Strategic Programme for Primary Care

National Primary Care Board

Title: **SPPC Fund 2022-23 Obesity Prevention Projects Benefits and Outcomes**

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Purpose and summary of key issues/points:

The purpose of this paper is to highlight the benefits and outcomes that are anticipated from the SPPC Fund 2022 investment into the suite of obesity prevention projects across Wales.

Ten projects to address obesity prevention, listed in table 1 below, are being progressed across the 7 health boards.

National Primary Care Board is asked to note the reported benefits and outputs for each project and anticipate an end of year report to reflect progress against the benefits and outputs in Spring 2023.

Strategic Programme Board (SPB) is asked to:					
Approve		**Discuss**		**Note for information**	X

Benefits and Outcomes of SPPC Fund 2022

Projects to Support Obesity Prevention

1. Background

The £3.8 million Strategic Programme for Primary Care Fund (SPPC Fund) commenced in April 2022 with agreement that the Fund is to be used in 2022/23 by Health Boards to support the implementation of the Accelerated Cluster Development Programme and investment into primary care projects to support obesity prevention, aligned with the Healthy Weight Healthy Wales Strategy (HWHW). These two investment areas were agreed by the Directors of Primary Care Peer Group and endorsed by the National Primary Care Board; 17 proposals were signed off in February 2022.

2. Purpose

The purpose of this paper is to highlight the benefits and outcomes that are anticipated from the obesity prevention projects. Ten projects to address obesity prevention, listed in table 1 below, are being developed across the 7 health boards. Details of the individual projects can be found on Primary Care One.

Table 1: List of projects by health board

Health Board	Project
Aneurin Bevan UHB	Weight Management Brief Advice and Self-Directed Support in Primary Care (Level 1)
Betsi Cadwaladr UHB	Development of a Digital Programme to Enable Virtual Group Pathways for people living with Type 2 Diabetes who are able to use weight loss as part of the management of their condition
Cardiff and Vale UHB	Type 2 Diabetes prevention brief interventions at Cluster level, aligned to the All Wales Diabetes Prevention Programme
	Living Well
	Get Cooking
Cwm Taf Morgannwg UHB	Enhanced Inverse Care Law Programme, including type 2 diabetes prevention aligned to the All Wales Diabetes Prevention Programme
Hywel Dda UHB	Primary Care Led Healthy Lifestyle Management
	Community Pharmacy Led Weight Management
Powys Teaching HB	Diabetes Prevention Early Interventions, aligned to the All Wales Diabetes Prevention Programme
Swansea Bay UHB	Diabetes Prevention, aligned to the All Wales Diabetes Prevention Programme

3. Projects components

There is variation in the approaches being taken by the different projects and health boards, but key themes have emerged:

- Building capacity for level 1 'services'/support through social prescribing and the non-registered workforce
- Integration of weight management with long term condition pathways
- Expansion of the All Wales Diabetes Prevention Programme (AWDPP)
- Role of wider primary and community care in linking to/ referring to weight management services.

4. Anticipated benefits and outcomes

Details of each project and their individual anticipated benefits and outcomes are presented in appendix 1.

The benefits and outcomes anticipated from the 10 projects overall can also be categorised into themes at different outcome levels (individual, population and system):

Individual outcomes include:

- Achieving a healthier weight and prevention of weight gain
- Prevention of progression to type 2 diabetes, aligned to the AWDPP
- Measurable reduction in HbA1c levels
- Prevention of complications from type 2 diabetes
- Changes to health behaviours, especially nutrition and levels of physical activity to improve health and wellbeing
- Attainment of skills and education
- Enablement of self-referral to services and self-management of conditions
- Increased accessibility of services.
- Increase in a person-centred approach to obesity prevention through integration with other clinical pathways

Population health outcomes (to be realised in the longer term) include:

- Contribution to an impact on the prevalence of type 2 diabetes
- Contribution to an impact on prevalence of overweight and obesity

System benefits include:

- Expansion of services to cover broader populations, reducing variation
- Generation of evidence
- Establishment of referral pathways and integration of pathways
- Potential reduction in GP workload through utilisation of alternative roles
- Potential reduction in requirements for a primary care consultation
- Meeting gaps in service provision and the weight management pathway
- Increased capacity for delivery of preventative interventions
- Workforce skills
- Utilisation of existing community assets to support patients with weight management.

5. Next steps

The PC Hub has met with health board colleagues leading each of the projects on an individual health board basis to explore the project proposals, potential benefits and outcomes, and discuss the idea of forming a peer network. All health boards positively responded to the concept of establishing such a forum.

The peer network will be led and facilitated by the PC Hub, with a first meeting scheduled for July 2022. The network will allow peer support, sharing of learning and overcoming challenges, support with measuring outcomes and evaluation, and ensure that the projects are aligned with the HWHW strategy, AWWMP, etc.

Broad themes that could be considered by the peer network which emerged from the initial discussions include equity, evaluation, quality and workforce and will inform the content of the peer network meetings.

An end of year one report will be produced in spring 2023 to capture progress within each project against the identified benefits / outcomes where applicable.

APPENDIX 1

ANEURIN BEVAN UHB
Weight Management Brief Advice and Self-Directed Support in Primary Care (Level 1)
Budget: Year 1 - £153,509 and Year 2 - £288,694
Expected end date: 31 March 2024
Project components
- Communications and engagement programme to amplify, showcase and bring to life local activity that supports people to maintain or achieve a healthy weight. This will include use of social media, film, print, peer support, networks and local events - A programme of brief advice training, practice-based materials (based on the 5As framework) and incentives for signposting adults with a BMI 25-30 without co-morbidities to community assets and support networks - Collaborative partnership working with local organisations supporting healthy weight to identify support needs of individuals, address gaps and explore opportunities to enhance community offer - Additional lifestyle support for people who require more intensive intervention or engagement to strengthen their motivation, assistance with self-navigation or facilitated self-help for weight management - Project management and administrative support for each NCN entering the intervention phase of the All Wales Diabetes Prevention Pathway, and to ensure integration with the development of the Level 1 weight management component of the AWWMP.
Anticipated benefits and outcomes of project
- The project ultimately aims to prevent patients from significant weight gain and to support weight loss - The project will ensure patients identified as requiring level 1 intervention can be signposted to trusted sources of support and evidence-based resources, which addresses a gap in the current pathway in ABHB - The project will enable utilisation of existing community assets to support patients with weight management, promotion and facilitated access to local resources - A comprehensive level 1 programme of support should help to reduce pressure on level 2 and 3 aspects of the pathway - The project will support the existing workforce to ensure the weight of all patients is monitored and discussed in a sensitive and non-stigmatising manner, and will enable increased capacity for lifestyle advice to be offered for people who require more intensive support with motivation and accessing available resources - The project will create capacity to support integration of the AWDPP with level 1 of AWWMP.

BETSI CADWALADR UHB
Development of a Digital Programme to Enable Virtual Group Pathways for people living with Type 2 Diabetes who are able to use weight loss as part of the management of their condition
Budget: £106,972
Expected end date: 31 March 2023
Project components
- Development of a digital program to enable virtual group pathways for people living with a long-standing Type 2 Diabetes diagnosis who are able to use weight loss as a treatment for their diabetes., - The intervention uses a supported 'virtual' very low calorie diet (VLCD) for ANY person with Type 2 diabetes of ANY duration - The platform will be a guided self-management resource with clinical expertise available as required - The platform will provide an on-line learning space that enables ease of access, and optimal teaching support, plus facilities for people with diabetes who wish to lose weight using a VLCD.
Anticipated benefits and outcomes of project
- The project seeks to create a coproduced intervention that is more inclusive than existing services and allows increased accessibility. There are work-streams in place to offer VLCD in 3 National projects, but access is restricted to a duration of diabetes of 6 years or less. - The platform will maximise reach for people who are hard to reach/disengaged and for the more complex cases. - The project seeks to build on the outcomes demonstrated by a local pilot study, which comprised of 25 patients who completed the 8-week program and had data available at 6-months. - Comparing baseline to 6-month data there was a mean reduction in HbA1c of 11.1mmol/mol (68.6 vs. 57.5mmol/mol, $p<0.05$), resulting from a reduction in weight of 11.5kg (105.0 vs. 93.5kg, $p<0.05$), a reduction in BMI of 4.1kg/m2 (36.5 vs. 32.4kg/m2, $p<0.05$) and a reduction in monthly drug costs of £40.01 (£60.65 vs. £20.64, $p<0.005$). - It is anticipated that in time, the proposed program would facilitate the delivery of a minimum 60 patients per week (~2500 per year) - The project is an opportunity to develop and evaluate an innovative approach which has the potential, once developed, to be scaled up and utilised across Wales.

CARDIFF AND VALE UHB

Type 2 Diabetes prevention brief interventions at Cluster level, aligned to the All Wales Diabetes Prevention Programme

Budget: £106,972

Expected end date: 31 March 2023

Project components

- The project will expand the implementation of the All Wales Diabetes Prevention Programme (AWDPP) in C&VUHB into an additional cluster, in addition to the 2 clusters in the health board already receiving funding for this from Welsh Government via the national grant, and 1 cluster via local cluster funding
- The programme aims to reduce the risk of developing type 2 diabetes for individuals identified at being at high risk by supporting the introduction of a robust prevention and intervention pathway for those who have a blood test (an HbA1c) result in the pre-diabetic range. Through the rollout of this programme at scale, the programme also aims to support a population impact on the prevalence of type 2 diabetes, alongside other developments within the wider Healthy Weight Healthy Wales strategy.

Anticipated benefits and outcomes of project

The funding will enable the AWDPP to be offered to a greater proportion of the population in Cardiff and Vale of Glamorgan, with a view to supporting an impact on the prevalence of Type 2 Diabetes within the identified clusters.

The project will be monitored and evaluated in line with the AWDPP which aims to:

- Prevent relevant patients from progression to type 2 diabetes
- Produce measurable reduction in HbA1cs
- Support an impact on the prevalence of type 2 diabetes (in the longer term).

Living Well

Budget: £57,000

Expected end date: 31 March 2024

Project components

- Delivery of Foodwise for Life and Escape Pain as well as other activity sessions to support obesity management at a cluster level
- Foodwise is a structured weight management programme, designed to be delivered by community based staff, and ESCAPE-pain is a group rehabilitation programme for people with chronic joint pain that integrates educational self-management and coping strategies with an exercise regimen individualised for each participant
- Physiotherapist and dietitian capacity will be recruited to alongside a health care support worker. The health care support worker will be trained to deliver group education programmes, ongoing supervision of the programme and programme management will be undertaken by the dietitian / physiotherapist.
- A full evaluation of both aspects of the programme including service user experience will be undertaken

- When fully operational 20 8 week programmes will be delivered per year, supporting a minimum of 200 participants.

Anticipated benefits and outcomes

- Project meets an identified gap in C&V at level 1 of the AWWMP
- Offering self-referral at a cluster level to these interventions supports patients to self-manage their weight and MSK problems earlier
- Project will enable people to access self-management programmes close to home and in a timely manner which enhances uptake and participation
- Enabling self-referral will support people accessing different routes for support and reduce requirement for a primary care consultation.

Get Cooking

Budget: £60,000

Expected end date: 31 March 2024

Project components

- Accredited nutrition skills training for community workers.
- Co-production of healthy eating initiatives with community groups.
- A dietitian will train and supervise a support worker to deliver a range of healthy eating initiatives with community groups including Get Cooking (Level 1, 2 credits) a practical cooking skills course
- Training will also be provided to health care support workers in primary care to enable them to deliver additional practice base education and support.

Anticipated benefits and outcomes

- The skills and education programmes the project will provide are not currently available at cluster level in C&V and are only accessible to specific population groups through flying start and similar programmes. The project will enable adults with obesity access to these programmes to support their self-management of obesity
- Limited cooking skills and ability to adapt recipes and budget effectively impacts on people's ability to access healthy affordable meals
- The relationship between learning to cook and having the opportunity to do so leads to improved nutrition, improved mental health and stronger family connections (Utter et al 2016).

CWM TAF MORGANNWG
Enhanced Inverse Care Law Programme, including type 2 diabetes prevention aligned to the All Wales Diabetes Prevention Programme
Budget: Year 1 2022/23 - £573,099, Year 2 2023/24 £573,099
Expected end date: 31 March 2024
Project components
- Further development, alignment, implementation and integration of prevention activities within primary care to include a health board wide diabetes prevention programme, cardiovascular health check and wellness service, Education for Patient Programme (EPP) patient education under the direction and governance of one programme, which will adopt the overarching name 'Wellness Improvement Service' (WISE) - In addition to the two clusters in CTM already receiving funding for the All Wales Diabetes Prevention Programme (AWDPP) from Welsh Government via the national grant, funding for an additional six clusters to deliver a diabetes prevention intervention to all individuals with blood test (HbA1c) results in the pre-diabetic range across the entire CTM footprint. This will be achieved through expansion of the current Inverse Care Law health check team. The team will provide a lifestyle advisor who will support behaviour change and access to level 1 weight management, physical activity and community connection across CTM to support individuals to have and maintain a healthier weight - Recruitment of a manager to provide leadership, co-ordination, development of PROMS and PREMS, and development of a combined population outcomes framework and dashboard system to measure intervention impact and improvement activity across the Health Board - Development of a model for an annual health check for patients aged 18+ with a serious mental illness (SMI) within the Inverse Care Law CVD health check programme which is responsive to patient needs in a group known to be suffering from increased risk of CVD for (approx. 4300 additional patients per annum) - Recruitment of a CNS prescribing nurse to develop process for maximisation of therapies following identification of CVD risk, they will add patients to chronic disease registers and design follow up clinics for those identified with abnormal clinical findings. In addition, a d GP with a cardiology interest to support this wider development of improvement throughout primary care - Development of a quality improvement role to support initiatives and standardisation across primary care.
Anticipated benefits and outcomes of project
- Integration of all prevention activities allowing flow of patients across existing pathways including establishment of an outcome's framework for primary care/population health - Reduction in GP workload through employment of a prescribing nurse - Recommendations for a standard agreed model of delivery for patients with SMI taking into consideration the QAIF framework for

GMS Additional identification for hypertension and Atrial Fibrillation to an estimated additional 10,000+ patient's pa

- Mapping of level one community activity to understand the demand, capacity and gaps to inform recommendations with partners and gathering evidence to inform plans to invest and develop tier 1-3 services Prevent relevant patients from progression to type 2 diabetes
- Produce measurable reduction in HbA1cs
- Support an impact on the prevalence of type 2 diabetes (in the longer term)
- Support reduction in weight through LA support
- Improved maximisation of drug therapies in agreed groups
- GP systems have improved information on patients e.g. height, weight, register status
- Patients to have improved PROMS and PREMS
- Increased health literacy and self-management
- Agreed quality improvement support and plan for primary care/GMS.

HYWEL DDA UHB
Primary Care Led Healthy Lifestyle Management
Budget: £341,000 per annum
Expected end date: 31 March 2024
Project components
- An intensive, group led lifestyle programme aimed at diabetes remission, covering all aspects of lifestyle including food, sleep, stress management and exercise with advice on habit formation - The programme tackles weight management, diabetes prevention and management of diabetes and therefore is not a single focus programme - Each group comprises between 10 and 12 people and is 8 weeks in duration. Follow up continues for 12 months after commencing the programme - The programme is led by a local GP, supported by a Dietician - Scoping work will be conducted to agree on a model that could be extended across the health board.
Anticipated benefits and outcomes of project
- Builds on a programme which has been successfully evaluated - Reduction in HBA1C in all individuals participating in the programme, along with sustained lifestyle changes improving health and wellbeing - Prevention of complications from diabetes e.g. nephropathy, retinopathy and neuropathy - Reduction in prescribing - Establishment of a referral pathway across all contractor professions for individuals identified as requiring improved lifestyle management.
Community Pharmacy Led Weight Management
Budget for this project: £76,000
Expected end date: 31 March 2024
Project components
- 12 week package of support (commissioned from either Slimming World or Weight Watchers) for individuals identified by a Community Pharmacist as being diabetic and wanting to lose weight - Intention to incorporate signposting information to local exercise schemes, walking groups etc. through the service - Social prescribing would also be a key factor in the programme and the aim would be to eventually cross-refer in Community Pharmacy.
Anticipated benefits and outcomes
- Generation of evidence of effectiveness of a weight management referral programme through Community Pharmacy - Minimum aim would be to deliver the programme in at least a 1/3 of Community Pharmacies (around 32/33) - Specific outcome measures will be determined in conjunction with the provider commissioned.

POWYS THB

Diabetes Prevention Early Interventions, aligned to the All Wales Diabetes Prevention Programme

Budget: Year 1 £58,000 SPPC Funds (plus an additional £30,000 cluster funds)

Expected end date: 31 March 2023

Project components

- This project is part of a mixed funding model utilising SPPC and South Cluster funding, to expand provision of the All Wales Diabetes Prevention Programme (AWDPP) into an additional cluster to the two clusters already receiving funding for this from Welsh Government funding through the national grant. The South Cluster will additionally expand cohorts from 3 months to a longer timeframe and consider additional at risk patient cohorts.
- The programme aims to reduce the risk of developing type 2 diabetes for individuals identified at being at high risk by supporting the introduction of a robust prevention and intervention pathway for those who have a blood test (an HbA1c) result in the pre-diabetic range.
- Through the rollout of this programme at scale, the programme also aims to support a population impact on the prevalence of type 2 diabetes, alongside other developments within the wider Healthy Weight Healthy Wales strategy
- Individuals' blood pressure will also be taken.
- The project will be delivered directly by the practices within the South Cluster, supported by Red Kite Health Solutions CIC, and will provide early intervention lifestyle/ health and wellbeing advice.

Anticipated benefits and outcomes of project

The funding will enable the AWDPP to be offered across the whole of Powys.

The project will be monitored and evaluated in line with the AWDPP which aims to:

- Prevent relevant patients from progression to type 2 diabetes
- Produce measurable reduction in HbA1cs
- Support an impact on the prevalence of type 2 diabetes (in the longer term)

In addition to the SPPC Fund monies, South Cluster funds will be used to enhance the cohort of at risk patients and time frame and develop access to a health and wellbeing support programme.

SWANSEA BAY UHB
Diabetes Prevention, aligned to the All Wales Diabetes Prevention Programme
Budget: £170,000
Expected end date: 31 March 2024
Project components
- The project will expand the implementation of the All Wales Diabetes Prevention Programme (AWDPP) in SBUHB into an additional 3 clusters, in addition to the two clusters in SBUHB already receiving funding for this from Welsh Government via the national grant. - The programme aims to reduce the risk of developing type 2 diabetes for individuals identified at being at high risk by supporting the introduction of a robust prevention and intervention pathway for those who have a blood test (an HbA1c) result in the pre-diabetic range. Through the rollout of this programme at scale, the programme also aims to support a population impact on the prevalence of type 2 diabetes, alongside other developments within the wider Healthy Weight Healthy Wales strategy. - The project will seek to evaluate additional models of delivery including virtual/video consultation and increase access to weight management interventions within clusters.
Anticipated benefits and outcomes of project
The funding will enable the AWDPP to be offered to a greater proportion of the population in Swansea and Neath Port Talbot, with a view to supporting an impact on the prevalence of Type 2 Diabetes within the identified clusters. The project will be monitored and evaluated in line with the AWDPP which aims to: - Prevent relevant patients from progression to type 2 diabetes - Produce measurable reduction in HbA1cs - Support an impact on the prevalence of type 2 diabetes (in the longer term).