YEAR-IN-REVIEW 2016

EXECUTIVE SUMMARY

With Western Sydney having been identified as a diabetes ‘hot spot’, the work of the Western Sydney Diabetes initiative has gathered pace over the past 12 months to bring on board partners from across the state. The work we are doing in Western Sydney closely aligns with other initiatives at the local, state and national levels.

A major focus from an Integrated Community Health perspective is on keeping people healthy and keeping people with diabetes well. This would save on future healthcare expenditure. A key piece of work being developed in partnership with PwC is the Investment Portfolio which has identified the benefit/cost ratio for supporting people with diabetes to stay well to be at least 3 to 1 over seven years period and for prevention a similar return over 15 years. Over a lifetime, the prevention benefits could be enormous.

To deliver against our priorities, the core team has grown over the past year to ensure that we are in a stronger position to promote the Investment Portfolio across the region, to stakeholders, government and private sector.

Over the past year, the Western Sydney Diabetes initiative has achieved a number of milestones across its four key delivery areas of:
- Primary Prevention
- Screening linked with lifestyle coaching
- Building the community capacity to better manage diabetes
- Enhancing the hospital and specialist management of diabetes.

This year in review is structured around those four key delivery areas and the governance of the Western Sydney Diabetes initiative.

In closing I thank our executive and partners for the ongoing support over the past 12 months. I also greatly appreciate the input of PwC and our core team’s hard work over the past year. The successes so far can be attributed to the efforts of many.

Glen Maberly
Program Lead, Western Sydney Diabetes

Western Sydney Diabetes website was launched in 2016
www.westernsydneydiabetes.com.au
To build a diabetes self-management app, we have established a communication content group through a new partnership with two groups in Sydney University to help us develop a process of taking our diabetes education into a digital format. This approach will build a capability to ensure our education messages are culturally and linguistically appropriate for our communities. We will partner with an IT developer in 2017 to build the diabetes app. We are working closely with PwC to develop a business case and an investment prospect for attracting future funding for the program.

RAISING OUR PROFILE

The Western Sydney Diabetes website which was launched in 2016 has been a key enabler for the promotion and information portal for our partners and clinicians to share successes. In addition, the Western Sydney Diabetes team has produced a number of publications, held forums, workshops and working groups, as well as presented at external conferences.

Brochures and Papers
- Taking the Heat out of our Diabetes Hotspot: The time is now
- Taking the Heat out of Diabetes Hotspot: WSD Score card
- Beating Diabetes Together Prevention Strategy
- Beating Diabetes Together WSD Prevention Strategic Alliance: Economic case for prevention of type 2 diabetes

Forums, workshops and working groups
- Consumer Forum (90 participants)
- Pharmacy Forum (65 participants)
- Two Western Sydney Diabetes Prevention Strategic Alliance workshops (100 people)
- Smart Data for Decision Making (65 participants)
- Building a Surveillance System (30 participants)
- Food Working Group (4 meetings)
- Physical Activity Working Group (2 meetings)
- Transport and urban build working group (2 meetings)

Education sessions
- Six GP Evening Education Sessions on Diabetes Management (a total of 80 GPs)
- Four Improving Diabetes Management for Practice Nurse Sessions (45 nurses/session)

Presentations
- Royal Australian College of Physicians Annual meeting (100 participants)
- Endocrinology Grand Rounds St Vincent’s Hospital (15 people)
- Endocrinology Grand Rounds Royal North Shore Hospital (15 people)
- Australian Diabetes Society Annual meeting (100 participants)
2. PREVENTION

Only 7.1% of Western Sydney residents (NSW 8.4%) are eating the recommended daily intake of vegetables. Western Sydney has some of the lowest rates of physical activity in NSW. Poor diet and an unhealthy lifestyle are predictors of diabetes. Preventing rising rates of diabetes will only occur through change in the behaviour and lifestyle of the Western Sydney community.

Change is required to enable the residents to purchase affordable fresh food, to have access to safe areas for physical exercise and to reduce the dependency on car travel in favour of active transport.

A multi-sectoral approach is needed to engage decision makers and a united effort required to commit resources to facilitate, educate and motivate the residents to adopt healthier diets and to incorporate physical activity into their daily lives. To generate this community-wide involvement is a major goal of the Western Sydney Diabetes initiative.

The key drivers of obesity, diabetes and chronic disease epidemic are reduced physical activity, unhealthy food consumption and lack of a socially inclusive environment. These are the key elements to be addressed within the prevention program.

For primary prevention most of the interventions are beyond the health sector so partnership with the Department of Premier and Cabinet bringing on board scores of partners is the way forward.

Achievements:
- We now have over 50 partners associated with the Western Sydney Diabetes initiative (see at right).

IN THE SPOTLIGHT

The Western Sydney Diabetes initiative has caught the media imagination. In 2016, Western Sydney Diabetes was profiled on the 7.30 Report on ABC-TV, a Channel 7 regional television report, a front page Sun Herald feature article and radio interviews with 2GB and ABC-702. In addition, there were 10 stories that ran in local Western Sydney newspapers.

The next step will be a public engagement and campaign with a geographic focus. This will focus on securing community buy-in and bring the initiative to a larger scale.
FOCUS ON SALSA – CHANGING BEHAVIOUR IN YOUNG PEOPLE

The SALSA Program, developed in partnership with Rooty Hill High School and Mt Druitt General Practitioners Association, empowers young people to make better dietary choices and to be more physically active. University students train Year 10 students to become effective peer leaders, who in turn educate their younger Year 8 peers. Currently running in 28 western Sydney high schools, the SALSA Program has reached over 10,000 secondary school students since inception.

The SALSA Program’s acknowledged success is in engaging students to make their own healthier lifestyle choices. This is achieved through games and activities in a fun and supportive school setting. An important component of the SALSA Program is the School Action Plan brainstormed by Year 10 Peer Leaders to promote a healthier school environment.
3. SCREENING

The HbA1c case detection within emergency departments at Western Sydney hospitals identifies patients with diabetes and patients with a high-risk of developing diabetes. In addition, Western Sydney Diabetes initiative is supporting the identification of individuals at high risk of developing diabetes within the community by providing training for practice nurses, in collaboration with Diabetes NSW and through the Healthy Workers Initiative.

Those people who are found to be at high risk are encouraged to follow up with their GP and to participate in the Get Healthy telephone coaching. GP training will be ongoing to support the testing of individuals and the provision of a series of options for a variety of local, online and telephone lifestyle modification programs.

Particular emphasis will be placed on high-risk populations through basic risk screening and increasing referrals to the Get Healthy Service, and increasing Bilingual Educator Diabetes Prevention Programs.

We have also been working with larger GP practices in Western Sydney to encourage their practices to screen for patients’ HbA1c at their practices. This is already being undertaken by one of our partners, Kildare Road Medical Centre in Blacktown.

Achievements:
• Earlier in 2016, 6870 people presenting at Blacktown and Mt Druitt emergency departments were tested for HBA1c with the following results. Diabetes is undetected in many patients presenting at Western Sydney emergency departments. Up to 30% of them are at risk of developing Type 2 diabetes within four years. The general population of Western Sydney has higher incidence of diabetes than the average at approximately 15% of the population.
• The HbA1C testing within emergency departments has consolidated numbers and confirmed the high incidence of diabetes and pre-diabetes in Western Sydney patients presenting to emergency departments.

4. ENHANCED MANAGEMENT

Specialised hospitalised services manage the more complex cases of Type 2, Type 1 and gestational diabetes. In Western Sydney, there is an innovative approach involving a more integrated healthcare system. The focus has been on developing a healthcare system that delivers better care to patients in the community supported by improved linkage with hospital-based care when needed. This is supported by building eHealth systems and the capacity of healthcare workers to better manage diabetes. This model of care is consistent with, and an exemplar for, the Agency for Clinical Innovation (ACI) new diabetes model of care.

The case conferencing program has been progressing since early 2014, and has been demonstrated to be both effective at improving clinical outcomes for patients and well accepted by general practitioners who are involved.

Key achievements:
• Case conferencing numbers continue to climb:
  - PATIENTS SEEN: 900
  - GPS REACHED: 145
  - PRACTICES ENGAGED: 47
5. SPECIALISED CONSULTATION

The testing of HbA1c is now an established approach in the emergency department of Western Sydney. It is part of an enhanced diabetes model of care which enables patients with diabetes to be identified when admitted through an emergency department for more appropriate hospital management.

Together with the current in-hospital diabetes service and the Western Sydney Integrated Care demonstrator project, patients with diabetes are being better managed within hospital and in the more comprehensive community-based part of the service.

We are also piloting the management of patients with diabetes with the Mental Health Service and geriatric and rehabilitation services. Endocrinologists and diabetes educators are seeing patients in joint consultation with care teams from these services to build their capacity to manage patients with diabetes.

Achievements:

- Out-patient diabetes clinics are now managing patients more actively with many patients with Type 2 diabetes being discharged back to routine care by their GP.
- The diabetes out-patient clinics have been adapted to be part of the Rapid Access and Stabilisation Service clinics in the Better Health Together Integrated Care Demonstrator Program.
- Western Sydney Diabetes has been working with Western Sydney Local Health District foot clinics on the ‘Save a Leg’ project to develop a 60-second screening tool. This has led to an increase in screening of patients with diabetes, which along with education for the patient about diabetic foot complications, has increased timely referral into hospital podiatry services.
- Western Sydney Diabetes is a partner of the Western Sydney Community Eye Care Project in which diabetic eye disease is one of two conditions (the other glaucoma) being screened for in this pilot project connecting the Blacktown and Westmead eye clinics with general practice and optometrists.
- Continuous glucose monitoring was trialled as a management tool for 50 patients with Type 2 diabetes at the Blacktown Hospital diabetes clinic. This highlighted episodes of hypoglycaemia and enabled the clinic to talk to patients about how their lifestyle, diet and activity affected their blood glucose levels.

KEY AWARD FOR WESTERN SYDNEY DIABETES PROGRAM LEAD

Western Sydney Diabetes program lead, Professor Glen Maberly, was awarded the prestigious 2016 Sir Kempson Maddox Award during a World Diabetes Day event at NSW Parliament House in November 2016.

Professor Glen Maberly, senior staff specialist (endocrinology) at Blacktown and Mount Druitt hospitals, received Diabetes NSW & ACT’s top award in recognition of his contribution to scientific research, education and advocacy in diabetes.

In his role for the Western Sydney Diabetes Prevention Alliance, Professor Maberly works with other health organisations to reduce the diabetes epidemic sweeping western Sydney.

“My long career in diabetes has been fuelled by my passion to make a difference to the lives of people living with the disease,” said Professor Maberly.

Professor Glen Maberly (on left) receiving his award from Diabetes NSW & ACT CEO Sturt Eastwood.
6. RESEARCH

Grant Applications
• NSW Government – Office of Social Investment – PwC, WSD, WSPHN, Telstra Health – $148M over 7 years – unsuccessful
• NHMRC – WSD, University of Wollongong, $704K for 2 years – successful
• EOI TRGS – DDMS: translating screening into action in a multilingual and socioeconomically diverse setting, WSLHD, WSPHN, University of Sydney, Diabetes NSW, University of Wollongong - $680K for 2 years – unsuccessful
• EOI TRGS – Improving health facility food environments: opportunities for action – WSLHD, SLHD, HNELHD, The George Institute, Ministry of Health, $400K for 1.5 years – unsuccessful
• ARC grant – Developing Patient-Orientated, Culturally-Adapted Resources for CALD T2D Health Translation Innovation, WSLHD, WSPHN, University of Sydney, University of Wollongong, Diabetes NSW, $640K for 2 years – in preparation

Posters and Presentations
• ADS presentation 2016 – Glen Maberly: Using an App to Engage and Educate People with Diabetes in Western Sydney

Publications

Awards
• 2016 Sir Kempson Maddox Award, Diabetes NSW & ACT
• 2016 Vice Chancellor’s Award for Outstanding Achievement in Research Partnership – University of Wollongong