WESTERN SYDNEY DIABETES PLAN 2017
OVERVIEW

The Western Sydney Diabetes Plan 2017 document outlines the blueprint of how we will be delivering the Western Sydney Diabetes initiative across the four key delivery areas of:

• Primary prevention
• Screening linked with lifestyle coaching
• Building community capacity to better manage diabetes
• Enhancing hospital and specialist management of diabetes.

This work will be supported by the enablers through the work in:

• The investment portfolio
• Website and communications
• Monitoring and surveillance
• The Blacktown focus
• Forums and events.

In addition, the program of work will be supported through the organisational structures identified as 'Organisational Enablers'. The Western Sydney Diabetes Core Team is expanding to deliver the program of work and the budget is growing to accommodate additional priorities as identified in this planning document.

The governance structure for the Western Sydney Diabetes initiative (as shown below) provides a robust framework for delivering the programs of work.
WESTERN SYDNEY DIABETES CORE TEAM supports all activities

BUDGET underpins work
## PRIMARY PREVENTION

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<th>DESCRIPTION</th>
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| **Urban Planning**              | • Undertake key stakeholders consultation prior to workshop  
• 4 themes to be analysed and progressed – 1. Policies required to support liveable communities 2. Urban design and greening 3. Transport 4. Promoting consumer engagement  
• Strategy to be refined with an emphasis on advocacy, convening relevant project groups, plus monitoring and surveillance | 2017 Q1 Q2 Q3 Q4 Q4 onwards |
| **Progressing interventions**   | • Low investment interventions to be advanced with motivated stakeholders  
• Currently potential exists with: GP walking groups, SALSA, Stephanie Alexander Kitchen Gardens, Pre-natal education, Cooking classes, Playgroup education and Live Life Get Active boot camps  
• Working groups to commence the planning and implementation of selected initiatives  
• Blacktown chosen to initially launch programs | 2017 Q1 Q2 Q3 Q4 Q4 onwards |
| **Staff Health and Wellbeing Program** | • Diabetes awareness campaign  
• Screening and ‘Know your numbers’ to be conducted for staff members  
• Staff ‘Champions’ to be identified for program promotion  
• Lifestyle modification programs to be offered based on personal preferences | 2017 Q1 Q2 Q3 Q4 Q4 onwards |
| **Key community enablers**      | • Incorporate psychological expertise into planning for motivating consumers  
• Conduct community consultation on proposed initiatives  
• Expand the membership of the Prevention Alliance (currently over 50) with special emphasis on greater Council representation | 2017 Q1 Q2 Q3 Q4 Q4 onwards |
## SCREENING AND COACHING

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| **Link HbA1c measurements to community coaching** | • Nurse to undertake formative research with GP and patient to explore why low uptake with NSW Health’s Get Healthy program  
• Connect with Primary Prevention to promote local healthy lifestyle programs  
• Link with the Western Sydney Diabetes Self-management App and University of Sydney communication groups | 2017: Q1, Q2, Q3, Q4  
2018 onwards: Q1, Q2, Q3, Q4 |
| **Promote diabetes detection and coaching by GP**  | • Continue Kildare Road Medical Centre, Blacktown trial  
• Promote diabetes detection to large corporate GP practices in Blacktown  
• Promote diabetes detection to GPs at case conferencing sessions  
• Promote diabetes detection to GPs together with Western Sydney PHN | 2017: Q1, Q2, Q3, Q4  
2018 onwards: Q1, Q2, Q3, Q4 |
| **Collate and promote lifestyle**                 | • Engage partners to develop new opportunities for lifestyle programs  
• Promote lifestyle programs on Western Sydney Diabetes website  
• Promote lifestyle programs via identified events and evaluate take-up of programs | 2017: Q1, Q2, Q3, Q4  
2018 onwards: Q1, Q2, Q3, Q4 |
| **Pharmacy engagement**                          | • Establish Pharmacy working group to progress community pharmacy engagement  
• Ensure presence at and presentations to National Pharmacy meetings  
• Trial engaging pharmacies in Blacktown area | 2017: Q1, Q2, Q3, Q4  
2018 onwards: Q1, Q2, Q3, Q4 |
## COMMUNITY ENHANCEMENT

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<th>TIMEFRAMES 2017</th>
<th>2018 onwards</th>
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| Advance Western Sydney Diabetes App | • Collaborate with two USyd groups (Health literacy and CALD) to produce customised messaging/education for our patch  
• Pre-test some of the content via PhD student with target GPs/patients  
• Produce one-line messaging, videos, library of content  
• Go to tender with business case, potentially with established app | Q1 | Q2 | Q3 | Q4 | onwards |
| Expand case conferencing | • Double capacity to 600 cases in 2017 (minimum 13 per week over 46 weeks)  
• Promote case conferencing with brochures, phone calls, GP site visits and talk nights, GP recommendations, PENCAT data, cycle of care, GP associations, engage patients, practices in geographic focus and higher HbA1c results via nurse, other media to engage consumers  
• Apply for RACGP accreditation for Continuing Professional Development points via PHN  
• Measure outcomes with HbA1c change, GP satisfaction assessment, patient satisfaction  
• Integrate prevention projects into case conferencing | | | | | |
| Expand High-Risk Foot Service & Save a Leg | • Increase capacity with additional podiatrist  
• Promote and increase awareness of High Risk Foot Service to GPs  
• Collaborate closely with vascular, infectious diseases, and wound care teams  
• Work with ACI guidelines and Diabetes Taskforce  
• Deliver and promote Save a Leg (Foot) Forum  
• Promote use of ‘60-second foot check’ screening tool in community and inpatients | | | | | |
| Advance Community Eye Program | • Use standardised forms for optometrist-GP communication  
• Attend regular C-EYE-C steering committee meetings  
• Start pilot trial with optometrists in Blacktown/Parramatta and engage with Westmead Hospital ophthalmologist to triage patients requiring urgent treatment | | | | | |
| Expand coaching opportunities | • Continue practice nurse training  
• Deliver ‘Know your numbers’ and education to pharmacists  
• Investigate dentist coaching | | | | | |
| Explore ways to connect with psychological support/mental health | • Employ a psychologist for diabetes clinic or within Integrated Care | | | | |
## HOSPITAL ENHANCEMENT

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| **Continue Diabetes Detection and Management Strategy (DDMS) at Blacktown** | • Continue routine HbA1c testing at Blacktown  
• Develop strategy for inpatient management, including enhancement of IT infrastructure for inpatient surveillance and management  
• Identify Key Performance Indicators including turnaround time of HbA1c results, accuracy of GP information related to the strategy, time to consultation, accuracy of obtaining data  
• Implement ongoing education program for hospital staff  
• Improve patients’ uptake of lifestyle coaching programs, including Get Healthy  
• Identify GP practices suitable for case conferencing based on levels of HbA1c  
• Track changes in patients’ HbA1c with recurrent admissions | Q1 | Q2 | Q3 | Q4 | onwards |
| **Implement Blood Sugar Levels/DDMS at Westmead**                | • Extend Routine HbA1c Testing pilot to Westmead ED – a focus on identifying patients with less well-controlled diabetes  
• Secure funds for support nurse and administration officer to support identified patients requiring follow-up with their GPs  
• Define parameters to assess effectiveness, workload and cost | Q1 | Q2 | Q3 | Q4 | Q2 |
| **Capacity building in Cardiology, Respiratory, Mental Health, Aged Care** | • Identify opportunities to build capacity | Q1 | Q2 | Q3 | Q4 | Q2 |
| **Integration of care in out patient clinics**                   | • Assess viability of running as separate lists  
• Continue to use Rapid Access and Stabilisation Services (used by GPs, ED, other specialities)  
• Integrate Diabetes and Integrated Care clinics  
• Recruit additional staff – dietician, psychologist, another podiatrist  
• Trial with Health2Sync App versus traditional insulin phone stabilisation | Q1 | Q2 | Q3 | Q4 | Q4 |
| **Use Continuous Glucose Monitoring (CGM)**                      | • Promote as an educational tool to patients to assist with stabilisation of glycaemic control before discharging patients back to GPs  
• Prepare and submit business case for routine use in the Out Patient Diabetes clinic  
• Prepare a paper reviewing the literature on use of CGM in this setting | Q1 | Q2 | Q3 | Q4 | Q2 |
| **Obesity/metabolic services at Blacktown**                      | • Participate in planning for the bariatric and metabolic surgery clinic  
• Community advanced trainee to assist with clinic | Q1 | Q2 | Q3 | Q4 | Q2 |
| **Connect with Rouse Hill Planning**                            | • Participate in discussions in future planning for Rouse Hill Hospital | Q1 | Q2 | Q3 | Q4 | Q2 |
## PLAN 2017

### PROGRAM ENABLERS

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<td>iry and management</td>
<td>2017</td>
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<td>• Work with PwC to prepare a prospectus document for WSD</td>
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<td>• Review and combine models into economic model for prevention and management</td>
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<td>Investment Portfolio</td>
<td>• Develop and cost urban build initiatives for inclusion in the model and economic case, including with Greater Sydney Commission, universities leads, Western Sydney councils, NSW Transport</td>
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<td>• Bring together management and prevention economic case into one document to be available on the WSD website</td>
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<td>• Identify potential funding models so WSD program can be expanded in size and increased in pace</td>
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<tr>
<td>Website and Communications</td>
<td>• Prepare and implement communications strategy for Western Sydney Diabetes initiative</td>
<td>2018</td>
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<td>• Work with Corporate Communications on identifying media opportunities</td>
<td>Q1</td>
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<td>• Build social media presence to promote key program areas, campaigns and Blacktown geographic campaign</td>
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<td>• Develop communications collateral for key program areas, including Prevention Alliance, Health and Wellbeing for Staff, Enhanced Management and case conferencing</td>
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<td>• Work with partners on joint communications (eg C-EYE-C project, CHAMPION, SALSA, Diabetes and Ramadan etc)</td>
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<td>• Develop website content to reflect current state of initiative, including healthy living options and key program areas</td>
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<td>• Improve linkages with partner websites to increase visitation and useability for consumer</td>
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| Monitoring and Surveillance | • Create monitoring and surveillance system strategic plan (with support from PwC, Western Sydney PHN, Diabetes NSW and others), including benchmarks, surveillance per intervention, and reporting for communication, implementation and management  
  • Scope current data and data gaps and test out some early parts of the system  
  • Build system around the geographic focus  
  • Design and build system to service Integrated and Community Health, Western Sydney PHN and Western Sydney LHD data needs  
  • Develop a system for current level of resources and insert overview plan in the investment portfolio  
  • Secure an ongoing position for Monitoring and Surveillance/Research Coordinator for 2017-2018 by August 2017 |            |
| Blacktown Focus | • Geographic sites selected for concentration of combined efforts in prevention, screening and case conferencing and determined by resources, stakeholder mapping and community feedback  
  • Prepare for initial site to be Blacktown City, followed by Toongabbie, Mt Druitt and possibly Rouse Hill  
  • Undertake evaluation and monitoring prior to expansion into additional areas |            |
| Forums and Events | • Health and Wellbeing for Staff week (29 May – 2 June)  
  • Diabetes and Mental Health, 4 May 2017 6-8pm  
  • Diabetes and Cardiology, July 2017  
  • Blacktown Geographic Focus, July 2017  
  • Diabetes Awareness Week, 10-16 July  
  • Save a Leg (High Risk Foot), October 2017  
  • Community Engagement and Diabetes Awareness, November 2017 |            |
## ORGANISATIONAL ENABLERS

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| **Executive Management Team** | • Meet quarterly to agree and manage resource inputs of WSLHD and WSPHN and to review important management decisions:  
  - Meeting #1 22nd February 9-10am  
  - Meeting #2 24th May 1-2pm  
  - Meeting #3 30th August 1-2pm  
  - Meeting #4 29th November 1-2pm |            |
| **Leaders Alliance Meetings** | • Provides leadership, strategic directions and structure:  
  - Meeting #1 May 3rd, 1.30 – 3.30pm  
  - Meeting #2 October 25th, 1.30 – 3.30pm |            |
| **Working Groups**            | • Food Working Group to meet to plan and progress chosen initiatives  
  • Physical Activity Working Group to meet to plan and progress chosen initiatives  
  • Urban Planning Workshop  
  • Western Sydney LHD and Western Sydney PHN monthly working group  
  • Communication working group for App  
  • Clinical working group – on projects  
  • Research Monitoring and Surveillance  
  • Community Pharmacy  
  • Community Eye Care |            |
| **Parliamentary support**     | • Parliamentary Support Group and briefing session to be pursued through:  
  - Hon Scott Farlow (Parliamentary Committee)  
  - Ray Williams (Member Castle Hill)  
  - Stuart Ayres (Minister for Western Sydney)  
  - Geoff Lee (Parliamentary Secretary Western Sydney)  
  - Hugh McDermott |            |
| **Location**                  | • Identify additional space for locating larger core team |            |