Strategic Programme for Primary Care

Strategic Programme for Primary Care Fund 2022-2024 (SPPC Fund)

Section 1 – Overview

Health Board	**Cwm Taf Morgannwg**
SPPC Fund allocation	**£575,000**
Number of projects to be funded	1

Section 2 – Projects to be funded *Add further tables for any additional projects*

Project 1

SPPC Fund alignment 2022	~~ACD Programme~~	**Obesity**	~~Other~~
Project title	**Enhanced Inverse Care Law Programme**		
Budget for this project	Copy of Copy of pre diabetes 091121.xlsx **Year 1 2022/23 Total cost** : £573099 **Year 2 20232/24 Total cost £**:573099		
Short project description	Cwm Taf Morgannwg Health Board combined data from 2018-19 and 2019-20 shows that 67% of adults in Cwm Taf Morgannwg are overweight and obese; this is the second highest among health boards in Wales- of this figure more than 121,000 people are obese. This project aims to; 1. Utilise the current Inverse Care Law CVD Health Check team to enable roll out of a pre-diabetes brief intervention to the 6 primary care clusters not included in roll out of the wider All Wales Pre-pre-diabetes programme (AWDPP). This will be in addition to the 2 clusters identified as part of the pilot to ensure that the entire CTM footprint is included. This will also include supporting access to level 1 weight management, physical activity and community connection across CTM to support pre-diabetes patients maintain a healthy weight.		

2. Alignment of the separate health improvement work streams (existing and new) which aim to address obesity, together into a Strategic Improvement Programme.

3. Development of a combined population outcomes framework and dashboard system to measure intervention impact and improvement activity across the Health Board.

Until recently the Health Board did not have a structured level1-3 weight management service, however funding has been granted and a new level 2 and 3 service is in the process of being implemented in the Health board.

This proposed programme will focus on further developing, aligning and initially bringing together the following services so that the focus is on changing behaviours and reducing the prevalence of obesity and ensuring that the impact of any intervention is maximised. The four services to be included will be

- Inverse Care Law Health Check Programme,
- Prevention Health Checks for Patients with serious mental illness
- The All Wales Weight Management service
- Wellness Improvement Service & Education Patient Programme (EPP)to deliver a self-management service
- All Wales Pre-Diabetes Prevention

This will be under the direction and governance of one programme which will adopt the overarching name Wellness Improvement Service (WISE).

The project resources and costs for this project are included above but key enhancements are:

- Expansion of the current Inverse Care Law health check team to deliver a brief intervention for patients with pre-diabetes across the entire CTM footprint.

- Recruitment of a manager to provide leadership, co-ordination and development of PROMS and PREMS, and development of an evaluation dashboard.

- Inclusion of patients aged 18+ with a serious mental illness (SMI) to the Inverse Care Law health checks programme for an annual health check. This equates to approx. 4300 additional patients per annum.

- The aim will be to improve physical healthcare for people living with SMI, it is essential to proactively reduce existing health inequalities and prevent avoidable causes of premature death in this patient

	group. Evidence shows that people living with SMI are at higher risk of developing cardiovascular disease and being obese, this is intrinsically linked with their psychological, physical and mental wellbeing. People with SMI die on average 15–20 years earlier than the general population. People with SMI are more likely to smoke, suffer with obesity, diabetes, dyslipidaemia, lung cancer and breast cancer compared to the general population.[i] Poor physical health among people with SMI is estimated to be the reason for 2 in 3 deaths which are believed to be preventable. • Recruitment of lifestyle advisors to set goals, reduce risky behaviours (overweight) and support behaviour change. This builds on the learning from a pilot of a pre-diabetes intervention in South Cynon where it was identified that patients who need to make change need additional support for that behaviour change e.g. exercise, change eating habits, improve their physical markers and also to address health literacy and inequalities in access. • Recruitment of a prescribing nurse. It has been the experience of the Inverse Care Law programme that patients do not always attend for follow up with their GP or practice nurse when an abnormal finding is identified at a health check, e.g. raised blood pressure. The role of a prescribing nurse will be to develop procedures, add patients to chronic disease registers and design follow up clinics for those identified with abnormal clinical findings. This will ultimately reduce GP workload.
Key objectives of this project	• Integration of a CTM pre-diabetes brief intervention programme, weight management pathway implementation, Inverse Care Law and wellness service, EPP patient education. • Provide upstream prevention of diabetes and weight management support. • Develop an integrated outcome framework and reporting dashboard for all primary care health improvement activity. • Increase the capacity and reach of the Inverse Care Law programme to support reducing. inequalities and provide consistent equitable health checks in these population groups • Innovate and build on digital opportunities including social prescribing platforms and self-management. • Work to embed the weight management strategy with partners including the RPB and local authority with a renewed effort on initiating large scale change not only within communities but within the organisations.

	• Support patients to access level 1 and 2 of the weight management service pathway. • Offer opportunities to improve access to community physical activity and healthy eating opportunities. • Improve social prescribing to seek to address loneliness and isolation which can contribute to obesity. • Work to understand local community engagement and tailored messaging approaches. • Understand impact and gaps of level 1 weight management opportunities in the CTM footprint and develop plans to improve. • Support patients to access behaviour change opportunities and achieve their goals. • Implement the local model of AWDPP by recruiting staff (HCSW and dietician capacity) to deliver the AWDPP intervention to patients with an HbA1c in the non-diabetic hyperglycaemic range. • Support the process and outcome evaluation of the AWDPP by collecting the minimum dataset required. • Develop and deliver group education sessions delivered in cluster to improve patients understanding and opportunity to change. • Improve and standardise access to physical health checks and follow up interventions for people with SMI. • To develop and improve the quality of physical health checks and follow up interventions for people with SMI. • Provide advisor support to Pre-diabetes and SMI patients to assist with behaviour change and motivation to improve risky behaviours. • The programme will in addition employ a development nurse who will support the plans and implementation with a view to understand the additional prescribing needs with the aim of developing a nurse work up clinic to improve the follow up activity required post Inverse Care Law health check.		
Start date	April 2022 [SPPC fund available from April; Jan-March 2022 to be AWDPP funded]	Expected End date	March 2024
How will you monitor and evaluate this project?	• Evaluation of the AWDPP is being led by Public Health Wales' Research & Evaluation Division. • Quantitative monitoring and evaluation of SPPC-funded clusters will be done as part of the national AWDPP evaluation; however in depth qualitative process evaluation will be restricted to the 2 x		

	clusters per health board funded by the AWDPP grant from Welsh Government. • A service review will be undertaken of the Inverse Care Law programme to include PROMS, PREMS and agreed outcomes with the support of the value based health care team. • We will undertake the use of PROMS and PREMS and patient engagement to build on the current model.
Describe how this project differs to what is already in place locally or what has been tested elsewhere?	This project will enable the co-ordinated delivery of an evidence-based brief lifestyle intervention for patients with pre-diabetes across the whole of Cwm Taf Morgannwg University Health Board, in addition to the two primary care clusters funded from the All Wales Diabetes Prevention Programme. There is currently no consistent approach to the management of patients with pre-diabetes across Cwm Taf Morgannwg, and this funding would provide the opportunity for this brief intervention to be trialled across the three local authority areas. There is currently no level 2 or 3 weight management option in CTM UHB for patients and this programme will support the implementation and improvement of level1-3 services. This will be undertaken with community engagement and inclusion, taking a value based healthcare approach. CTM UHB does not have an existing equitable service that offers patients with SMI a health check- the systems in place within the current Inverse Care Law programme will allow for developing and implementing a quality assured evidence based health check. Welsh Government's 'Together for Mental Health delivery plan' aims to identify and reduce health inequalities by developing a Health Equity Status Report (HESR) for Wales to support policy action. As we know the inequality gap for physical healthcare in SMI, it is our responsibility as a health board, to better understand our current physical healthcare service for SMI patients and look at how we can develop the programme to meet the needs of our patients.

[i] Public Health England. Severe mental illness (SMI) and physical health inequalities [Internet]. 2018. [01/02/2021] Available from: https://www.gov.uk/government/publications/severe-mental-illness-smi-physical-health-inequalities