TYPE 2 DIABETES PREVENTION & REMISSION IN WALES: WHAT'S BEEN HAPPENING SINCE I LAST ATTENDED PCDS????

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DIABETES UK CLINICAL CHAMPION 2020-22

GIG CYMRU NHS WALES | Grŵp Gweithredu Diabetes | Diabetes Implementation Group

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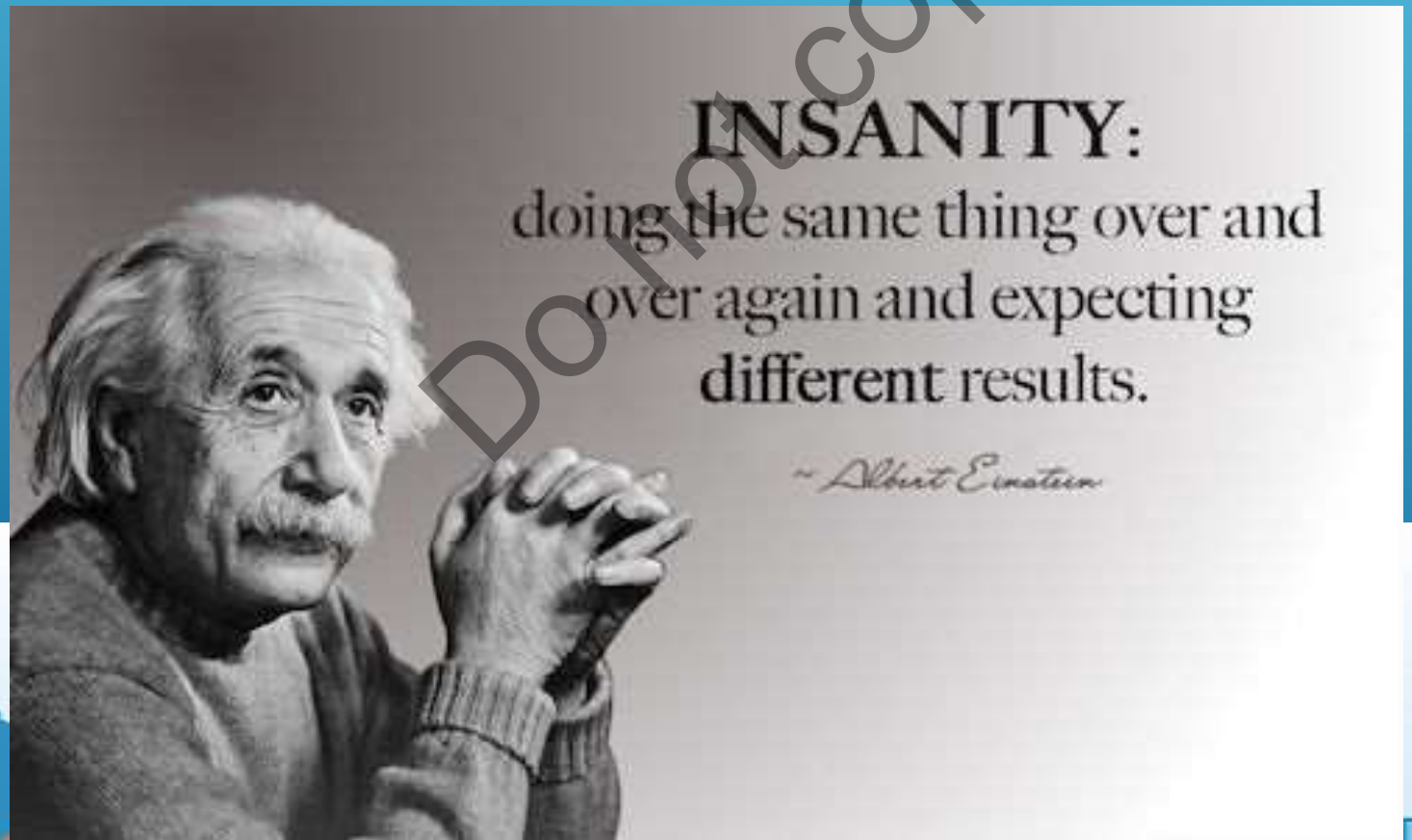
TYPE 2 DIABETES PREVENTION, EARLY DETECTION & INTERVENTION



The All Wales Diabetes Prevention Programme

AWDPP

- Business case to Welsh Government to fund a systematic approach to T2D prevention in Primary Care, based on the models used in the pilot areas.

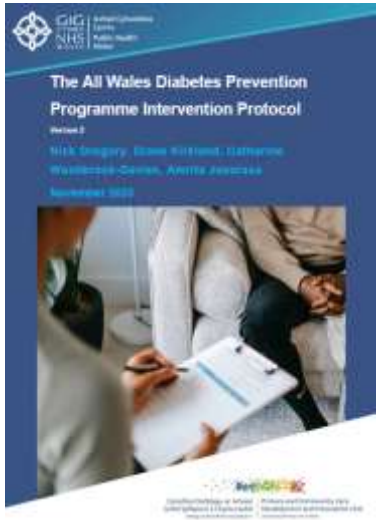
- Welsh Government commitment an initial £1 million per year, for a two year period (2021-2023) which was subsequently extended to 2023-2024 and again to 2024-2025.

- The development of the AWDPP has been led by PHW, supported by a steering group and four workstreams comprised of multidisciplinary professionals and the Diabetes Patient Forum.

- The AWDPP, launched formally in June 2022, is a targeted, standardised brief intervention providing an effective, equitable approach to T2D prevention, delivered through primary care across Wales for people at high risk of the disease.

- The embedded national evaluation enables rigorous assessment of:

    - the fidelity of intervention delivery
    - effectiveness against a core set of patient and clinical outcomes
    - the value of the intervention
    - the factors for successful implementation across Wales



14/9/2023

All Diabetes Prevention Programme Roadmap

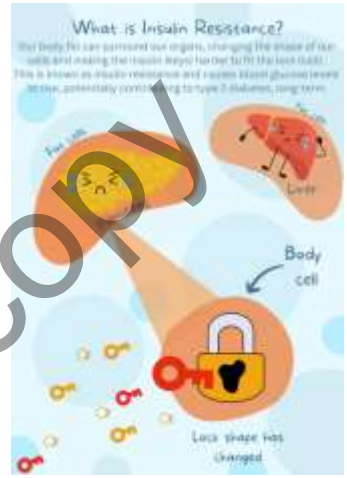
2021-2023

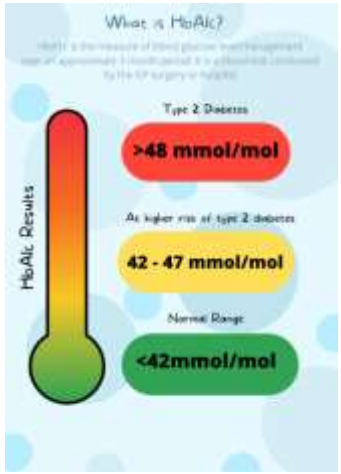
2 Year Journey

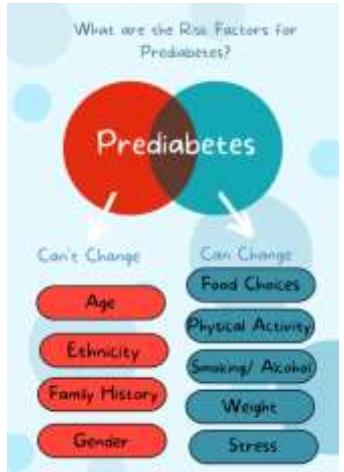
Delivering the AWDPP Consultation

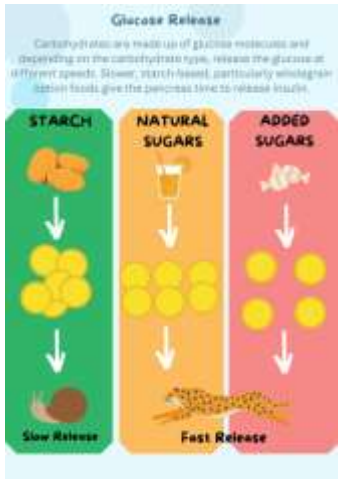
AWDPP Consultation Manual & Desktop Resource

- Person centred ‘what matters to you’ conversation.
- HbA1c result, T2D risk factors, diet, nutrition & physical activity.
- Goal setting
- Referral to additional support i.e. weight management & PA services as well as others such as smoking cessation.
- Patient resources: DUK Information Prescriptions ‘Eating Well’ and ‘Being Active’, NHS Eatwell Guide, Let’s Prevent digital resource.









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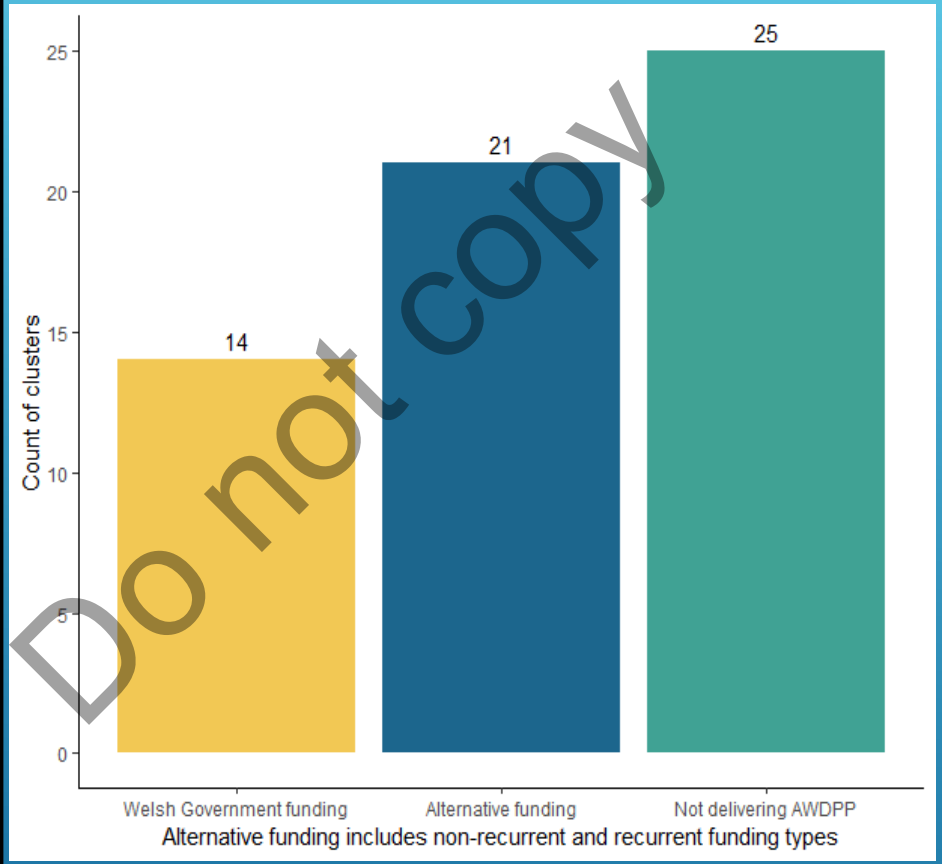
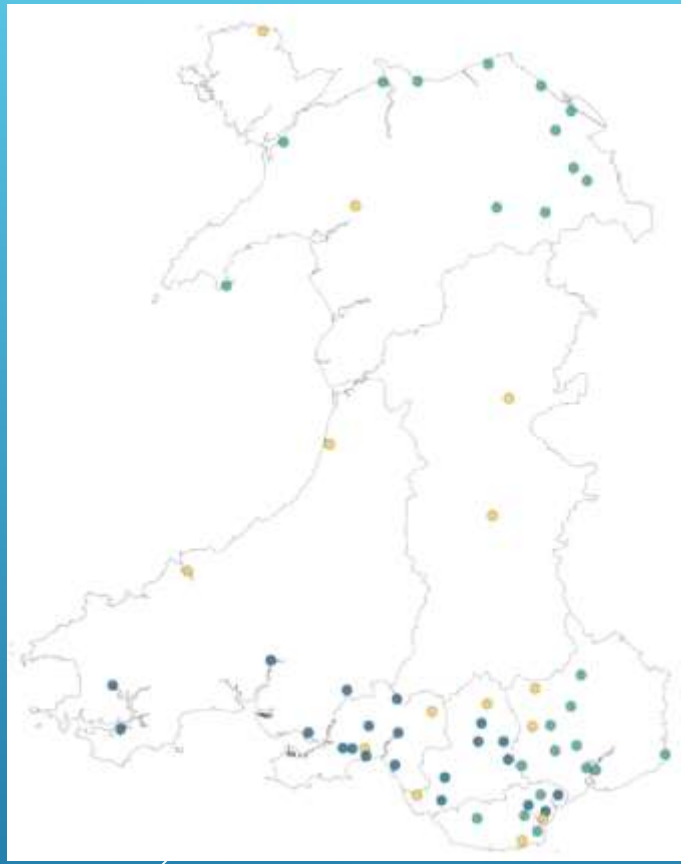
All Wales Diabetes Prevention Programme (AWDPP): First Year

Activity Report: June 2022 – May 2023

AWDPP OVERVIEW

- In March 2021, Welsh Government announced funding of £1m per annum up to March 2024, to commence the rollout, with embedded evaluation, of a national type 2 diabetes prevention programme, led by PHW.
- 1st phase: funding supported delivery of the AWDPP in **14 primary care** clusters
- In some health boards, **other sources of funding** are being used to extend the rollout of the AWDPP **to additional clusters.**
- This data presents **12 months of activity** data for the AWDPP following its launch during Diabetes Awareness Week on 16th June 2022
- The AWDPP involves a brief intervention, delivered by **trained Health Care Support Workers, supervised by local dietitians**, to people identified as being at risk of developing type 2 diabetes (HbA1c 42-47 mmol/mol.





Key Statistics: June 2022– May 2023

Identification, Invitations, Bookings, Attendance and Uptake*

People identified using search template[1]	10,875
Invitations sent (following manual triage)*	7058
Consultations booked	4524
Consultations attended	3804
% Uptake = (consultations attended ÷ invitations sent)	54%
Booked consultations recorded as 'Did not attend'	301 (7%)

84% attendance rate

[1]See All Wales Diabetes Prevention Programme Protocol for further information on eligibility criteria

Consultation Delivery

Consultations booked for delivery face-to-face	4030
Consultations booked for delivery virtually	21
Consultations booked for delivery by telephone	473

Additional Referrals/Signposting to

Weight management	563
Physical activity	406
Other support services (including Digital programme Let's Prevent Diabetes)	771

*All data displayed is received on a rolling basis and subject to data lag between stages of the AWDPP

KEY MESSAGES

Date Period: June 2022– May 2023

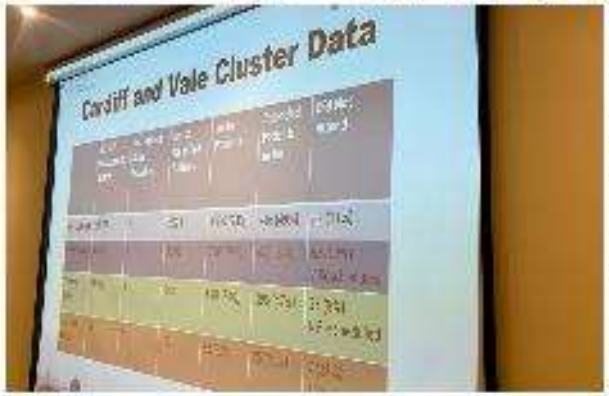
14 Welsh Government funded clusters commenced delivery of the AWDPP following the programme's launch in June 2022

21 clusters funded by other sources have additionally commenced delivery of the AWDPP

25 healthcare support workers have been trained and delivering the AWDPP

84% of AWDPP appointments booked were **attended**

DEVELOPING & GROWING THE AWDPP WORKFORCE



AWDPP Community of Practice

AIM: To **bring together** groups of practitioners, to promote productive discussion and encourage collaborative solutions to overcome common challenges as well as contribute to the development and implementation of the AWDPP.

To provide a forum where colleagues with experience and responsibility in the AWDPP from across Wales can **meet together, compare learning and share good practice**

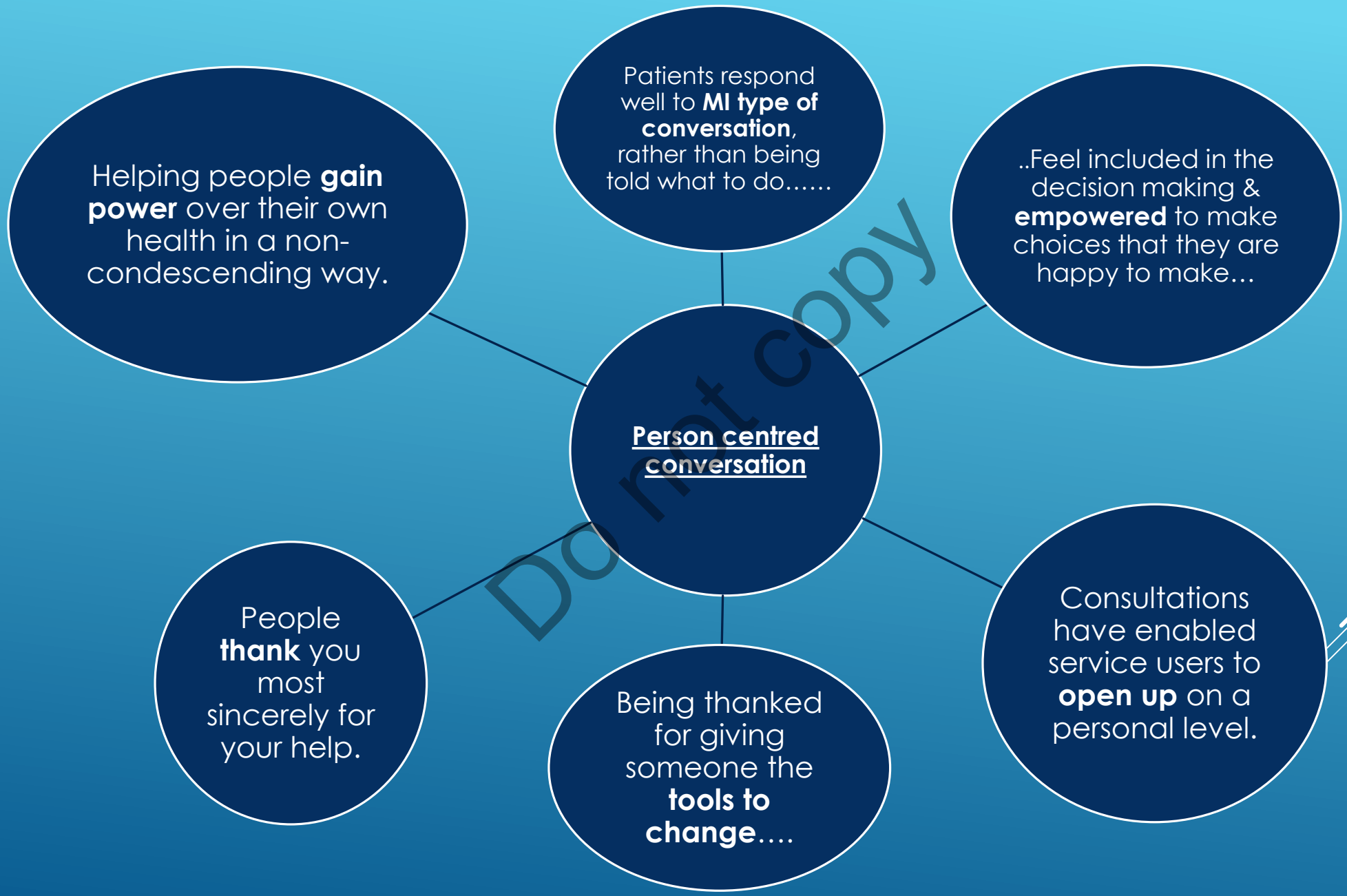
To **contribute to the development of resources** to support delivery and implementation of the national AWDPP model of delivery and to share learning more widely with colleagues across Wales.

AWDPP Community of Practice

What's gone well?

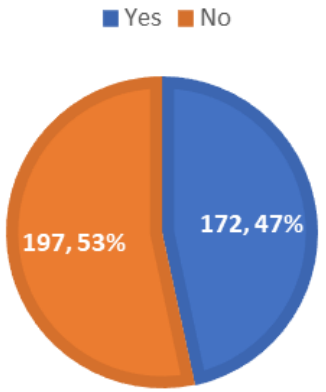
Themes	Example Comments Feb 2023	Example Comments Nov 23
Service user engagement	• Lots of patients explicitly say they're **so glad** the service is now available….. • Patients are **grateful** for us explaining to them about HbA1c level…not had support ..before	• Phone calls support engagement • **Low DNA rate** • Invite letter & information leaflet **supports engagement** • Making **changes pre-appointment** • Service user feedback (positivity, enthusiasm) • **Uptake & attendance rates** • Patients can **attend own surgery** or local leisure centre
Support network & Team work	• Thorough induction • Cath is amazing! Very **approachable,** knowledgeable & fun • Working as **part of an all Wales team** & having a good supportive advocate heading up the service. • **Supported, appreciated, valued** & interested in • Team building • **Working as a team** & learning off each other. • **Supportive team** & passionate about making a difference.	• **Great team** • **Partnership & collaborative working** • Surgeries supporting the AWDPP staff to feel part of the team • AWDPP staff also delivering ongoing support services such as Foodwise for Life • **Sharing best practice** • Increase awareness of the service
Standardisation	• Being **part of a wider** supportive team. • Being **part of prevention**	• **Part of a national programme** • Working across whole HB (in some areas) • **Standard approach** whilst having ability to tailor to individual needs

AWDPP Community of Practice

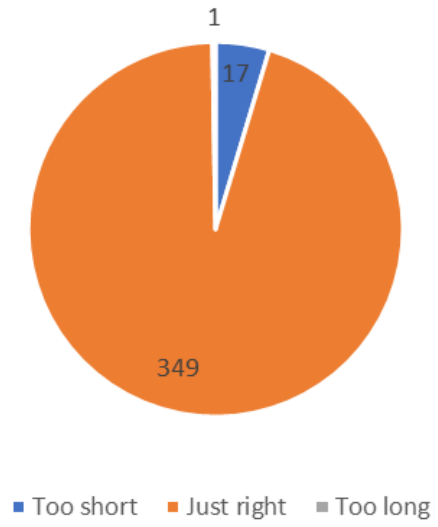


AWDPP PREM (N= 369)

BEFORE YOU WERE CONTACTED ABOUT THE ALL WALES DIABETES PREVENTION PROGRAMME, DID YOU KNOW YOU WERE AT RISK OF DEVELOPING TYPE 2 DIABETES?



Did you feel the length of the appointment was:-

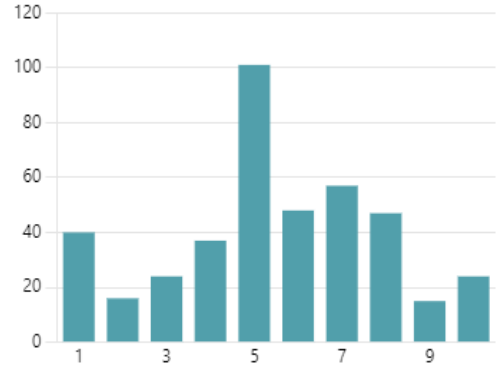


10. **Before** the appointment, how would you have rated your knowledge around the risk factors for developing Type 2 Diabetes?

(On a scale of 1= Very little knowledge, 5=Some knowledge, 10= Very good knowledge)

More Details Insights

5.46
Average Rating

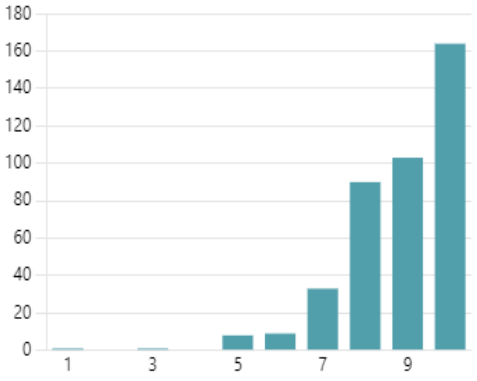


11. **Following** the appointment, how would you now rate your knowledge around the risk factors for developing Type 2 Diabetes?

(On a scale of 1 = very little knowledge, 5= Some knowledge, 10= Very good knowledge)

More Details Insights

8.84
Average Rating



IS THERE ANYTHING ELSE YOU WOULD LIKE TO TELL US ABOUT YOUR EXPERIENCE OF THE ALL WALES DIABETES PREVENTION PROGRAMME?

I am so glad it is available, my **blood sugars have gone back to normal** so I am extremely happy

Put **my mind at ease, reducing my stress** by explaining the changes I could make to help

I **had no idea I was in the risk** group the GP said my tests were fine. Glad I attended as I found it really useful to get the information I needed..

Before I came to the appointment I was so **afraid** of getting diabetes. [HCSW] helped me work through some of **my misconceptions**, **after a lot of tears I was able to move on and think about what I could do** to get my blood sugars down. I felt [HCSW] was so **supportive** and gave lots of information around services to improve my health

I really thought it was going to be a **waste of time** attending. I **was wrong**, I got so much out of this appointment I'm **so glad I attended**.

Lovely, friendly counsellor. Helpful, encouraging and **non-judgemental**

Future of the AWDPP – Upcoming Plans

1. Consolidate the learning- data collection ongoing.
2. What we want to achieve- What does good looks like?
3. Monitoring outcomes and quality improvement - Produce quality statements around key AWDPP processes.
4. Monitoring of grant expenditure and work with health economics teams to look at system benefits.
5. Work with WG colleagues to look at what the next phase of the AWDPP would look like (health board model?).
6. Work towards embedding T2D prevention work into the wider diabetes system, linking all diabetes workstreams so that care pathways are improved.
7. Embedding of the AWDPP equity toolkit to ensure that access and uptake rates are maximised.

WALES TYPE 2 DIABETES REMISSION

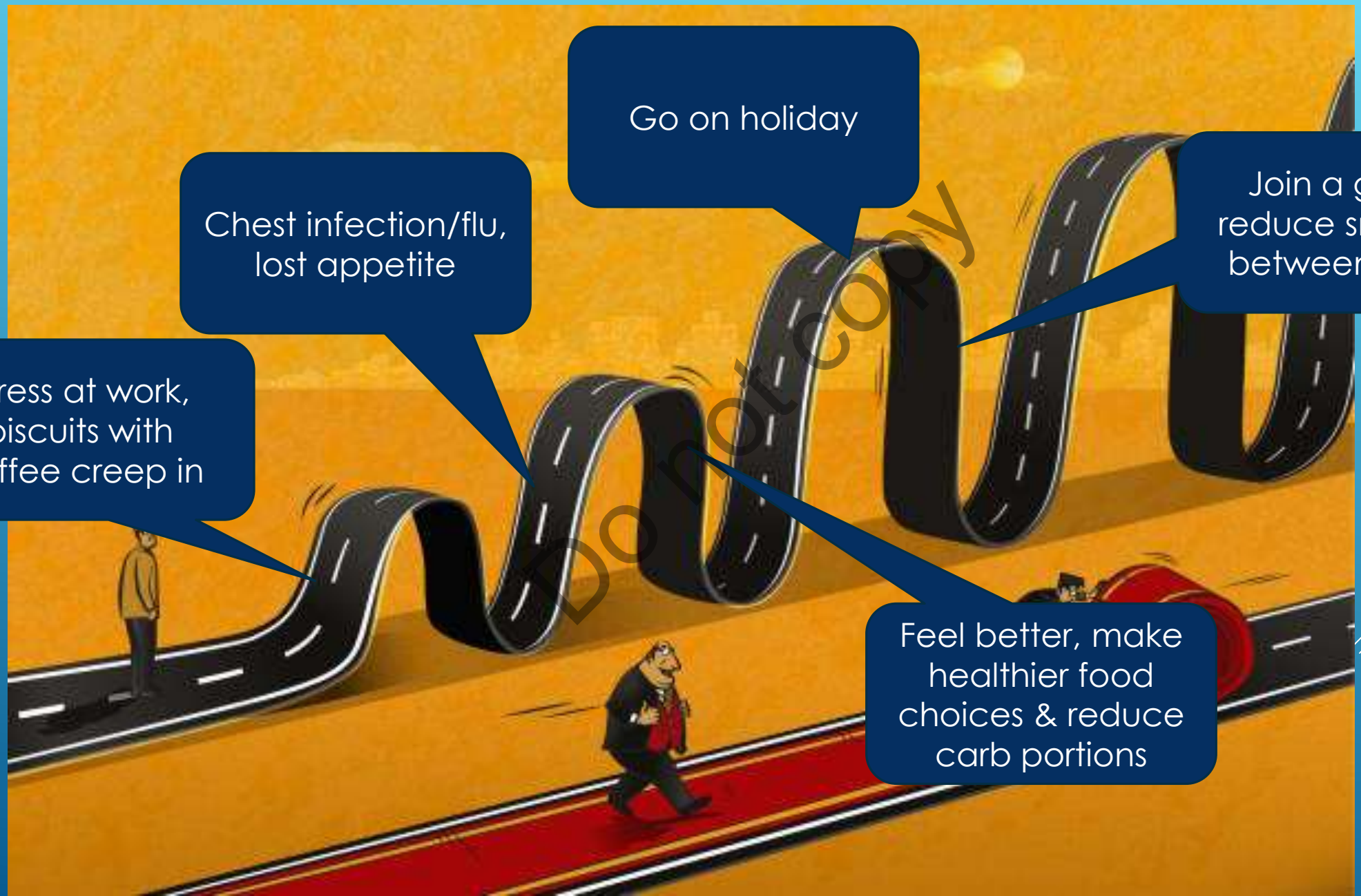
WHAT ARE THE BENEFITS OF A NUTRITION THERAPY APPROACH & OF PUTTING TYPE 2 DIABETES INTO REMISSION?

- ✓Stopping or reducing the number of medications taken
- ✓Reducing risk of hypoglycaemia
- ✓Reducing the risk of heart disease & other long term diabetes related complications
- ✓Improved mental wellbeing
- ✓Help to sleep better & generally feel ‘more healthy’
- ✓Improve joint health

REMISSION STATUS FOR PARTICIPANTS WHO HAD 2 HBA1C RESULTS RECORDED & HAD FINISHED THE 12M PROGRAMME

	Completed the Programme	Remission	% achieved remission
England (Dec'22 Data presented at DUK Conference April'24)	450	145	32%
Wales (2020-2023 data)	57	34	60%

TYPE 2 DIABETES ROADMAP TO REGRESSION OR REMISSION



A JOURNEY OF DISCOVERY: KATH'S STORY

Background & history

- Kath struggled with weight since childhood, attended slimming world at age 11.
- Diagnosed with underactive thyroid at 15 and a long history of mental health and depression which she was prescribed anti-depressants and mood stabilisers which drove her appetite & hunger levels resulting in further weight gain. During this time she had an inpatient stay at Whitchurch hospital

TIMELINE

2012:
Frequent admissions due to nausea, constipation & reflux.
Diagnosed with IBS

2013:
Weight= 110kg (BMI =46)

Significant deterioration in MH
Diagnosed with T2D

2014:
Weight= 110kg
HbA1c=72

Attended X-PERT

2016:
Followed the FODMAP diet which improved IBS & nausea
Made lots of dietary changes

Weight= 101.1kg (BMI=42)
HbA1c= 80

TIMELINE

March 2020:

Started onto Insulin March
Fiasp 25u/8u/8u
Lantus 20u/48u
Weight= 107kg
BMI= 44.5
HbA1c = 51

Keen to start IVF, had been told needs to lose 5st

Aug 2020:

Iron infusion, lots of stress, attending CBT for self-esteem, expressed feelings of guilt & shame towards food. Told by gynae she needed a BMI <30 for IVF. Struggling with pain & insomnia

Sept 2020:

DSN reduced Lantus & started GLP1. noticed a change in appetite.

Oct 2020:
Weight= 106kg
GLP1 increased insulin reduced further

April 2021:

Weight= 110kg
Contacted dietetic dept told needed 30g carb per meal, wasn't sure how to do this.

TIMELINE

April 2021:

Fiasp 15u/5u
Lantus 10u /24u
Feeling v unwell, vomiting & diarrhoea.
Felt unable to manage meals & insulin due to erratic eating pattern
PLAN:
commence meal replacements to rest bowels

May 2021:

Weight=98 to 93kg
BMI= 41- 38.7
BMs 4-6mmol
Nausea & vomiting stopped
BO normally
STOPPED ALL insulin

June 2021:

Weight =91 to 88kg
BMI= 37.9 – 35.8
HbA1c= 37mmol
Dapa & GLP1 stopped

July 2021:

Re introduced food
Weight = 86kg
BMI= 35.8

Aug 2021:

Weight= 86kg
Reduced anti-depressants
Introduced more food, no nausea

Sept 2021:

Stop CPAP & HT meds

Oct 2021:

Weight= 82kg
BMI=34
Home life very stressful

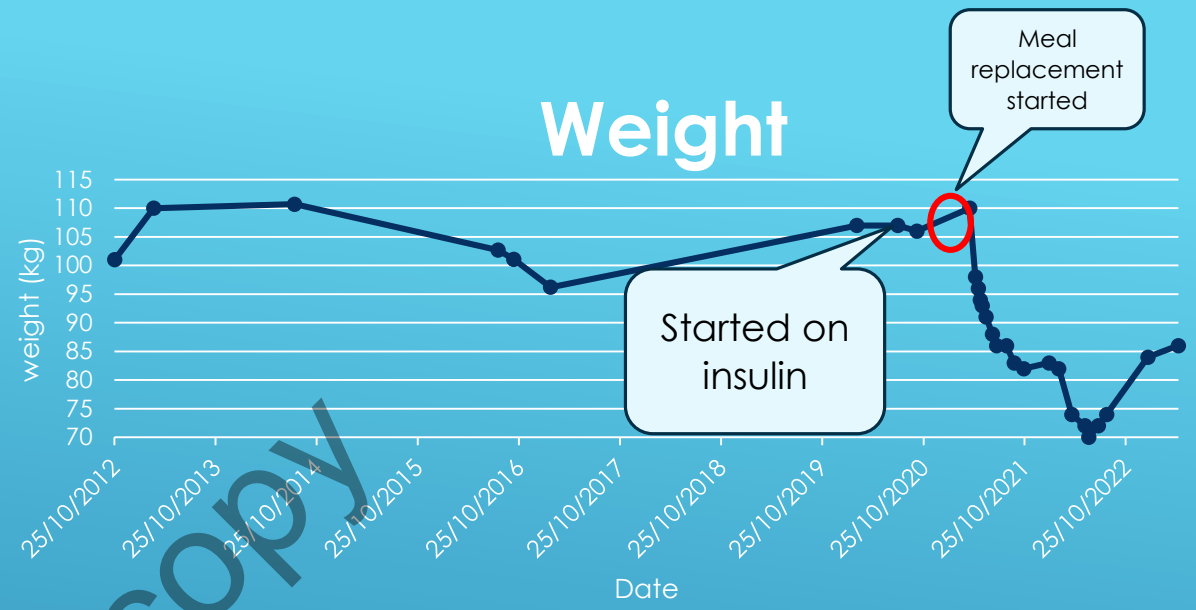
April 2022:
Weight= 74kg
BMI=30.8
HbA1c= 37
Started running

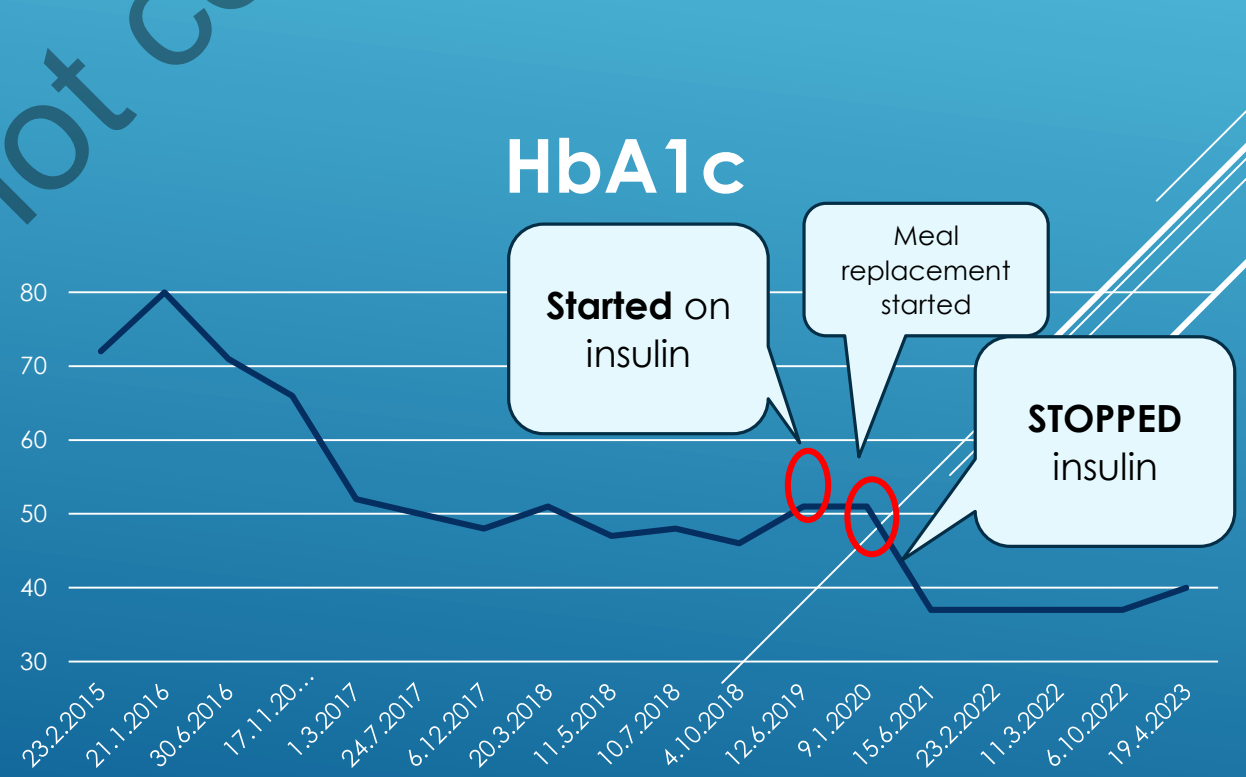
May 2022:
Weight = 72kg
BMI=29.4

Sept 2022:
Received fertility treatment

Jan 2023:
Father unwell & subsequently died
Struggled with MH
Weight= 84kg
BMI=34
HbA1c= 40

Sept 2023:
Weight = 88kg
On NERs scheme





SUMMARY: NUTRITION THERAPY

Previously:

- Poor relationship with food
- poor quality food
- sluggish, in pain and nauseous
- told that she would be on insulin and beta blockers for life
- She felt like there was ‘no hope’

Enabled her:

- To gain control
- Regain a love for fresh food
- Given structure
- Less thought needed initially
- More energy and nutritionally complete

WHAT NEXT???

- Analyse data for cohort 2.
- Future support to open this up to those individuals who would like support to aim for Type 2 diabetes remission utilising nutrition based approaches, irrespective of where they live.
- We recognise that ‘no one size fits all’ and the meal replacement/Low calorie approach will **NOT** be suitable for everyone.
- Support people early in their T2D journey to aim for remission/ regression via which ever medical nutrition therapy would suit their social circumstances, ie. Via X-PERT/1:1 support/ F2F/Digital.

Thank you for your attention

Any questions???

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BDA The Association of UK Dietitians

Trust a Dietitian

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