PC 34
Ymchwiliad i ofal sylfaenol
Inquiry into primary care
Ymateb gan: Grŵp Cynghori Arweiniol Dietetig Cymru
Response from: Welsh Dietetic Leadership Advisory Group

WDLAG response to the Health and Social Care Committee on request for views on the functioning of primary care clusters and opportunities to support primary prevention and improve health outcomes.

WDLAG is a Statutory Advisory Group to the Welsh Therapies Advisory Committee (WTAC). Membership comprises Heads of Service and Operational Dietetic Managers from all NHS Wales Health Boards/LHB and Velindre Trust, and representation from Registered Dietitians in Public Health Wales and Cardiff Metropolitan University. It's role is to address issues relevant to managing Nutrition and Dietetic Services in NHS Wales and to provide specialist dietetic advice to WTAC.

Food and nutrition is part of everyday life. Dietitians support people to make food choices throughout life that will maximise their health. They provide evidence-based nutrition and dietary advice and guidance to the public, healthcare professionals and managers, local councils, industry, academic institutions and the media.
Dietitians are the only nutrition professionals to be regulated by law. This means people are protected and can be assured that they will get the latest credible evidence-based information.

We welcome this opportunity to submit written evidence in response to the HSCC consultation.

1. **How GP cluster networks in Wales can assist in reducing demand on GPs and the extent to which clusters can provide a more accessible route to care.**

1.1 Primary care clusters working with dietitians provide an ideal opportunity to influence lifelong health. Good nutrition and healthy weight is essential to mitigate against the risk of child and adult obesity and other chronic conditions including type 2 diabetes, cardiovascular disease, high blood pressure, some cancers, osteoarthritis and depression. Healthy lifestyle interventions and support are best delivered at cluster level in partnership with the local community.

1.2 The World Health Organisation identify that key lifestyle interventions can significantly reduce the incidence of Diabetes and the progression of the disease, these include:

- achieve and maintain healthy body weight;
- eat a healthy diet of between 3 and 5 servings of fruit and vegetables a day and reduce sugar and saturated fats intake; (WHO 2015)

  This is supported by large scale research studies in America and Finland where they reduced the incidence of Type 2 Diabetes in high risk individuals by 58% through lifestyle interventions, primarily focussing on weight reduction. (Perrault et al 2012; Lindstrom 2013)

  Diabetes is one of the main Ambulatory Care Sensitive Conditions, reduction in the prevalence and improved self management of Type 2 Diabetes will reduce hospital admissions and reliance on GP services (Kings Fund 2010)

1.3 Cluster level services are local to a person's home but with the economies of scale to ensure that there is an appropriately trained workforce in the specialist area of Nutrition and Dietetics. There are several examples where a cluster level dietetic service could reduce the demand on both GPs and secondary care services:

1.4 Led by Cardiff and Vale UHB All Wales Nutrition Training Co-ordinator, Foodwise for Life, an 8 week structured weight management programme, has been developed. Details of the programme are embedded below along with initial evaluation. There are opportunities to train support workers in each cluster to deliver this programme at cluster level to support patients with the management of obesity, prevention of diabetes and management of musculo-skeletal problems.

Annex 1

Annex 2

1.5 ABUHB has a cluster level Diabetes Prevention Programme to support people with Pre-Diabetes (Impaired Glucose Tolerance) as weight management is key in its treatment and preventing it progressing into type 2 Diabetes. The service was piloted in Blaenau Gwent with the service currently running in north Monmouth. The pilot results showed that 81% of patients lost weight and 70% saw an improvement in their blood glucose results an 40% fell below the pre-diabetic range which means they were no longer at risk of Diabetes.

1.6 Primary Care Dietetic Service can support patients with Irritable Bowel Syndrome- Irritable Bowel syndrome (IBS) is a chronic & debilitating functional Gastro-intestinal disorder that **affects 10-20% of the general population** with a cost of £45.6 million per annum (NICE 2008) and the prevalence is increasing. About half

of these patients consult their GP, and of these 29% are referred to a hospital gastroenterologist. Irritable bowel syndrome is the commonest disease diagnosed by gastroenterologists in secondary care, and amounts to between 20 and 50% of new clinic appointments. A dietetic led gastro service for patients following referral by a GP can provide an-evidence based effective dietetic intervention and a reduction in primary care demand for repeated patient follow ups. In addition, there will be a reduction in gastroenterology waiting times & reduction in waiting time demand for Endoscopy, with the associated costs of this.

Annex 3

2.0 **The emerging multi-disciplinary team (how health and care professionals fit into the new cluster model and how their contribution can be measured).** It is important that the new cluster model is recognised as a community health and social care model as outlined in 'Setting the Direction', rather than a GP cluster model and it must incorporate members of the wider health and social care team. The cluster model requires development of local action plans to improve the health of the community. It is imperative if we are to meet the needs of the population that the wider health and social care team are involved in the development of these plans and that each agreed action has robust performance measures against it. Without engagement of the wider MDT at this planning stage we will not be able to consider more effective or innovative ways of meeting the population health needs.

3.0 **The current and future workforce challenges.**

There are significant workforce challenges in meeting the health needs of an aging population with the current medical workforce provision. More consideration needs to be given to utilising the unique skill set of dietitians and other allied health professionals to meet this increasing demand.

Through the Dietetic ***Nutrition Skills for Life™*** (NS4L) Life Training programme there is an opportunity to provide dietetic training, advice and support to 'up skill' the health, social care and early years workforce in nutrition and hydration and contribute to improving the health and wellbeing of vulnerable population groups in Wales. The dietetic profession is currently contributing to the consultation of regulated qualifications in Health and Social Care including childcare. Our aspiration is to ensure nutrition and hydration is included within the core mandatory qualifications for the whole health, social care and early years workforce.

Annex 4

4.0 **The funding allocated directly to clusters to enable GP practices to try out new ways of working; how monies are being used to reduce the pressure on GP practices, improve services and access available to patients.**

The maturity of clusters varies across Wales and as a result the opportunity for professions outside GP practices to input proposals to new ways of working is variable and limited. With the action plan development and delivery of new services all being driven at cluster level there is a loss of opportunity for shared learning across Wales with the result of variation in services accessible based on postcode. The need for support with diet and healthy lifestyles spans all populations and clinical conditions and consideration needs to be given for some national service developments that can be delivered locally, to avoid duplication. The Dietetic NS4L programme is an example of how a programme can be co-ordinated nationally to ensure local delivery of up to date evidence based nutrition messages. More detail of the programme and its evaluation is attached. There are opportunities to roll this out wider within clusters which will avoid the need for each area to develop the supportive resources required for delivery.

Annex 5

5.0 **Workload challenges and the shift to primary prevention in general practice to improve population health outcomes and target health inequalities.**

5.1 There is a link between health inequities and poor diet - individuals living in more deprived areas consume a less healthy diet than those living in less deprived areas (WHO 2014:9, Welsh Government 2015: 114). Rates of obesity, iron deficiency anaemia and dental caries are all higher in lower socio economic groups (James et al 1997). Food poverty can be defined as an inability to choose, buy, prepare and eat an adequate quantity of good-quality foods in keeping with social norms. Food poverty is a crucial factor in the relationship between childhood deprivation and ill-health.

5.2 Obesity is recognised as a priority in Our Healthy Future (2010) with a focus on reducing unhealthy eating and increasing physical activity. (Welsh Government 2009 Our Healthy Future: p7). One of the 7 well-being goals of The Wellbeing of Future Generations (Wales) Act (2015) is a Healthier Wales, 'a society in which peoples physical and mental well-being is maximised and in which choices and behaviours that benefit future health are understood'

5.3 Improving people's knowledge and access to an affordable healthy balanced diet is essential if we are to tackle health inequalities and improve the diet of the people

of Wales. There are opportunities for this primary prevention work to be undertaken at cluster level by trained workers who understand the barriers and opportunities in that community. With the existing demand on General Practice it is not appropriate for this work to be undertaken at practice level but delivery should be at cluster level by the wider workforce including the third sector. This would then reduce the demand on General Practice. An example of this local delivery is through the Flying Start nutrition programme in Cardiff that works with flying start areas to support giving children the best start in life.

Annex 6

Annex 7

5.4 A recent audit undertaken with Flying Start Health Team managers and Dietetic Service managers showed that whilst all 22 flying start programmes are accessing some nutrition skills training through the NS4L programme, only 4 programmes fund a dedicated dietetic services. There is an opportunity, with appropriate resource, to utilise the successful, award winning ***Nutrition Skills for Life***™ (NS4L) training model and integrate this into other national schemes and programmes including Flying Start. This would ensure that all populations covered by Flying Start programmes across Wales can benefit equally. A prudent "once for Wales" approach would enable a service that is efficient and equitable, quality assured and delivered by appropriately qualified health professionals.

6.0 The maturity of clusters and the progress of cluster working in different Local Health Boards, identifying examples of best practice.

There is a large variation in maturity of clusters across Wales, even within each health board area. Engagement with the wider healthcare team is variable across all health boards. There are several successful programmes across Wales where dietitians are supporting the primary care prescribing services around the appropriate use of oral nutritional supplements.
One example is in ABUHB- A Community Nutrition Support Team established in 2013 supporting patients that are housebound or in care home at risk of malnutrition receive timely access (less than 4 weeks) to a dietitian. This resulted in improvement of oral intake and a reduction in ONS expenditure and ongoing cost savings.

7.0 Local and national leadership supporting the development of the cluster infrastructure; how the actions being taken complement those in the Welsh Government's primary care plan and 2010 vision, Setting the Direction

We would welcome the opportunity to have further involvement in cluster development and leadership at a local and national level. Dietetic service managers should be involved at health board level in contributing to a more co-ordinated approach to workforce planning across professions.

It would be beneficial to reinforce the original aim of clusters, in line with 'Setting the Direction', around engagement with the wider health and social care team and utilisation of the wider workforce to meet service needs.

8.0 Greater detail on the aspects being evaluated, the support being supplied centrally and the criteria in place to determine the success or otherwise of clusters, including how input from local communities is being incorporated into the development and testing being undertaken.

We would welcome a co-ordinated approach across Wales to the sharing of best practice where new models have been trialled and successfully evaluated within a cluster. Also to have the opportunity to share how dietetic services can support cluster work going forward through a co-ordinated communication structure rather than solely through direct liaison with individual clusters.

Prepared by Helen Nicholls, Chair WDLAG on behalf of WDLAG

Submitted 3rd Feb 2017.

Annex 2

Prevention and Management of Type 2 Diabetes through Targeted Diet & Lifestyle Structured Education Programmes

Part of proposal for dietetic support to GP clusters

Background:
The Health Minister highlighted the exponential growth in Diabetes and Obesity as a primary Diabetes risk factor in 'Together For Health' A Diabetes Delivery Plan for Wales 2013 and The All Wales Obesity Pathway 2010.

'Around 175,000 adults in Wales are currently being treated for Diabetes, with type 2 increasing at an alarming rate. It is nothing less than a ticking time bomb for the health service in Wales. Every effort must be made to positively influence people's lifestyle choices if we are to reduce the number of people with type 2 Diabetes. We, the population of Wales, also have a clear role to play in taking responsibility for our own health to reduce the risk of contracting Diabetes.' (WG 2013)

The World Health Organisation identify that key lifestyle interventions can significantly reduce the incidence of Diabetes and the progression of the disease, these include:

- achieve and maintain healthy body weight;
- eat a healthy diet of between 3 and 5 servings of fruit and vegetables a day and reduce sugar and saturated fats intake; (WHO 2015)

This is supported by large scale research studies in America and Finland where they reduced the incidence of Type 2 Diabetes in high risk individuals by 58% through lifestyle interventions, primarily focussing on weight reduction. (Perrault et al 2012; Lindstrom 2013)

Diabetes is one of the main Ambulatory Care Sensitive Conditions, reduction in the prevalence and improved self management of Type 2 Diabetes will reduce hospital admissions and reliance on GP services (Kings Fund 2010)

Aim:
To provide dietetic led lifestyle intervention programmes in each GP cluster, empowering people through the provision of skills, knowledge and behaviour change strategies. Building on success of existing programmes which show that 70% of people completing dietetic led and Foodwise For Life weight management programmes successfully lose weight.

Objectives:

- Identify those at high risk of developing Diabetes through the GP systems.
- Stratify patients according to weight and risk factor
- Based on stratification offer either first line community based Foodwise For life structured weight management programme or a more intensive dietetic led weight management programme.
- Provide weight management programmes incorporating key nutritional and lifestyle messages, linking in with relevant partners around opportunities to increase physical activity levels
- Increase the number of Structured Diabetes Education (SDE) Programmes to support lifestyle changes in those with pre existing Type 2 Diabetes. This will support implementation of the Diabetes Delivery Plan target of all people with newly diagnosed Diabetes having access to SDE

Outcomes:
Process data: number people identified; number of programmes delivered; attendance rates; number completing intervention.
Outcome Data: Improvement in Quality of Life measured through EQ5D
% weight loss of those completing the programme
At Risk patients: Number developing Diabetes
Pre existing diabetes: improvement in HbA1c; improvement in BMI

Annex 3

Primary Care Dietetic service proposal for managing Irritable Bowel Syndrome (IBS) in the community

Background:
Irritable Bowel syndrome (IBS) is a chronic & debilitating functional Gastro-intestinal disorder that **affects 10-20% of the general population** with a cost of £45.6 million per annum (NICE 2008) and the prevalence is increasing. About half of these patients consult their GP, and of these 29% are referred to a hospital gastroenterologist. Irritable bowel syndrome is the commonest disease diagnosed by gastroenterologists in secondary care, and amounts to between 20 and 50% of new clinic appointments.

Aim:
To provide a dietetic led gastro service for patients following referral by a GP resulting in access to an-evidence based effective dietetic intervention and a reduction in primary care demand for repeated patient follow ups. In addition, there will be a reduction in gastroenterology waiting times & reduction in waiting time demand for Endoscopy, with the associated costs of this.

Objectives:
1. Implement NICE guidance CG61 of IBS in primary care
2. Development of an IBS pathway from primary care to secondary care with the dietetic intervention as an integral part of that
3. Reduce the need for repeated GP Consultations
4. To appropriately manage IBS patients in line with the evidence base.
5. To treat people safely & effectively.
6. To reduce the quality of life impact of IBS.
7. To make best use of resources.
8. To phase out ineffective treatment & advice.
9. To ensure patients with IBS make well informed decisions about the management of their IBS & are empowered to self manage their condition.
10. To develop staff knowledge & skills; both as individuals & teams.
11. To promote & support audit & research in the area of IBS.
12. To produce an annual report for the population served to share the impact & outcomes & to support ongoing quality improvement

Measurable Outcomes:
1. Number and percentage of patients with no red flags / diagnosis of IBS managed effectively without Gastro referral.
2. Reduction in Gastroenterology waiting times / additional sessions.
3. Number and percentage reduction in investigations compared to baseline; to include Endoscopies
4. A reduction in prescription volume & costs.
5. Number of adults with IBS successfully managed using dietary intervention / FODMAPS. Resolution of IBS symptoms.
6. Reduction is Consultant costs and diagnostic costs
7. Adherence to NICE guidance.

Annex 4

Supporting Information

Poor nutrition has an impact on health and wellbeing across the life course (WHO 2014: 9). During pregnancy it is linked to low birth weight and has a negative impact on the health of the mother and infant (Welsh Government 2009: 8). Obese pregnant women and their babies experience significantly greater risks compared with women of a healthy weight (Royal College of Obstetricians and Gynaecologists 2011:2).

Good nutrition is essential for optimum growth and development of infants and children. Low income is associated with poor nutrition at all stages of life. There is increasing evidence that poor nutrition contributes to:

- poorer immune status,
- poorer cognitive function and learning ability,
- higher dental caries rates in children,
- increased risk of obesity, diabetes, cardiovascular disease and cancer,
- increased falls and fractures in older adults (Faculty of Public Health 2005:2)

Lack of knowledge of what constitutes a healthy diet and lack of skills to prepare healthy foods are recognised as barriers to healthy eating (Garcia et al 2014).

There is a link between health inequities and poor diet - individuals living in more deprived areas consume a less healthy diet than those living in less deprived areas (WHO 2014:9, Welsh Government 2015: 114). Rates of obesity, iron deficiency anaemia and dental caries are all higher in lower socio economic groups (James et al 1997). Food poverty can be defined as an inability to choose, buy, prepare and eat an adequate quantity of good-quality foods in keeping with social norms. Food poverty is a crucial factor in the relationship between childhood deprivation and ill-health.

Obesity is recognised as a priority in Our Healthy Future (2010) with a focus on reducing unhealthy eating and increasing physical activity. (Welsh Government 2009 Our Healthy Future: p7). One of the 7 well-being goals of The Wellbeing of Future Generations (Wales) Act (2015) is a Healthier Wales, 'a society in which peoples physical and mental well-being is maximised and in which choices and behaviours that benefit future health are understood'

The major health benefits of a healthy balanced diet include the prevention, delay and management of chronic conditions such as Coronary Heart Disease, Stroke, Cancer and Type 2 Diabetes. Improving diet could prevent an estimated third of cancers whilst maintaining a healthy weight can reduce the risk of certain cancers by up to 40%.(NHS Choices 2016).Consumption of an extra piece of fruit and vegetables per day could decrease the risk of coronary health disease by 4% and stroke by 6% (Xia Wang et al 2014). Obese people that lose 10kg of weight could decrease their overall risk of mortality by 20-25% (Department of Health 2008: 28).

Dietitians are the only nutrition professionals to be regulated by law. This means people are protected and can be assured that they will get the latest, credible, evidence-based information, advice and treatment. Dietitians work with health teams, partner organisations and communities providing training, professional support, practical advice and initiatives to enable children in Wales to access a healthy balanced diet.

Nutrition initiatives developed by Dietitians on an all Wales level that could be incorporated into Flying Start programmes

1. **Nutrition training for health professionals, nursery nurses, support workers and the voluntary sector**

***Nutrition Skills for Life* ™** is a programme of quality assured nutrition skills training and initiatives developed and co-ordinated by dietitians working in the NHS in Wales. It operates in all health boards and aims to support community workers from health, social care and third sector organisations to promote healthy eating and incorporate evidence based food and nutrition messages into their work. Courses include;

- **Community Food and Nutrition Skills (accredited Level 2, 3 credits)** For community workers, Agored Cymru accredited Level 2 Community Food and Nutrition Skills training enables them to develop the competencies required to promote key healthy eating messages focussing on the Eatwell Guide. It teaches practical skills such as budgeting, shopping for healthy foods, understanding food labels and how to adapt recipes. This course is attended by those who plan to deliver healthy eating initiatives such as level 1 accredited courses as part of their work.
- **The Community Food and Nutrition Skills for the Early Years (Level 2)** course equips early years and childcare workers with the nutrition knowledge and skills to cascade food and nutrition messages to children and families and improve food and drink provision in their setting. Flying Start workers can access nutrition skills training in most health board areas.
- **Eating for 1, Healthy and Active for 2 -** training for community midwives to build their knowledge and confidence in giving nutrition, physical activity and weight management advice to women during pregnancy.
- **Getting the Best Start** training for health visitors to support parents with nutrition and healthy weight messages
- **Nutrition and Hydration in Early Years and Childcare Settings** optional module within the Children's Care Learning and Development Diploma for the early years and childcare workforce.

2. **Nutrition initiatives for community groups**

***Nutrition Skills for Life* ™** Dietitians support trained staff that have completed the Community Food and Nutrition Skills Course to plan, implement and evaluate healthy eating initiatives with communities they work with. This can include;

- **Get Cooking** and **Come and Cook** accredited Level 1 courses. Developed with families these courses equip participants with practical food skills to enable them to prepare healthy, affordable meals. Gaining credit for learning and access to further lifelong learning and employment opportunities can impact positively on the life chances of individuals (Institute of health Equity, 2014).
- **Foodwise for Life** 8 week structured weight management programme for parents to empower them to manage their weight and make healthy food choices for themselves and their families. Suitable for women ante-natally and post-natally.
- **Foodwise in Pregnancy** 6 week healthy lifestyle programmes to support pregnant women to eat well. Be active and achieve a healthy weight gain during pregnancy
- **Weaning parties** to support parents with complementary feeding (weaning)
- **Promotion of Healthy Start** to encourage eligible families to access the national Healthy Start scheme, particularly vitamin supplements to improve uptake rates across Wales

3. **Creating health promoting environments**

- **Gold Standard Healthy Snack Award (GSHSA) and Tiny Tums best practice award**
  Support childcare settings to achieve the GSHSA/ Tiny Tums best practice award

4. **Other national schemes contributed towards**

- **Healthy and Sustainable Pre School Scheme (HSPSS).** Delivery of the Community Food and Nutrition Skills for the Early Years training and local award schemes support settings to meet the nutrition criteria of the scheme.

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