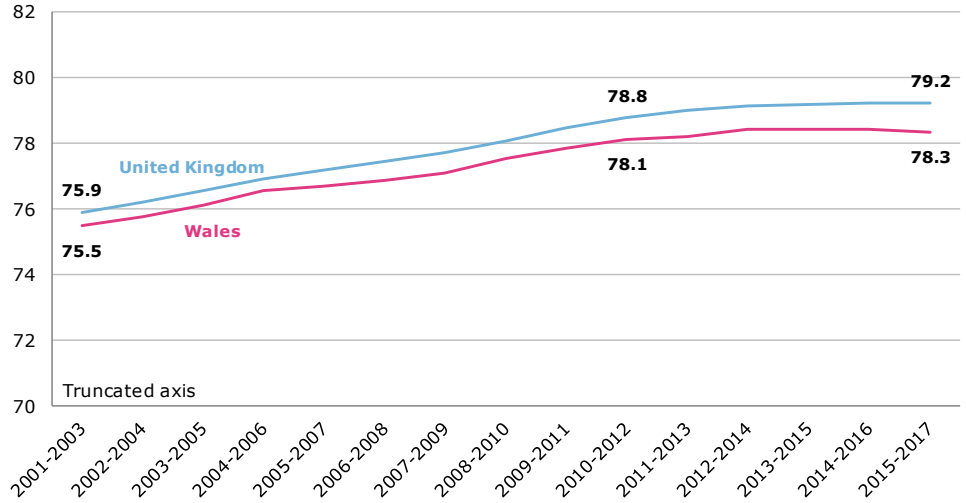
The gap in mortality rates between deprivation quintiles have slightly widened in recent years.

Life expectancy decomposition analysis shows that for both males and females, those aged around 60-84 years were the main contributors to increasing life expectancy but these improvements have slowed down considerably between the periods studied.

Similarly, improvements in circulatory disease mortality rates have slowed down, halving its contribution to increasing life expectancy between the periods studied.

Increased mortality from respiratory disease and dementia and Alzheimer's disease have had a negative contribution on life expectancy improvement.

Life expectancy at birth, years, males, United Kingdom and Wales, 2001-03 to 2015-17
Produced by Public Health Wales Observatory, using PHM & MYE (ONS)



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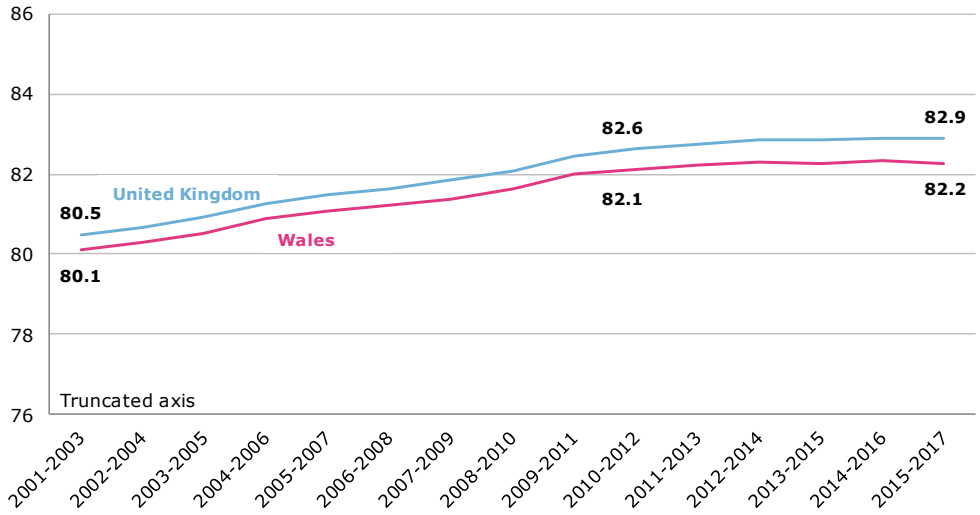
Life expectancy at birth, years, females, United Kingdom and Wales, 2001-03 to 2015-17
Produced by Public Health Wales Observatory, using PHM & MYE (ONS)



NHS and social care services

- **The readiness of local NHS and social care services to treat people with chronic conditions within the community.**

Enhanced community based care and treatment has been introduced to meet urgent care needs efficiently and effectively to reduce the need for Emergency Department attendance and / or hospital admission. When admission is required, the enhanced community care capacity will also support facilitation of discharge from hospital as early as possible. We have secured an additional 3222 hours annually from GP practices across Hywel Dda to help support and manage Urgent Primary Care (UPC) needs in the community.

Use of Technology Enabled Care (Telehealth and Telecare) solutions that enable individuals to maintain independence and Self-Management of their conditions while allowing the early identification of condition deterioration and alerting professionals that help is required.

Development and phased implementation of a 'Clinical Streaming Hub' for doctors and other professional colleagues to use to strengthen signposting and scheduling to safe alternatives to hospital based care. Multi-disciplinary clinicians (Specialist Urgent Primary and Intermediate Care doctors, therapists and nurses based in the Hub in Carmarthenshire have

benefited from Advanced Paramedic Practitioners (APP) from the Welsh Ambulance Services NHS Trust (WAST). The APP liaises with paramedic crews at scene and along with the Hub clinicians consider safe alternative to conveyance to hospital. This approach has been externally evaluated and which demonstrated positive outcomes for patients. The approach will now be extended across the Health Board footprint.

Enhanced 'Home First' provision for our frail population including intermediate care and palliative care to support safe alternatives to hospital admission and expedite discharges from hospital. This is also known as 'wrap around' Urgent Primary Care' service and includes 3222 hours of additional time for the patient's own GPs to manage their complex care needs at home (not in hospital). Our UPC / Home First service also benefits from Technology Enabled Care (TEC) solutions such as Telecare and Telehealth which are a core part of a care and support plan and which enables the patient to maintain their independence and self-manage their conditions. TEC also provides an ability to proactively manage at risk populations and provide 'early warning' notifications to our clinicians to ensure prompt intervention and avoid conveyance and admission to hospital.

- **Access to essential services and ongoing treatment, and any barriers faced by certain groups, including women, people from ethnic minority backgrounds and disabled people.**

- **Support available to enable effective self-management where appropriate, including mental health support.**

Hywel Dda has a Be Well Programme that delivers a number of self-management programmes for people living with chronic conditions and their carers.

See Appendix 1: HDdUHB Be Well Service Self Management Education Programmes

Multiple conditions

- **The ability of NHS and social care providers to respond to individuals with multimorbidity rather than focusing on single conditions in isolation.**

Weight Management Service provides needs led and compassionate support for individuals living with obesity and complex co morbid physiological and psychological health conditions. Support provided from multidisciplinary team, offering interventions based on individual patient's needs. Interventions include dietetic led, psychology led, occupational therapy led, physiotherapy led and medically led support. Individuals undergo a full multi-disciplinary biopsychosocial assessment in order to assess where there needs will be best met within the WMS.

The WMS also provides support for people with slightly less complex needs at level 2 of the All Wales Weight Management Pathway (AWWMP) through the provision of Dietetic Assistant Practitioner led one to one interventions and the delivery of the Foodwise for Life weight management programme.

We also signpost individuals to self-directed on line support and to proactive care delivered in the community.

Acute and Specialist Complex In-patient Rehabilitation

This tier includes all in-patient rehabilitation services including but not limited to;

- Inpatient complex rehabilitation e.g. complex brain injury, major trauma
- Less complex inpatient rehabilitation including stroke, frailty, post-operative e.g. planned orthopaedic surgery

Community Care

This tier includes all community based care teams including but not limited to;

- Specialist community rehabilitation e.g. neuro-rehabilitation post stroke
- Community resource teams, re-ablement, VIPAR, cardiac rehabilitation
- National Exercise on Referral Scheme (NERS), community walking groups, local leisure activity
- Specialist support groups, e.g. stroke club, headway

Proactive Care

Including but not limited to;

- Self-management
- Health and leisure centres
- NERS
- Walking Groups, dance clubs
- On-line tools
- Sports at school

Locality Resilience

Including but not limited to;

- Self-directed activities
- Parks
- Cycle paths
- Accessible walking trails
- Smart phone apps
- Access to leisure facilities
- Play areas

- Same Day Emergency Care (SDEC) provision is available in Prince Phillip Hospital (PPH), Glangwilli General Hospital (GGH), Withybush General Hospital (WGH) and Ceredigion Intermediate Care Centre (Same Day Urgent Care). To date, all have contributed to reducing conversion rates for patients with ambulatory case sensitive conditions and our frail patient group. Hywel Dda were the first Health Board in

Wales that accepted direct referrals to SDEC from WAST paramedics. Local and national evaluation of our SDEC provision has been undertaken and further opportunities to extend this service identified.

- **The interaction between mental health conditions and long-term physical health conditions.**

Delivery of psychologically informed weight management service and the introduction of the biopsychosocial assessment ensures that patients mental health needs are fully considered as part of their treatment within the WMS.

Impact of additional factors

- **The impact of the pandemic on quality of care across chronic conditions.**

WMS had to move to virtual delivery via the Attend Anywhere platform. This meant the service is more accessible for some people who no longer have to travel to appointments but a lack of digital access/ poor internet connections is a risk to some people being able to access the service. Our UEC system has, for a number of years, been challenged by a level of demand that exceeds capacity and the pressure on the system has further deteriorated since the COVID-19 pandemic. Our data demonstrated that patients continued to present to Emergency Departments when their needs could have been met by a range of information, advice and assistance available in the community. It also demonstrated that patients admitted to hospital may have benefited from care and treatment at home as a safe alternative. Hospital admissions can be detrimental to vulnerable patients such as our frail and elderly. For this population care and treatment at home therefore should be considered preferable where it is considered by doctors and their multi disciplinary colleagues as safe and appropriate to do so.

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Utilising Welsh Government's Six Goals for Urgent and Emergency Care framework and associated guidance, the Health Board, has developed and commenced implementation of a programme of change to improve access to urgent and emergency care. Our Transforming Urgent and Emergency Care (TUEC) Programme centres around the provision of the following which collectively we refer to as our 'Home First' approach:

- Proactive management and early identification of patients in the community who are at high risk of needing urgent care.
- Enhanced community based care and treatment to meet urgent care needs efficiently and effectively to reduce the need for Emergency Department attendance and / or hospital admission. When admission is required, the enhanced community care capacity will also support facilitation of discharge from hospital as early as possible. We have secured an additional 3222 hours annually from GP practices across Hywel Dda to help support and manage Urgent Primary Care (UPC) needs in the community.
- Same Day Emergency Care (SDEC) provision across Carmarthenshire, Ceredigion and Pembrokeshire which provides rapid access to GPs and Paramedics to diagnostics and specialist assessment allowing the provision of treatment at home and avoiding a hospital admission. Local and national evaluation of our SDEC provision has been undertaken and further opportunities to extend this service identified.

- Development and phased implementation of a 'Clinical Streaming Hub' for doctors and other professional colleagues to use to strengthen signposting and scheduling to safe alternatives to hospital based care. Multi disciplinary clinicians (Specialist Urgent Primary and Intermediate Care doctors, therapists and nurses based in the Hub in Carmarthenshire have benefited from Advanced Paramedic Practitioners (APP) from the Welsh Ambulance Services NHS Trust (WAST). The APP liaises with paramedic crews at scene and along with the Hub clinicians consider safe alternative to conveyance to hospital. This approach has been externally evaluated and which demonstrated positive outcomes for patients. The approach will now be extended across the Health Board footprint.
- Strengthening skills and knowledge base of acute hospital staff in effective discharge planning and coordination through training and process improvement.
- Joint working with Local Authority and Voluntary Sector colleagues to strengthen assessment for and availability of care to ensure patients return home as soon as they no longer require acute hospital treatment.
- Use of Technology Enabled Care (Telehealth and Telecare) solutions that enable individuals to maintain independence and self management of their conditions while allowing the early identification of condition deterioration and alerting professionals that help is required.

Our priorities for the TUEC programme **2023/24** are:

- Further development of the Hywel Dda Clinical Streaming Hub will include integration of the Out of Hours GP service with our multidisciplinary Urgent Primary Care / Home First community provision providing a 'skill mix' resource to meet a range of presenting needs.
- The Hub will also explore 24/7 Telemedicine Care Home Support and evaluate impact to inform definitive provision
- Furthering integration of community care provision with Local Authority colleagues to develop an integrated care service for the population of West Wales centred around our Home First approach.
- The enhancing of our SDEC/SDUC models to include the recommendations from recent local and Welsh Government evaluations of the service
- Development and implementation of 72 hour assessment units in our acute hospital sites
- Continued focus on implementing effective and efficient discharge practice and processes to reduce avoidable long lengths of stay in hospital particularly for our frail adult population.

- **The impact of the rising cost of living on people with chronic conditions in terms of their health and wellbeing.**

  This is relevant within the WMS with people finding it more difficult to eat healthily due to rising costs. Our WM team will work with people individually re this and make suggestions for eating well on a very low budget but much wider scale intervention is needed for this on a population level

- **The extent to which services will have the capacity to meet future demand with an ageing population.**

Prevention and lifestyle

- **Action to improve prevention and early intervention (to stop people's health and wellbeing deteriorating).**

Weight management service available to support people to prevent development of chronic conditions and to prevent worsening of existing chronic conditions.

Introduction of the Diabetes Prevention Programme (See Appendix 2 Diabetes Prevention Programme PowerPoint presentation)

- **Effectiveness of current measures to tackle lifestyle/behavioural factors (obesity, smoking etc); and to address inequalities and barriers faced by certain groups.**

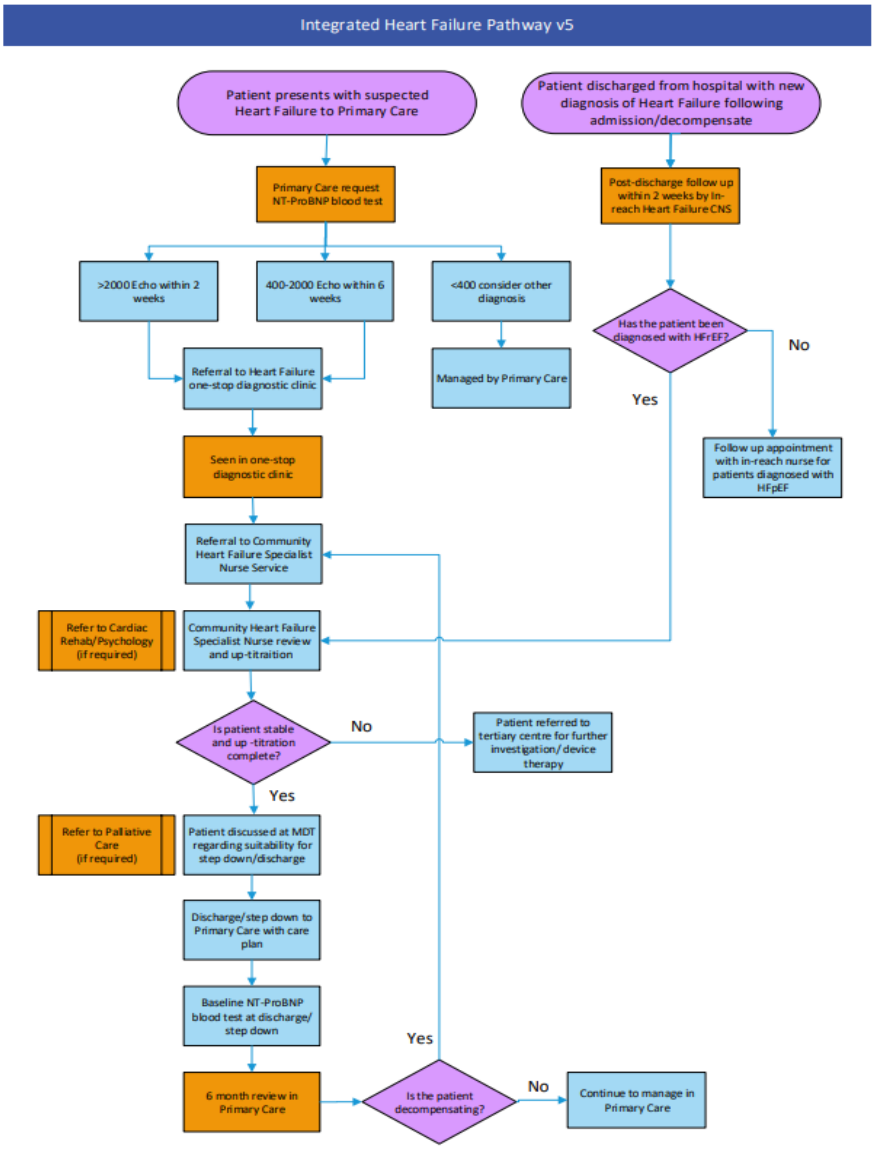
The aim of the Health Coach programme is to increase the amount of lifestyle screening that routinely occurs within primary care. Specifically focussed on alcohol and smoking, the use of the AUDIT C alcohol screening tool is to not only highlight and support those addicted or higher risk drinkers but to also identify those people who consume alcohol in an 'increasingly risky' manner and offer them health coach support so their issues do not escalate.

See Appendix 3 The Hywel Dda Health Coach Programme flyer

The approach is evidence based, building on the years of research around motivational interviewing and brief intervention as well as trusting the patient pathways (smoking cessation and our commissioned drug and alcohol services) if

patients require referral/ signposting into these. There are also a range of pathways developed to support the person's wellbeing based on interactions with the health coach and we describe these as a 'spiderweb' around the patient: everything and everybody that might make the person's life 'better.' This may be social prescribers, NERS, dietetics, the fire service to carry out home safety checks, links to carers' support, the police if the person is vulnerable and at risk of cuckooing or county lines. You can see the breadth of partners and support we have developed to bolster the HC offer.

Newly developed integrated heart failure pathway to improve titration of medication and quality of life for people living with heart failure



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Conclusion

Please note this is a snap shot of services that have responded to a request for information and there is a lot more work being undertaken throughput the health board.
Areas such as diabetes, epilepsy (neurological conditions) are under review

Appendix 1

Hywel Dda Be Well Service
Self-management Education Programmes

All are nationally accredited structured programmes which are quality assured and formally evaluated.
To enquire on course dates, availability and/or to be placed on our mailing list please call 0300 303 8322 (Option 5) or email epp.hdd@wales.nhs.uk

'Helping you live your life your way'

Self-Management Programme	Programme Detail
Cancer: Thriving and Surviving	This is a 6 week, 2 ½ hours per week Self-management programme for anyone who has survived cancer and would like some support getting back into the usual daily routine. **Some of the areas we cover include:** • Healthy eating • Regaining fitness during and after cancer treatment • Living with uncertainty • Positive thinking • Making decisions • Cancer and relationships This course is led by two lay tutors that have experience of living with cancer or for caring for someone that has.
Chronic Disease Self-Management Programme (CDSMP)	This is a 6 week, 2 ½ hours a week Self-management programme for anyone with any long-term health condition. **Some of the areas we cover are:** • Preventing falls and improving balance • Making decisions • Pain and fatigue management • Better breathing • Medication usage • Working with your Healthcare Professional This course is delivered by two lay tutors that live with a chronic condition.
Diabetes Self-management Programme (DSMP)	This is a 6 week, 2 ½ hours per week Self-management programme for anyone with Type 2 Diabetes (non-insulin dependent). **Some of the areas we cover are:** • What is Diabetes • Monitoring and managing your Diabetes • Preventing complications • Communication skills • Relaxation techniques This course is delivered by two lay tutors with experience of living with Type2 diabetes.
Foodwise for Life	This is an 8 week, of 1 ½ hours per week Self-management programme for anyone with a BMI of 25 and above, in some areas we also recruit those with a HbA1c of 42 – 47mmol/mol in addition to the BMI of 25 and above. Includes those considered pre-diabetic.

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Weight Management Programme	**Some of the areas we cover are:** • Preparing to change for life • Portion sizes & you • Up & about (benefits of exercise), • Food labels • Meal Planning • Food & drink swaps This course is delivered by Dietetic Assistant Practitioner's.
Foundation Pain Management Programme	This is a 6 week 2 ½ hours per week Self-management programme for anyone with chronic pain. **Some of the areas we cover are:** • What is chronic pain • Physical activity and exercise • Fatigue management • Moving easy This course is delivered by two lay tutors with experience of living with Chronic pain.
Healthy Ageing	This is a 2 ½ hour session for anyone who would like to learn ways to look after yourself as you age and reduce the signs of frailty. **Some of the areas we cover are:** • Foot care • Improving balance and preventing falls • Healthy eating and nutrition • Medications
Healthy Bladder and Bowel	This is a 2 ½ hour introductory session for anyone with continence problems or for anyone who would like to know more about continence issues and its management. **Some of the areas we cover are:** • Types of continence and management • Bladder irritation triggers • Physical activity • Healthy eating • Bowel continence issues and management
Healthy Footsteps	This is a 2 hour interactive session on personal foot care for all those who are deemed to be low risk within the podiatry service or those who are deemed to not need to access the podiatry service. **Some of the areas we cover are**: • Self-care what is it

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'Helping you live your life your way'

	• Footwear • Falls prevention • Healthy lifestyle-healthy eating • Paying attention to your feet The course is delivered by a lay tutor with support from a podiatrist.
Introduction to Health and Wellbeing (ISM)	This is a 3 hour introduction session for anyone with any long-term health condition and / or carers. **Some of the areas we cover are:** • Healthy eating • Positive thinking • Communication • Managing daily activity • Medication • Relaxation This course is delivered by a lay tutor with experience of living with a long-term health condition.
Introduction to Health and Wellbeing for Carers (I to LAM)	This is a 2 ½ hour session introducing carers to skills to support health and wellbeing and develop their Self-management skills. **Some of the areas we cover are:** • Making difficult decisions • Managing down days • Positive thinking • Healthy eating This course is delivered by a lay tutor with experience of being a carer.
Living with COPD	This is a 7 week, 2 ½ hours a week Self-management programme for anyone living with Chronic Obstructive Pulmonary Disease (including breathlessness). **Some of the areas we cover are:** • What is COPD? • Planning & problem solving • Dealing with difficult emotions • Managing daily activities • Working with your Health Care Professional This course is delivered by two tutors who have COPD or have cared for someone that has COPD, with clinical support on week 1 and week 7 from a Respiratory Specialist.
Living with Lymphoedema	This is a 2 ½ hour session for anyone living with Lymphoedema. **Some of the areas we cover are:**

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'Helping you live your life your way'

	• Treating Lymphoedema & reducing risks • Skin care • Healthy eating • Benefits of physical activity This course is delivered by a lay tutor with the support of a Lymphoedema Assistant Practitioner.
Living with Long COVID	This is a 2 ½ hour session for anyone living with the after-effects of COVID 19 known as Long COVID. **Some of the areas covered are:** • What is Long Covid and the Symptoms • Managing the Symptoms • Dealing with low mood and depression • When to seek help This course is delivered by Lay tutors.
STANCE	This is a 2 ½ hour foot health session for anyone with Diabetes, giving information on diabetes and how it effects your feet and how to reduce the risk of further complications. **Some of the areas we cover are**: • Diabetes and my body • Poor circulation • Nerve damage • Foot complications • Steps to reduce problems with your feet This course is delivered by a lay tutor with the support of a podiatrist.
X-Pert Diabetes Programme (X-PERT)	This is a 6 week, 2 ½ hours per week Self-management programme for anyone with Type 2 Diabetes. **Some of the areas we cover are:** • What is Diabetes • Digestion and blood glucose • Self-monitoring, medications, weight management • Carbohydrate awareness • Possible complications of Diabetes • Goal setting This course is delivered by Diabetes Specialist Nurses and Diabetes Specialist Dieticians.

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'Helping you live your life your way'

Insulin X-Pert Diabetes Programme (X-PERT Insulin)	This is a 6 week, 2 ½ hours per week Self-management programme for anyone with Diabetes on insulin. **Some of the areas we cover are:** • What is Diabetes / the roles of insulin • Digestion and blood glucose • Self-monitoring, medications, weight management • Carbohydrate awareness • Possible complications of Diabetes This course is delivered by Diabetes Specialist Nurses and Diabetes Specialist Dieticians.

Appendix 2

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Diabetes Prevention Programme

Emma Kate Davies
Diabetes Prevention Clinical Lead Dietitian

Hywel Dda University Health Board

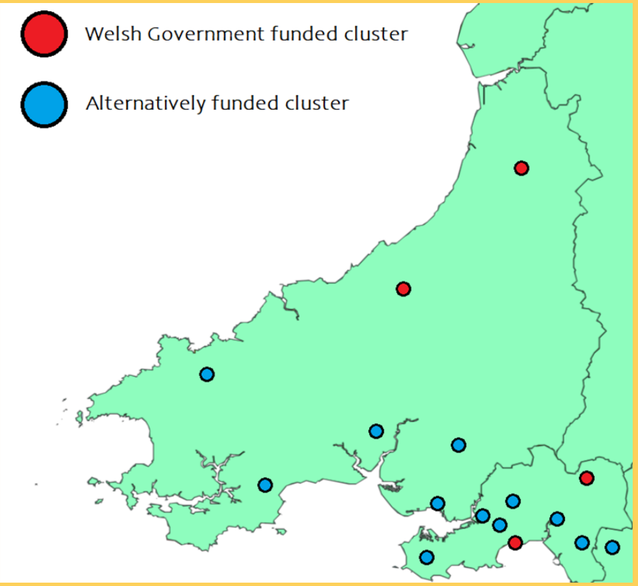
Data Period: January/2023 - March/2023

Version 1 - Publication Date: 05.04.2023

Hywel Dda University Health Board

Diabetes Prevention Programme

- Hywel Dda University Health Board launched the delivery of the Diabetes Prevention Programme in January 2023.
- Diabetes Prevention Clinical Lead Dietitian was appointed in June, 2022.
- In October 2022, 7 Health and Wellbeing Facilitators commenced their employment.
- They completed a structured training programme throughout the months of October, November and December under the supervision of the Clinical Lead Dietitian.
- Brief Intervention Clinics are currently being delivered in Cardigan, Aberystwyth, Llanelli, Carmarthen and Milford Haven Leisure Centre.
- Brief Intervention Clinics are due to commence in Ammanford, Lampeter, Haverfordwest, Tenby and Pembroke Dock in the coming weeks.
- Unlike the AWDPP Model, the Hywel Dda Model includes the delivery of the Foodwise for Life Programme, as well as dedicated funding to deliver NERS.



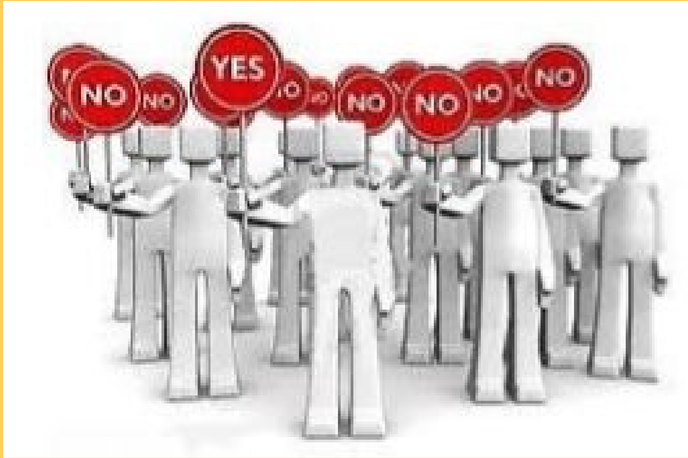
Inclusion and Exclusion Criteria
(as per All Wales Diabetes Prevention Programme Criteria)

Inclusion:

- HbA1c 42-47mmol/mol in last 3 months
- >18 years of age

Exclusion:

- <18 years of age
- Ever diagnosed with Type 1 or Type 2 Diabetes
- Current BMI <23kg/m²
- Currently prescribed metformin or other medication which lower blood glucose levels
- Receiving palliative care
- Pregnancy
- Artificially fed
- >80 years with BMI <25kg/m²



Key Statistics: January/2023 – March/2023

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Identification, Invitations, Attendance and Uptake

People identified using AWDPP search template[1]

773
since start of programme

Invitations sent to attend the AWDPP (following manual exclusions)*

276
since start of programme

AWDPP consultations booked

137
since start of programme

AWDPP consultations completed

102
since start of programme

% Uptake to the AWDPP (booked consultations/ invitations sent)

50%
since start of programme

Consultation Delivery

Consultations booked for delivery face-to-face since start of programme	100
Consultations booked for delivery virtually since start of programme	0
Consultations booked for delivery by telephone since start of programme	2

Additional Referrals

Referred to Foodwise for Life since start of programme	47
Referred to physical activity since start of programme	38
Referred to other support services since start of programme	1

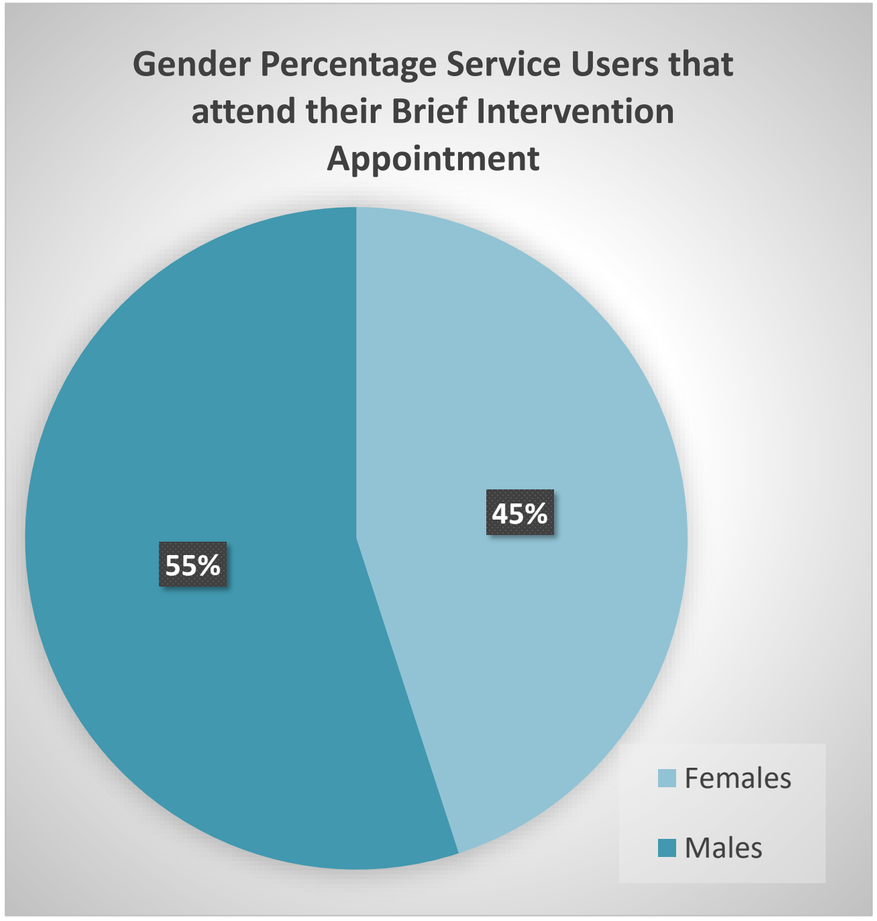
DEMOGRAPHICS

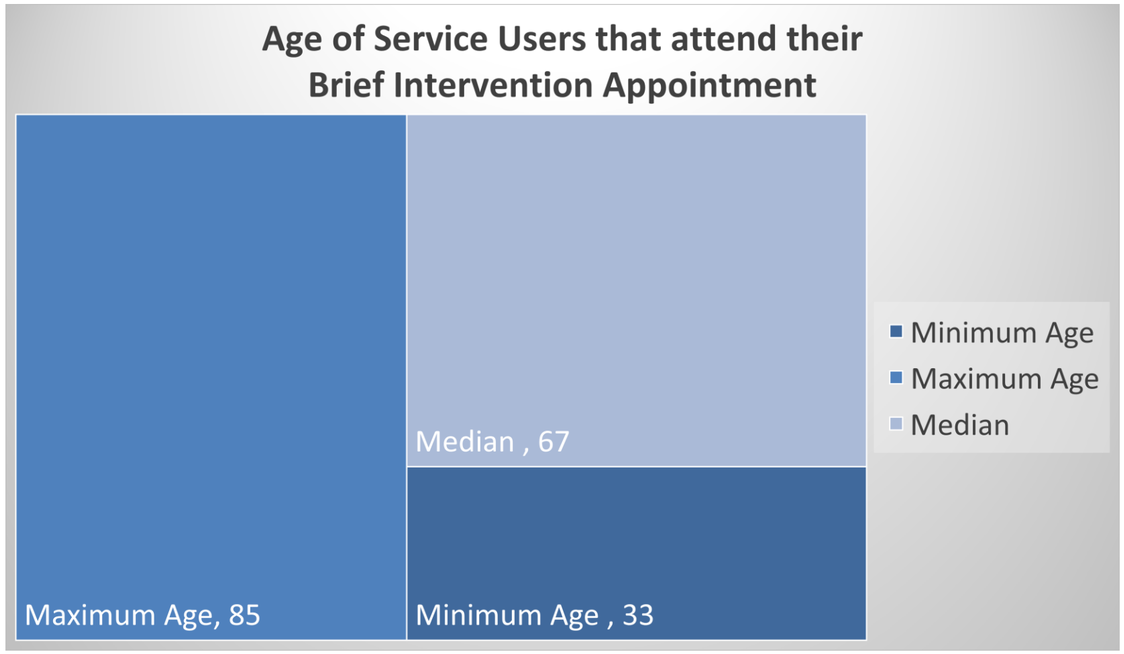
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

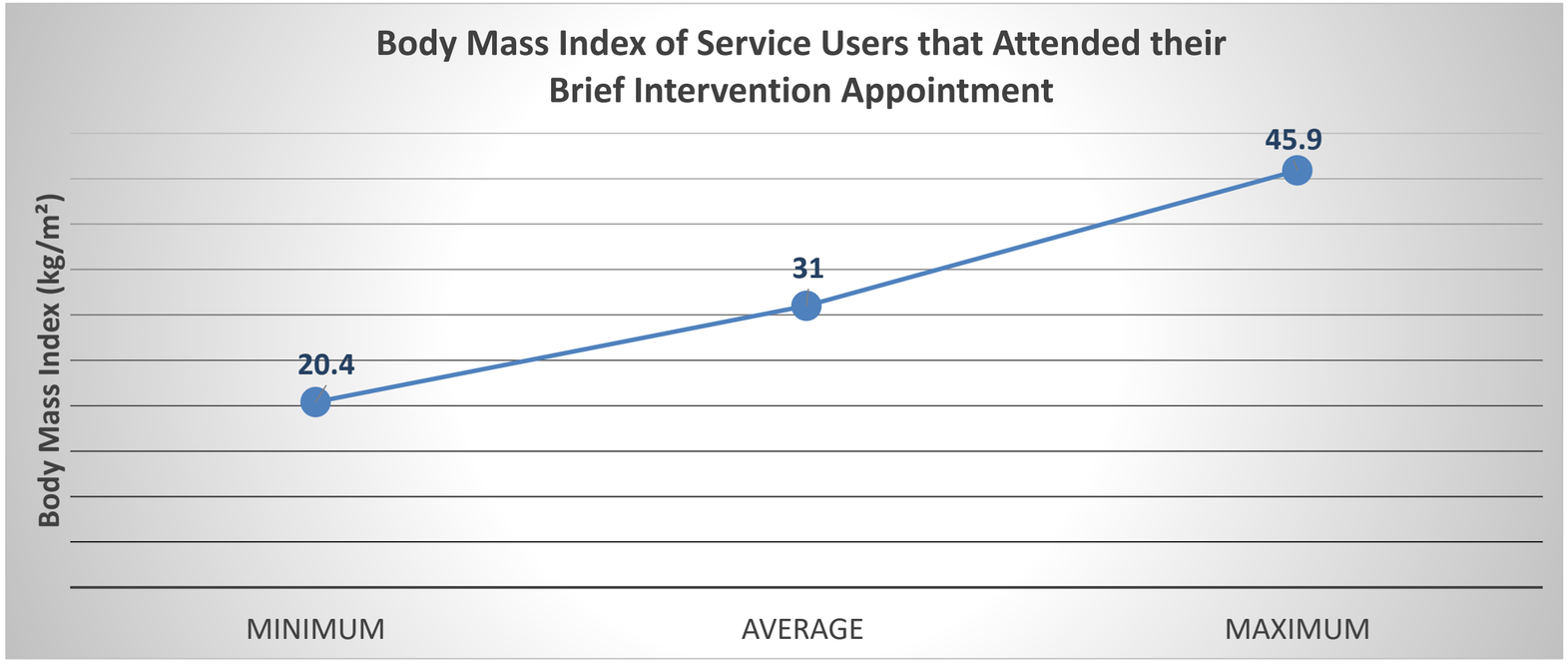
Date period

January/2023– March/2023

(n = 102)







Outcome Measures

- Gender
- Age
- Venous HbA1c
- HbA1c via Point of Care Testing
- Blood Pressure
- Heart Rate
- Height
- Weight
- Body Mass Index
- Waist Circumference
- Waist to Height Ratio
- EQ5D
- PHQ2
- Referrals to Foodwise
- Referrals to Level 3 Weight Management Service
- Referrals to NERS
- Referrals to others
- Service User Evaluation Form
  - (currently being developed by AWDPP Dietetic Group)

Date Period: January 2023– March/2023

What's going well and what are the current challenges?

1. Dedicated administrator for the programme. Supports and organises Brief Intervention Clinics and the Foodwise for Life programme. To further support clinics, admin is currently arranging for clinics to be booked using WelshPAS.
2. Four of the Health and Wellbeing Facilitators have completed their initial quality assurance and are competent to deliver the Brief Intervention Clinics independently.
3. Delivering the Brief Intervention Clinic to service users across 5 of the clusters within the Health board. Due to commence the delivery in another cluster end of April/May.

1. Triaging – very time consuming. Health and Wellbeing Facilitators are triaging patient lists and are escalating any concerns to Dietitian. Dietitian is then triaging any escalated service users for each GP Practice across the Health Board.
2. HbA1c via Point of Care Testing has not been accurate and has increased confusion with service users. Ordering of equipment to complete POCT has been difficult and disruptive.
3. Access to GP systems. Currently have access to 21 GP practices across the Health Board.

Date Period: January 2023– March/2023

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

KEY MESSAGES

2 AWDPP grant funded clusters have begun the delivery of the Diabetes Prevention Programme

3 clusters funded by health board sources have additionally begun delivery of the Diabetes Prevention Programme

7 Health and Wellbeing Facilitators have been trained and 4 are delivering the clinics independently

35 Brief Intervention clinics have been completed over the last 12 weeks

98% Attendance rate

1 DNA, 1 Cancelled appointment

Contact

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Appendix 3

The Hywel Dda Health Coach Programme

Do you have patients who smoke? Do you ask about how much alcohol your patients drink?
Can you think of a patient who would benefit from quitting or reducing?
Have you tried to encourage them but with no success?

If you've answered 'yes' to any of the questions above then the **Health Coach** programme is just what you and your patients need

KEY MESSAGES:

- Smokers' expect to be asked about their smoking. If clinicians do not mention smoking, patients are given the impression that it is not affecting their health and so take it as tacit permission to continue.
- 12% of Smokers will attempt to quit if ADVISED to by their health care provider, but only 3% will succeed if not given access to support.
- 60% will make a quit attempt if given access to support.
- 40% of the Hywel Dda population drink above the alcohol guidelines
- Alcohol is associated with over 200 types of chronic diseases, injuries and accidents
- It is estimated that alcohol has a societal harm of over £1 billion in Wales per year

How to refer to a Health Coach

➢Complete the referral form with the patient (see the flow chart below)
➢Email the referral form to HLWT.HC.HDD@wales.nhs.uk
➢Referrals will be allocated to a Health Coach who will make contact with the patient asap and arrange an initial consultation session

➢The Health Coach and patient will then progress through the specific Health Coach patient pathway

ASK

- **Ask** Are you a Smoker? Do you consume alcohol?

ADVISE

- **Advise** Would you like further information/support?
  We are currently offering an in-house Health Coach pilot.

ACT

- **Act** Refer - Fill in Health Coach referral form with patient and send to the email address above. If the patient doesn't want to be referred **give patient Audit C scratch card** to take away.