



Western Sydney Diabetes Year in Review 2025



Purpose

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This document serves as the Year in Review 2025 for Western Sydney Diabetes (WSD).

It provides a consolidated account of work delivered across the partnership during the year, supporting transparency, shared learning and accountability for system leaders, partners and the WSD team.

WSD is not a single organisation. It is a coalition of partner organisations and individuals, united by a shared vision: *beating diabetes together*. The work described in this Review reflects the collective contribution of clinicians, community partners, managers, researchers, industry supporters and people with lived experience who together shape and deliver WSD's work.

The primary purpose of this *Year in Review* is to document what was delivered during 2025 using existing resources, partnerships and capacity, and to link activity and outcomes to WSD's broader strategic direction.

How this document is organised

The Year in Review is structured to support readers with different interests and responsibilities:

- The Foreword and Summary provide a high-level account of progress, context and priorities, intended primarily for system leaders, policymakers and partners.
- Diabetes: Action Now sets out the scale and urgency of the diabetes challenge in Western Sydney.
- The Framework for Action describes how WSD organises its work across prevention, clinical care and system enablers.
- Our Team outlines the multidisciplinary capability that underpins delivery.
- The remainder of the document reports in detail on activity and progress delivered during 2025, organised under the three WSD action domains and their associated themes.
- Contributions to this work are wide ranging and reflect the distributed nature of the WSD partnership. Where individuals or groups have contributed and are not explicitly named, this is unintentional; readers are encouraged to contact the editorial team so records can be updated and contributions appropriately acknowledged.

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Foreword: Chair's Statement



Jasmin Ellis

General Manager, Integrated
and Community Health
Western Sydney Local Health District

The burden of diabetes in Western Sydney is well known. What is less common is having a practical, functioning platform capable of responding at scale — acting earlier, integrating care across the system, and addressing inequity in a sustained and deliberate way.

This *2025 Year in Review* demonstrates that WSD has reached that point. The work described reflects a program that has moved beyond pilots and isolated initiatives to deliver a coherent, integrated approach spanning prevention, early detection, clinical care, digital enablement and community action across a complex and diverse region.

In 2025, WSD strengthened how diabetes care is delivered across the system. Specialist expertise has been deliberately brought upstream, supporting general practice through shared care, case conferencing and digitally enabled models of care. Prevention initiatives — including Western Sydney Changing Diabetes and the *2kg Challenge* — are now explicitly connected to clinical pathways, ensuring that identification of risk is followed by timely, structured and supported action.

Equity sits at the centre of this work. The program prioritises communities carrying the greatest burden, including culturally and linguistically diverse populations, Aboriginal communities and people experiencing socioeconomic disadvantage. This focus reflects both the realities of Western Sydney and the direction of state and national health reform agendas.

As Chair of the EMT, I see first-hand the value of the partnership and governance model that underpins this work. Co-chaired by WSLHD and the WSPHN, the EMT provides a practical mechanism for alignment, shared accountability and collective problem-solving across health, community, academic and industry partners. Refinements to governance in 2025 have further strengthened readiness for scale and sustainability.

This collective effort was recognised in August, when WSD was named Collaborative Team of the Year at the WSLHD Achievements in Integrated & Community Excellence Quality Awards. This recognition reflects

the depth of collaboration across the partnership and, importantly, the sustained work of the WSD team and partners in translating integrated and community-based care into practice.

This report also makes clear that incremental change will not be sufficient. Rising rates of diabetes, prediabetes and gestational diabetes mean that future burden is already embedded unless action accelerates. The evidence, partnerships and delivery models are now in place. What is required is sustained leadership and coordinated investment across state and Commonwealth systems.

The Director's Summary that follows outlines what was delivered in 2025 and the direction ahead. Taken together, this work marks a transition, from readiness to impact and presents a clear opportunity to translate evidence into system-level change and deliver measurable improvements for the communities of Western Sydney.



WSPHN CEO Andrew Newton, WSLHD ICH General Manager Jasmin Ellis and WSD Director Prof Glen Maberly at the Masterclass Face to Face Day.



Professor Glen Maberly discusses WSD with the First Lady of Zimbabwe Dr Auxillia Mhangagwa during her visit to Blacktown Hospital to explore healthcare partnerships, focusing on maternity, children's care, oncology, and diabetes.



Andrew Newton

Chief Executive Officer
WentWest Limited (Western Sydney
Primary Health Network)

Western Sydney continues to experience one of the highest burdens of diabetes in Australia. The scale of this challenge and its impact on individuals, families, primary care, hospitals and the broader community, remains profound. In this context, Western Sydney Diabetes (WSD) has emerged as a mature, credible and increasingly scalable platform for prevention, early detection and integrated care.

In 2025, WSD, led jointly by WSLHD and the WSPHN, and supported by a broad alliance of community, academic, industry and government partners, moved beyond proof of concept. The focus shifted decisively from demonstrating what is possible to accelerating what works: more systematically, more equitably and at greater scale.

From a primary care perspective, this year marked a strengthening of the interface between general practice, specialist services and community-based prevention. Integrated models of care are no longer isolated initiatives; they are functioning pathways that support general practitioners to identify risk earlier, manage complexity with confidence, and access specialist input in ways that reduce fragmentation and improve continuity for patients.

Key achievements during 2025 include the continued expansion of the *2kg Challenge* as a practical, evidence-based prevention intervention embedded in general practice and community settings; further maturation of integrated diabetes clinics and case conferencing models; and increasing use of digital tools, including continuous glucose monitoring and

shared platforms, to support proactive, person-centred care. Importantly, these efforts have been accompanied by a deliberate focus on equity, prioritising communities with the highest burden, including culturally and linguistically diverse populations and those experiencing socioeconomic disadvantage.

What distinguishes WSD is not any single program, but the way prevention, primary care, hospital services and community action are deliberately aligned. The partnership has demonstrated that when general practice is properly supported with clear pathways, shared care arrangements, data-enabled tools and trusted relationships, integrated care becomes standard practice rather than the exception.

Looking ahead to 2026, the challenge is no longer one of intent or evidence, but of scale and sustainability. The work documented in this *Year in Review* makes clear that incremental change will be insufficient to alter the trajectory of diabetes in Western Sydney. What is now required is coordinated action, aligned funding and sustained leadership across state and Commonwealth systems to match the scale of the problem.

As Co-Chair of the WSD EMT, and on behalf of the WSPHN, I am proud of what this partnership has achieved. Diabetes prevention and management is a whole-of-system responsibility.

Through its stewardship of primary care, commissioning capability and data-enabled quality improvement, WSPHN plays a critical role in supporting practices to deliver accessible, culturally safe and person-centred care.

Working as part of WSD and in close partnership with WSLHD, we are turning evidence into everyday practice and building a system where prevention is practical, detection is timely, and care is coordinated.

Summary: Director's Overview



Professor Glen Maberly

Director, Western Sydney Diabetes

Opening — From Ten Years of Learning to the Opportunity to Act at Scale

Diabetes is now one of the most consequential health challenges shaping Western Sydney. Its impact reaches far beyond clinical care - influencing hospital demand, workforce participation, community wellbeing and long-term system sustainability. While substantial effort has been invested over many years, the overall trajectory has not yet turned. Experience now makes clear that this is not because the problem is poorly understood, nor because effective solutions are absent, but because too few of those solutions are operating at the scale required to change outcomes.

In 2024, WSD marked ten years of sustained system building. That milestone was important not simply as a celebration, but as a moment of clarity - confirming both how much has been learned and what remains unresolved. Over a decade, WSD and its partners have developed and tested integrated, place-based and digitally enabled approaches that are already preventing diabetes, improving care, and reducing progression toward complications. Many of the elements needed to change the trajectory are now known, proven and operating in practice.

What that reflection also revealed is more challenging - and more interesting. Clearly articulating the nature of the problem and demonstrating effective solutions, while essential, is not sufficient on its own to turn the tide. Doing so requires broader engagement: by the public, by communities, and by public, private and civic organisations in the wider community and across the health neighbourhood, alongside all levels of government. Crucially, it also requires a deliberate and sustained commitment from the health system itself to lead, align and enable action at scale.

Over the past year, WSD has been working with this understanding in mind. The focus has shifted from further demonstration to a more fundamental question: how do we take what is already known to work and mobilise it — consistently, coherently and at sufficient scale — to deliver population-level impact?

This is not about starting again, nor about adding new layers of complexity. It is about making better use of what already exists and aligning effort where it can make the greatest difference.

WSD enters this phase with a level of readiness that has been deliberately built over time. Ten years of partnership across general practice, hospitals, community organisations, industry and government have created trust, shared purpose and practical ways of working that are difficult to replicate. The opportunity now is to use this platform more intentionally - engaging beyond the health sector while recognising that health must lead - and to act with the confidence that comes from evidence, experience and maturity.

This Director's Summary should be read alongside the Chairs' Foreword, which sets out the shared leadership intent of WSLHD and WSPHN. Together, they frame this *Year in Review* not as a request, but as an invitation: to consider what becomes possible when proven approaches, committed partners and aligned leadership are brought together with the intent to act decisively.

From Readiness to Action: Turning What We Know into What We Do

With the challenge defined and the capability increasingly clear, the question now is how readiness is translated into action. It is in this context that WSD articulated *Facing the Diabetes Burden - Changing the Trajectory in Western Sydney*. The proposal was widely circulated across government, health system leadership, primary care, academia, industry and community partners, and was strongly endorsed in principle. However, it has not yet progressed to implementation.

That experience reinforces a consistent lesson from the past decade. Evidence, partnerships and goodwill are essential, but they are not sufficient on their own. Structural change requires sustained leadership, aligned funding and coordinated action across



Aruni Ratnayake, Sumathy Ravi, Prof Glen Maberly from WSD, Dr Kerry Chant and Megan Cobcroft from MoH, and Sarah Driscoll (WSD).

organisational and jurisdictional boundaries. Without these conditions, even well-supported and well-evidenced proposals struggle to move from broad agreement to real-world impact.

The proposal distils more than a decade of learning into a focused, scalable pathway from evidence to system change. It concentrates on a small number of interlocking priorities that together describe what must now be done differently if the diabetes trajectory is to change.

It calls for earlier and more systematic action, embedding routine detection of diabetes and prediabetes in general practice and linking this consistently to clear, funded pathways for prevention and care. It seeks to make integrated care standard practice, strengthening the interface between general practice, specialist services and community care through shared care arrangements, case conferencing and digitally enabled specialist support. It treats cardiovascular and renal risk as integral, recognising cardiovascular-renal-metabolic disease as a single, inter-related burden that requires coordinated management rather than fragmented responses.

The proposal also deliberately shifts care upstream, reducing avoidable pressure on hospitals while strengthening general practice capability by bringing specialist expertise closer to patients. It addresses inequity by design, prioritising communities with the highest burden, including culturally and linguistically diverse and socio-economically disadvantaged populations. Finally, it is explicitly concerned with scalability, using Western Sydney as a proof-of-practice site for joint State-Federal investment that can be adapted and replicated elsewhere.

Delivering on these priorities requires deliberate alignment between State and Federal health systems. Each plays a distinct and necessary role, yet neither on its own is currently configured to support integrated diabetes care at scale. State governments are rightly focused on the acute system-hospitals, specialist services and the growing burden and cost of complex disease. The Commonwealth's primary responsibility lies with general practice and community care, with reform efforts aimed at improving quality, sustainability and patient experience. Integrated care sits between these domains. It is not owned by either system, yet it is essential if diabetes is to be prevented earlier, managed more effectively and prevented from progressing to costly complications.

To date, WSD has been able to operate successfully in this space largely through professional goodwill - from specialist services and from general practitioners who see the value of integrated care for their patients. This has allowed WSD to demonstrate what is possible when care is coordinated across settings.

However, goodwill alone cannot support routine delivery of care at scale.

What must now change is the transition from a successful, locally enabled model to one that is structurally supported. This requires explicit investment in integrated care as a core function of the health system, rather than an exceptional activity dependent on individual motivation. Practice-level investment is required so that practice owners and managers can support the time, coordination and follow-through associated with activities such as case conferencing and shared care. In parallel, financial incentives beyond traditional fee-for-service arrangements are needed so that general



(L-R): Panellists Ana Svensson, Hon Blacktown MP Stephen Bali, Jane Assange, Belinda Doig and Jasmin Ellis at the May Leader's Alliance Meeting.

practitioners can participate meaningfully in integrated models without carrying uncompensated workload.

WSD has engaged most readily with highly motivated and well-developed general practices. Yet the greatest burden of diabetes is often concentrated in less well-resourced and less digitally enabled practices, where participation in integrated care is hardest to sustain without structural support. Without targeted investment, the very practices serving communities with the highest need risk being left behind.

The central proposition of *Facing the Diabetes Burden – Changing the Trajectory in Western Sydney* is therefore not that more should be done, but that what is already known to work must now be supported to operate routinely and at scale. The full proposal is available. This Year in Review focuses on the context, rationale and system conditions required to move from broad agreement to implementation, and from readiness to impact.

Leadership, Partnership and System Opportunity

With a clear understanding of what is required, attention now turns to whether the system conditions exist to act. Over the past year, a genuine opportunity has emerged to move from readiness to action. Leadership changes, reform agendas and growing recognition of the limits of fragmented care have aligned in ways that make integrated approaches to diabetes both timely and achievable.

Within WSLHD, leadership under Amanda Larkin has brought a renewed focus on clinical engagement, system coherence and practical reform. Drawing on her involvement in the *Special Commission of Inquiry into Healthcare Funding and Delivery*, this creates a strong foundation for a shared understanding that

diabetes cannot be addressed effectively through isolated interventions, but requires coordinated action across prevention, early detection, general practice, specialist services and community care. The opportunity now is to translate this reform logic into practice - emphasising alignment rather than restructuring and making better use of existing capability to deliver different outcomes.

This direction aligns closely with broader system signals. The findings of the Special Commission of Inquiry highlighted the need for earlier intervention, stronger integration between hospital and community care, clearer accountability for outcomes, and sustained investment in models that reduce avoidable hospital demand. Importantly, the Commission reaffirmed the central role of prevention - long acknowledged as essential, but too often weakly embedded in funding, performance and accountability frameworks. These priorities closely mirror the long-standing focus of WSD.

At a state level, this alignment is reinforced through close engagement with Dr Kerry Chant, Chief Health Officer and Deputy Secretary of NSW Health. Dr Chant has been explicit in strengthening expectations around prevention, including diabetes, within Local Health District performance frameworks. WSD is working closely with Dr Chant and colleagues on this agenda, including refinement of the *2kg Challenge* as a scalable, evidence-informed prevention intervention with potential for broader application across NSW.

Governance-level support has also been visible and tangible. Loretta Di Mento, Chair of the WSLHD Board, together with Board members, has engaged directly with WSD through Leaders Alliance meetings and site visits. This visible engagement reflects Board-level recognition that integrated prevention and care are central to addressing both health outcomes and long-term system sustainability in Western Sydney.

WSD's partnership model positions it well to respond to this moment. Its joint governance with WSPHN provides a practical mechanism for aligning State and Federal priorities at a regional level. Long-standing collaboration across general practice, specialist services, community organisations, industry and academic partners has created a platform capable of translating policy intent into operational delivery.

Over time, WSD has also established credibility as a trusted intermediary - able to work constructively across organisational boundaries, engage clinicians meaningfully, and support implementation in real-world settings. That trust has been built deliberately and is a critical asset at a time when the system is seeking models that can move beyond pilots and deliver sustained impact.

Taken together, these factors point to a convergence of opportunity. The challenge of diabetes in Western Sydney is well understood. Effective approaches have been developed and tested. What is different now is the alignment of leadership, reform priorities and partnership maturity that makes coordinated action feasible. It is this convergence - rather than any single initiative - that underpins the case for moving from readiness to action.

Turning Support into Action

With the foundations in place, attention has turned to whether there is sufficient political readiness to move from agreement to action. Momentum toward change has been building steadily. In 2024, the release of the recommendations of the *Federal Parliamentary Inquiry into Diabetes* coincided with WSD's 10-year anniversary - a moment that brought national attention to both the scale of the diabetes challenge and the limitations of current approaches. That anniversary event, facilitated by journalist Dr Norman Swan, provided an important forum for discussion and reflection, attended by the Hon. Dr Mike Freelander MP, Chair of the Inquiry, and several other political leaders referenced below.

The Inquiry's recommendations align closely and powerfully with the approach WSD has developed over more than a decade. They emphasise prevention, earlier detection, integrated models of care, and stronger alignment between general practice, specialist services and community-based supports. Notably, the Inquiry recommended broader access to continuous glucose monitoring for people with type 2 diabetes - an area long championed by WSD as a practical, patient-centred tool to improve self-management, guide clinical decision-making and reduce downstream complications. It also called for wider adoption of joint Specialist-GP case conferencing as a mechanism to improve care coordination and support general practice in managing complex disease.

These directions also echo the reform logic set out by the *NSW Special Commission of Inquiry into Healthcare Funding and Delivery*, reinforcing the need to intervene earlier, work more seamlessly across hospital and community settings, sharpen accountability for outcomes, and invest in approaches that reduce avoidable pressure on acute services. Taken together, the Parliamentary Inquiry and the Special Commission present a consistent and reinforcing reform narrative: diabetes and other complex chronic conditions will not be effectively addressed without integrated care models that span traditional system boundaries.

Throughout 2025, WSD has continued to engage extensively with political leaders at local, state and federal levels to build on this alignment and deepen shared understanding of both the urgency of the challenge and the opportunity to act. At the federal level, this has included correspondence with the Hon. Mark Butler MP (Federal Minister for Health and Aged Care; Member for Hindmarsh), and discussions with the Hon. Dr Mike Freelander MP (Member for Macarthur), the Hon. Ed Husic MP (Member for Chifley), the Hon. Chris Bowen MP (Minister for Climate Change and Energy; Member for McMahan), and the Hon. Andrew Charlton MP (Member for Parramatta). At the state level, engagement has included the Hon. Stephen Bali MP (Member for Blacktown) and the Hon. Dr Hugh McDermott MP (Member for Prospect).

In 2025, with the support of the Hon. Stephen Bali MP, WSD was invited to NSW Parliament to engage directly with Members representing Greater Western Sydney. These discussions reinforced a consistent message across electorates and jurisdictions: the burden of diabetes is growing, its consequences are increasingly visible, and incremental change will be insufficient to alter the trajectory.

WSD has remained in close dialogue with Dr Freelander as the proposal *Facing the Diabetes Burden - Changing the Trajectory in Western Sydney* has been developed. That ongoing engagement has been constructive and has helped connect regional, place-based experience with national policy reform.

In parallel, Diabetes Australia has been a core partner in this advocacy. WSD welcomes its increasing emphasis on prevention and looks forward to continued engagement with Justine Cain, Chief Executive Officer, including the national policy and advocacy meeting in Canberra in March 2026.

Looking ahead, the focus now shifts from alignment in principle to coordinated action. The intent is to bring together political leaders, national advocacy and regional system partners in Canberra in 2026 - linking the Inquiry recommendations and the NSW Special

Commission reform agenda with practical, tested models from Western Sydney.

With sustained political leadership and coordinated State-Federal support, Western Sydney can serve as a beacon -demonstrating how evidence, partnership and system reform can be brought together to change the diabetes trajectory at scale.

The Framework for Action: How to Read This Review

With the case for action established, the remainder of this *Year in Review* is organised around the WSD Framework for Action. The Framework provides a concise way of understanding how WSD's work fits together and a practical guide for navigating the sections that follow.

The Framework is deliberately stable. It reflects a shared understanding of what is required to address diabetes effectively at a population level. What changes from year to year is not the structure, but how the Framework is activated in practice -the mix, maturity and scale of activity shaped by learning, evidence, partnerships and available resources.

For senior readers, the Framework is intended as a navigation aid rather than a detailed account. It brings prevention, clinical care and system capability into a single, coherent structure, allowing readers to orient quickly and move directly to the area's most relevant to their interests or responsibilities.

The Framework is organised around three interconnected domains that together form a continuum: Early Prevention and Risk Reduction; Clinical Prevention and Integrated Management; and Enablers. These domains move from upstream prevention, through integrated clinical care, to the system capabilities required to sustain impact at scale.

The sections that follow report in detail on work undertaken across each domain. Within each, the narrative describes how the work has matured, what was achieved during 2025, and where it is leading - whether through planned expansion where resources allow, or through consolidation and learning where constraints remain.

In this Director's Summary, we do not attempt to reproduce that detail. Instead, we present a small number of illustrative examples from each domain to signal the direction of travel and show how the Framework is translating into action. These examples are intentionally selective, designed to orient the reader and provide clear entry points into the more detailed sections of the report.

Readers will notice variation in tone and emphasis across sections. This is intentional. Sections are

authored by different managers and clinical leads, reflecting WSD's deliberately distributed leadership model and the diversity of work and perspectives across the partnership.

Together, the sections that follow demonstrate that the Framework is not an abstract construct, but a practical roadmap guiding an increasingly mature, integrated and scalable system response to diabetes in Western Sydney. The pages that follow illustrate how this roadmap is being applied in practice, beginning with prevention.

Early Prevention and Risk Reduction

WSD's prevention approach is grounded in a clear understanding of where diabetes risk emerges and how it can be modified early and effectively. In Western Sydney -a region characterised by cultural diversity, socioeconomic disadvantage and disproportionate disease burden -prevention must be place-based, culturally grounded and embedded in everyday life, rather than delivered through generic, top-down programs.

Accordingly, WSD's prevention work is built around community-led action, with the health system acting as an enabler rather than the driver. During 2025, WSD strengthened partnerships with communities experiencing the highest burden of diabetes and the greatest barriers to care. Across Aboriginal communities and culturally and linguistically diverse populations, a consistent insight has emerged: communities are not passive recipients of prevention initiatives, but active agents of change. WSD supports this leadership by contributing clinical credibility, data, education and practical tools to locally driven action. Established platforms include Aboriginal-led prevention initiatives, Healthy Living Toongabbie, and culturally specific partnerships with Filipino, Chinese (Mandarin-speaking), Arabic-speaking and Pacific Islander communities.

Within this community prevention effort, early detection functions as a critical system lever. Recorded prevalence underestimates true burden, and more systematic HbA1c testing reveals a substantial pool of undiagnosed diabetes and prediabetes - creating a time-limited window for prevention and early intervention. WSD has therefore focused on normalising HbA1c testing within routine general practice and deliberately linking detection to action. Through Western Sydney Changing Diabetes, people identified at risk are connected directly to practical, scalable supports such as the *2kg Challenge*, ensuring identification leads to timely intervention rather than reassurance alone.

Together, these elements describe a coherent prevention model that combines community-led

action, systematic detection and clear pathways to support, explicitly designed to address inequity and reduce future disease burden. The programs, outcomes and learning from this work in 2025 are described in detail in the Early Prevention and Risk Reduction section that follows.

Clinical Prevention and Integrated Management

WSD's clinical strategy starts from a simple but consequential premise: diabetes is rarely a standalone condition. For most people, it sits within a tightly interlinked cardiovascular-renal-metabolic (CVRM) burden, and fragmented models of care miss opportunities to intervene earlier, reduce risk more effectively and prevent avoidable complications.

In response, WSD has focused on embedding integrated, person-centred care into routine practice rather than creating parallel services. During 2025, this included strengthening shared-care models that deliberately bring specialist expertise upstream into general practice and community settings. The emphasis is on earlier identification of CVRM risk, routine kidney health assessment, coordinated multidisciplinary management and the use of digital decision support to guide timely, evidence-based care. These models are intentionally practical and GP-led, designed for real-world delivery and for communities carrying the greatest burden of disease.

Education and workforce capability are essential to making this integration work at scale. WSD uses education as a system lever, supporting the extended multidisciplinary workforce to implement contemporary, integrated models of care consistently. Through the maturing Masterclass Series, embedded case conferencing, digital education resources and point-of-care guidance, clinicians are supported to translate evidence into everyday practice across diverse settings.

Together, these elements describe a clinical prevention and management model that strengthens routine care, improves outcomes and reduces downstream system pressure. The evidence, partnerships and learning from this work in 2025 – and priorities for further strengthening – are described in detail in the Clinical Prevention and Integrated Management section that follows.

Enablers

WSD's ability to operate at scale and sustain impact depends on a small number of enabling functions that are deliberately embedded within routine delivery rather than treated as add-ons. Monitoring, evaluation and research are used as practical tools to support



Professors Stephen Twigg, Louise Baur and Glen Maberly at DOAG forum.

learning, accountability and strategic decision-making as the model matures.

During 2025, WSD strengthened its approach to monitoring and evaluation to ensure activity moves beyond pilots toward durable system change. Evaluation is embedded across programs to understand reach, effectiveness and equity, and to inform refinement and prioritisation in real time. This includes aligning measures with the Framework for Action and focusing on questions that matter most to scale, impact and value.

Research complements this evaluative function by generating applied, practice-based evidence in real-world settings. WSD's research agenda is closely aligned with service priorities, supporting translational studies in prevention, early detection, integrated cardiovascular-renal-metabolic (CVRM) care and digital enablement. A deliberate emphasis is placed on disseminating findings through the peer-reviewed literature and other knowledge-sharing platforms, recognising that publication is essential to enable replication, adaptation and scale beyond Western Sydney. In 2025, research partnerships and capability were further strengthened to ensure learning flows directly into practice, policy and future system design.

Together, these enabling functions ensure that WSD's work is adaptive, evidence-informed and positioned for scale. The methods, findings and learning from monitoring, evaluation and research in 2025 - and how these inform future directions - are described in detail in the Enablers section that follows.

This Year in Review shows a system moving with greater coherence, confidence and intent - translating shared purpose into practical action, and steadily shifting the diabetes trajectory across Western Sydney.

Diabetes: Action Now

**Dr Gideon Meyerowitz-Katz, MPH PhD,
Epidemiologist**

The prevalence and impact of diabetes in Western Sydney is stark and confronting. The most recent population data for WSLHD indicate that 13.1% of adults have diabetes in the region (1).

However, this is an acknowledged underestimate due to widespread underdiagnosis, and the true number could be up to 50% higher (2). If accurate, this would mean that close to one in five adults in Western Sydney are living with diabetes.

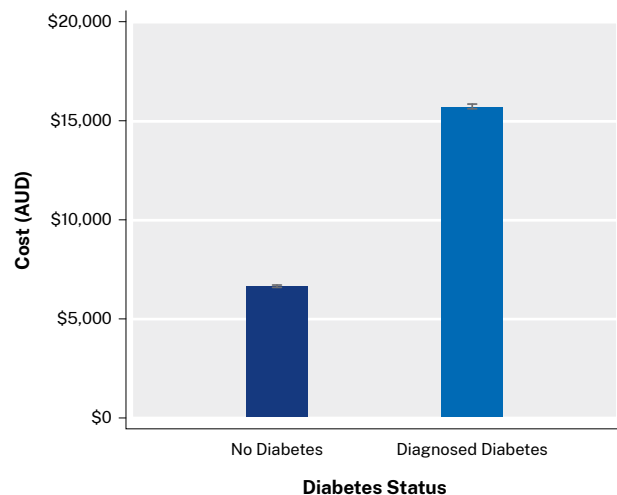
Despite this evidence, many organisations continue to rely on National Diabetes Services Scheme (NDSS) sign-ups to estimate the number of people living with diabetes. Using the most recent year of data, NDSS registration suggests a diabetes prevalence of only 7.2% of the WSLHD population -dramatically lower than the true burden of disease (3).

The problem with NDSS estimates is that they rely on people intentionally registering with the scheme. Many people with diabetes, particularly those with type 2 diabetes, do not register because they do not use NDSS services, are unaware they should register, or do not perceive an immediate benefit. As a result, NDSS data have been shown to underestimate true diabetes prevalence by as much as 80%. Using NDSS data to plan services or assess burden therefore creates a fundamental mismatch between resources allocated and the actual level of need in the community.

WSD has demonstrated, through direct testing in community and clinical settings, that diabetes prevalence in Western Sydney is far higher than NDSS estimates suggest. Community-based HbA1c testing shows that 18% of adults attending Blacktown and Mount Druitt hospital EDs, local general practices, or community venues such as the Workers Blacktown have HbA1c levels consistent with diabetes, with a further 30% in the pre-diabetes range (4,5). This approach reveals a substantial hidden burden of disease that registry-based estimates consistently miss. The 13.1% figure from NSW Health's large population telephone survey further confirms that diabetes prevalence in Western Sydney substantially exceeds NDSS-based estimates.

Diabetes is also a far larger and more complex problem than is commonly understood. While it is often asymptomatic at diagnosis, diabetes confers lifelong increases in the risk of serious and costly complications. Diabetes approximately doubles the risk of heart attack, stroke, heart failure, kidney failure, lower-limb amputation, blindness, dementia and some cancers. Hospitalisation costs for people with diabetes are estimated to be 2.1 times higher than for people without diabetes (6; see Figure 1).

Figure 1: Age- and sex-corrected cost of a hospital admission in WSLHD by diabetes status (n = 1,475,956 admissions)



The economic burden is correspondingly immense. Type 2 diabetes costs an estimated \$18,000 per person per year when direct healthcare and broader social costs are combined. In the WSLHD catchment alone, this equates to approximately \$1.8 billion per year. Ongoing weight gain in adults, alongside powerful social and cultural determinants of disease, further compounds this burden.

Diabetes has never been a larger challenge than it is today. National and state-level data show deeply concerning increases in diabetes prevalence across Australia and NSW, with more severe consequences to come as the epidemic progresses. Without intervention, diabetes will continue to place escalating pressure on health services across Western Sydney and NSW.

Hospitalisation costs for people with diabetes are estimated to be

2.1 times higher than for people without diabetes

In this section, we examine the scale and nature of the diabetes epidemic in Western Sydney. We summarise the challenge faced by people living within the WSLHD catchment, review evidence that the epidemic is continuing to grow, and describe how this burden is already affecting the population and health system.

The Future Burden: A Crisis Already Locked In

Perhaps the most alarming aspect of Western Sydney's diabetes epidemic is not only what is visible today, but what is already locked in for the coming decade. Two indicators in particular - pre-diabetes and gestational diabetes - demonstrate that a substantial future surge in diabetes cases is already embedded in the population's health trajectory.

Prediabetes: Tomorrow's Diabetes Today

Rates of pre-diabetes provide a direct and highly informative insight into what diabetes prevalence will look like over the next decade. HbA1c testing undertaken in the Emergency Departments (ED) of Blacktown and Mount Druitt hospitals shows that 36% of people undergoing blood tests have results consistent with pre-diabetes. This represents hundreds of thousands of people in Western Sydney who are already on a trajectory toward type 2 diabetes.

Importantly, pre-diabetes should no longer be viewed solely as a "pre-disease" state. A growing body of evidence demonstrates that people with pre-diabetes already experience significantly increased risks of cardiovascular disease, chronic kidney disease and microvascular complications compared with people with normoglycaemia. Large meta-analyses show higher rates of myocardial infarction, stroke, heart failure and all-cause mortality among individuals with pre-diabetes, as well as increased risk of chronic kidney disease and early renal impairment (9,10). In this context, pre-diabetes is more appropriately

understood as early-stage metabolic disease rather than a benign risk marker.

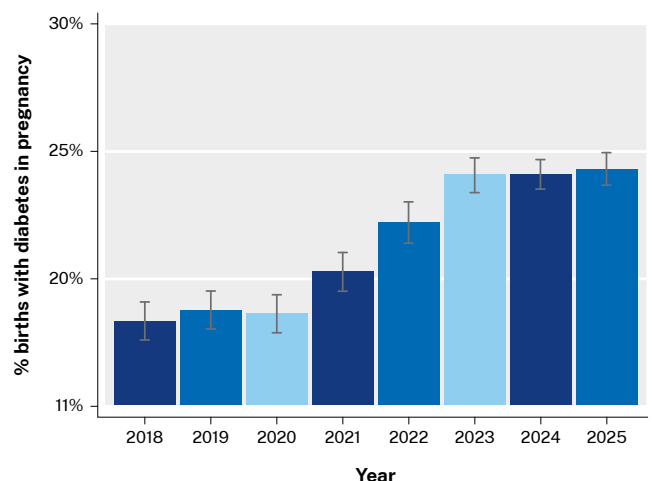
Longitudinal research further demonstrates that a substantial proportion of people with pre-diabetes will progress to diabetes over time. While recorded pre-diabetes rates dipped briefly during the COVID-19 pandemic as people avoided hospital settings, rates have rebounded strongly in 2024 and 2025. The fact that more than one in three adults tested in ED has blood glucose levels in the pre-diabetes range virtually guarantees a significant rise in diabetes incidence over the coming years. Without substantial intervention, this represents a locked-in increase of potentially tens of thousands of new diabetes cases in Western Sydney alone by 2030.

Gestational Diabetes: The Coming Wave

Even more concerning is the rapid and sustained increase in gestational diabetes across Western Sydney. Gestational diabetes is a powerful predictor of future type 2 diabetes. Women who experience gestational diabetes have nearly a 20-fold increased risk of developing type 2 diabetes, and long-term follow-up studies show that approximately one in four will develop diabetes within 15 years.

Gestational diabetes has been a longstanding issue in Western Sydney, but recent trends are particularly alarming. In 2025, approximately one in four women giving birth in Western Sydney hospitals - including Westmead, Auburn, Blacktown and Mount Druitt - had diabetes in pregnancy, the majority of which was gestational diabetes (see Figure 2). This represents not only a current clinical challenge, but a demographic time bomb.

Figure 2: Age-corrected proportion of births with maternal diabetes in WSLHD by year since 2018 (n = 102,796 births)



Approximately

11%

of all hospitalisations in Australia are associated with diabetes

Each year, thousands of young women in Western Sydney develop gestational diabetes. Over the next decade and a half, many of these women will transition to type 2 diabetes, often in their 30s, 40s and 50s. This implies decades of ongoing disease management, complication risk and health service utilisation. The human and economic costs of this locked-in burden are substantial.

While some of the observed increase reflects changes in diagnostic criteria, WSD data demonstrate a clear underlying rise in true disease prevalence, even when accounting for these changes.

The Inevitable Surge

Taken together -the 37% prevalence of pre-diabetes among adults tested and the 25% prevalence of diabetes in pregnancy – these indicators point to an unavoidable and substantial increase in diabetes prevalence over the next decade. This is not a hypothetical scenario or a worst-case projection. The individuals who will develop diabetes in 2030, 2032 and 2035 are already living in Western Sydney, many with established metabolic dysfunction.

This creates an urgent imperative for action. While this future burden cannot be eliminated entirely, its impact can be substantially reduced through targeted prevention programs, early intervention for people with pre-diabetes, and sustained follow-up for women with gestational diabetes. The choice is not whether the surge will occur, but whether the system will be prepared or overwhelmed.

Diabetes in Australia and Western Sydney

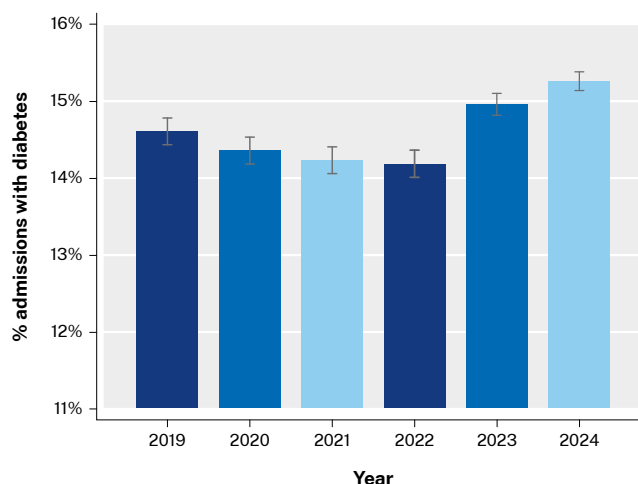
Diabetes has transitioned from a relatively uncommon condition in the early 1990s to one that now affects more than one in ten Australian adults. Prevalence

has risen sharply over the past three decades and is projected to continue increasing.

The impact on hospital systems has intensified accordingly. Current Australian Institute for Health and Welfare (AIHW) estimates indicate that approximately 11% of all hospitalisations in Australia are associated with diabetes, equating to around 1.2 million admissions annually. This figure is likely an underestimate due to underdiagnosis. Rising diabetes prevalence closely tracks increasing obesity rates, with AIHW data indicating that more than 30% of Australian adults are now obese.

In Western Sydney, diabetes-related complications -including lower-limb amputation, retinopathy, cardiovascular disease and chronic kidney disease -have continued to increase over the past decade. Within WSLHD hospitals, both the proportion and absolute number of admissions involving diabetes and chronic kidney disease have risen steadily since 2016, representing hundreds of additional admissions each year (see Figure 3). Similar trends are observed for cardiovascular, eye and vascular disease.

Figure 3: Proportion of hospital admissions with diagnosed diabetes in WSLHD by year since 2019 (n = 1,144,926)



Based on triangulation of multiple data sources, including Emergency Department and general practice HbA1c testing encompassing more than 500,000 patient records, WSD estimates diabetes prevalence in Western Sydney (a population of about 1 million) to be approximately 13%, with a further 38% of adults at high risk.

Diabetes classification	% of adults	Estimated number of people
Type 2 diabetes	13%	99,125
High risk of diabetes	38%	290,000
Low risk of diabetes	49%	373,625

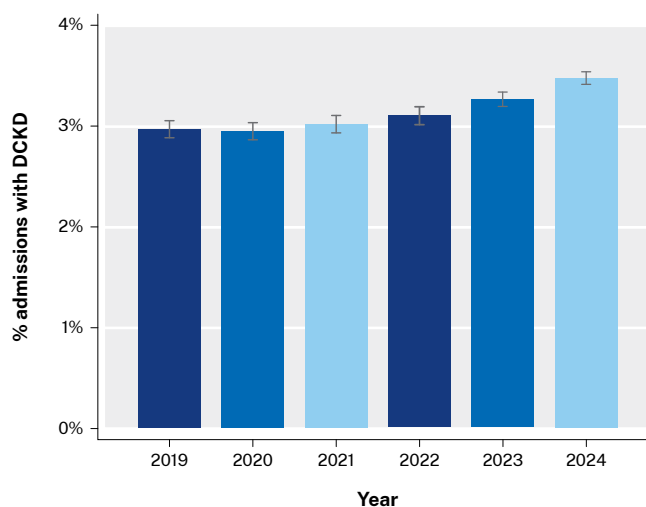
Recent statewide data published in *Diabetes: A Case for Change* confirm that diabetes prevalence in NSW has risen to approximately 12%, with rates in Western Sydney exceeding this average.

Hospital Testing: A Troubling Trajectory

Since 2016, a HbA1c testing program has run in the EDs of Blacktown and Mount Druitt hospitals. Under this program, all patients who have blood taken in the ED also have an HbA1c test performed, providing a indicator of diabetes prevalence and severity.

Prior to the COVID-19 pandemic, the proportion of patients with HbA1c levels consistent with diabetes increased by approximately 0.5% per year. During the pandemic, attendance by people with diabetes declined as patients were advised to avoid hospital settings. Since 2023, this trend has reversed. By 2024–2025, 20% of people tested through this program had HbA1c levels consistent with diabetes -precisely in line with pre-pandemic projections (see Figure 4).

Figure 4: Proportion of hospital admissions with diabetic chronic kidney disease (DCKD) in WSLHD by year since 2019 (n = 1,144,926)



The Crisis of Severe Dysglycaemia

Of particular concern is the sustained rise in severe hyperglycaemia. While rates of HbA1c $\geq 6.5\%$ initially fell during the pandemic and then rebounded, the proportion of people with HbA1c $\geq 9\%$ has increased every year since 2020 after previously declining.

If current trends continue, more than one in ten Emergency Department presentations in WSLHD hospitals could involve severely dysregulated diabetes by 2030. This increase has been linear for more than five years, indicating a sustained deterioration in glycaemic control across the population.

The implications for hospital services are profound. Without effective prevention and early intervention, EDs risk becoming overwhelmed by people with advanced, poorly controlled diabetes and preventable complications.

Diabetes Equity: A Disease of Disadvantage

Diabetes is fundamentally an inequitable disease, disproportionately affecting people experiencing social and economic disadvantage (7), and these inequities are especially pronounced in Western Sydney. In Western Sydney, this inequity is particularly pronounced.

Aboriginal communities

People who identify as Aboriginal are approximately 50% more likely to be diagnosed with diabetes than non-Aboriginal people, despite having a younger age profile overall. Among people admitted to WSLHD hospitals, nearly 20% of Aboriginal patients have diagnosed diabetes, compared with approximately 14% of non-Aboriginal patients. These disparities reflect the cumulative effects of social determinants of health, access barriers and systemic disadvantage.

Pacific Islander Communities

Inequities are also evident among Pacific Islander communities. Even after diagnosis, people from Pacific Island backgrounds have a 40% higher risk of developing diabetic retinopathy compared with people born in Australia or Western Europe. This highlights not only increased diabetes prevalence, but a greater burden of complications and challenges in long-term management.

Cultural and Migration Patterns

Country of birth is a strong predictor of diabetes risk. People born in India, China, Africa, South-East Asia and the Middle East experience higher rates of diabetes than those born in Australia, Europe or North America. While routinely collected data limit more granular analysis, available evidence suggests that elevated risk often persists into second and third generations.

Socioeconomic Disadvantage

Socioeconomic status strongly influences diabetes risk and outcomes. WSD data show that people living in lower-income areas are far more likely to have diabetes and to be hospitalised with complications. Individuals from the highest socioeconomic strata in WSLHD are approximately half as likely to

be hospitalised with diabetes as those in the lowest strata.

Addressing these social determinants is an essential — if challenging — component of any effective response to the diabetes epidemic.

NSW's Future Health and System Impact

NSW Health projections indicate that overall healthcare demand will almost double over the next decade, driven largely by chronic disease. Diabetes alone is projected to cost at least \$22 billion in direct healthcare expenditure between 2022 and 2030 (8).

NSW has identified specialist outreach and integration with primary care as foundational strategies to manage this demand, based on evidence of improved outcomes and system efficiency.

Preventing the Surge

Diabetes is often described as a silent pandemic, but its consequences are increasingly visible across Western Sydney. Data on pre-diabetes and gestational diabetes make clear that Western Sydney is facing a guaranteed increase in diabetes-related hospital presentations over the coming decade.

While the future burden is substantial, much of it is preventable. The majority of type 2 diabetes can

Diabetes alone is projected to cost at least

\$22 billion

in direct healthcare expenditure between 2022 and 2030 (8).

be prevented or delayed through effective lifestyle intervention and appropriate pharmacotherapy. WSD has demonstrated the effectiveness of these approaches over many years but has been unable to deliver them at the scale required to meet population need.

Without action, the coming surge will overwhelm health services. With timely investment and scaled implementation, it is possible to alter the trajectory. Every individual with pre-diabetes who avoids progression to diabetes, and every woman with gestational diabetes who maintains healthy glucose levels after pregnancy, represents decades of avoided complications, hospitalisations and suffering.

The surge is inevitable without action, but it is not unstoppable. The time to act is now.

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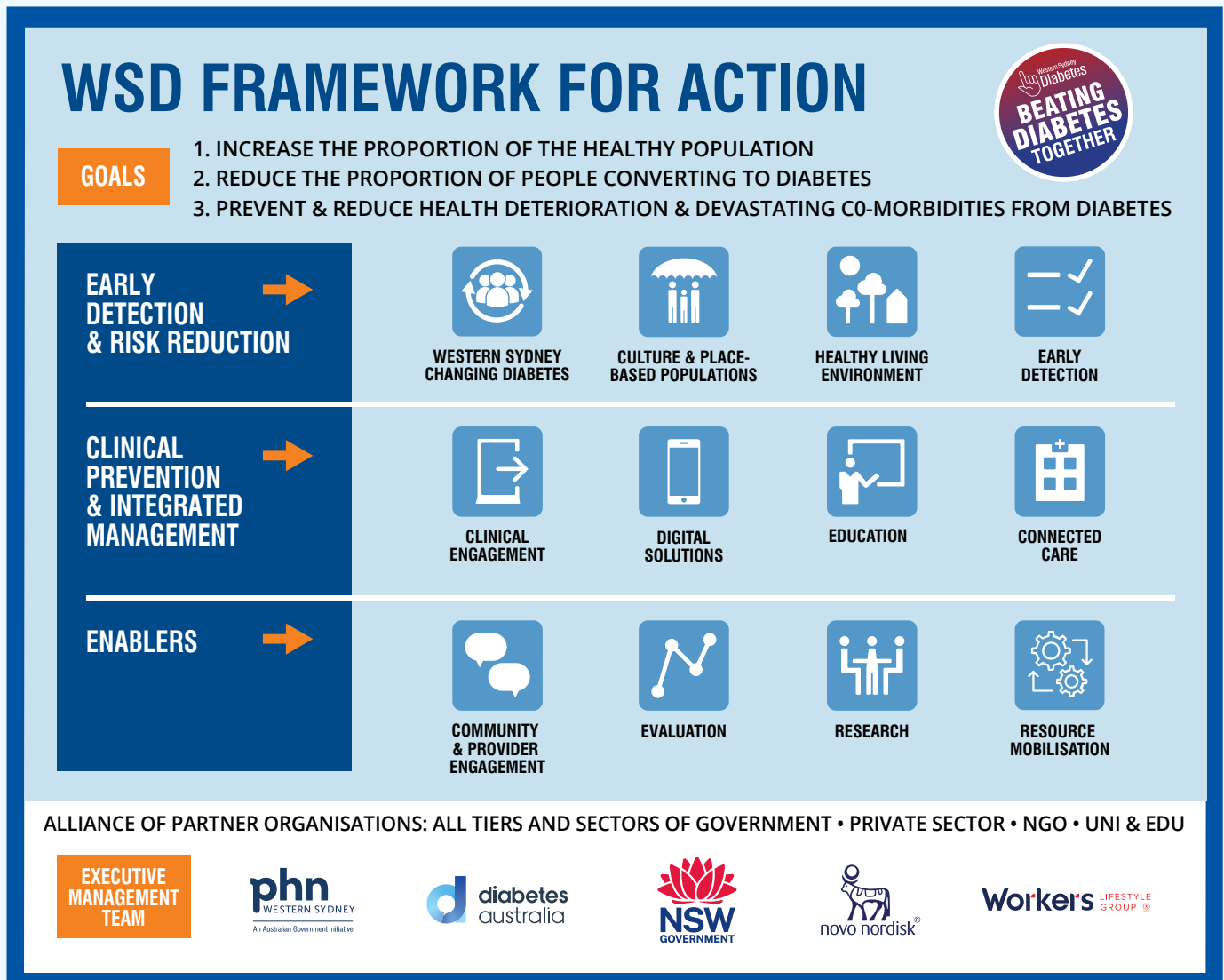
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WSD Framework for Action

Established in 2014 within WSLHD, WSD is a mature, system-level program characterised by strong clinical leadership, formal governance and enduring cross-sector partnerships.

WSD operates through a formal EMT, jointly stewarded by WSLHD and the WSPHN, with representation spanning hospital services, general practice, primary care commissioning, community organisations, academia, industry partners and Diabetes Australia.

The *WSD Framework for Action* provides the organising structure for this work. It integrates early prevention and risk reduction, clinical prevention and integrated management, and system enablers into a single,



coherent model that supports planning, delivery, evaluation and reporting across the partnership. While the Framework itself has remained stable over time, the activities delivered within each domain evolve annually in response to population need, learning and available resources.

Primary system stewardship is provided through the joint leadership of WSLHD and WSPHN. Within this partnership, WSPHN plays a critical role in enabling effective primary care delivery at scale, including practice facilitation, commissioning capability, continuous quality improvement infrastructure, assessment of digital readiness, and data-enabled improvement support. These functions are essential to embedding prevention, early detection and integrated diabetes care into routine general practice across Western Sydney, and to strengthening the interface between primary care, specialist services and community-based prevention.

The EMT functions as WSD's formal governance body and was refreshed in 2025 to strengthen accountability, clarify roles and ensure closer alignment between strategy, delivery and partner investment. Through this structure, the EMT provides coordinated clinical, community, academic and system leadership to support consistent implementation of the Framework for Action.

Beyond formal governance, WSD is supported by a broad Leadership Alliance of approximately 140 partner organisations spanning health services, primary care, community organisations, local government, academia, industry and the not-for-profit sector. This Alliance provides reach, capability and shared ownership across the Western Sydney diabetes system, enabling place-based action and sustained collaboration at scale.

Together, the *Framework for Action* and the partnership structures that support it provide a stable platform for coordinated delivery across prevention, care and system reform, while retaining the flexibility required to respond to emerging evidence, policy direction and local priorities.

A small, skilled WSD core team provides day-to-day coordination, working closely with partners to translate the *Framework for Action* into implementation across diverse settings.

Resources to support delivery are primarily contributed by WSLHD and WSPHN, complemented by investment through Western Sydney Changing Diabetes (WSCD) via WLG and Novo Nordisk. Additional support is provided through competitive grant funding from the NSW Ministry of Health and targeted sponsorship from industry partners, including Novo Nordisk, Abbott, Dexcom, Eli Lilly, Sanofi, AstraZeneca and Boehringer Ingelheim.

Structure of the Framework

The *Framework for Action* is designed to reflect the full continuum of diabetes risk and care in Western Sydney – from early risk and prevention, through to clinical care, stabilisation, and the prevention of deterioration and complications. This continuum is supported by a set of cross-cutting enablers that allow the model to operate effectively and at scale.

The Framework is organised into three inter-connected domains. Within each domain, a small number of activity areas describe how the Framework is operationalised and provide a clear guide to the work presented in subsequent sections of this document.

1. Early Prevention and Risk Reduction

Focused on reducing future diabetes risk through population-level and targeted approaches, particularly among communities and individuals at elevated risk.

Key activity areas include:

- Western Sydney Changing Diabetes – a long-standing, place-based initiative focused on prevention, early intervention and community activation through partnerships with local government, community organisations, workplaces and industry.
- Culture- and place-based approaches – tailored prevention strategies co-designed with priority populations, including culturally and linguistically diverse communities, Aboriginal communities and socio-economically disadvantaged groups.
- Healthy living environments – action to shape environments that support healthier choices through advocacy, local policy influence, built-environment initiatives and partnerships that promote physical activity, healthier food environments and reduced sedentary behaviour.
- Early detection – systematic approaches to identifying people at risk of diabetes and pre-diabetes, particularly through hospital EDs, general practice and the community, supported by data, decision support and clear pathways to action.

2. Clinical Prevention and Integrated Management

Focused on improving outcomes for people living with diabetes through integrated, person-centred models of care that embed prevention within routine clinical practice.

Key activity areas include:

- Clinical engagement – collaboration between general practice, specialist services and hospital-based teams to support evidence-based care and timely escalation when required.
- Digital solutions – use of digital health tools to support self-management, remote monitoring, data sharing and care coordination across settings.



The WSD team at the Masterclass Face to Face Day.

- Education – education for people living with diabetes, communities and health professionals, including structured education programs, masterclasses and practice-focused learning.
- Connected care – models that improve coordination across primary, secondary and community care, including shared care arrangements, case conferencing and multidisciplinary approaches. This includes how the WSD clinical team works alongside hospital-based diabetes services and other WSLHD clinical services to support integrated, whole-of-system care.

3. Enablers

Foundational capabilities that support and sustain all domains of work.

Key activity areas include:

- Community and provider engagement – engagement with communities, clinicians and partners to build trust, align priorities and support co-design, supported by coordinated communication, media activity, digital platforms and events.
- Evaluation – evaluation embedded to understand reach, effectiveness and equity, and to inform continuous improvement and decision-making.
- Research – applied, translational research embedded in service delivery to generate evidence, support innovation and inform scale-up.
- Resource mobilisation – securing and aligning resources from health systems, grants and partners to sustain activity and support expansion where impact is demonstrated.

Refinement of Framework Language in 2025

In 2025, WSD refined the language used within the *Framework for Action* to better reflect the scope, intent and maturity of the work now underway. These refinements are semantic rather than structural: the framework itself, its domains and activities are

unchanged, and all sections of this report continue to align with it.

- The domain previously described as Primary Prevention is now referred to as Early Prevention and Risk Reduction, recognising that much of this work occurs in populations already at elevated risk and focuses on early intervention and prevention of progression.
- The domain previously described as Secondary Prevention and Management is now referred to as Clinical Prevention and Integrated Management, reflecting that prevention is embedded throughout clinical care and is focused on optimising management, preventing deterioration and reducing long-term complications.

Together, these refinements clarify that prevention is a core organising principle across the entire framework, from community-based early intervention through to ongoing clinical care and stabilisation.

Adaptive and Dynamic Approach

The *WSD Framework for Action* is reviewed annually to reflect learning, emerging evidence and changes in the operating environment. In 2025, this included clearer articulation of priority domains of work across the three core categories, supporting greater focus, alignment and accountability while retaining the overall Framework structure.

Annual Implementation and Reporting

An annual implementation plan translates the *Framework for Action* into practical activity and guides the allocation of available resources. Progress is monitored throughout the year and reported through the annual Year in Review, providing a transparent account of activity, reach and learning. Supporting materials, including program descriptions, resources and evaluation outputs, are available on the WSD website to complement this report.

About our Team

Sumathy Ravi,
WSD Program Manager

The names and affiliations of individuals contributing to WSD - including EMT members, core team members, partners and collaborators - are listed in full in the Contributors section at the end of this document and on the WSD website. To avoid duplication, individuals are not listed again here.

Executive Management Team (EMT)

The EMT provides strategic leadership and governance for WSD and meets quarterly. The full membership of the EMT, which was refreshed and expanded in 2025, is listed in the Contributors section and on the WSD website.

At the helm of WSD is a senior leadership group anchored by the General Manager of Integrated and Community Health (ICH) at WSLHD and the Chief Executive Officer of WSPHN, who jointly co-chair the EMT. This leadership structure is further supported by the EMT secretariat, comprising the Director and Program Manager of WSD and the Director of Primary Care Transformation and Integration at WSPHN. Together, this group provides strategic direction, operational oversight and system alignment to advance WSD's mission.

WSD Core Team

The WSD Core Team includes staff employed by ICH within WSLHD. Core team members are based across the ICH offices at Blacktown Hospital, Mount Druitt Community Health Centre and Westmead Hospital. Over the past decade, this team has grown to approximately 26 staff, reflecting the expansion and increasing complexity of WSD activity.

Additional core contributions are provided by staff from WSPHN, who support WSD through a range of roles that extend beyond the program itself but make substantive and ongoing contributions to its delivery. Further key contributors come from the WSLHD Centre for Population Health, WLG, and industry partners, particularly Novo Nordisk. While some of these individuals are not formally employed within WSD, their contributions are integral to the program's success and are recognised as part of the broader core team. A comprehensive list of contributors is provided in the Contributors section.

Beyond the core team, WSD's work is supported by a wider faculty, including presenters and facilitators within the WSD Masterclass Series, as well as individuals actively involved in place-based and culturally specific partnerships across Western Sydney.



The WSPHN and WSD teams at a joint planning day chaired by Ian Corless, December 2025.

Throughout 2025, WSD brought together staff and partners through several significant leadership forums and events. Notably, WSLHD and WSPHN staff participated in a full-day joint planning and exchange forum in December 2025. This highly engaging session generated new ideas, strengthened cross-organisational relationships and led to the formation of new working groups, positioning the partnership for an even more productive 2026.

A clear and shared message emerged from this collective planning process: while team members are employed across different organisations within the partnership, they operate as a single, integrated team. Participants consistently articulated that they do not experience themselves as separate entities, but as one WSD team, united by a common purpose and shared accountability. This sense of collective identity — *We Are All WSD* — is a defining strength of the program and underpins its ability to work across organisational boundaries to deliver impact at scale.

Workforce changes in 2025

Welcome to the WSD team



Neha Saini
Research Enrolled Nurse

Neha supports the delivery of research projects by assisting with participant recruitment, data collection, device management, and study related assessments. She also contributes to data quality, participant follow-ups, and coordination with the research team to ensure the protocols are timelines are followed.



Marianne Bannawe
Virtual Care Support Nurse

Marianne is a Registered Nurse and provides support to both virtual and in-person clinics through education and assisting T2DM patients in managing their chronic conditions. She assists technology device application and management, in addition to the research nurse with data collection to assist in monitoring patients.

Workforce changes in 2025

Farewell and acknowledgement

WSD also notes that several key staff transitions occurred in 2025, with active recruitment underway to strengthen capacity into 2026.



Sian Bramwell
Credentialed Diabetes Educator

Sian has been central to strengthening WSD's clinical services, modelling excellence in patient education, multidisciplinary collaboration and compassionate, person-centred care. Her professionalism, commitment to quality and reliability set an exceptional standard for the team.

Beyond her clinical achievements, Sian has been a cornerstone of WSD culture - steadfast, supportive and consistently proactive. Her organisation, clarity and calm have elevated the work of those around her, and her ability to anticipate needs and foster cohesion has had a lasting impact on the service.

As Sian concludes her time with WSD, we acknowledge her remarkable contribution with deep gratitude. Her leadership has strengthened our service, enriched our workplace and positively influenced countless patients and colleagues. We wish her every success and fulfilment in the next chapter.



Nazila Aghaie
Administration Officer

In 2025, we also farewelled Nazila Aghaie from our team as she relocated overseas. Nazila started working with WSD at Westmead hospital in 2019 and supported Dr Cecilia Chi in the setting up of the Westmead diabetes case conferencing clinics. Her input has been valuable especially in the coordination of diabetes case conferences, communications with GP practices and support for the inpatient HbA1c testing program at Westmead hospital.



Kathy Lindsay
Marketing and Communications
Manager, Workers Lifestyle Group

WSD's collaboration with Kathy began during her tenure at WLG, where her strategic insight and collaborative approach were immediately evident. As Program Manager for the *2kg Challenge*, Kathy expertly managed and chaired the 2kg Working Group, playing a pivotal role in shaping the program into its current robust and effective form. WSD and the Working Group thank Kathy for her invaluable contribution and wish her every happiness and good health in her well-earned retirement.



Mark Scott
Public Affairs Manager, Novo Nordisk

WSD would like to thank Mark Scott for his ongoing commitment to diabetes prevention through the Western Sydney Changing Diabetes partnership. As a core member of the *2kg Challenge* Working and Leadership groups, Mark brought real breadth and depth of healthcare experience and inputted strategic and operational insights that helped strengthen our initiatives and our collaboration with Novo Nordisk. WSD greatly appreciates his contribution and dedication to preventing diabetes in our community.



The WSD Team with WSLHD Integrated and Community Health General Manager Jasmin Ellis (left).

Awards and recognition

Integrated & Community Excellence Quality Awards

In August 2025, WSD was honoured with the *Collaborative Team of the Year* award at the WSLHD Achievements in Integrated & Community Excellence Quality Awards. The *2kg Challenge* also received a special mention, recognising the exceptional cross-sector collaboration that underpins its success.



Celebrating Excellence: Sian Bramwell – NSW CDE of the Year 2025

WSD proudly celebrated the achievement of Senior Clinical Nurse Educator Sian Bramwell, who was awarded *Credentialled Diabetes Educator of the Year (NSW)* at the Australian Diabetes Congress. This award recognises her sustained contribution to diabetes care and her leadership within the WSD program.



Tanaja Shipley – Administrative Professional Awards

Congratulations to Tanaja Shipley, Administration Officer, who won the Leadership category of the Administrative Professional Awards for Blacktown and Mount Druitt Hospitals within WSLHD. Tanaja was recognised for exceptional leadership, mentorship and her ability to inspire collaborative, high-performing teams.

Early Prevention & Risk Reduction

Sarah Driscoll,
Prevention Program Manager

Early prevention and risk reduction within WSD is structured through the *WSD Framework for Action* and reflects a deliberate, system wide approach to reducing diabetes risk as early as possible in the disease trajectory.

Rather than focusing narrowly on individual behaviour change, this work integrates population level, community based and primary care strategies to increase the proportion of people who remain metabolically healthy and to slow or prevent progression toward type 2 diabetes.

Within the Framework, early prevention and risk reduction is organised across four complementary streams of activity. Across all four streams, WSPHN plays a critical enabling role by supporting general practice engagement, quality improvement, data systems and commissioning mechanisms that allow prevention initiatives to be embedded and sustained at scale. Together, these streams address the multiple and interacting drivers of diabetes risk in Western Sydney and ensure that prevention efforts are scalable, equitable and embedded within everyday practice.

- Western Sydney Changing Diabetes (WSCD) focuses on practical, evidence informed prevention initiatives that can be delivered at scale through general practice and community settings. Programs such as the *2kg Challenge* translate strong evidence into simple, achievable actions that support people at risk to make early and sustainable changes.
- Culture and place based approaches recognise that prevention is most effective when it is locally relevant and culturally responsive. This stream prioritises engagement with communities experiencing the highest burden of risk, tailoring prevention activities to local context, language and lived experience, and working through trusted community settings and partners.

- Healthy living environments address the broader conditions that shape diabetes risk, including access to healthy food, opportunities for physical activity and supportive community infrastructure. By partnering across sectors, this stream seeks to create environments that make healthier choices easier and more sustainable over time.
- Early detection, embedded within primary prevention, ensures that metabolic risk is identified before progression to established disease. Systematic use of HbA1c testing, opportunistic screening and community based detection strengthens the link between prevention and care, enabling timely intervention and reducing avoidable progression.

While presented as distinct streams for clarity, primary and secondary prevention are not rigid or sequential stages. Instead, they represent a continuum of action across the progression of metabolic risk, with interventions becoming more targeted and clinically intensive as risk increases. Much of WSD's work intentionally sits at this interface — acting early, before diagnostic thresholds are reached, while remaining responsive to emerging clinical complexity.

This framing reflects the lived reality of diabetes progression and supports the core objective of Western Sydney Diabetes: to intervene earlier, more proportionately and more effectively, aligning prevention and care to change the long term trajectory of diabetes across Western Sydney.



WESTERN SYDNEY CHANGING DIABETES

Sarah Driscoll, Prevention Program Manager

Western Sydney Changing Diabetes (WSCD) is a five year public-private-civic partnership (December 2022–December 2027) led by WSD in collaboration with Workers Lifestyle Group (WLG) and Novo Nordisk.

Operating in one of Australia's highest risk regions for type 2 diabetes and obesity, WSCD brings together clubs, community organisations, primary care, hospitals and industry partners to enable earlier, more effective action to reduce diabetes risk across Western Sydney.

Now in its third year, WSCD has transitioned from concept to a recognised, award winning initiative with demonstrated scale and momentum. The partnership has strengthened primary prevention efforts, improved early identification of diabetes risk, and delivered practical, community based approaches to health and wellbeing. This work is underpinned by sustained financial and strategic commitment, with WLG investing \$100,000 per annum in WSCD activities, matched by an equivalent annual investment from Novo Nordisk.

A portfolio model of delivery

WSCD operates as a portfolio of complementary programs rather than a single initiative. Partner investment supports both independent and co designed programs delivered in collaboration with WSD. Within this portfolio, core WSCD programs focus on strengthening early detection of diabetes risk in community and partner settings, alongside the *2kg Challenge*, a structured early intervention pathway aligned with general practice. The PHN's role in enabling practice participation, supporting data-driven quality improvement and aligning programs with existing funding and reporting structures has been central to this portfolio approach.

In 2025, integration strengthened with

116

general practices onboarded

The 2kg Challenge – From Concept to Scale

Purpose and approach

The *2kg Challenge* is WSCD's flagship prevention initiative and a central mechanism for enabling early, locally tailored action across the diabetes risk continuum. The program is free to participants and complements existing state wide prevention services, aligning with NSW Health priorities and national strategies for obesity, chronic disease and preventive health.

Delivered through a place based, community embedded model, the *2kg Challenge* supports adults with prediabetes or at risk of type 2 diabetes, who are above a healthy weight. Its emphasis on modest, achievable early change offers a pragmatic alternative to more intensive long term programs, supporting engagement prior to the onset of established disease.

With an evidence base demonstrating that a weight loss of approximately 2kg is associated with up to a 30% reduction in the risk of developing type 2 diabetes. This framing has proven effective in shifting conversations away from abstract lifestyle advice toward concrete, achievable early action.

Integration with general practice

The *2kg Challenge* is designed to align with general practice workflows, creating a scalable referral pathway from routine care, opportunistic screening and targeted community detection. In 2025, integration strengthened with 116 general practices onboarded, supported through engagement activities and an early



Professor Stephen Twigg and Dr Kerry Chant on the panel at the Leaders Alliance Meeting to discuss the 2kg Challenge.

detection campaign delivered in partnership with primary care and community organisations.

The program has entered its next phase, focusing explicitly on early identification and proactive intervention for people with prediabetes. This includes targeted identification of at risk patients, optimised HbA1c monitoring and increased patient activation through health professional engagement. A Diabetes Prevention Toolkit, launched by the WSPHN on World Diabetes Day, supports GPs in identifying and referring at-risk individuals, embedding prevention into everyday care through consistent guidance, tools and practice-level support.

Program maturity and refinement

In 2024, WSD reported on the establishment and early implementation of the 2kg Challenge, including its rationale, evidence base, digital delivery model and early uptake. During 2025, the program matured significantly, with clearer articulation of purpose, refinement of the participant journey and strengthening of evaluation processes. These



developments have positioned the 2kg Challenge as a system ready, scalable prevention model.

Participant journey and experience

From a participant perspective, the program offers a clear, guided and supportive journey from enrolment through to longer term maintenance. Key features include self referral via community, workplace or clinical pathways, access to a structured eight week digital program delivered through the 2kg Challenge website, and weekly curated content focused on nutrition, physical activity and everyday habits.

Content is practical and strength based, emphasising small, cumulative changes. Recognising the challenge of sustaining behaviour change, the program explicitly supports self monitoring and forward planning beyond the initial eight weeks. Following completion, participants receive ongoing reinforcement through monthly digital newsletters and social media engagement, alongside clear pathways to longer term supports such as the NSW Get Healthy Service.

Reach, engagement and learning

Engagement continued to strengthen throughout 2025, with almost 1000 participants enrolled to date, the majority residing in Western Sydney. New enrolments averaged approximately 10 participants per week. Early feedback highlights reported weight loss, improvements in health markers and increased adoption of healthy eating and active living behaviours.

In 2025, the 2kg Challenge progressed to a system ready prevention model supported by a robust evaluation framework. In collaboration with the NSW Ministry of Health Centre for Population Health, program logic and evaluation processes were refined, with data collection and reporting systems established to inform continuous improvement, demonstrate impact and guide future scale up.



This work has been undertaken in close collaboration with WSPHN, reflecting its role in supporting evaluation, data quality and system readiness across primary care.

Equity and cultural adaptation

Equity and cultural relevance remain central to program design and delivery. During 2025, priority work included co design of a Pasifika adaptation of the *2kg Challenge* in partnership with the Pasifika Preventing Diabetes Programme, scheduled for launch in early 2026. Development of South Asian adaptations is also underway, with plans to expand to other priority populations. All adaptations maintain fidelity to the core evidence base while improving relevance and accessibility.

Community based early detection and activity

WSCD also supports complementary community based prevention and early detection activities. SiSU Health Stations at Workers Blacktown provide free, self administered health checks, including blood pressure, BMI and diabetes risk assessment. By the end of 2025, more than 11,000 health checks had been completed, over 3000 checks generated a recommendation to see a GP, and more than 9000 individuals had used the stations. Risk profiles remained above national averages, reinforcing the need for sustained prevention efforts.

WSCD further supports accessible physical activity programs at Workers Blacktown, including line dancing (twice weekly classes averaging 170 participants) and Tai Chi (approximately 50 participants weekly), promoting movement, balance and wellbeing in inclusive community settings.

Partnerships, engagement and leadership

WSCD initiatives form a coordinated framework that combines partner led programs with joint initiatives delivered alongside WSD. Key partners include WLG, Novo Nordisk, Diabetes Australia, the University of Newcastle (No Money No Time), SiSU Health Group, Box Divvy, Live Life Get Active, local councils, and partners across WSLHD and WSPHN. WSPHN plays a distinct system leadership role within this partnership, bridging community-based prevention, general practice and hospital services to support coordinated action at scale.

Leadership Alliance engagement remains central to the model. A forum facilitated by Adjunct Professor Dr Jim Taggart OAM in May featured speakers including Dr Kerry Chant, NSW Chief Health Officer and Deputy Secretary, and Professor Stephen Twigg, Head of the Central Clinical School at the University of Sydney.

Interactive discussions enabled partners to explore strategies for broader implementation of the *2kg Challenge* and reinforced collective commitment to scaling prevention.

WLG made a particularly significant in kind contribution by providing access to the Workers Blacktown Club's Grand Ballroom for WSCD and WSD events throughout the year. The availability of a centrally located, fully supported venue was critical to sustaining partner engagement and enabling regular collaboration and planning.

Community engagement and public awareness

Throughout 2025, WSCD delivered sustained community engagement and public awareness activities, including coordinated promotion of World Diabetes Day and National Diabetes Week through local media, health system communications and social media. WSCD also maintained a strong presence at major community events, including the Westpoint Wellness Expo and the Mount Druiitt Community Health Centre 50th Anniversary, supporting ongoing visibility, awareness and engagement across Western Sydney.

Clinicians and community unite to fight diabetes

WESTERN Sydney Diabetes (WSD) launched its health preventative campaign, the *2kg Challenge*, to staff in Western Sydney Local Health District's teams. Losing just 2kg can lower your risk of type 2 diabetes by up to 30%.

More than 120 leaders and partner organisations were brought together by Western Sydney Diabetes to the bi-annual Leaders Alliance forum held at Workers Blacktown on May 22. The event highlighted the strong commitment to advancing health and preventing diabetes across Western Sydney.

The *2kg Challenge* is an 8-week weight loss program where participants are supported to lose 2kg with coaching programs, simple ways to move more and tools to help you stay on track.

General Manager of Integrated Community Health (ICH) Joanne Ellis used the event as a springboard to encourage ICH directors and staff to lead the campaign across WSLHD and sign up.

“We’re going to get on board, prevention starts with us,” Ms Ellis said.

“We need a healthy workplace, we are part of the community, we need to better model what we’re talking about, and we need stronger evidence across the community. It can absolutely start with us,” Ms Ellis said.

Chief Health Officer and Deputy Secretary for NSW Health, Dr Kerry Chant was one of the esteemed leaders, along with Prof Stephen Twigg, Head of Central Clinical School, University of Sydney who discussed the burden of diabetes and the importance of grassroots prevention initiatives.

“It doesn’t matter where you live, diabetes is a real stressor... and it resonates across all the districts,” Dr Chant said.

“It’s a real driver for renal transplantation, contributing significantly to cardiology, strokes, heart disease, dementia... it’s endemic.”

“There’s a recognition that if we want to improve the health of our communities, we as our acute system have to step up and embed some of this prevention in it. Therefore, we have to make it.” Dr Chant said.

“So my challenge to you would be for our clinicians to value embedding these kinds of prevention initiatives, as you would a new cancer lab.”

A panel was held to discuss practical ways of expanding the program’s reach including Stephen Hall MP, Jane Assange (Workforce – Western Sydney PHN), Belinda Dugg (Cumberland Council), and Ann Symonson (Novo Nordisk Oceania).

“The *2kg Challenge* isn’t just a campaign, it really is a part of a system shift towards preventative health,” Ms Ellis said.

“By doing the *2kg Challenge*, we’re really assessing that special commission inquiry into health care funding that really pushes the mood from reactive to preventative health.”

The *2kg Challenge* is a collaboration of Western Sydney Changing Diabetes, a partnership between WSD, Western Sydney Primary Health Network, Novo Nordisk and Workers Lifestyle Group.

More than 500 people have signed up to the challenge since the program was rolled out to 27 local GP practices during National Diabetes Week in 2024.

WSD Alliance partners heard from leading voices in prevention, policy, and community action, with discussions on what’s working – and what more can be done.

Sign up to the *2kg Challenge* to stay up to date and experience it firsthand.

The Leader's Alliance meeting was promoted in the Western News.

Blacktown shoppers encouraged to test for diabetes

Published: 27 June 2025
Relevant to: Western Sydney Local Health District

Blacktown residents are being invited to head to Westpoint Blacktown from July 2 to find out if they have diabetes.

Promotion for National Diabetes Week 2025 was done in WSLHD's The Pulse.



CULTURE AND PLACE-BASED POPULATIONS

**Aruni Ratnayake,
Prevention Officer**

WSD's Place and Culture based prevention work is grounded in the epidemiological realities outlined earlier in this document under *Diabetes Now: Action Now*.

That analysis demonstrates that diabetes risk, earlier onset and complications are not evenly distributed across Western Sydney but are disproportionately concentrated in culturally and linguistically diverse communities and in areas of socioeconomic disadvantage. These patterns of inequity provide a clear rationale for a prevention strategy that is explicitly place based, culturally responsive and designed with equity at its core.

At its heart, this work is about prevention across the full continuum. It focuses both on preventing the development of type 2 diabetes in people at high risk, and on preventing progression to serious cardiovascular, renal and other complications among people already living with diabetes. The emphasis is deliberately on *healthy living for whole communities*, rather than on treatment alone.

In response to this burden, WSD has invested in prevention approaches that are embedded within communities and normalised as part of everyday life. Experience in Western Sydney consistently shows that prevention is more effective and more sustainable when it is delivered in trusted local settings, shaped by cultural context, and reinforced through social and community networks rather than relying solely on generic, population wide messaging.

A defining feature of WSD's primary prevention strategy is its longstanding commitment to place and culture based approaches, first established in 2016 and progressively strengthened over the past decade. This reflects an early recognition that meaningful prevention in Western Sydney must be locally grounded, culturally informed and community led, particularly in communities bearing the greatest burden of diabetes.

From the outset, this approach has focused on working *with* communities rather than delivering programs *to* communities. In establishing these groups, WSD deliberately identified and supported local champions — including general practitioners, nurses and allied health professionals — who were prepared to take on leadership roles within their own communities. These champions have been central to shaping priorities, convening participation and sustaining momentum over time.

Alongside the clinical profession, WSD has worked closely with cultural and community leaders beyond the health sector to broaden reach and deepen engagement. This has included partnerships with trusted local organisations and civic groups — such as the Lions Club in Toongabbie — as well as faith adjacent, sporting and community organisations, and schools. Together, these nonhealth partnerships have been critical in normalising healthy living, extending influence beyond clinical audiences, and embedding prevention in community life.

The WSD core team has participated actively in planning processes and community events, while being explicit that their role is to enable, support and strengthen, rather than to lead or direct. This distinction has been essential in building trust and ensuring initiatives remain genuinely community owned.

To support this work, WSD has invested in a dedicated, fulltime Prevention Officer focused on culture and place-based prevention, whose role is to foster relationships, support local leadership, coordinate activities and provide continuity across communities. This role has been instrumental in sustaining engagement and supporting the organic growth of these groups.

Importantly, the WSD core team itself reflects the cultural diversity of Western Sydney. Many team members come from the same cultural communities involved in this work and bring lived experience, language skills and community connections. This shared cultural grounding further strengthens trust and enables this approach to function effectively, while preserving community ownership and cultural integrity.

While the primary emphasis is on prevention and healthy living, treatment and management options are also discussed within these forums when relevant. These discussions are most often led by health professionals from within the same cultural communities — including general practitioners, specialists, dietitians, diabetes educators, exercise physiologists, pharmacists and academic contributors — allowing cultural translation to occur naturally and credibly, while keeping prevention as the central focus.



NAIDOC Week 2025 at Riverstone was an opportunity to engage the community about diabetes and 29 free point-of-care HbA1c tests were conducted.

The sections that follow describe these initiatives in more detail. In recognition of Aboriginal and Torres Strait Islander peoples as the First Nations custodians of this land, and acknowledging that Aboriginal health requires distinct, self-determined approaches, the document first outlines WSD's work with Aboriginal communities. This is followed by place and culture-based initiatives delivered with culturally and linguistically diverse communities across Western Sydney.

Aboriginal and Torres Strait Islander Communities – Culturally Safe, Community Led Prevention

Aruni Ratnayake, Prevention Officer

WSLHD is home to one of the largest urban Aboriginal populations in Australia, with a disproportionately high burden of type 2 diabetes and related complications. WSD's work with Aboriginal and Torres Strait Islander communities has focused on strengthening culturally safe prevention, early detection and care pathways, guided by Aboriginal leadership and community priorities.

This work is undertaken in partnership with Aboriginal Community Controlled Health Organisations and local Aboriginal services, with a strong emphasis on trust, continuity and cultural safety.

Key activities and achievements during 2025 included:

- Participation in major community events, including Close the Gap Day, Elders Olympics and NAIDOC aligned activities, using these settings to promote healthy living, diabetes awareness and culturally safe engagement.

- Onsite point of care HbA1c testing at selected community events, delivered in outdoor and community-controlled settings to support early detection and engagement.
- Collaboration with Aboriginal health services, including Baabayn Aboriginal Corporation, Western Sydney Integrated Team Care program and Greater Western Aboriginal Health Service, to align prevention messaging with local priorities and service pathways.
- Governance and leadership through the Diabetes and Aboriginal Health Steering Committee, co chaired by the Director of Aboriginal Health Strategy and the Director of WSD, providing strategic oversight and alignment.

This work continues to evolve, with a focus on supporting community led initiatives, strengthening early detection pathways and preventing progression to complications through culturally safe engagement.

Healthy Living Toongabbie – A Mature, Community Led Model

Sumathy Ravi, Program Manager

Healthy Living Toongabbie (HLT) is WSD's longest established and most mature place based prevention group, operating continuously since 2016. In 2025, HLT experienced a particularly active and impactful year, characterised by strong community engagement, visible leadership across major cultural events, and a sustained commitment to health promotion and disease prevention in and around Toongabbie.

HLT's work is grounded in promoting healthy living for the whole community, with prevention framed



CULTURE AND PLACE-BASED POPULATIONS

positively around physical activity, food, social connection and wellbeing rather than disease management alone. The breadth, diversity and consistency of activity during 2025 reflect deep local ownership, trusted partnerships and a high level of organisational maturity.

Key activities and achievements during 2025 included:

- Active participation in major cultural and community celebrations, using high visibility events to deliver culturally appropriate health education and awareness. Events included the *Sydney Pongal Festival*, *Tamil New Year celebrations at Girraween Park*, *ANZAC Day commemorations*, the *Wentworthville Deepavali Festival*, and the *Tamil Arts & Culture Association (TACA) Annual Sydney Chithirai Festival*.
- Fundraising and advocacy through community partnerships, most notably the ongoing collaboration with the Australian Tamil Chamber of Commerce (ATCC) Walkathon on March 2 at Parramatta Park. The event attracted more than 50 participants and raised approximately \$1200 in support of HLT activities, demonstrating strong community backing and civic engagement.



Members of HLT with Parramatta MP Andrew Charlton and WSD Director Prof Glen Maberly.

- Early detection and prevention activities at large community events, including a joint WSD/HLT booth at the TACA Sydney Chithirai Annual Festival on May 4 at Blacktown Leisure Centre, Stanhope. A multidisciplinary team of medical professionals, nurses, dietitians and educators delivered diabetes risk awareness, point of care HbA1c testing and healthy lifestyle education, reinforcing HLT's focus on early detection and prevention.



WSD and HLT members at the TACA Sydney Chithirai Annual Festival.

- Capacity building through the Nagarathar Sangam Health Workshop Series, delivered across multiple sessions from April to September. This extensive program addressed diabetes risk assessment, nutrition, exercise, food labelling, mental health, child psychiatry, and traditional Tamil martial arts as a form of physical wellbeing, reflecting HLT's holistic and culturally grounded approach to health.
- Contribution to professional and academic forums, including a poster presentation at the Australasian Diabetes Congress on the Gold Coast in August 2025, which received positive feedback from national and international delegates and showcased the HLT model to a wider professional audience.
- Delivery of a flagship community forum, *Listen to Your Heart and the Experts*, held on 4 September at Toongabbie RSL Club. The forum brought together expert speakers across cardiology, endocrinology, general practice and dietetics, and delivered practical, accessible heart health and prevention messages for the local community.
- Ongoing engagement with WSD education initiatives, including participation in the WSD Face to Face Masterclass, with HLT hosting an information stall focused on pre diabetes and community based prevention.
- Strengthening governance and sustainability, with the year concluding in November with the HLT Annual General Meeting, election of a new executive committee, reflection on achievements, and setting of priorities for the year ahead.

Collectively, these activities demonstrate how a mature, community led organisation can deliver sustained, culturally grounded prevention at scale, while remaining adaptable, credible and deeply embedded within its local community.



Filipino Australian Community - Community Driven Prevention and Healthy Living

Aruni Ratnayake, Prevention Officer

The Filipino Australian community in Western Sydney experiences a high prevalence of type 2 diabetes, often at younger ages and lower BMI. WSD's engagement with this community has been strongly community driven, emerging from partnerships with Filipino health professionals and community leaders.

The Filipino Australian Diabetes Support Network (FADSN) group has enjoyed ongoing engagement all year, bringing together community leaders, health professionals and volunteers to promote diabetes prevention and healthy living.

Key activities and achievements during 2025 included:

- A large community response to 'Step it up for Diabetes' on a Spring morning for a walk and education session for the community at Bungarribee Park (pictured);



FADSN Dietitian/Exercise Physiologist Dean Paningbaton ran an exercise session.

- FADSN joined in the celebrations of the Philippine Independence Day at the Nurragingy Reserve. An array of culture, festivities and community engagement opportunities to promote their work;
- Delivery of community forums and education sessions, supported by NDSS and community partnerships, reaching audiences with culturally relevant messages;
- Promotion of physical activity and peer support, including walking groups and social media-based engagement to reinforce healthy living; and



Jaybee Serrano, Jasmin Ellis, Aruni Ratnayake and Bernadette Sadsad at the WSLHD Nursing and Midwifery Awards 2025.

- Recognition of the volunteer work by Filipino nurses of FADSN at WSLHD Nursing and Midwifery Awards 2025.

This work demonstrates the power of culturally led, peer driven approaches to prevention and provides a strong foundation for further development.

Chinese Community (Mandarin Speaking) – Digital and In-Person Engagement

Aruni Ratnayake, Prevention Officer Dr Cecila Chi, WSD Staff Specialist, Westmead

Engagement with the Mandarin speaking Chinese community has focused on addressing gaps in accessible, Australia specific diabetes information through digital platforms and community forums.

Key activities and achievements during 2025 included:

- Continuation of the Mandarin diabetes education video series, delivered by Mandarin speaking health professionals and disseminated through WeChat, with strong engagement particularly around diet and lifestyle topics.
- Community forums and in-person education sessions, responding to demand for face-to-face engagement and discussion. This is in partnership with Parramatta Deputy Lord Mayor Charles Chen, G'Day Neighbour, Epping Senior Citizens, City of Parramatta libraries and Multicultural Health Communications Wechat service.



Community leaders & health professionals at the Chinese forum.

- Diet focused education, informed by community feedback and supported by dietitians and clinicians familiar with Chinese food practices.
- Use of early detection messaging, including discussion of pre diabetes and body composition, to motivate preventive action.

This blended digital community approach has enabled broad reach while maintaining cultural relevance and trust.

Auburn Community – A New and Emerging Place-Based Initiative

Aruni Ratnayake, Prevention Officer

The Auburn place-based initiative represents the newest phase of WSD’s culture and place based prevention work. Auburn is a recognised diabetes hotspot with exceptional cultural diversity and a younger population profile, presenting both high risk and significant opportunity for early intervention.

Key activities and achievements during 2025 included:

- Launch of the Auburn Diabetes Initiative in July 2025. Auburn Diabetes Leadership Forum, co-hosted with Cumberland City Council and Western Sydney Community Forum, bringing together local government, health services, community organisations and community champions. It was opened by Cumberland Mayor Cr Ola Hamed (pictured).
- Shared analysis of local diabetes burden and lived experience, supporting a common understanding of risk and opportunity.
- Co design of initial local priorities, focused on simple, positive messaging around healthy living, prevention and early action.

The Auburn initiative is now positioned to move from engagement and planning into delivery, using the same community led principles that underpin WSD’s more established place-based groups.

The PHN Cumberland Healthcare Neighbourhood events in 2024–25 provided a valuable opportunity

HEALTH FORUM FOR THE CHINESE COMMUNITY

**DO YOU HAVE DIABETES?
ARE YOU AT RISK OF DIABETES?**

FREE!

- Are you over 40?
- Do you have a family history of diabetes?
- Had diabetes during pregnancy?

SATURDAY, OCTOBER 25

Hear from Mandarin-speak about diet and diabetes

- Free blood test (HbA1c) with immediate results (No fasting required)
- People living with diabetes can be assessed to experience wearing a Continuous Glucose Monitor sensor

MUST RSVP by October 20
Scan the QR code:

Where: Epping Leisure and Learning Centre, 1 Chambers Court (off Pembroke St. Next to Epping Library, only a 3-minute walk from Epping metro/train station).

你是糖尿病患者吗?
你想降低患糖尿病的风险吗?

免费

- 你的年龄在40岁以上吗?
- 你有糖尿病的家史吗?
- 你在怀孕期间是否被诊断出妊娠期糖尿病?

2025年10月25日, 星期六 上午9:30至11:30
(请于上午9点到达注册)

聆听健康专家讲解糖尿病、饮食, 并进行血液检查!

- 糖化血红蛋白检测
- 参与者会被评估是否合适试戴动态血糖仪

请于2025年10月20日之前注册

地点: Epping Leisure and Learning Centre (Epping图书馆旁, 离Epping地铁站/火车站步行3分钟)
地址: 1 Chambers Court (off Pembroke Street), Epping

查询方式: 扫描二维码, 发送电子邮件
info@gooddayneighbour.com.au
致电 0404 820 014

A bi-lingual flyer was created to promote the Chinese forum.



Auburn Diabetes Leadership Forum

to promote the early intervention directly within the health services engaging with culturally and linguistically diverse populations, including groups experiencing language barriers and historically low participation in preventive health programs.

All Groups

Aruni Ratnayake, Prevention Officer

Linking Awareness, Early Detection and Action

Across all place based groups, a consistent theme has been the intentional linking of awareness creation, early detection and action. Community events and activities provide opportunities to discuss diabetes risk in nonclinical, culturally appropriate ways, often using screening, self reflection or personal stories as motivators rather than diagnostic labels alone.

The *2kg Challenge* has become a key connector in this pathway. Community members engaged through place based activities are invited to participate in the Challenge, where they receive structured guidance, digital support and ongoing motivation. This creates a coherent progression from community engagement to sustained behaviour change, rather than isolated or one off interventions.

Culture Specific Content and the Next Phase

As outlined in the *2kg Challenge* section, WSD is now working with each place based group to codevelop culture specific prevention content, ensuring that dietary advice, physical activity messaging and behavioural strategies reflect local norms, preferences and lived experience. This work builds

directly on relationships established over many years and positions place based groups as cocreators of prevention resources rather than passive recipients.

Sustainability and Future Support

These place based, culture based groups represent a critical component of WSD's prevention infrastructure. Their longevity, community ownership and demonstrated impact make them well placed for further development and scale. Experience to date has shown that relatively modest, flexible funding can substantially increase the reach, consistency and effectiveness of community led prevention activity.

Looking ahead, WSD is proposing the establishment of a dedicated Culture and Place Based Prevention Support Fund, designed to provide participating community groups with access to approximately \$5000-\$10,000 per group per year. This funding would be intentionally light touch and flexible, enabling groups to:

- Support venue hire, materials and culturally appropriate resources for community events
- Enable point of care testing, screening consumables and prevention activities
- Remunerate community facilitators or cultural leaders where appropriate
- Strengthen coordination, continuity and local governance
- Pilot new ideas and respond quickly to community identified priorities

Importantly, this approach recognises that community led prevention does not require large program budgets to be effective, but it does require



CULTURE AND PLACE-BASED POPULATIONS



HEALTHY LIVING ENVIRONMENT



(L-R): Professor Emma George, Professor Xiaoqi Feng, Professor Thomas Astell-Burt, Paul Stuart, Kelly Gee, Helen Ryan, Melissa Mason and Ian Corless.

predictable, sustained support. A pooled fund model allows groups to retain ownership of their agenda while benefiting from a shared framework for accountability, evaluation and alignment with WSD's broader prevention strategy.

As outlined in the attached proposals, WSD is recommending that this fund be supported through a combination of health system investment and contributions from industry partners, including pharmaceutical partners, in a manner that preserves clinical independence and community trust. Funds would be administered either through incorporated community organisations or through approved WSD trust arrangements, depending on local governance structures.

Positioned this way, future investment in place and culture-based prevention represents a high value, low cost opportunity to consolidate proven models, deepen engagement, and accelerate progress in communities experiencing the greatest diabetes burden. Together, these groups illustrate how sustained, place-based investment can translate into durable prevention capacity, equitable reach and meaningful long term impact in Western Sydney.

HEALTHY LIVING ENVIRONMENT

Greening Focus: Enhancing Health and Equity in Western Sydney

Sarah Driscoll, Prevention Program Manager

WSD continues to prioritise creating healthy living environments as a core component of its broader prevention strategy. Evidence demonstrates that access to green spaces and thoughtfully designed urban environments is strongly associated with increased physical activity, improved mental health, and reduced risk of chronic disease. In Western Sydney, one of Australia's fastest-growing and most diverse regions, these factors are critical levers for improving health equity and reducing diabetes risk.

What We Did and Why It Matters

In 2025, WSD strengthened partnerships with local councils, urban planners, and public health leaders to embed health considerations into urban



greening initiatives. Through regular meetings, WSD collaborates to identify emerging issues, share ideas, and establish working groups that develop practical, evidence-informed solutions. WSD ensures a health perspective is consistently applied across these conversations, drawing on ongoing research led by Alliance members, Professors Thomas Astell-Burt and Xiaoqi Feng, to support the development of healthier, more sustainable communities.

WSD also expanded these efforts through the WSD Leaders Alliance event themed From Nature to Neighbourhoods. The meeting explored how the built environment and connection to nature influence community health, bringing together nearly 80 leaders from academia, health, government, and the not-for-profit sector at Workers Blacktown.

The program featured a range of expert speakers, who examined the role of environmental design, urban planning, and place-based coalitions in addressing barriers and identifying opportunities to increase physical activity and create healthier, more active communities.

Central to all discussions was the purpose of the WSD Leaders Alliance: to foster collaboration, strengthen networks, and drive innovation across the system, ensuring that efforts to create healthier living environments are integrated, strategic, and evidence-based.

Walking Groups

Aruni Ratnayake, Prevention Officer

This year a review was completed with WSPHN on the Heart Foundation Walking (HFW) groups in Western Sydney looking at how many walking groups were in the area and as result a flyer was created to share with interested parties.

Two new walking groups commenced in 2025:

- The Easy Walking Group in Ermington; and
- The Holistic Walkers in Wentworthville.

The Ermington group was used as an example in WSD's Masterclass to not only highlight the benefits of walking, but how WSD can support the start of a walking group with Aruni as the local coordinator for HFW.

Healthicare Medical Practice walking group was recognised by HFW for its efforts.



Aruni Ratnayake (right) out and about with the Stockland Merrylands Walkers.

GP-led walking groups are a simple yet powerful prevention strategy for WSD and Western Sydney Cardiology programs, supporting regular physical activity, social connection, and early risk reduction. In 2026, scaling and embedding these walking groups will be a key engagement strategy to grow community participation, strengthen preventive care and expand group-based models within general practice.

EARLY DETECTION

Sarah Driscoll, Prevention Program Manager

Why early detection matters

Early detection of type 2 diabetes mellitus (T2DM) underpins effective prevention, early intervention and long term system sustainability. Identifying diabetes and prediabetes early enables individuals to understand their risk, supports timely behaviour change, reduces avoidable complications, and lowers long term healthcare costs. However, detection alone is insufficient. For early detection to have real impact, it must be deliberately linked to education, support and clear options for action.

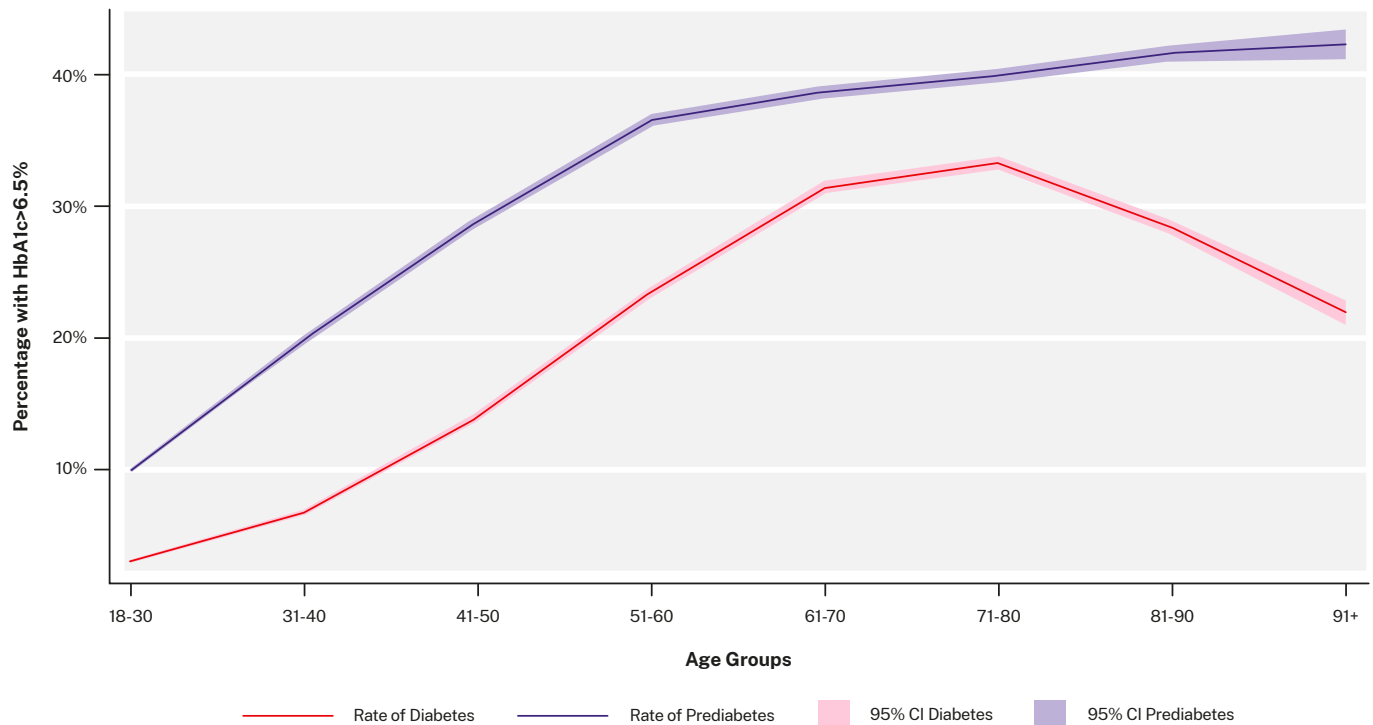
Across Western Sydney, WSD has consistently shown that a substantial proportion of diabetes and prediabetes remains undiagnosed. When HbA1c testing is applied systematically rather than opportunistically, it reveals a much larger burden of disease than is apparent through routine clinical encounters. Making this burden visible has been essential for individuals, clinicians and policy makers, reframing diabetes as a widespread population challenge rather than a condition affecting a small minority.



EARLY DETECTION

Figure 5: The prevalence of diabetes and prediabetes increases with age

Age-specific prevalence of diabetes and prediabetes based on HbA1c testing, Blacktown and Mount Druitt (n = 290,396 tests)



WSD's early detection approach is therefore built on three core principles: embedding HbA1c testing within routine settings where people already interact with the health system; ensuring results are immediately linked to education and practical pathways for action; and using detection data to inform service design, clinical practice and policy discussion.

A central focus of this work is the identification of prediabetes, which represents the largest and most modifiable component of future diabetes burden.

Work led by WSD researchers, including an Australian Medical Journal paper accepted for publication in 2026, highlights prediabetes as a largely hidden condition in Australia, with prevalence substantially underestimated in routine data sources. That work demonstrates that systematic HbA1c testing across hospital and primary care settings consistently identifies prediabetes in approximately one quarter to one third of adults tested, far exceeding current recorded prevalence in general practice. Importantly, the paper reinforces that prediabetes is not benign: even modest dysglycaemia is associated with increased cardiovascular risk, and early identification creates a critical window for prevention through lifestyle intervention and structured programs such as the *2kg Challenge*. This evidence underpins WSD's emphasis on linking early detection directly

to action, rather than treating prediabetes as a diagnostic endpoint.

From hidden burden to visible risk: why multiple settings matter

No single setting can adequately address the hidden burden of diabetes across a population as large and diverse as Western Sydney. Over the past decade, WSD has deliberately developed, evaluated and refined multiple complementary approaches to early detection. Together, these approaches provide both the evidence base and the practical foundation for scalable, sustainable prevention.

Making the invisible visible at scale: Emergency Department detection

Routine testing for diabetes in adults presenting to the EDs of Blacktown and Mount Druitt hospitals was established in 2016. HbA1c testing has automatically been undertaken when blood is sampled.

The scale and impact of this program have been substantial. More than 300,000 adults have now received HbA1c testing through EDs, creating one of the largest sustained diabetes detection datasets in Australia. The results revealed a strikingly high prevalence of undiagnosed diabetes and prediabetes,



Nurse Nianci Lyu tests WSLHD Acting Executive Director Operations Peter Rophail at the Westpoint Wellness Expo Blacktown.

with risk rising sharply from the early 30s onwards. This visibility of risk at scale created a powerful ‘wow factor’, fundamentally changing how diabetes burden is understood within the health system.

As shown in Figure 5, diabetes prevalence increases steeply with age, while prediabetes follows a similar trajectory before plateauing in older age groups. These data demonstrate limited screening yield in adults under 30 years, with rapidly increasing returns from the early 30s onwards, providing a strong empirical basis for age informed, risk based screening strategies. Beyond detection, this work has become the foundation for a data driven hospital diabetes management system, supporting early specialist review, inpatient optimisation and improved follow up planning.

At Westmead Hospital, a complementary ED HbA1c testing pathway was introduced in 2017, targeting patients presenting with blood glucose levels greater than 10 mmol/L. This targeted approach has strengthened recognition of poor glycaemic control, enabled earlier diagnosis of previously unrecognised diabetes, and improved inpatient management through timely review by specialist nursing staff.

Confirming the signal in the community: evidence from general practice

To determine whether the high prevalence observed in EDs reflected a hospital specific population or a broader community burden, WSD undertook systematic detection studies in general practice. These included intensive HbA1c testing across multiple practices over a one month period, as well as sustained testing over 12 months within a large practice.

The findings were consistent and robust. Diabetes and prediabetes prevalence detected in general practice closely mirrored rates observed in EDs. In the practice undertaking 12 months of testing, the proportion of active patients diagnosed with diabetes increased by 22%, reflecting uncovering of previously unrecognised disease rather than changes in underlying incidence.

These studies confirmed that the burden of diabetes is pervasive across the community and that even short, time limited periods of systematic testing in general practice can substantially increase detection. This evidence directly informed WSD’s strategic focus on general practice as the primary setting for scalable early detection, supported by MBS subsidised HbA1c testing for people at risk.

Reaching beyond the health system: community based point of care testing

In parallel, WSD explored community based point of care HbA1c testing to reach people less likely to attend general practice. An initial pilot, supported through a Novo Nordisk grant, deliberately combined testing with immediate education delivered by nurses and diabetes educators.

Across community settings, results were consistent with those seen in hospital and primary care, with more than half of participants identified as having either prediabetes or diabetes. The distinguishing feature of this approach was not detection yield, but engagement. Having trained clinicians available to explain results, contextualise risk and outline next steps led to high acceptability, strong follow through and meaningful connection to prevention pathways. These outcomes were formally evaluated and published.

In 2025, WSD continued targeted community testing in selected settings where awareness creation and engagement were strategic priorities, including shopping centres, major cultural festivals and workplace programs. Community based testing was particularly valued by place based and culturally diverse community groups, where it supported conversation, trust and collective understanding of diabetes risk.

While highly effective for engagement and advocacy, community point of care testing is resource intensive, requiring substantial staff time and higher per test costs.

In addition to public facing events, early detection activities were also embedded within the health workforce itself. During National Diabetes Week, ICH



EARLY DETECTION

staff were offered free diabetes detection, providing an opportunity to raise awareness, identify previously unrecognised risk, and strengthen engagement with local prevention pathways among staff delivering care across the district.

Given the scale of the Western Sydney population, it is not feasible as a universal detection strategy. WSD has therefore positioned community testing primarily as a complementary approach for awareness creation outside the healthcare system, rather than as the main mechanism for population wide detection.

What we did in 2025: Community Point of care Testing Results

During 2025, WSD delivered a total of 832 point of care HbA1c tests across community events. Overall results are summarised below and illustrated in Figure 5.

HbA1c category	Number of people tested
Normal	508
Prediabetes (known and new)	205 (including 111 newly identified cases; 67 undisclosed status)
Diabetes (known and new)	119 (including 26 newly identified cases; 25 undisclosed status)
Total	832

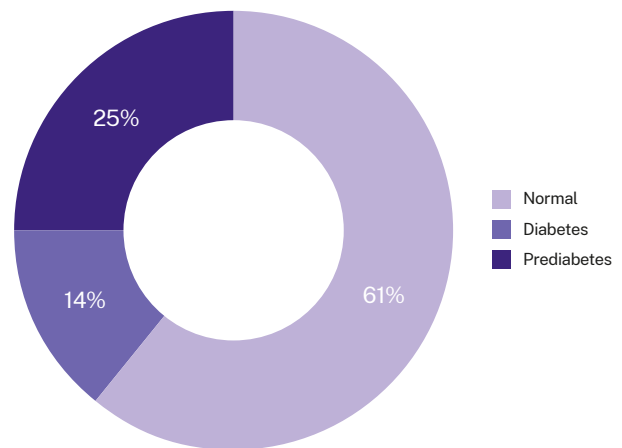


WSD carried out detection to ICH staff during NDW.

These findings again demonstrated a high burden of previously unrecognised risk in community settings, reinforcing the importance of proactive detection coupled with immediate education and referral pathways.

Figure 6: Distribution of HbA1c results from community point-of-care testing in 2025

HbA1c categories from point-of-care testing delivered by Western Sydney Diabetes at community events, 2025 (n = 832 tests)



Alongside testing, WSD also delivered targeted education focused prevention activities in community and youth settings, deliberately separating awareness and education from formal detection where this was more appropriate.

Music for You – Diabetes Prevention Session (Youth Program)

In July 2025, at the invitation of the Western Area Adolescent Team (WAAT), WSD delivered a diabetes prevention session as part of *Music for You*, a youth focused wellbeing program in Mount Druitt for young people aged 12–18 years.

The program combines music education with nutrition and health workshops, using creative approaches to build life skills, confidence and connections to local support services. The WSD session focused on healthy eating, guided by the Australian Guide to Healthy Eating, and included an interactive activity where participants estimated the sugar content of popular beverages.

The session was well received, with many participants surprised at the findings. A healthy cookbook prize



encouraged continued learning at home, supporting families to explore healthier choices together.

Cumberland Healthcare Neighbourhood Networking Event

WSD participated in the WSPHN Cumberland Healthcare Neighbourhood Networking Event, which centred on strengthening place based approaches to community health.

The WSD stall engaged general practitioners, nurses, pharmacists, residential aged care staff and allied health providers from across the region. This provided an opportunity to showcase locally available healthy eating and active living initiatives, and to highlight prevention programs such as the *2kg Challenge* as practical, community embedded supports relevant both to residents and to the healthcare professionals who care for them.

From pilots to practice: what changed in 2025 and what comes next

Building on this accumulated evidence, 2025 marked a transition from pilot and evaluation to broader implementation. On World Diabetes Day, WSD launched an ongoing general practice focused early detection initiative, encouraging practices to systematically test adults attending during defined periods and to refer people with prediabetes or early diabetes to structured prevention programs such as the *2kg Challenge*.

While initial uptake was modest, this approach is intentionally designed as an ongoing program rather than a one off campaign. It reflects strong alignment

with emerging policy directions and will continue to be refined and expanded through 2026 and beyond.

Across hospital, general practice and community settings, early detection has become a cornerstone of WSD's overall prevention strategy. By making the scale of diabetes risk visible to individuals, clinicians, communities and policy makers — and by ensuring clear pathways exist to support understanding and action — WSD has demonstrated how early detection can drive awareness, inform policy and enable meaningful prevention at scale.

Synthesis across settings

Taken together, WSD's detection activities show a consistent and important pattern. Emergency Department testing provides unmatched scale and system level insight, revealing the true population burden of diabetes and prediabetes and informing hospital based care and policy discussion. General practice testing demonstrates that this burden is not confined to acute care settings, confirming similar prevalence in the community and offering the most efficient, scalable and sustainable pathway for routine detection through existing MBS subsidised mechanisms. Community based point of care testing yields comparable detection rates, but its greatest value lies in engagement — creating awareness, building trust and enabling immediate education and action in settings where people may not otherwise interact with the health system. Together, these approaches reinforce a clear conclusion: detection yield is consistently high across settings, but impact is maximised when detection is matched to purpose, cost effectiveness and clear pathways for action.



WSD CDE Jaybee Serrano tested employee Kathryn McKeich at the Cumberland City Council Staff Safety Day.



(L-R): Nurse Thi Tran, Sarah Driscoll and Nurse Lyndall Lundberg at the Mount Druitt Community Health Centre 50th Anniversary.



Clinical Prevention & Integrated Management

CLINICAL ENGAGEMENT

Dr Rajini Jayaballa, Clinical Lead

Clinical Engagement as the Foundation of System Delivery

Clinical engagement is the foundation of the WSD Model of Care (Figure 7). It is where specialist expertise, partnership with general practice, multidisciplinary teamwork, and digital tools converge to translate strategy into consistent day-to-day practice.

In 2025, WSD deliberately strengthened this clinical core-refining how patients are prepared, how GPs and specialists collaborate, and how digital information is used to support better clinical decisions, behaviour change, and system efficiency.

The expanded use of digital tools has been central to this evolution. WSD deepened its partnership with Health2Sync, extending joint development to tailor the platform specifically to the WSD Model of Care. Health2Sync is now embedded as a core clinical tool, supporting CGM data review, patient engagement, and shared decision-making across the care pathway.

In parallel, WSD continued to advocate strongly for the use of continuous glucose monitoring (CGM) in people with type 2 diabetes, recognising its ability to make glucose patterns visible, support behaviour change, and accelerate clinical improvement.

A further marker of maturity in 2025 was the evolution of the Diabetes Nurse Educator-led pre-clinic process. Pre-clinic preparation is now a consistent and well-established step prior to virtual case conferencing with the patient's GP, ensuring that CGM data, pathology, patient priorities, and education are in place before specialist review. Together, these elements position clinical engagement not as a single service or clinic, but as an integrated pathway

spanning referral, preparation, consultation, follow-up, and transition back to primary care. The model is deliberately designed to operate across the spectrum of clinical complexity - from early behavioural activation through to insulin stabilisation and, where appropriate, timely transition back to GP-led care. This clinical foundation underpins the workforce development, education, digital enablement, and evaluation activities described in the sections that follow, and provides the base for extending the model beyond diabetes to broader cardiometabolic care across Western Sydney.

Primary care integration within this model is enabled through WSPHN, which supports practice engagement, data-driven quality improvement and alignment with routine funding and reporting structures.

From foundations to a functioning system

The work undertaken in 2025 builds directly on the foundations described in the *2024 Year in Review* and reflects a deliberate shift from establishing individual components to operating a coherent system. Preclinic activation, CGM enabled care, nurse led workflows and virtual case conferencing have matured into a coherent and reliable clinical system. This maturation has improved consistency, efficiency and clarity of purpose, and has positioned the model for formal evaluation and scale-consistent with the system shift objectives outlined in the Summary: Director's Overview. Importantly, this progress has been achieved without additional clinical staffing, with WSD exceeding its 2024 occasions of service (OOS) and Nationally Weighted Activity Unit (NWAU) activity in 2025-reflecting productivity gains and more effective use of the existing workforce.

Recognition, Capability and Workforce Impact

2025 was also a year of significant external recognition for the WSD Model of Care. The model was presented at major national forums, including a dedicated symposium at the Australian Diabetes Congress (ADC) and a national virtual symposium through the National Association of Diabetes Centres (NADC), and was further strengthened by peer-



reviewed publications. Readers are referred to the Evaluation and Research sections of this report for a detailed overview of the presentations, publications, and competitive grant applications progressed by the WSD team during 2025. Collectively, this body of work is notable given the size of the core team and highlights the academic, clinical, and translational contribution achieved alongside service delivery, reinforcing the credibility of the model described in the Chair's Foreword.

This external recognition has been matched by tangible workforce development. Twenty-nine General Practitioner Visiting Medical Officers (GP VMOs) participated in WSD clinical activities for extended periods of six to twelve months before returning to practices across Western Sydney, where they embedded new approaches to diabetes management and implemented local service improvements. Through this mechanism, WSD has effectively developed an extended, well-trained workforce beyond the core team, amplifying impact across the region.

Education, engagement and reach at scale

Capacity building has been further strengthened through education at scale. The 2025 WSD Masterclass Series was larger than in previous years, very well received, and is now a flagship program for diabetes capability building across Western Sydney. The addition of a dedicated rural Masterclass day in Dubbo extended this impact beyond metropolitan Sydney. In parallel, WSD's educational library and purpose-built video resources expanded substantially, supporting clinicians, patients and allied health providers to apply the Model of Care in practice.

Engagement with general practice has reached a scale rarely achieved by specialist services in Australia, reflecting the deliberate focus on primary care partnership highlighted in the Director's Summary. More than 800 of approximately 1200 GPs practising within the WSLHD catchment have participated in WSD's virtual case conferencing model. Most participating GPs report positive experiences, with many returning as part of ongoing shared care - demonstrating both acceptability and practical value in frontline primary care.

Mature, but not yet at population scale

While the model is now mature, evidence based and externally validated, it is not yet operating at sufficient reach to materially alter the overall diabetes trajectory

across Western Sydney at a population level. The next phase therefore focuses on consolidation and scale - strengthening the multidisciplinary workforce, embedding preclinic activation and case conferencing as standard pathways for people with complex type 2 diabetes, and improving continuity and transition back to primary care, as foreshadowed in the Chair's call to action.

Extending the Model and Preparing for the Future

Building on its success in diabetes, WSD is preparing to extend its general-practice-centred, case-conferencing, digitally enabled model to cardiovascular-renal-metabolic (CVRM) risk. This direction aligns with the future-facing priorities set out in the Chair's Foreword and the MRFF GP CARE proposal. It reflects a clear reality: diabetes rarely exists in isolation. Lasting impact requires integrated cardiometabolic care.

In line with these priorities, WSD submitted a targeted request for priority funding in response to the District's December 2025 call for proposals. The proposal focuses on strengthening the multidisciplinary clinical team and consolidating this proven model within community and integrated health settings.

WSD also recognises that artificial intelligence will reshape how care is delivered. Our approach is deliberate and clinically responsible. AI will not replace clinical judgement. Instead, it will be used to augment decision-making, personalise care, improve efficiency, and support safe scale.

Strengthening Communication and Evaluation Infrastructure

In parallel, 2025 marked the start of a multi-year program to strengthen how the WSD Model of Care is communicated and evaluated. A dedicated web-based node is being developed to provide clearer, audience-specific explanations of how the model works and how it differs from traditional specialist care.

To support stronger evaluation and research as the model scales, WSD is also planning a dedicated REDCap database. This will streamline data capture, support quality improvement, and enable timely research translation - reinforcing the accountability and transparency commitments outlined in the Summary.



WSD Clinical Model of Care and Specialist Clinics

Figure 7: WSD Model of Care – in person and virtually.



In 2025, WSD delivered a single, integrated clinical service across Blacktown, Mount Druitt and Westmead hospitals, supported by virtual delivery via Healthdirect.

The service operates through a hybrid model that combines in-person specialist and multidisciplinary clinics with virtual case conferencing involving patients and their GPs. Care is supported by targeted phone and digital follow-up and by CGM-enabled, data-driven clinical decision-making.

The figure above illustrates the preferred WSD Model of Care and represents the full expression of this approach. It is not a separate program, but the complete version of the same clinical service delivered across all sites. The model is deliberately sequenced to ensure preparedness, shared decision-making and continuity of care: nurse- and educator-led pre-clinic preparation; CGM application and review; diabetes educator engagement; virtual case conferencing with the GP and specialist team; an agreed management plan; and coordinated follow-up with transition back to GP-led care.



Implementation and Variation

In 2025, approximately 30% of consultations delivered the full WSD Model of Care as depicted in Figure 7. Here, the full model refers to delivery of the complete, sequenced pathway: nurse-and educator-led pre-clinic preparation; CGM application and review; diabetes educator engagement; virtual case conferencing with the patient's GP and specialist team; an agreed management plan; and structured follow-up with transition back to GP-led care.

Delivery of the full model was most consistently achieved in the ICH virtual clinics at Blacktown, where the required multidisciplinary and pre-clinic infrastructure was in place. Partial implementation occurred in the Wednesday and Friday Blacktown Outpatients clinics, reflecting adaptation of the model within established outpatient workflows.

The Westmead program differed in its configuration. Care was delivered primarily through a more traditional virtual case conferencing model, without routine access to a diabetes educator-led pre-clinic service. CGM was used frequently but was commonly initiated within general practices, often with support from industry representatives rather than through a structured educator clinic. Follow-up case conferences were used selectively and reserved for situations of ongoing clinical complexity or instability.

The main factor limiting adoption of the full model across settings was GP participation in virtual case conferencing. For many practices, scheduling real-time case conferences during routine consulting sessions is challenging, particularly in the context of high patient demand and widespread bulk billing, where opportunity costs for non-billable clinical time are substantial. At Westmead, these constraints were compounded by more limited diabetes educator capacity, which restricted routine delivery of the pre-clinic pathway.

These findings reflect a broader system issue. Both the *Federal Parliamentary Inquiry into Diabetes* and the *NSW State-wide Diabetes Management Program* identify specialist-GP case conferencing as a core mechanism for integrated diabetes care. However, without a dedicated practice-and GP-level incentive or reimbursement mechanism, widespread uptake remains difficult, particularly in settings where bulk billing predominates.

Accordingly, WSD's future funding proposal includes provision for practice and GP incentive payments to

In 2025, approximately

30%

of consultations delivered the full WSD Model of Care...

support participation in virtual case conferencing. Addressing this structural barrier is critical to enabling adoption of the full Model of Care at scale. WSD will revisit and seek to strengthen alignment with the full model at Westmead and in other settings in 2026, subject to workforce capacity and funding arrangements.

Despite these variations in delivery, all clinical activity in 2025 was underpinned by the same core principles of shared care, GP engagement, virtual collaboration and CGM-informed decision-making.

Activity by Clinic Streams (2025)

In 2025, the WSD clinical team delivered care across phone, virtual and face-to-face modalities at Blacktown Hospital, Mount Druitt Community Health Centre. This hybrid delivery model supported a broad and complex case mix, including people with poorly controlled type 2 diabetes, type 1 diabetes, high-risk foot disease, peri-operative and integrated care needs, as well as rural outreach through virtual services.

Clinical activity was delivered through a combination of specialist clinics, multidisciplinary clinics and virtual case conferencing. This flexibility allowed care to be matched to patient complexity and clinical need, while maintaining continuity across settings. Diabetes educator and nursing activity remained a consistent and critical component across all streams, underscoring the importance of nurse-and educator-led pre-clinic preparation in improving readiness for review, clinic efficiency and the effectiveness of subsequent specialist and GP consultations.



Key operational features

Several core operational features underpinned delivery of the model in 2025:

- Hybrid case conferencing with general practitioners;
- Pre-clinic triage by Endocrine Advanced Trainees, with appointments typically scheduled within 3–12 weeks;
- Structured orientation and onboarding for first-time GPs participating in case conferencing; and
- Increasing referral volumes among participating practices over time, reflecting the perceived value of the collaborative model.

Hybrid case conferencing model

In 2025, the Healthdirect platform was introduced, replacing the previous MyVirtualCare platform. The platform supports real-time interaction between specialists, GPs and patients, and enables the sharing of CGM data, pathology and allied health input, including interpreter services. GP participation strengthens education, upskilling and shared management, and reinforces continuity between specialist and primary care.

Weekly clinic structure (operational delivery)

Clinical services were delivered through a structured weekly program:

- Monday: Aboriginal Diabetes Clinic (MDCHC); Nurse- and Educator-led Pre-Clinic (Blacktown Outpatients)
- Tuesday: Virtual case conferencing (Blacktown and Westmead)
- Wednesday: Complex type 2 diabetes, pre-surgical assessment, High Risk Foot Service and type 1 diabetes (Blacktown Outpatients)
- Thursday: Complex type 2 diabetes, MDCHC GP VMO clinic; Virtual case conferencing (Blacktown and Westmead)
- Friday: Complex type 2 diabetes (Blacktown Outpatients); Rapid Access and Integrated Care Diabetes Clinic (Westmead)

Activity is reported using total Occasions Of Service (OOS) and National Weighted Activity Units (NWAU). Monthly OOS in 2025 exceeded those recorded in 2024 despite unchanged staffing levels, indicating improved productivity and more effective use of the existing workforce.

Month	Calendar year 2024		Calendar year 2025			
	OOS	NWAU	OOS	NWAU	var OOS	var NWAU
Jan	663	21	1,075	27	412	6
Feb	1,247	34	1,386	38	139	3
Mar	1,122	33	1,562	40	440	7
Apr	864	27	1,204	33	340	5
May	1,219	37	1,674	44	455	7
Jun	827	23	1,198	35	371	12
Jul	1,087	31	1,283	36	196	4
Aug	854	24	940	28	86	4
Sep	917	26	1,172	34	255	7
Oct	917	26	1,172	34	255	8
Nov	1,040	29	1,295	36	255	7
Dec	633	19	826	22	193	3
Total	11,390	330	14,787	405	3397	75

Patient-Centred Engagement and Shared Decision Making

Patient-centred engagement is a core component of the WSD Model of Care and aligns directly with the early, preparatory stages shown in the Model of Care (Figure 7). In 2025, this was delivered through the systematic use of a codesigned patient preferences survey, sent to all new referrals prior to specialist review.

Patient Priorities Survey

The survey captures patient reported goals, concerns and priorities, providing structured insight into what matters most to patients as they enter the WSD care pathway. It is sent to patients ahead of the Diabetes Educator clinic as part of preclinic preparation; where it has not been completed in advance, completion is reinforced and supported during the educator appointment.



Survey responses are reviewed by the multidisciplinary team during pre-case conference discussions, alongside CGM data, pathology and clinical information. This ensures consultations are focused, relevant and aligned with patient priorities, and supports shared decision making, clear goal-setting and personalised care planning during educator reviews and virtual case conferences. Patients consistently report that this process reinforces that their concerns are being actively heard and addressed.

Between January and December 2025, the survey was distributed to 550 new referrals, achieving a 44.36% open rate and a 30.36% response rate. The Diabetes Priorities Questionnaire generated consistent, actionable insights into patient understanding, concerns and support needs, and has become a routine input into pre clinic preparation and consultation planning.

Patient priorities

As illustrated in Figure 8, patients’ most reported concern about diabetes-related complications, particularly eye, foot, cardiovascular and kidney health. When asked where they needed the most help, priorities focused on avoiding high blood glucose levels, preventing complications, understanding diabetes, improving diet, supporting weight loss and increasing physical activity. These findings reinforce the importance of early education, CGM-enabled feedback and structured multidisciplinary support within the WSD model.

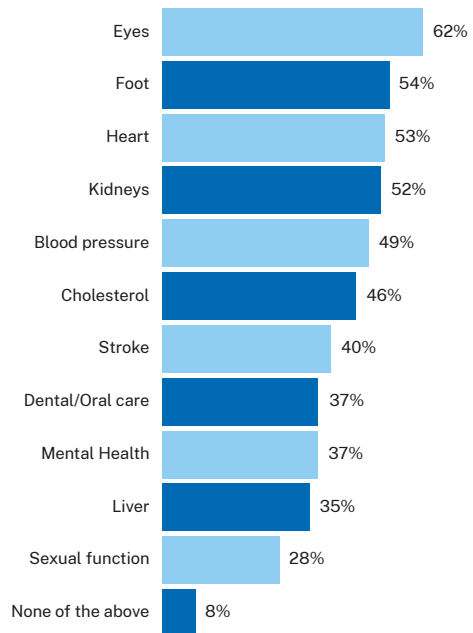
The figure is presented to summarise these findings visually.

Integration with the WSD Model of Care

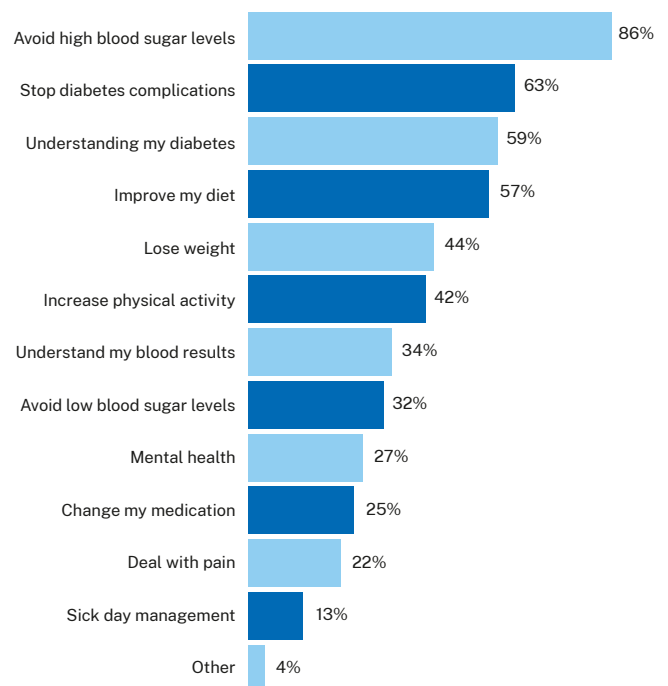
Survey findings are used in conjunction with CGM data and educator assessment to guide care intensity, inform agenda setting for virtual case conferences, and support decisions about follow-up and transition back to GP led care. Where the survey has not been completed prior to the initial case conference, patients are again invited to complete it, with results incorporated into subsequent follow-up consultations. Work is underway to integrate the survey directly into Health2Sync to streamline workflows, reduce duplication and improve uptake across services.

Figure 8: Patient Priorities

Self-reported concerns related to diabetes and its complications (n = 136 participants)



Self-reported priority areas for diabetes support (n = 136 participants)





Future directions

Building on this foundation, future priorities include:

- Routine use of patient reported measures to guide care intensity and sequencing within the Model of Care; and
- Greater use of survey data to inform follow up planning and transition decisions.

Full digital integration of the survey within Health2Sync to support scalability and person targeted approaches.

Nurse and Educator Led Pre-Clinic Engagement

A defining and substantially strengthened feature of the WSD clinical model in 2025 was the consolidation of a structured, nurse and educator-led pre-clinic engagement function. Positioned deliberately between referral and specialist review, this component addresses a critical system gap: the period between referral and appointment that has traditionally represented lost time, fragmented information and limited patient activation.

In 2025, WSD deliberately repurposed this interval into an active phase of care. Rather than waiting passively for specialist review, patients, clinicians and clinical data are prepared in advance, enabling higher-quality shared decision-making and more focused, productive specialist consultations.

All referrals are reviewed by an Endocrine Advanced Trainee and prioritised according to clinical urgency, with appointments typically scheduled within 3-12 weeks. This approach enables early risk stratification while allowing structured pre-clinic preparation to occur in parallel with waiting time, rather than delaying care.

Pre-clinic inputs, activities and outputs

The pre-clinic function is supported by a defined set of workforce, digital and operational inputs, including CDEs, a dedicated Enrolled Nurse (EN), access to CGM, the Health2Sync digital platform, and Trust Fund investment to support workforce capacity not covered by recurrent funding.

Core pre-clinic activities include orientation to the WSD Model of Care and expectations for shared management; initiation of CGM with structured education on sensor application, interpretation and safety; completion of patient-reported surveys

capturing goals, barriers and priorities; completion of outstanding pathology and baseline clinical measurements; and integration of CGM and clinical data into Health2Sync to support multidisciplinary review and case conferencing.

The immediate outputs of this process are patients attending specialist review with CGM data already available, clarified goals and priorities documented in advance, complete baseline clinical datasets, and improved readiness for shared decision-making at first specialist contact. Collectively, this shifts specialist consultations away from orientation and data collection toward interpretation, treatment optimisation and collaborative decision-making.

Outcomes and system impact

Evaluation of this pre-clinic intervention, conducted by a WSD Advanced Trainee Registrar, demonstrated a clinically meaningful improvement in glycaemic control prior to specialist review. Detailed findings are presented later in this document in the Enablers section under Evaluation. Importantly, this improvement occurred before any change in specialist management, indicating early behavioural activation and improved engagement rather than treatment intensification.

From a system perspective, the pre-clinic function delivers multiple downstream benefits. These include more focused and productive specialist consultations, higher-quality multidisciplinary case conferencing supported by complete and timely data, reduced duplication of investigations, improved clinic flow, and an enhanced patient experience through clearer expectations and earlier engagement.

The nursing role as the critical value driver

A critical enabler of this strengthened model in 2025 was the employment of a dedicated Enrolled Nurse (EN) funded through the WSD Trust Fund. This role represents the single highest-value staffing investment within the pre-clinic model and is essential to its effectiveness, consistency and scalability.

At Blacktown Outpatients Clinics, the introduction of the WSD EN was necessary to maintain service viability. Blacktown Hospital withdrew administrative and nursing staff previously responsible for patient registration on arrival and basic clinical assessments. Without replacement capacity, clinics would not have been able to function safely or efficiently. The WSD-funded nursing role directly addressed this gap



Experience from 2025 demonstrates that without a dedicated nursing role, pre-clinic preparation becomes fragmented, educator time is diverted to operational tasks, and the reliability and consistency of patient preparation and data capture are compromised.

and was essential to ensuring continuity of care and smooth clinic operation.

The nurse undertakes key operational and clinical support functions including patient registration, clinical observations, CGM sensor application, data upload and day-to-day clinic logistics. By absorbing these time-intensive but essential tasks, the role enables CDEs to focus on high-value clinical functions such as education, behaviour change support and clinical decision-making.

Experience from 2025 demonstrates that without a dedicated nursing role, pre-clinic preparation becomes fragmented, educator time is diverted to operational tasks, and the reliability and consistency of patient preparation and data capture are compromised. The intensity required for effective pre-clinic engagement cannot be sustained without this role.

Implementation status and scale-up

The nurse and educator-led pre-clinic model is now fully implemented and embedded as standard practice at MDCHC and Blacktown Outpatients Clinics. These sites function as demonstration sites, providing proof of implementation, operational feasibility and evaluable outcomes.

Westmead represents the next translation step. Using existing WSD workforce capacity, the model will be replicated and adapted through staged implementation, reflecting higher service complexity, clinic volume and local infrastructure, while preserving the core elements demonstrated at Mount Druitt and Blacktown.

Sustainability, value for money and future directions

While the Trust-funded nursing position has demonstrated clear clinical and system impact, it is not currently supported through recurrent funding. Experience from 2025 indicates that without a permanently funded nursing role, the pre-clinic function -and by extension the broader integrated care and case conferencing model -would not be viable at scale.

Securing recurrent funding for a full-time EN is therefore the highest workforce priority for WSD. This investment protects efficiency gains already achieved, maximises the return on specialist and educator time, and underpins improved patient outcomes. Relative to specialist staffing costs, the nursing role represents a highly cost-effective intervention with disproportionate system benefit.

In 2026, WSD will focus on strengthening and scaling the pre-clinic function by embedding pre-clinic process and outcome metrics into routine service evaluation; linking pre-clinic data with Lumos and other population-level datasets to support longitudinal outcome tracking; consolidating demonstration sites; and progressively scaling nurse-led pre-clinic preparation across additional clinics and rural services, aligned with workforce capacity and digital infrastructure.

Integrated Specialist-GP Consultation, Multidisciplinary Care and Transition

Together with structured pre clinic preparation, the day of Specialist and GP consultation, between visit support and transition back to primary care complete the WSD Model of Care as an integrated continuum rather than discrete episodes of care. This phase is deliberately designed to ensure specialist input is focused where it adds greatest value, general practice capability is strengthened, and continuity of care is maintained beyond the specialist setting.

In 2025, WSD consolidated this middle and downstream phase of care to improve clinical focus, workflow efficiency and continuity across the care pathway. The focus was on making specialist consultations purposeful, follow up proactive, and transition back to primary care timely, well supported and safe.

Day of Specialist and GP Consultation Model

Most initial consultations in 2025 were delivered through a blended model, with patients attending



WSD clinics in person while their GP joined virtually via Healthdirect. This model supports a shared clinical conversation between the patient, GP and specialist team, anchored in CGM data, pathology and patient reported priorities established during pre clinic preparation.

At MDCHC, the Blacktown Integrated Care Clinic and Blacktown Outpatients Clinics, a defining feature of practice is the structured multidisciplinary discussion that occurs before patients are seen. Specialists, Advanced Trainees, RMOs and GP VMOs meet with CDEs, nursing staff and dietitians to review each patient in advance. CGM data, pathology, patient survey responses and GP referral information is synthesised into a concise preclinic summary document that serves as a shared reference point for clinical decision-making.

These pre-consultation discussions align clinical thinking across the team, support learning for ATs, RMOs and GP VMOs, and promote consistent decision-making across sites. They also provide a structured opportunity to reflect on cases and refine pathways, workflows and decision-making. In this way, the pre-consultation process functions both as clinical planning and as an embedded continuous quality improvement mechanism within the WSD Model of Care.

The pre-clinic workup and summary document also underpin communication with general practice following consultation. Information synthesised prior to review is used by Specialists, ATs and GP VMOs to generate clear, consistent correspondence to the patient's GP. Where the GP is not present in the virtual consultation, WSD medical staff -including Staff Specialists, AT registrars and GP VMOs - routinely contact the GP directly to invite input into management decisions and confirm agreed next steps. This direct engagement is most consistent at key transition points, particularly when care is being formally transferred back to general practice.

The blended consultation model supports:

- Face-to-face patient education, examination and CGM support;
- Real time GP involvement, education and upskilling; and
- Coordinated multidisciplinary input, including CDEs and dietitians where indicated.

A central strength of this model is its deliberately multidisciplinary design. A CDE is present in every

consultation, acting as the coordinating clinician who brings the team together, translates clinical recommendations into practical actions, and ensures patients understand how to implement agreed management plans in daily life.

Dietitians are routinely involved following Specialist and GP consultations, with appointments scheduled to support patients to work through agreed dietary strategies informed by CGM patterns and patient-identified priorities. This sequencing ensures nutritional advice is closely aligned with clinical decisions and personalised goals, rather than delivered in isolation.

The ongoing use of CGM, together with the Health2Sync app, enables continuity between visits. Educational videos and resources delivered through GoShare directly within the app reinforce consultation messages, support self-management and reduce reliance on repeated face-to-face or telephone contact. It is the integration of multidisciplinary consultation, coordinated education, digital monitoring and targeted education -delivered as a single, coherent package – that underpins the consistently strong outcomes observed in the WSD Model of Care. Evaluation of this integrated approach is presented later in this report under the Evaluation section, with findings published in the peer reviewed literature.

Where clinically appropriate, subsequent consultations occur virtually or are hosted within general practice. This supports continuity, convenience and reduced duplication between primary and specialist care. In 2026, WSD will continue to expand GP hosted consultations and further streamline shared care through integrated digital platforms.

Post consultation and Between Visit Support

Following specialist review, patients receive structured post-consultation and between-visit care designed to maintain momentum, optimise therapy and reinforce self-management. This phase is delivered through close collaboration between Nurse Practitioners and CDEs, with a clear focus on insulin stabilisation, medication titration and consolidation of agreed management plans.

Care is provided through a blended approach that combines telephone follow-up, secure in-app messaging via Health2Sync and face-to-face review when required. Ongoing review of CGM



data-supported by targeted Health2Sync messaging and GoShare educational resources-enables timely intervention and data informed adjustment of therapy, while reducing reliance on telephone contact.

Insulin stabilisation remains a core component of this phase of care. In 2025, referral volumes continued to rise, with at least 30 patients per week supported through structured stabilisation pathways. Secure digital communication improved responsiveness and enabled efficient titration based on CGM trends, supporting both patient safety and workflow efficiency.

Operational nursing support is integral to effective between visit care. The introduction of an EN role in 2025 strengthened clinic capacity by supporting CGM insertion, data uploads and day-to-day processes, allowing educators and clinicians to focus on higher value clinical tasks.

Looking ahead, WSD will expand data triggered follow-up and explore AI enabled feedback within Health2Sync to further enhance between visit care, scalability and system efficiency.

Transition Back to Primary Care

A central objective of the WSD clinical model is timely and confident transition back to GP-led care once clinical targets are achieved or stabilisation is complete. Throughout 2025, WSD emphasised shared learning during consultations, clear and actionable management plans, and accessible rereferral pathways to support continuity and safety.

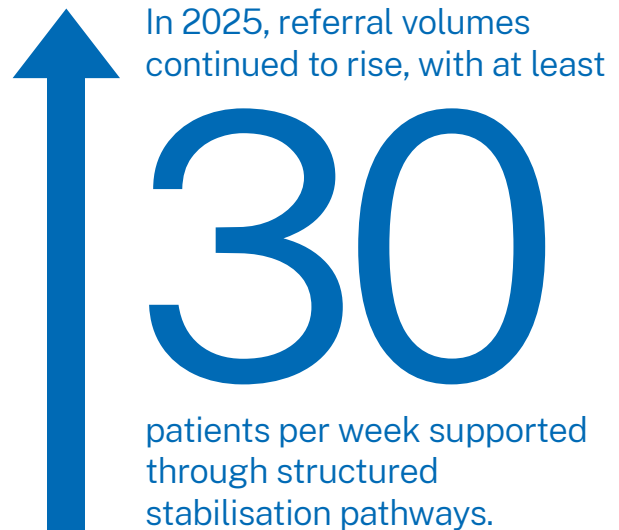
In 2026, WSD will strengthen this transition phase by:

- Formalising transition criteria within the WSD Model of Care;
- Improving tracking of post discharge outcomes; and
- Strengthening links between clinical services and GP education initiatives, including the WSD Masterclass Series.

Together, these elements complete a coherent, end-to-end Model of Care that extends beyond episodic specialist review and supports sustained management within primary care.

Model Impact and System Value

Taken together, this phase of the WSD clinical model delivers value across multiple dimensions. For patients, it supports clearer goal setting, more



consistent follow-up and improved readiness for care, resulting in more meaningful consultations. For the workforce, it provides a structured learning environment for ATs, RMOs, GP VMOs, Nurse Practitioner, Educators, nurses, and dietitians reinforcing shared standards, clinical confidence and multidisciplinary capability.

From a system perspective, the deliberate sequencing of pre clinic preparation, coordinated consultation and proactive follow up improves clinic efficiency, reduces duplication between primary and specialist care, and ensures specialist input is targeted where it adds greatest value.

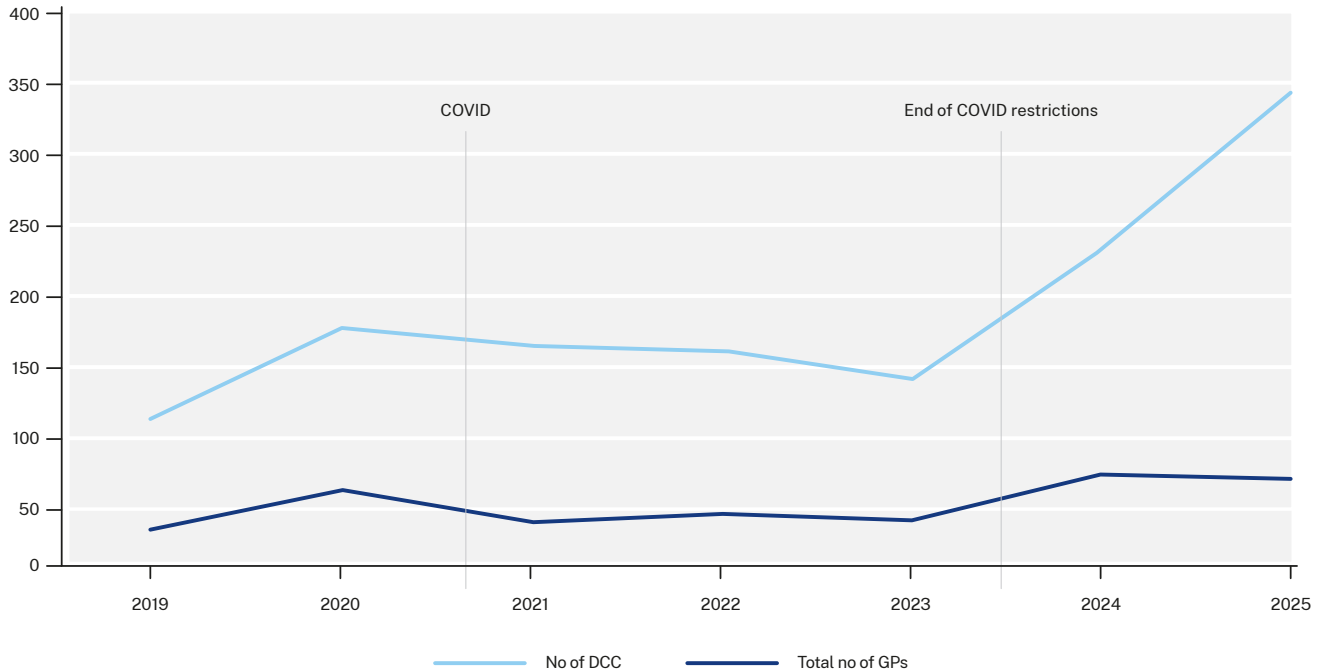
Few hospital outpatient services operate with this level of integration and throughput. The WSD model combines high patient flow with embedded multidisciplinary teams, structured preparation and well documented outcomes. A strong emphasis on timely discharge back to GP led care preserves specialist capacity for patients with the greatest clinical complexity and underpins the operational performance and sustainability of the model.

Westmead Specific Clinical Pathways

While aligned to the same core principles of shared care, GP engagement and digitally enabled decision making, clinical delivery at Westmead in 2025 reflected local staffing configurations and service capacity rather than fundamental differences in model design. Two complementary services illustrate how the WSD model has been adapted to meet local need while extending specialist reach.



Figure 9: Annual number of diabetes case conferences and participating GPs at Westmead, 2019–2025



Westmead Diabetes Case Conferencing

The Westmead Diabetes Case Conferencing service continued to support GPs already engaged with the program while progressively expanding access to new practices. It addresses gaps in hospital based diabetes clinics by providing structured virtual case conferences for GPs whose referrals do not meet criteria for face to face review in the Westmead Type 2 Diabetes Clinic.

In 2025, 63 GPs participated in 344 virtual case conferencing sessions (see Figure 9). As illustrated, activity was sustained through the COVID period, with a marked increase following the lifting of COVID restrictions, reflecting both pent up demand and the growing acceptance of virtual case conferencing as a routine component of shared care. This sustained activity demonstrates the value of extending specialist input into primary care, supporting complex decision making and strengthening GP capability without increasing pressure on outpatient clinics.

Rapid Access and Integrated Care Diabetes Clinic – Westmead

WSD’s Westmead endocrinologist plays a key role in the delivery of the Rapid Access and Integrated Care Diabetes Clinics at Westmead. These clinics provide timely specialist review for people with diabetes requiring urgent assessment, supporting both admission avoidance and safer transitions from hospital to community care.

In 2025, the service strengthened hospital-community integration by enabling rapid clinical input for patients whose needs could be managed without inpatient admission and facilitating early discharge with appropriate follow up. Key features include urgent specialist review within one-week, ambulatory management to reduce avoidable admissions, and coordinated follow up to support continuity of care in the community.

Together, the Westmead case conferencing service and the Rapid Access and Integrated Care Clinics demonstrate how the WSD Model of Care can be implemented through different operational pathways, while reinforcing the same system objectives:



extending specialist expertise into primary care, improving access and flow, reducing avoidable hospital utilisation, and supporting high quality, patient centred diabetes care. In 2026, WSD plans to deploy its clinical and educator workforce differently to support wider adoption of the core elements of this model at Westmead, subject to available staffing resources.

Policy and Funding Implications

The effectiveness of this model currently relies on the professional goodwill of specialists and general practitioners working collaboratively across traditional funding and organisational boundaries. While this has enabled the model to function, it is not a sustainable basis for widespread adoption.

WSD has demonstrated the clinical value of active GP engagement in specialist consultations, shared decision making and structured transition back to primary care. Reflecting this, current research proposals -including the eCARE project in rural NSW -explicitly include practice and GP payments to support participation, coordination and ongoing engagement. Early experience indicates that such structural supports are critical to scaling the model equitably beyond highly motivated individuals and sites.

To enable broader uptake, policy and funding settings must evolve to support collaborative care, shared consultations and longitudinal management. Aligning reimbursement mechanisms with this way of working would legitimise and normalise the model, reduce reliance on goodwill, and make participation feasible across diverse practice settings. The evidence generated by WSD provides a strong foundation for policymakers to consider and support this as a high value Model of Care.

Multidisciplinary Community Diabetes Clinics at Mount Druitt Community Health Centre (MDCHC)

Ana Murugesan, Nurse Practitioner

Overview and maturity of the model

The multidisciplinary MDCHC delivers specialised, comprehensive diabetes care for the Mount Druitt community each Thursday morning. Established and refined over more than five years, this distinctive community-based model is now a mature, well-embedded program within WSD.

The model has been formally evaluated and documented by the Agency for Clinical Innovation (ACI) and demonstrates strong, consistent clinical and system outcomes. It is no longer a pilot or proof-of-concept, but a stable, high-performing service that WSD intends to maintain as a core element of its clinical delivery.

GP Visiting Medical Officer (VMO) workforce model and capability building

A defining feature of the MDCHC clinic is its GP VMO workforce model. At any one time, the clinic employs four GP VMOs drawn from the local community, typically appointed for six- or 12-month periods. These clinicians work in a hybrid role that combines elements of registrar-level specialty training with the breadth, contextual understanding and continuity of experienced general practice.

This structure enables delivery of high-quality specialist-supported care while deliberately building advanced diabetes capability within the general practice workforce. GP VMOs develop confidence and expertise in managing complex diabetes through close supervision and multidisciplinary input and then carry this capability back into their own practices at the conclusion of their appointments.

To date, 27 GP VMOs have completed the program, supported by extended one-year contracts that enhance continuity of care and allow deeper skill development. Through participation in the clinic, GP VMOs build capability in:

- Managing complex diabetes in the context of social determinants and lifestyle factors;
- Medication optimisation, including initiation and titration of insulin therapy;
- Application and interpretation of CGM sensor data; and
- Integration of CGM insights into routine clinical decision-making.

Beyond direct clinical care, GP VMOs contribute to broader workforce development. They routinely contact patients' usual general practitioners when those GPs are unable to join virtual case conferences, to seek input, align management decisions and maintain engagement. This collaborative approach is highly valued by local GPs, who view the MDCHC clinic as strongly complementary to routine general practice care. Many GP VMOs also contribute to delivery of the



WSD Masterclass Series, extending the reach of the model and disseminating practical expertise across primary care.

Orientation, training and professional development

New GP VMOs receive a comprehensive digital orientation pack developed by the WSD team. This includes structured training materials and professional education videos designed to support consistent, high quality clinical practice and ongoing professional development in diabetes care.

Multidisciplinary Model of Care

The effectiveness of the MDCHC clinic is underpinned by a tightly integrated, co-located multidisciplinary team that works together before, during and after each clinic session.

Each Thursday clinic is supported by two inTouch nurses who attend in person. They participate in pre-clinic multidisciplinary discussions and see patients alongside GP VMOs during consultations, enabling the team to address the social, behavioural and system-level complexity that frequently accompanies diabetes care.

While diabetes management is often clinically straightforward, patients' circumstances can be complex. The involvement of inTouch nurses allows the team to respond to this complexity in a practical, patient-centred way, supporting achievable, incremental progress in partnership with patients.

The core clinical team includes:

- The Nurse Practitioner, who facilitates the Thursday GP VMO clinic and provides clinical leadership, coordination and continuity;
- Endocrinologists, CDEs and a Diabetes Nurse Practitioner, providing specialist oversight and education;
- Dietitians, present on the day of the clinic and embedded within the model to deliver personalised nutrition assessment aligned with clinical decisions; and
- inTouch nurses and care navigators, providing health coaching, care coordination and social support alongside clinical care.

Specialist input is provided on-site, with four consultation streams running in parallel. This allows specialist expertise to be leveraged across multiple

patients simultaneously, increasing reach and efficiency compared with traditional one-to-one outpatient consultations while maintaining clinical oversight.

CGM plays a central role across the clinic. CGM supports patient engagement, guides clinical decision-making for GP VMOs and specialists, and serves as a powerful teaching tool within the multidisciplinary team, reinforcing consistent, data-driven care and accelerating workforce skill development.

Nurse Practitioner clinics and ongoing support

Across the week, the Nurse Practitioner delivers comprehensive diabetes education and ongoing support, with a strong focus on insulin stabilisation, self management skills and patient empowerment. Advanced digital tools, including Libre CGM systems and the Health2Sync app, enable efficient communication, timely review of glucose trends and accurate insulin dose adjustment.

The Nurse Practitioner also provides expert guidance for insulin pump initiation, optimisation and troubleshooting, with tailored follow up to ensure safe and effective therapy. Additional support is provided for patients who experience challenges with technology, including regular telephone contact and individualised one to one sessions to build essential self management skills such as blood glucose monitoring, insulin administration, hypoglycaemia management and lifestyle modification.

Integrated care and inTouch support

Collaboration with the inTouch Integrated Care team is a core component of the MDCHC model. inTouch nurses and care facilitators support patients with complex needs by addressing social, behavioural and practical barriers that influence diabetes management and overall wellbeing.

In addition to clinic-based care, inTouch staff provide follow-up, health coaching and care coordination between appointments. Support includes goal setting, navigation of services, reinforcement of self-management skills and sustained encouragement over time.

A structured 12-week self-management program supports behaviour change through skills development, regular follow-up and patient empowerment. In 2025, 377 patients were referred to the inTouch service from the Mount Druitt clinics, with 83 enrolled. Of these, 31 required dedicated care



coordination and 68 were supported through health coaching. These activity patterns are illustrated in the accompanying figures.

The integration of inTouch nurses into pre-clinic planning and consultations is highly valued by GP VMOs and local general practitioners, who view the MDCHC clinic as strongly complementary to routine general practice care.

Sustainability, system value and future directions

The MDCHC clinic is a proven, high value model that WSD intends to maintain as a core service. Importantly, the volume and complexity of clinical activity generated through the clinic produces substantial NWAU activity, which largely offsets the direct costs of service delivery. This makes the model operationally sustainable within existing funding frameworks.

The principal additional value of the MDCHC clinic lies not in marginal clinical throughput, but in its role as a workforce and system capability builder. The GP VMO model develops a cadre of highly skilled general practitioners with deep expertise in the WSD Model of Care, including multidisciplinary working, CGM enabled decision making and shared care with specialists. As GP VMOs rotate back into community practice, this capability is retained within the local health system and diffuses across primary care.

Local GPs consistently value the MDCHC clinic and view it as strongly complementary to routine general practice, reinforcing shared care rather than competing with it. The active engagement of GP VMOs with patients' usual GPs, together with their involvement in delivering the WSD Masterclass Series, further extends the reach and impact of the model beyond the clinic itself.

WSD does not propose to redesign or fundamentally change this model; it is working well and delivering consistent outcomes. However, with targeted, additional investment, the model could be replicated in other parts of the Local Health District. Such expansion would require deliberate funding to support the GP VMO workforce and Nurse Practitioner roles that underpin the model, rather than reliance on short term or ad hoc arrangements.

The return on this investment would be a scalable, workforce embedded model that strengthens general practice capability, extends specialist expertise into the community, and supports sustainable, high quality diabetes care at scale.

GP VMO and inTouch reflections

Selected reflections from GP VMOs and inTouch clinicians are below. These perspectives illustrate the professional development, multidisciplinary collaboration and patient centred impact that underpin the ongoing success of the MDCHC model.



Dr Melissa Lau

“The opportunity to work as a GP VMO at the Mount Druitt Diabetes Clinic this year has been both professionally rewarding and personally meaningful. Working with a diverse and often complex patient population strengthened my skills in managing diabetes within a multidisciplinary team, while deepening my understanding of culturally appropriate, patient-centred care. I truly value the opportunity to collaborate closely with Prof Maberly and Dr Jayaballa, the incredibly experienced nurse practitioners, and allied health staff, and to support patients in achieving practical, sustainable improvements in their health. Overall, the role has reinforced my commitment to chronic disease management in underserved communities in Western Sydney.”



Dr Libby Ashton-Jones

“Working at the Mount Druitt Community Centre Diabetes clinic has been a thrilling headfirst dive into the cutting edge of diabetes care in the community. It has been inspiring watching the multidisciplinary team scaffold our patients to achieve success, and it has opened my eyes to the amazing resources we have in Western Sydney for our patients and primary care clinicians. I am looking forward to learning as much as I can for the rest of my time with the team.”



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Figure 10: Referrals, clinical encounters, and enrolments to the inTouch service from Mount Druitt clinics, 2025

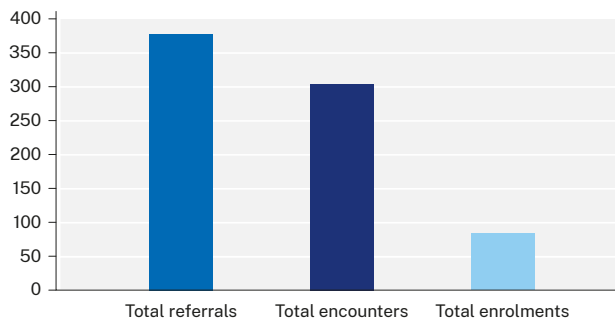
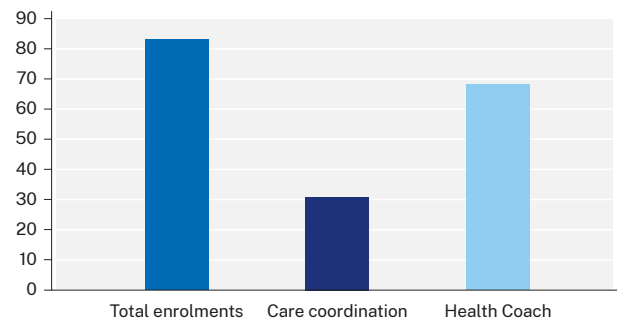


Figure 11: Distribution of enrolled patients by type of inTouch support, Mount Druitt clinics, 2025 (Total enrolled = 83)



“WSD is focused on glycaemic control in Type 2 diabetes. I often hear, ‘Diabetes is easy, people are difficult.’ As an inTouch clinician, I see how complex patients’ lives can be, and how this affects their care. By offering self-management support and helping patients set SMART goals, we can better support them to manage their health.”

Katie Todd, inTouch Nurse

Looking Ahead

To improve efficiency and patient flow, referrals for inTouch review will now be initiated directly by WSD staff, ensuring timely allocation of support and stronger collaborative pathways.

Dietetics and Exercise Physiology

Victoria Silvestro, Senior Dietitian

Purpose and role within the WSD Model of Care

Dietetic and exercise interventions are foundational to effective diabetes prevention, early intervention and long-term management and are embedded across the WSD Model of Care. Diabetes Australia recommends that all people with diabetes receive individualised dietary education from a qualified dietitian. In line with this, WSD aims to ensure that people with pre-diabetes and diabetes have access to high-quality, evidence-based nutrition and lifestyle support that promotes sustained behaviour change, metabolic optimisation and, where possible, disease remission.

This function spans prevention, early detection and specialist management, reinforcing WSD’s integrated approach rather than treating dietetics and exercise as adjunct services.

Clinical activity and contribution to outcomes

In 2025, WSD Dietetics delivered more than 470 occasions of service, including 233 new patients. Dietetic consultations are closely aligned with the broader clinical pathway and typically occur following case conferencing and specialist review. Increasingly, consultations are supported by CGM, enabling



dietitians and patients to use AGP reports and food diaries to identify post prandial glucose responses and directly link dietary patterns to glycaemic outcomes.

This data informed approach supports more precise education, accelerates learning and improves self-management. It reflects WSD's emphasis on integration, patient activation and sustained improvement rather than episodic advice.

Population scale, capacity constraints and system design

WSD operates in a context of very large unmet need. Across the catchment, it is estimated that approximately 100,000 people are living with diabetes and a further 300,000 with pre diabetes. It is neither feasible nor appropriate for all these individuals to receive ongoing, individualised dietetic care through specialist services alone. This reality has shaped WSD's service design, requiring a combination of targeted specialist input, workforce partnerships, education and digital enablement.

WSD currently operates with approximately 1.2 full time equivalent dietitian positions across all clinics. Optimising the impact of this limited resource is therefore critical. In response, WSD is deliberately building a network of private practice dietitians and Accredited Exercise Physiologists across the region to deliver consistent, high quality care in partnership with the WSD team. Patient information resources have been developed to support appropriate referral and continuity of care beyond WSD clinics.

Integration with prevention, early detection and education

Dietetic services are closely linked to WSD's prevention and early detection programs. Early detection activities identify large numbers of people with pre diabetes, many of whom are referred into the WSD *2kg Challenge*. Developed and led by the WSD Prevention Manager, who is a dietitian, the *2kg Challenge* provides a structured, achievable entry point into lifestyle change.

The program encourages people who are overweight to lose an initial 2kg as a practical first step towards healthier eating and increased physical activity. For people with a recent diagnosis of type 2 diabetes (generally within six years), evidence indicates that weight loss of approximately 8–10% can often result in remission, positioning the *2kg Challenge*

as both a prevention intervention and an early management strategy.

Participants are actively connected to locally available physical activity opportunities, including low cost or free community based programs, and are encouraged to enrol in the NSW Health *Get Healthy Service* to access structured coaching and ongoing support. This integration strengthens continuity between population level prevention and clinical care.

To further extend reach, WSD has developed short, animated education videos covering key nutrition and lifestyle topics. These resources, described in detail later in this report under Education, are designed to extend dietetic expertise at scale and provide consistent, evidence based guidance to patients and primary care providers.

Digital enablement and CGM informed care

WSD is working closely with Health2Sync to develop a digital self management coaching platform. Patients can upload food photographs for analysis, supporting personalised feedback and recommendations. When combined with CGM data, this approach is particularly powerful, allowing patients and clinicians to directly observe the drivers of glucose excursions and collaboratively adjust dietary patterns to flatten glycaemic curves.

While CGM is valuable for clinicians and diabetes educators, it is often most transformative in dietetic practice. CGM provides objective insight into the timing and impact of carbohydrate consumption. CGM informed dietetic intervention allows patterns to be identified and addressed more effectively.

Dietetic care within WSD is therefore intentionally iterative and multidisciplinary. Patients commonly attend multiple dietetic consultations, often while wearing a CGM sensor, enabling advice to be refined over time. This approach supports improved outcomes across heterogeneous type 2 diabetes phenotypes, including people with obesity and insulin resistance as well as those with relatively preserved weight but limited insulin reserve. Close collaboration between dietitians, diabetes educators and medical staff is essential to co designing effective, individualised management plans.

Workforce development and evidence generation

Building system capability is a central objective of the dietetics program. The community network



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of dietitians and exercise physiologists is strongly represented within the WSD Masterclass Series, which provides advanced, up to date education to support consistent standards of care across the region.

In parallel, the Senior Dietitian is undertaking a PhD focused on CGM informed coaching models for dietary self management in workforce constrained environments. This work includes a pilot study comparing individualised dietetic care with app based self management education and will inform a future randomised controlled trial. Together, these initiatives aim to identify scalable models that preserve quality while extending reach.

Planned enhancements for 2026

In 2026, WSD will further strengthen dietetic and lifestyle support for people who are overweight or obese at the time of referral, particularly in the context of rapidly evolving pharmacotherapy for type 2 diabetes. Increasing use of GLP 1 receptor agonists and related agents has transformed weight management and glycaemic control but also introduces new risks, including rapid weight regain on cessation and loss of lean muscle mass during weight reduction.

These developments reinforce the need for professional, dietitian led care integrated with medical and exercise support. WSD is adapting its model to ensure patients receiving GLP 1-based and similar therapies are supported with appropriate nutrition education, monitoring and physical activity guidance.

For selected patients, structured weight reduction programs incorporating meal replacement strategies may offer additional benefit when delivered with appropriate dietetic oversight. To support scalability and efficient use of limited capacity, WSD plans to introduce group based dietetic sessions focused on weight management and meal replacement approaches. These sessions will complement individual consultations and digital supports, enable peer learning while strengthening WSD's integrated approach to weight management, diabetes remission and long term metabolic health.

Accredited Exercise Physiologists and Psychology

Accredited Exercise Physiologists (AEPs) play an important role in the prevention and management of type 2 diabetes. Structured exercise supports glycaemic control, weight management and protection of cardiovascular and renal health and is integral to sustainable lifestyle change.

More than

800

GPs have engaged with WSD

While WSD does not currently employ an AEP, the service works collaboratively with local providers, including participation in diabetes case conferences as part of the Diabetes Together Model of Care. The Senior Dietitian has taken on an expanded role in supporting physical activity advice and program linkage; however, this does not replace the specialist expertise of an AEP. The absence of a dedicated AEP within the core WSD team represents a recognised gap in the current model.

Similarly, WSD does not currently have access to embedded psychological expertise, despite the strong and well established links between mental health, diabetes self management, obesity, medication adherence and long term outcomes. Psychological distress, disordered eating, depression and anxiety are common among people living with diabetes and frequently undermine otherwise well designed clinical and lifestyle interventions.

Identified workforce gaps and future investment priorities

WSD considers the absence of an AEP and a psychologist within the multidisciplinary team to be a material limitation on the effectiveness and sustainability of the model. While strong partnerships and goodwill arrangements have partially mitigated these gaps, they are not a substitute for integrated, team based expertise.

WSD is therefore actively seeking resources to enable the appointment of a dedicated AEP and a psychologist within the service. Embedding these roles would strengthen comprehensive lifestyle intervention, support patients receiving newer



pharmacotherapies, improve mental health support, and further enhance outcomes across prevention, early intervention and specialist care. Investment in these roles would align with WSD's integrated model and significantly increase its capacity to deliver high value, patient centred diabetes care at scale.

Quality Improvement in Primary Care

Dr Rajini Jayaballa, Endocrinologist

Jaybee Serrano, Credentialed Diabetes Educator

Jane Assange, Director Primary Care Transformation and Integration

Jasmine Glennan, Senior Manager Primary Care

Maha Sedhom, Lead - Quality Improvement Implementation, WSPHN (WentWest)

WSD is implementing a Diabetes Quality Improvement (QI) Program in general practice to address the growing burden of *diabesity* - the co occurrence of obesity and type 2 diabetes - across Western Sydney. The program supports general practices to use structured audits, data driven feedback and practical quality improvement methods to improve how diabesity is identified, documented and managed in routine care.

This work is delivered in close partnership with the WSPHN, which enables implementation at scale through its established primary care engagement and continuous quality improvement infrastructure. Together, WSD and WSPHN support recruitment, data extraction, coaching and implementation across diverse general practice settings.

Through data driven audits and tailored practice support, the program aims to make care more systematic, proactive and sustainable. It aligns directly with WSD's broader strategy to change the diabetes trajectory in Western Sydney and links explicitly with the regional early detection agenda and the *2kg Challenge* - creating a clear pathway from early identification to structured prevention and management.

In 2025, participating practices were supported through field based engagement and CQI coaching, helping teams translate audit findings into practical, team based workflow changes.

Program stage and direction

Now entering its second year, the program's first phase (supported by Eli Lilly) focused on co

developing the audit tool with WSPHN, aligning it with existing primary care systems, and piloting the approach in early adopter practices. The focus for 2026 is scale up, extending the refined audits and improvement processes to a larger number of practices across Western Sydney.

What the Diabetes QI Program enables

Participating practices are supported to:

- Assess care delivery using structured audits
- Receive tailored, data driven feedback
- Embed practical and sustainable clinical workflows
- Act on practice level data to drive improvement
- Test and refine a scalable model of diabesity care

QI Program Components

The program combines WSD clinical leadership with WSPHN's practice support infrastructure - including Primary Care Facilitators and Coordinators and established Continuous Quality Improvement methods - to enable implementation across diverse general practice settings.

Data Analysis and feedback

PenCS based data analysis identify gaps in coding, documentation and clinical management.

Practice support

Education, clinical tools and technical support provided jointly by WSD and WSPHN.

Network integration

Alignment with WSPHN's Patient Centred Medical Home and CQI programs to support sustainability.

Engagement and reach

More than 800 GPs have engaged with WSD, providing a strong foundation for scale.

Baseline measures

Demographics; metabolic risk factors (smoking, BMI, waist); pathology (HbA1c, cholesterol, eGFR); complications; medications; and referrals.



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Followup

Baseline data analysis with 6- and 12-month follow-ups.

Root Cause Analysis

Practice visits identify workflow barriers, data entry issues, team capacity for change and system inefficiencies. These insights inform targeted, practice specific improvement strategies rather than generic interventions.

Interventions

Interventions are tailored to each practice and include:

- Practice specific action plans derived from audit findings
- Context specific improvement goals
- Early detection with referral to the *2kg Challenge*
- Case conferencing for complex care
- Ongoing support from the Primary Care Development team
- Continuous monitoring of implementation

Data and Outcomes

WentWest supports repeatable data extraction and reporting processes, enabling practices to benchmark performance and track improvement over time. Recruitment is supported through PenCS based data extraction and automated reporting to facilitate scalability.

Key outcome domains include:

- Improved documentation of BMI and waist circumference
- Reduced missing metabolic risk data
- Increased diabetes detection through HbA1c testing
- Greater use of evidence based therapies
- Stronger referral pathways to allied health and specialist care

The program is designed for long term impact through integration with WSPHN's CQI infrastructure, a practice agnostic audit model, ongoing WSD and Primary Care Development support, continuous data analysis refinement, and alignment with future public funding and incentive frameworks.

Monthly reviews and GP level feedback drove engagement and accountability, resulting in

93%

of patients having an up to date HbA1c

Development, scale and evaluation

2025 – Development and pilot

Key activities include the development of the Data Analysis tool development; pilot implementation across five practices; follow up data analysis; refinement of tools and workflows; education and implementation support.

2026 – Scale up and evaluation

2026 will include expansion to at additional practices; repeat data analysis; continued refinement and support; outcome analysis and preparation of a peer reviewed publication.

Early findings from participating practices

In 2024–2025, across seven practices (21,820 active patients), WSD analysed type 2 diabetes prevalence, HbA1c distribution and prescribing patterns. Findings highlighted clear opportunities for therapy optimisation, including high sulfonylurea use and lower uptake of SGLT2 inhibitors and GLP1 receptor agonists. These insights informed targeted actions using the Diabetes Connecting Care model, CGM-guided titration and clinician education. Follow up is planned for 2026, with the overarching objective remaining practice level quality improvement.



Table: Key outcome domains from participating practices in the last 12 months

Practice and date of data extraction	Active patients	Patients living with T2DM	HbA1c >7%	No HbA1c recorded	BMI for active T2DM patients NOT recorded	Waist circumference NOT recorded	SGLT2i	GLP1 RA	MBS 721 - Practice Management Plan for active T2DM patients
Practice 1, Nov 2024	4,125	388 (9.4%)	130 (33.5%)	10 (2.6%)	56 (14.4%)	99 (25.5%)	144 (37.1%)	91 (23.5%)	230 (59.3%)
Practice 2, Nov 2024	6,593	869 (13.2%)	340 (39.1%)	171 (19.7%)	173 (19.9%)	849 (97.7%)	365 (39.1%)	110 (12.7%)	74 (8.5%)
Practice 3, Jan 2025	1,238	78 (6.3%)	24 (30.8%)	31 (39.7%)	25 (32.1%)	40 (51.3%)	27 (34.6%)	26 (33.3%)	13 (16.7%)
Practice 4, Feb 2025	4,589	151 (3.3%)	52 (34.4%)	44 (29.1%)	35 (23.2%)	151 (100%)	30 (19.9%)	11 (7.3%)	47 (31.1%)
Practice 5, Feb 2025	2,075	205 (9.9%)	57 (27.8%)	37 (18%)	32 (15.6%)	166 (81%)	52 (25.4%)	27 (13.2%)	128 (62.4%)
Practice 6, Mar 2025	3,200	197 (6.2%)	65 (33.1%)	65 (33.0%)	85 (43.1%)	196 (99.5%)	58 (29.4%)	17 (8.6%)	84 (42.6%)
Practice 7, Apr 2025	20,720	1,299 (6.3%)	301 (23.1%)	432 (33.3%)	777 (59.8%)	1295 (99.7%)	304 (23.4%)	58 (8.4%)	519 (40%)

Partnership with WSPHN – practice collaboration (boxed summary)

Practice based quality improvement at scale

This work is fundamentally enabled by the partnership with the WSPHN, whose system level practice engagement and CQI infrastructure underpin the reach and sustainability of the Diabetesity QI Program across Western Sydney.

In 2024–2025, WSPHN delivered 3775 visits to general practices, engaging 455 general practitioners and 257 primary health care nurses. Acting as change facilitators, WSPHN supported practices to embed quality improvement approaches, respond to system reforms (including Chronic Conditions Management changes) and implement sustainable workflows that improve care coordination and patient experience.

Collaboration between WSPHN and WSD has been further strengthened through the jointly developed Diabetes Data Dashboard, supporting place based planning and improved outcomes, particularly across Cumberland.

Practice exemplars

Lejeune Family Practice

Faced with a large cohort of patients at risk of undiagnosed diabetes, the practice undertook a comprehensive data cleansing process using CAT4 tools. An initial list of 204 patients was refined to 57, many of whom were identified as having pre diabetes and enrolled in the *2kg Challenge*. The practice now maintains a more accurate diabetes register, improved coding practices and proactive processes for identifying pre diabetes.

Hills Family General Practice

Using run charts and detailed data analysis, the practice strengthened HbA1c monitoring and patient education. Monthly reviews and GP level feedback drove engagement and accountability, resulting in 93% of patients having an up to date HbA1c – demonstrating the impact of data driven quality improvement.



EDUCATION

Heloise Tolar, eEngagement and Education Manager

Education as a System Enabler

As outlined in the Clinical Engagement section, the WSD Model of Care is centred on building the capability of general practice and community diabetes care providers to deliver high quality diabetes prevention and management. The Education function builds on this foundation by providing the system level structures that align, reinforce and scale capability across the broader health neighbourhood.

Within WSD's framework for Clinical Prevention and Integrated Management, education functions as a deliberate system enabler. It connects specialist expertise with the settings in which diabetes is most commonly managed - including general practice, community health, allied health, hospitals and non traditional care settings – and supports clinicians to work from a shared evidence base and consistent models of care.

The case for this approach is driven by scale and complexity. In Western Sydney, around half of adults attending general practice have pre diabetes or diabetes. Many remain undiagnosed, and a substantial proportion do not achieve recommended targets for glycaemic control, blood pressure or cardiovascular risk. Rapid therapeutic change, combined with diagnostic delay and clinical inertia, contributes to avoidable complications and premature mortality, with the greatest impact borne by socioeconomically disadvantaged and culturally diverse communities.

WSD uses education as a practical system lever to address these gaps. Capability building is directed across the extended multidisciplinary workforce involved in diabetes prevention and care, spanning primary care, community and hospital services, pharmacy, Aboriginal health, allied health and specialist disciplines. This supports earlier diagnosis, timely treatment optimisation, appropriate de prescribing, and a stronger focus on prevention and risk reduction.

This role aligns directly with the WSD Framework for Action by strengthening connected care, enabling earlier intervention and supporting sustainable system improvement. The sections below outline the core education strategies used to operationalise this approach.

A Multi Layered Education Strategy

WSD's education strategy is deliberately multi layered, combining:

- Embedded clinical learning within routine care
- Structured professional education through formal programs
- Scalable digital resources to support reach and consistency

This approach recognises that no single modality is sufficient. Effective education must support real time clinical decision making, reinforce best practice over time, and reach large and diverse audiences across Western Sydney and beyond.

Case Conferencing and Embedded Learning

Case conferencing is a distinctive component of the WSD education ecosystem and is described in detail in the Clinical Engagement section. Within the education framework, it is acknowledged here as part of the overall picture - embedding learning within real patient care, strengthening shared care relationships and supporting multidisciplinary decision making across primary, community and specialist services.

Educational Videos

Digital education forms a central pillar of WSD's education strategy. GoShare educational videos provide short, targeted content for both health professionals and patients.

HealthPathways: Point of Care Clinical Guidance

HealthPathways complements digital education by providing clinicians with locally agreed, evidence based guidance at the point of care. In Western Sydney, HealthPathways is extensively used by general practitioners, nurses and multi-disciplinary health care professionals as a core clinical decision support tool.

The diabetes section is among the most highly utilised pathways and is kept current through close collaboration with the WSD clinical team, ensuring guidance reflects contemporary evidence, new therapies and locally available services. This integration ensures education is not only accessible but embedded directly into day to day clinical practice.



Helen Dick filming the GoShare educational videos.

Masterclass and Rural Masterclass Programs

The WSD Masterclass Series remains the flagship component of the education program, bringing together clinicians from general practice and across disciplines to share updates in diabetes prevention and management, emerging evidence and models of care.

In 2025, the introduction of the Rural Masterclass expanded this offering, providing tailored education to clinicians in regional and remote settings and supporting alignment between metropolitan and rural services.

Following each Masterclass, full presentation recordings and materials are added to the WSD resource library on myINTERACT, creating a large and growing, searchable repository that enables providers to review content on demand and supports sustained learning well beyond the live events.

An Integrated Education Ecosystem

Together, GoShare videos, HealthPathways, case conferencing, and the Masterclass and Rural Masterclass programs form a coherent education ecosystem. This integrated approach ensures that education is embedded within clinical practice, scalable through technology, responsive to local needs, and aligned with WSD's commitment to high quality, integrated diabetes care across Western Sydney and beyond.

Collectively, this program represents one of the most comprehensive and highly engaged diabetes education offerings for community-based providers in Australia. Without overstating the claim, the depth

of integration across in person, virtual, hands on and digital modalities, combined with strong participation from general practice and the wider multidisciplinary workforce, positions WSD as a national exemplar for system wide diabetes education, with relevance beyond Australia.

WSD is proud of the clinicians, educators, faculty, partners and supporters who contribute their expertise, time and leadership to this work. This includes pharmaceutical and industry partners whose collective support enables the practical delivery of the education program, including video production, venue and conference costs, and ontheday engagement through exhibition tables and the provision of educational materials such as CGM devices for participant learning. Together, this collective commitment enables education to operate at a level of sophistication capable of making a meaningful contribution to improving care, reducing risk, and changing the longterm trajectory of diabetes across Western Sydney and beyond.

Educational Videos for Health Professionals and Patients

Helen Dick, Diabetes Educator and Research Nurse Dr Rajini Jayaballa, Endocrinologist

For more than seven years, WSD has invested in the systematic development of short, high quality educational videos for both patients and healthcare providers. This work responds to a fundamental challenge in diabetes care: with very large and growing numbers of people living with diabetes, it



This brought the total WSD video library to more than

220

videos, including over

170 patient focused resources

and almost

50 videos for healthcare professionals

is neither feasible nor efficient to rely on one to one education alone. Scalable, consistent and accessible education is therefore required to reach people at population level while maintaining clinical accuracy and quality.

A Scalable Model for Patient Education

For patients, WSD has focused on short, professionally produced animated videos featuring trusted clinical experts, supported by clear visual storytelling and health literate graphics. These videos address a wide range of practical and clinical topics and are designed to complement clinical consultations, reinforce key messages, and support self management beyond the health system.

Since inception, this program has been supported through a series of transparent, arm's length sponsorship arrangements -initially with Sanofi, and subsequently with Lilly, Abbott and Novo Nordisk -enabling a new batch of videos to be produced each year. Importantly, these partnerships support

production costs only; all topic selection, clinical content and messaging remain led by WSD.

Content Development and Governance

Topics are selected annually based on identified need, emerging priorities and frequent areas of patient and provider enquiry. Scripts are developed by the WSD clinical team, with input from selected partners where appropriate, and are formally reviewed with guidance from the Health Literacy Program at the University of Sydney School of Public Health. This process ensures that content is clinically accurate, culturally appropriate and accessible to diverse audiences.

Healthily is contracted to develop storyboards and manage production. A professional video crew records presentations over several days, after which Healthily completes post production. All videos undergo final review and approval by the WSD team prior to release.

National Uptake and Recognition

During the COVID 19 pandemic, when education rapidly shifted to digital platforms, the value and quality of this resource were recognised by the National Association of Diabetes Centres (NADC) and ACI. WSD videos were incorporated into the Patient Education Resource Library (PERL) and made available on subscription to Diabetes Education Centres across Australia. These resources are now widely used at a national level.

This momentum continued in 2025, with a further 22 videos produced during the year. This brought the total WSD video library to more than 220 videos, including over 170 patient focused resources and almost 50 videos for healthcare professionals.

Topic Coverage

The patient video library spans a comprehensive range of topics supporting prevention, self management and ongoing care:

- Diagnosis
- Mental wellbeing
- Medicines
- Healthy eating and drinking
- Diabetes management
- General diabetes education
- Complications of diabetes



- Physical activity
- Weight management
- Nutrition and diabetes
- Multicultural educational videos
- Media and public information

Integrating Video Education into Program Delivery in 2025

In 2025, video production was deliberately integrated into WSD's core program activities. Educational content was not developed in isolation but embedded directly into major initiatives and campaigns delivered during the year. This approach strengthened consistency of messaging, supported implementation at scale, and linked education tightly to service delivery and prevention priorities.

- **2kg Challenge resources:** Three new videos were developed by the Prevention Manager, Sarah Driscoll - two designed for patients and one for healthcare providers. These resources are now used directly with participants and are also available via the *2kg Challenge* website, supporting consistent lifestyle messaging aligned with the program's goals.
- **DO CAG presentation – Early detection equals prevention:** In 2025, Professor Glen Maberly recorded his presentation to the Diabetes and Obesity Consumer Advisory Group (DO CAG), reinforcing WSD's core message that early detection is central to prevention. This video was developed specifically for general practitioners and is being used as part of the rollout of WSD's early detection campaign launched on World Diabetes Day 2025. Rather than serving as a patient education resource, the presentation is positioned as a clinician-facing illustration of the rationale, evidence and urgency for earlier identification of diabetes and prediabetes, supporting consistent messaging to GPs during campaign implementation.

Integration into Care Pathways

These videos are actively used with patients attending WSD clinics and are routinely shared through the GoShare platform - owned by Healthily - as part of clinic preparation and post consultation follow up. Increasingly, the video library is also being embedded within WSD's digital ecosystem, including the Health2Sync app (Diabetes Together), ensuring consistent access across multiple points of care.



Sarah Driscoll filming the 2kg Challenge videos.

Educational videos and resources are delivered through several complementary channels:

- WSD website
- National Association of Diabetes Centres (NADC) Patient Education Resource Library (PERL)
- myINTERACT
- GoShare platform
- Health2Sync WSD app (Diabetes Together)

This multi channel approach enables WSD to deliver consistent, evidence based education at scale, extend learning beyond the consultation, and support both patients and healthcare providers with timely, practical information that strengthens prevention, self management and high quality clinical care.

From a system perspective, this approach delivers a strong return on scale. A single, clinically governed video can support hundreds to thousands of patients and healthcare providers, far exceeding what is achievable through individual consultations alone, while preserving consistency, quality and equity of access across Western Sydney and beyond.

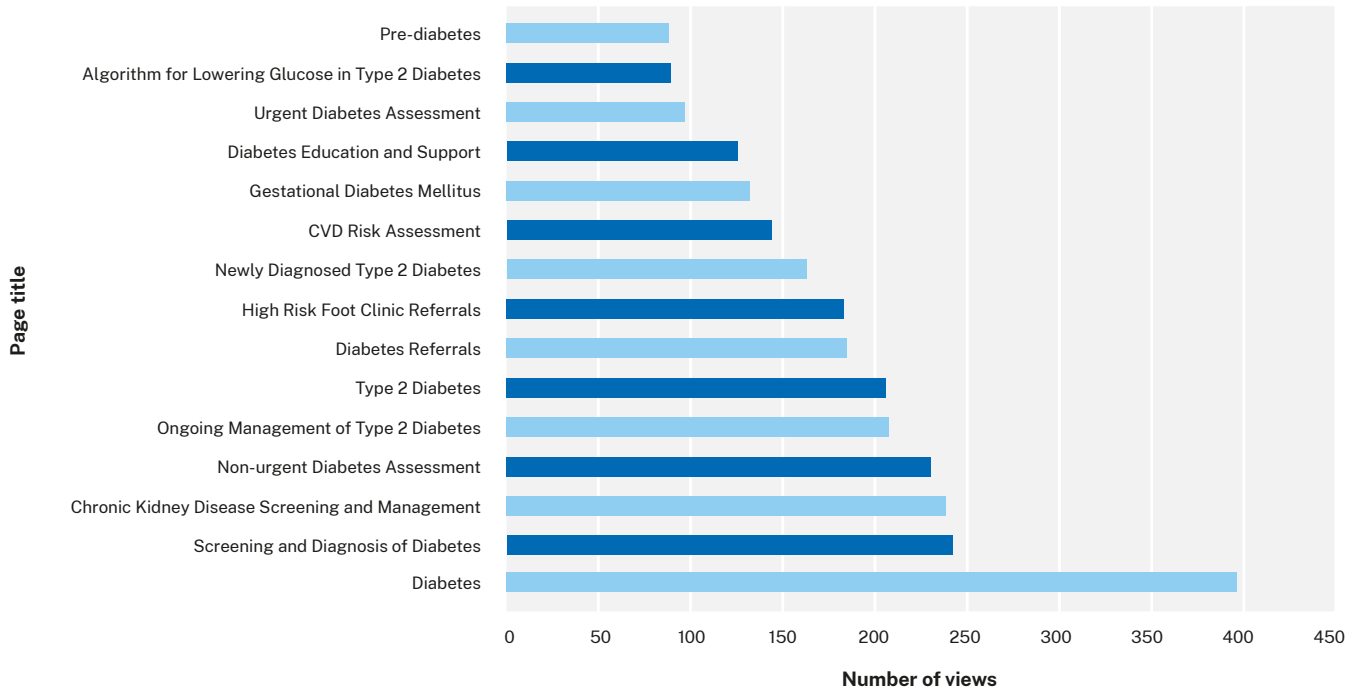
HealthPathways

Now in its 14th year, Western Sydney HealthPathways continues to provide locally tailored, evidence-based clinical guidance to support high-quality care across the region. Managed by WentWest (WSPHN), HealthPathways is a core clinical decision-support tool used extensively by general practitioners and community clinicians at the point of care.

HealthPathways assessment, management and referral pathways are evidence based and co-



Figure 12: Number of page views for diabetes-related HealthPathways pages, Western Sydney, 2025



designed and developed collaboratively by local GPs, specialists and multi-disciplinary health professionals.

Within this platform, diabetes pathways are a consistently high-use component and are maintained through close collaboration between WentWest and WSD’s clinical team. This partnership ensures guidance reflects contemporary evidence, emerging therapies and locally available referral pathways, embedding agreed models of care directly into day-to-day clinical practice.

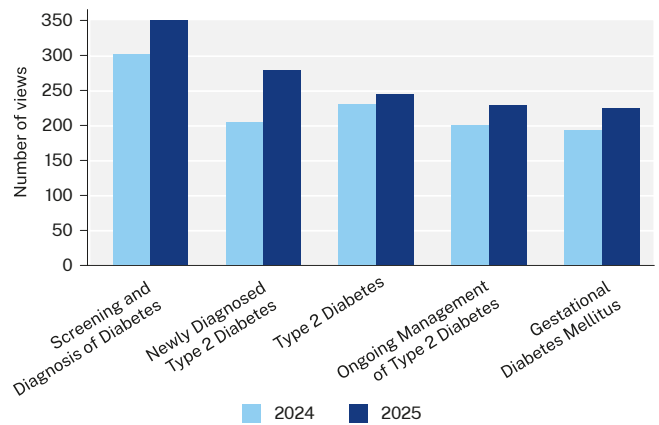
HealthPathways Activity and Use in 2025

In 2025, HealthPathways remained a trusted resource for clinicians caring for people with diabetes across Western Sydney. During the year, partners reviewed and updated multiple diabetes-specific pathways, strengthening clinical guidance, referral clarity and alignment with local services.

Page views increased from 3413 in 2024 to 3710 in 2025, representing an 8.7% year-on-year increase. The most frequently accessed pathways related to screening and diagnosis of diabetes, newly diagnosed type 2 diabetes, ongoing management of type 2 diabetes, and gestational diabetes.

Across the year, diabetes-related pages accounted for 3921 pageviews, representing 3.61% of total platform

Figure 13: Page views for the five most accessed diabetes-related HealthPathways pages in Western Sydney



usage, while comprising 3.32% of all WSLHD’s HealthPathways content. This level of engagement reflects the central role of diabetes management within primary and community care.

What the Data Shows

Patterns of use demonstrate strong clinician demand for clear, practical guidance at key decision points in the diabetes care journey – particularly early



Delegates listening to a Masterclass session.

detection, diagnosis and ongoing management. Growth in pathway views between 2024 and 2025 reinforces the role of HealthPathways as a frontline support for general practice and community healthcare.

Importantly, the prominence of screening and diagnosis pathways aligns with WSD's broader strategic emphasis on earlier detection and prevention, reinforcing consistency between clinical guidance, education initiatives and service delivery.

Integration with WSD Education and Future Direction

HealthPathways complements WSD's broader digital education ecosystem — including educational videos, myINTERACT, GoShare and the Health2Sync app — by providing concise, locally agreed guidance precisely when clinical decisions are being made. Together, these tools support consistent communication with patients, general practitioners and allied health professionals across the care continuum.

Looking ahead, the WSD clinical team is strengthening how it communicates its Model of Care to patients, general practitioners and allied health partners. In 2026, this work will be reflected more explicitly within HealthPathways, ensuring providers have clear insight into the WSD Model of Care, how it differs from usual specialist consultation and clinic processes, and how patients move through WSD services.

This focus will support clearer referral pathways, shared expectations and improved coordination for the community, reinforcing HealthPathways as both a clinical decision-support tool and a transparent guide to how diabetes care is delivered across Western Sydney.

Looking further ahead, there is an opportunity to strengthen integration between HealthPathways and the myINTERACT WSD Resource Library. At the December planning session involving WSLHD and WSPHN core teams, this was identified as a priority area for development. A dedicated resource development working group will lead this work, bringing platforms together to enhance content, improve navigation and ensure providers can more easily access consistent, high-value resources at the point of care.

Western Sydney Diabetes Masterclass Series

Heloise Tolar, eEngagement and Education Manager
Dr Jeremy Knott, Advanced Trainee

The WSD Masterclass Series is a core component of WSD's education strategy, designed to build workforce capability at scale by translating contemporary evidence into practical, locally relevant care. In 2025, WSD returned to a deliberately hybrid delivery model to maximise accessibility, engagement and value for the health system.

Across the year, the Series reached 1605 health professionals, including 1069 registrations for virtual sessions, 536 participants attending the Parramatta face to face Masterclass day, and a further 120+ clinicians attending the Rural Masterclass in Dubbo. This level of participation demonstrates both sustained demand and the efficiency of a hybrid education model in reaching clinicians across metropolitan, rural and regional settings.



Doctors represented approximately

21%

of virtual participants and

26%

of face to face attendees

The audience included a substantial medical cohort - general practitioners, specialists, junior medical officers and registrars - alongside a strong multidisciplinary workforce comprising nurses, diabetes educators, pharmacists and allied health professionals. Doctors represented approximately 21% of virtual participants and 26% of face to face attendees, underscoring the program's relevance to clinical decision making in general practice while supporting team based models of care.

In 2025, the Masterclass Series continued to mature as a hybrid program, combining high quality in person events with live streamed and recorded content. This approach preserved the depth and credibility of specialist education while extending reach, flexibility and sustainability across the health system.

Program Structure and Content

The Masterclass Series provides a structured forum for WSD to consistently surface and reinforce the core themes that underpin its Model of Care. These themes focus on areas of rapid change, high clinical impact and system priority, and are revisited annually to ensure content remains current, relevant and aligned with emerging evidence and local need.

A central focus is medication update and optimisation, reflecting the pace at which diabetes therapeutics continue to evolve. Sessions address new and emerging pharmacotherapies, including GLP 1 receptor agonists and SGLT2 inhibitors, and their implications for glycaemic control, cardiovascular and renal risk reduction, and models of care in general practice.

Prevention and early intervention are consistently emphasised. Sessions highlight awareness, early detection and timely action, including practical

approaches to identifying people at risk and implementing interventions such as the *2kg Challenge*, reinforcing WSD's prevention agenda and supporting earlier intervention along the disease trajectory.

The program also foregrounds culture and place based approaches, recognising that effective diabetes care must be grounded in the communities in which it is delivered. Content showcases local initiatives and models that respond to cultural context and place, strengthening relevance for clinicians working in diverse settings.

In 2025, the Masterclass Series further strengthened its focus on integrated cardiovascular-renal-metabolic (CVRM) care, addressing diabetes management in the context of renal and cardiovascular disease and reinforcing the shift toward integrated CVRM care within general practice.

Digital innovation is embedded throughout the program. Sessions demonstrate how WSD is using digital solutions, including the Health2Sync app, to support shared care, data informed decision making and patient engagement. The growing role of CGM in people with type 2 diabetes is a recurring theme, with practical examples illustrating how CGM is changing conversations, self management and clinical care.

The 2025 Masterclass Series was delivered as a structured, multi week program integrating in person Masterclass days, virtual evening sessions and on demand access to recordings. Each component served a distinct and complementary function.

The virtual Masterclass series focused on delivering up to date insights across emerging and high impact topics, supporting rapid translation of new evidence into practice and broad participation across geography.

In contrast, the in person Masterclass days were designed as interactive workshops, emphasising discussion, peer learning and audience participation. Sessions were delivered in parallel workshop streams and repeated to allow flexibility and meaningful engagement. These live events also provided valued opportunities for clinicians to connect in person and strengthen professional networks.

All sessions were recorded and are available through the myINTERACT WSD Resource Library. This supported both immediate access following live events and sustained engagement over time, enabling clinicians to revisit content, learn flexibly and claim Continuing Professional Development (CPD) points beyond live attendance.



In person Masterclass Day – Program Outline

The full day Masterclass program was structured into morning and afternoon sessions to balance clinical depth with applied discussion:

Morning sessions:

Session	Focus
Keynote	<i>Diabetes Together: How Western Sydney Diabetes Can Support Your Practice</i>
Diabetes Technology	Practical application of CGM and digital tools
Management of Diabetic Nephropathy	Renal risk, referral and integrated care
Early Detection and Pre Diabetes Management	Identification, intervention and prevention
Health Literacy	Communicating risk and complexity effectively

Afternoon sessions:

Session	Focus
Debating the Role of Supplements in Weight Loss	Evidence, myths and patient conversations
Quality Improvement in Primary Care	Audits, feedback and system change
Nature Prescription	Lifestyle, environment and wellbeing
Diabetes and Frailty	Managing complexity in older adults



Week 1 of the virtual Masterclass series focused on an update of diabetes medications.

Participant feedback

Masterclass (Face to Face) Feedback:

"The resource persons in this session were excellent in discussing their topics. Thank you everyone who organised this significant event. Well done!"

"Was extremely helpful to update knowledge."

"This Masterclass was set up very well. All sessions were thoroughly engaging. I would definitely recommend this education day to everyone!"

Virtual Masterclass Series – Evening Sessions

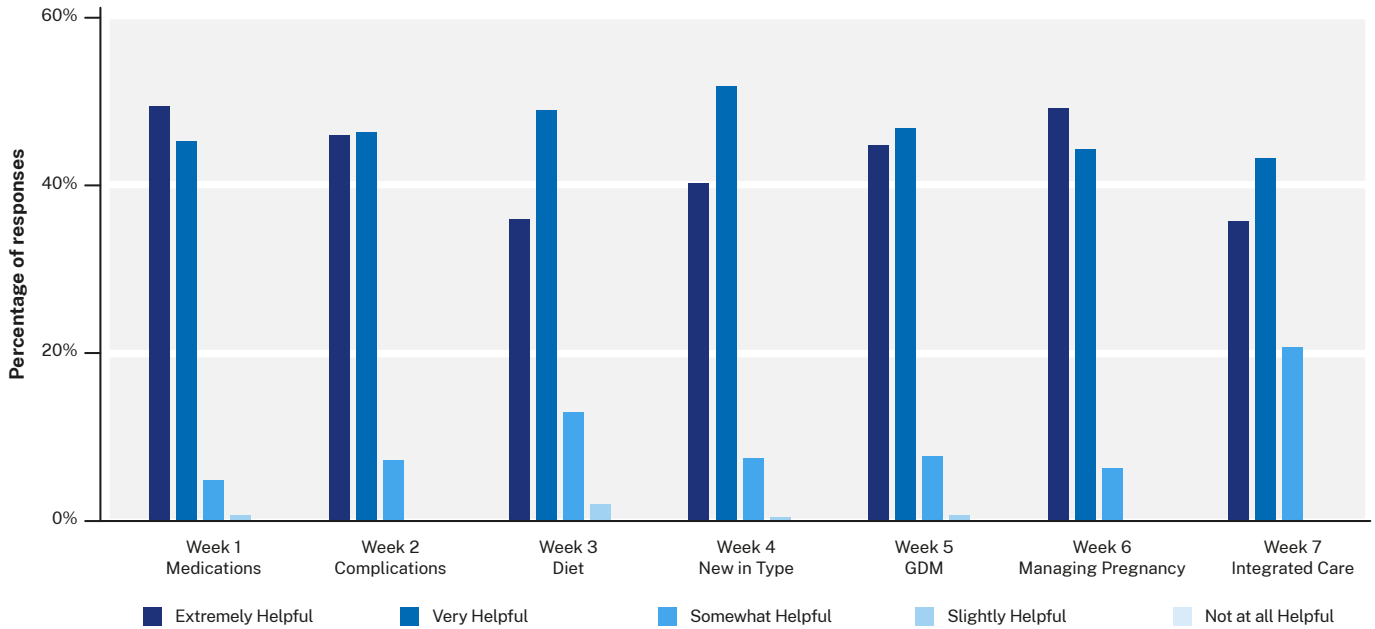
Complementing the in person program, a series of virtual Masterclass evenings reinforced these themes and enabled deeper focus on specific clinical topics:

Date	Topic
16 Sep	Medications
23 Sep	Complications
14 Oct	Don't Sugarcoat It – What Should I Eat?
21 Oct	What's New in Type 1?
28 Oct	Gestational Diabetes
4 Nov	Managing Pregnancy with Women Living with Pre Existing Diabetes or Post Bariatric Surgery
11 Nov	Integrated Models of Care

Sessions were sequenced to build knowledge progressively, moving from pharmacotherapy and complications through nutrition, pregnancy related diabetes and integrated models of care. Content was delivered by endocrinologists and senior clinicians with deep local experience, ensuring education remained clinically rigorous and grounded in real world practice.



Figure 14: The Masterclass Series was rated highly helpful across all sessions



Participation, Partnerships and Reach

Participation reflected both the scale of enrolment and the breadth of professional engagement. Faculty and participants were drawn from Western Sydney, South Western Sydney, Nepean Blue Mountains and Hunter New England Local Health Districts and Primary Health Networks, with strong academic and specialist contributions from Sydney Local Health District, the University of Sydney and the University of NSW.

The program brought together endocrinologists, general practitioners, diabetes educators, cardiologists and renal physicians, reflecting WSD’s continued movement toward an integrated cardiovascular-renal-metabolic model of diabetes care within general practice. Sessions also shared practical examples of community engagement, including learnings from the Diabetes Alliance Program Plus (DAP+).

Many sessions were chaired by general practitioners who are graduates of the WSD GP VMO program at Mount Druitt, demonstrating the maturation of local clinical leadership and reinforcing the program’s role in developing GP capability and confidence.

Professional Composition of Participants (Virtual and Face to Face)

Other health professions represented across the Series included podiatrists, optometrists, health

Profession	Virtual (%)	Face to Face (%)
Nurses (Diabetes Educators, Community, Practice, Hospital)	37.68%	31.33%
Other Health Care Professionals	27.01%	28.46%
Doctors (General Practitioners, Specialists, JMOs, RMOs)	20.97%	25.58%
Pharmacists	12.09%	9.23%
Dietitians	0.94%	2.69%

coaches, exercise physiologists, psychologists and care facilitators.

All faculty contributed their expertise and time without financial compensation, reflecting professional generosity and a shared commitment to improving diabetes care. Enrolments continued to grow during 2025, extending the reach and impact of the Masterclass Series across NSW and beyond.



Sarah Driscoll presenting at the face to face day.

Participant feedback and Outcomes

Participant feedback was consistently positive. Evaluation data showed that most respondents rated sessions as *Extremely Helpful* or *Very Helpful*, with particularly strong feedback for sessions addressing medications, complications, gestational diabetes and integrated care.

Masterclass (Virtual) Feedback:

"I am excited for next week's session because I'm learning so much."

"I really enjoy these Masterclasses. Thank you for putting them together and for sharing the knowledge and experience of your presenters."

"The session was highly informative and well-structured...It was very relevant to everyday patient care and helped strengthen confidence in applying updated guidelines."

Integration with the WSD Education Ecosystem

The Masterclass Series operates as a central pillar within WSD's broader education framework, alongside educational videos, HealthPathways, MyINTERACT, GoShare and the Health2Sync platform. In 2025, increased emphasis was placed on aligning Masterclass content with these assets, reinforcing consistent messaging around early detection, risk reduction and integrated care.

"These sessions seem to get better each year."

"This is great! Backs up university education well."

"The host and all resource persons were all equipped with knowledge, skills and abilities on the topics. Thank you so much everyone."



EDUCATION



The WSPHN team (l-r) Caitlin Miller, Jasmine Glennan, Andrew Newton (CE), Maha Sedhom and Peter Moxham at Masterclass.



Delegates enjoyed the different trade stalls.



Professor Xiaoqi Feng presented on Nature Prescription at the Masterclass Face to Face.



WSPHN Senior Manager, Primary Care, Jasmine Glennan presents in the early detection session of the face-to-face Masterclass.



The team from Abbott at their stall.



The team from Sanofi at the Masterclass day.



Place-Based Delivery: Rural and Regional Engagement

Rural Masterclass: Dubbo (June 2025)

On 14 June 2025, WSD delivered a Rural Masterclass in Dubbo for clinicians across Western NSW. Hosted at Taronga Western Plains Zoo, the event brought together more than 120 health professionals, reflecting strong demand for specialist diabetes education in rural settings.

The Masterclass was delivered in partnership with MetaDiab and Care Partnership – Diabetes (Western NSW Local Health District, Far West Local Health District, Western NSW Primary Health Network and the Rural Doctors Network), ensuring the program was tailored to rural practice while remaining aligned with contemporary evidence and models of care.

Program highlights included a keynote by Professor Ted Wu, Head of the Diabetes Centre at Royal Prince Alfred Hospital, on emerging therapies - particularly GLP1 receptor agonists and SGLT2 inhibitors - and their impact on diabetes management and cardiovascular and renal risk reduction. This was complemented by

a live case conference on managing poorly controlled diabetes in rural practice and sessions highlighting the role of CGM, Health2Sync and digital education in supporting care across distance and service boundaries.

Professor Glen Maberly and the WSD team shared practical learnings from CGM enabled care and promoted key education resources, including the *2kg Challenge* campaign, reinforcing the role of digital tools in improving continuity and shared understanding of care in rural and remote contexts.

The Dubbo Masterclass was supported by Abbott, Eli Lilly and Novo Nordisk. More broadly, the Masterclass Series would not be possible without the ongoing support of pharmaceutical partners, whose contributions enable delivery at scale while maintaining clinical independence in content development and faculty participation.

Together, the hybrid virtual program and targeted place-based Masterclasses demonstrate WSD's capacity to deliver specialist education at scale, adapting format and delivery to diverse clinical contexts while maintaining consistency, quality and alignment with broader system priorities.



The WSD panel discussing diabetes management. (l-r) Victoria Silvestro, Helen Dick, Dr Wilson Pujawiyatna and Prof Glen Maberly.



Speakers at the Rural Masterclass.



The panel on the Cracking the Code: Managing Diabetes When Control is Poor – A live Case Conference. (l-r) Dr Wilson Pujawiyatna, Prof Glen Maberly and Chair Dr Alex Hoyle.



DIGITAL SOLUTIONS

Dr Rajini Jayaballa, Clinical Lead

Clinical Engagement as the Foundation of System Delivery

Technology continues to reshape the delivery of diabetes care, and WSD recognised early the potential of digital solutions to transform how education, care coordination and self management could be delivered at scale.

From the outset of WSD, digital capability was viewed as a strategic enabler rather than an add on. Working closely with Diabetes NSW, WSD initially partnered with Telstra Health to begin developing a patient application designed to deliver targeted education at the point it was most needed. The intent was to integrate short educational videos, clear messages and practical fact sheets directly into the daily patient journey, reinforcing clinical advice between visits.

Subsequent changes in vendor leadership and market conditions required WSD, in partnership with NSW Health, to tender and transition to an alternative provider. While early progress was encouraging, the COVID 19 pandemic disrupted this work, and the vendor ultimately exited the market. In parallel and working with the WSPHN, WSD commenced development with a third provider; however, progress proved slower than required to meet clinical and system needs.

In 2025, CGM adoption continued to accelerate, with approximately

1300

CGM utilisations recorded using FreeStyle Libre 2 Plus

Over the past two years, WSD has established a new partnership with Health2Sync. This collaboration represents a step change in progress, as Health2Sync provides a mature diabetes specific patient application and clinician dashboard that closely aligns with WSD's long standing vision for digitally enabled, integrated care. The outcomes of this partnership are described in detail in this section.

The COVID 19 pandemic acted as a significant digital accelerator across health care, including diabetes services. During this period, WSD rapidly adopted virtual models of care, while previously developed digital assets - particularly educational videos - became essential tools for maintaining continuity of care and patient engagement.

Looking ahead, WSD recognises that artificial intelligence (AI) will increasingly shape health care delivery. Health2Sync has already begun incorporating AI enabled functionality, including food analysis from photographs and tailored patient advice. WSD views AI as a partner technology that can augment clinical care, support patients and improve system efficiency, rather than replace clinicians. Remaining engaged with this evolving digital landscape is an important part of WSD's ongoing journey.

Continuous Glucose Monitoring

Jaybee Serrano, Credentialed Diabetes Educator

Continuous Glucose Monitoring (CGM) is a core component of WSD's digitally enabled model of care, underpinning data driven clinical decision making, insulin titration and patient self management across specialist and primary care. In 2025, CGM adoption continued to accelerate, with approximately 1300 CGM utilisations recorded using FreeStyle Libre 2 Plus. The technology landscape for type 2 diabetes also expanded, with the introduction of Dexcom ONE+ alongside Accu Chek and Sibionics, increasing choice for both clinicians and patients.

Consistent with WSD's broader digital strategy, CGM is embedded within routine clinical workflows and integrated with complementary platforms such as Health2Sync, ensuring glucose data are readily available to support shared decision making. In 2025, WSD expanded access to Dexcom through the GDAY program, which provides a free first use sensor, and commenced work on Dexcom-Health2Sync integration to streamline data capture, reporting and clinical workflows. Collectively, these initiatives



strengthen real time data sharing, enhance clinical oversight and support personalised care planning across the multidisciplinary team.

While CGM subsidy in Australia remains largely limited to people with type 1 diabetes, WSD continues to advocate for broader access, particularly for people with type 2 diabetes requiring insulin or intensive management. This position is informed by both emerging evidence and national and international policy developments.

Following the Federal Parliamentary Inquiry into Diabetes, more than 700 submissions were received, with an overwhelming majority calling for expanded access to CGM in type 2 diabetes and broader use across the diabetes population. At the same time, evidence presented at major international meetings, including the American Diabetes Association (ADA) Scientific Sessions, has strengthened substantially. CGM is increasingly recognised not simply as a monitoring tool, but as a major advance in care for people with type 2 diabetes, supporting behaviour change, treatment optimisation and improved outcomes.

Reflecting this growing evidence base, the ADA has joined international advocacy efforts supporting CGM access for all people with diabetes, and the introduction of CGM subsidy within Medicaid in the United States represents a significant policy milestone. Many health systems, workplaces and regional providers have also moved to adopt CGM more broadly. In Australia, both Abbott and Dexcom have applied for expanded subsidy arrangements. While the interim report of the relevant advisory committee suggests challenges remain, a final decision is expected in early 2026.

WSD recognises that policy change in this area may take time. However, based on clinical experience and the rapidly accumulating evidence base, WSD anticipates that broader CGM adoption will occur and views this as an important opportunity for Australia to align with international best practice in diabetes care. Within the WSD model, CGM remains central to treatment decisions, behaviour change and continuity of care between specialist services and general practice.

Integrating CGM into Diabetes Case Conferencing at Westmead

At Westmead, CGM has been systematically incorporated into diabetes case conferencing as part of WSD's integrated digital care approach. This

ensures glucose data can be reviewed collaboratively by specialists, general practitioners and diabetes educators, alongside other digital tools such as Health2Sync, to support shared decision making and coordinated follow up.

In collaboration with Abbott, the Westmead team initially introduced CGM through individual patient trials. This evolved into a structured strategy to build capability within general practice. By 2025, the program had transitioned to routinely establishing GP practices with CGM supplies and technology, enabling consistent use of CGM within community based diabetes care.

Key milestones

- 2022: Four GP practices introduced to CGM through Abbott supported trials, including provision of supplies and technology.
- 2023: Expansion to 11 GP practices, reflecting increasing uptake and integration into clinical workflows.
- 2025: CGM embedded as a routine component of care for suitable patients, with 18 new GP practices established through the FreeStyle Libre 2 Plus Patient Start Program.

By integrating CGM into case conferencing and linking glucose data with digital platforms such as Health2Sync, WSD has strengthened clinical insight, enabled faster titration and improved continuity of care between specialist and primary care. This approach supports more accurate monitoring, better informed treatment decisions and improved patient outcomes, while building digital capability across general practice.

Health2Sync

Dr Rajini Jayaballa, Clinical Lead

Jaybee Serrano, Senior Credentialed Diabetes Educator

Health2Sync is a patient facing digital platform embedded within the WSD Model of Care to enable real time glucose tracking, guided self care, shared data access and improved communication between patients and clinicians across the care team. WSD is co designing a structured self management program with Health2Sync to further empower patients through targeted education and personalised feedback.



DIGITAL SOLUTIONS

Health2Sync is used to:

- Streamline real time glucose tracking, providing a shared, up to date view of readings for patients and clinicians.
- Deliver guided self care and personalised feedback aligned with individual goals and glycaemic patterns.
- Enable shared data access across the care team, improving coordination and reducing friction in decision making.
- Support behaviour change and enhance communication between patients, diabetes educators and clinicians.

Collectively, these capabilities improve engagement, accelerate titration decisions and help maintain momentum between clinical visits.

As an example, Figure 15 illustrates the integrated, day by day view available to both patients and clinicians through Health2Sync.

Glucose traces from CGM are displayed alongside physical activity (steps), medication use, meals and insulin dosing, with summary metrics including time in range, variability and daily activity totals. By bringing these data streams together in a single visual interface, patients can directly see how behaviours such as meals, activity and medication timing

Figure 15: Integrated, day by day view available to both patients and clinicians through Health2Sync





Table 1: Changes in Glycaemic Metrics Pre and Post Intervention (First 50 Patients, Nov 2024 – Jun 2025)

Metric	Pre-intervention	Post-intervention	Change
Glucose Management Indicator (GMI, %)	8.27	7.47	-0.80 (p<0.001)
Time in Range (TIR, %)	35.7	52.3	+16.6
Time Above Range (TAR, %)	52.3	39.2	-13.1
Time Below Range (TBR, %)	0.26	0.26	No change

Table 2: Patient Management Outcomes (First 50 Patients)

Recommendation	Number of patients	Percentage
Transitioned back to General Practitioner (GP)	33	66%
Ongoing management with WSD	17	34%
Total	50	100%

influence glucose patterns. For clinicians, the same view supports more precise therapeutic adjustment, focused education and shared decision making. This transparency is a powerful driver of behaviour change and more responsive, personalised care.

Early evaluation indicates that Health2Sync effectively supports the WSD Model of Care, contributing to:

- Improved glycaemic control
- Increased time in range (TIR)
- No increase in hypoglycaemia
- Successful transition of most patients back to GP led care

In 2026, use of the app will be further scaled across WSD clinics and in partnership with primary care colleagues.

Digital Health Maturity in General Practice

Western Sydney Primary Health Network (WSPHN)

To support scalable and equitable digital adoption

This transparency is a powerful driver of behaviour change and more responsive, personalised care.

across Western Sydney, the WSPHN undertook a Digital Health Maturity Assessment (DHMA) across general practices between October 2024 and January 2025. The assessment provided a region-wide view of digital readiness and informed a staged, capability-based approach to implementation, recognising that practices differ markedly in their capacity to adopt and sustain digital change.

The DHMA identified substantial variation across practices in telehealth utilisation, digital literacy, cyber security capability and meaningful use of clinical



data. These insights now shape how digital solutions are deployed across the region, ensuring adoption is practical, sustainable and aligned with real-world practice conditions.

A staged approach to digital transformation

In partnership with WSPHN, WSD has adopted a staged approach to digital transformation informed by the DHMA. Rather than a uniform rollout, digital tools are deployed in ways that match practice capability, supporting equitable uptake, sustainable workflows and avoidance of digital exclusion.

Based on assessed readiness:

- Digitally mature practices are supported to embed patient-facing and data-rich tools such as GoShare and Health2Sync, enabling remote monitoring, patient activation and shared review of clinical data.
- Practices with intermediate digital readiness focus on strengthening secure messaging, eReferrals and telehealth workflows to support multidisciplinary case conferencing and continuity of care.
- Practices at earlier stages of adoption receive foundational digital support, including assistance with core infrastructure, workflow redesign and digital literacy, to build readiness for subsequent transformation.

Impact on care delivery and equity

This maturity-informed approach has strengthened readiness for telehealth and multidisciplinary case conferencing, improved care coordination between general practice, specialist services and community-based programs, and supported more accessible and patient-centred care.

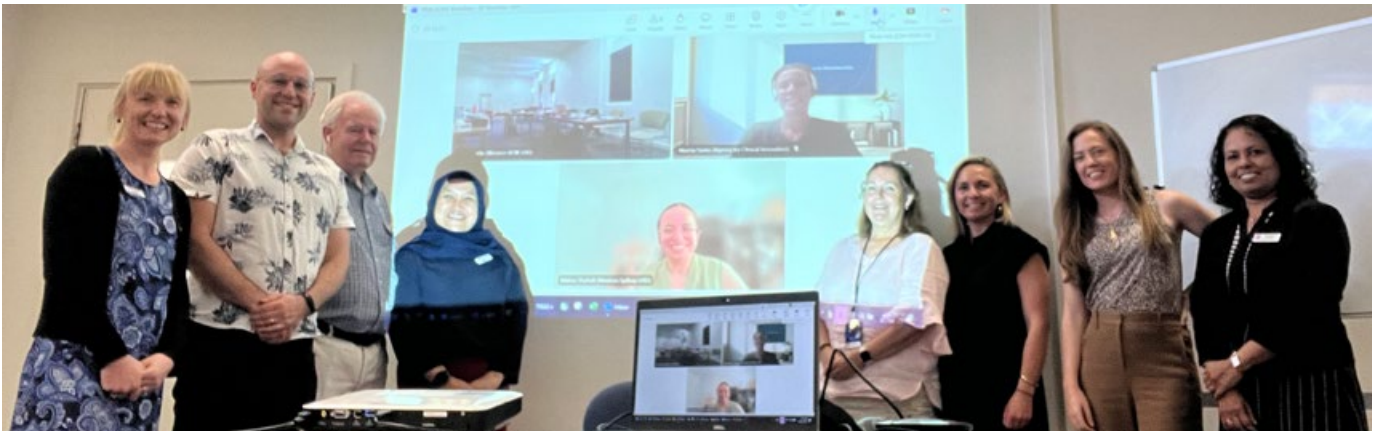
Critically, it also addresses digital inequity across Western Sydney. By aligning digital expectations with practice capability, the approach reduces the risk that less-resourced practices or communities are left behind, while enabling digitally confident practices to progress at pace.

System integration and sustainability

The Digital Health Maturity Assessment functions as a core system enabler for WSD's broader Clinical Prevention and Integrated Management agenda. By embedding digital solutions within existing primary care workflows - and aligning deployment with demonstrated capability - WSPHN and WSD are supporting sustainable, system-wide digital transformation rather than isolated or short-term pilots.

This approach underpins the effective use of digital tools across WSD initiatives, including CGM-enabled care, multidisciplinary case conferencing, education delivery and quality improvement. It will continue to inform staged digital investment and targeted support through 2026 and beyond.

By aligning digital expectations with practice capability, the approach reduces the risk that less-resourced practices or communities are left behind, while enabling digitally confident practices to progress at pace.



WSD team members met in Orange for the TRGS eCARE meeting.

CONNECTED CARE

Rural Engagement (eCARE)

Helen Dick, Diabetes Educator and Research Nurse

eCARE – Using digital solutions, Case conferencing, Activating general practices, Rural NSW, and Enhancing diabetes services

WSD has extended its Model of Care into rural and regional settings through the eCARE program, with targeted adaptations to support delivery at distance.

eCARE was established in 2023 by WSD in partnership with Care Partnership–Diabetes to support GPs and people living with type 2 diabetes across Western NSW through structured virtual case conferencing. The program is strongly motivated by WSD's commitment to addressing inequity. Data consistently demonstrate a high burden of diabetes in rural and regional communities, alongside longstanding shortages in specialist services across many townships, including areas with a high proportion of Aboriginal people.

The WSD Model is particularly well suited to this context. It leverages virtual case conferencing to enable specialist input regardless of geography, integrates digital tools to support care across distance, and—critically—focuses on building the capability of rural general practitioners and their teams to manage complex diabetes care locally over time, rather than providing episodic specialist intervention.

During the 2025 demonstration period, the core WSD Model of Care was deliberately adapted for rural delivery. Key modifications focused on enabling

virtual participation, simplifying referral and booking processes, and ensuring that general practice remained the central coordinating point of care, while still allowing timely specialist input and agreed follow up planning.

The decision to bring the WSD Masterclass Series to Dubbo in 2025 reflected this same capacity building intent, providing an opportunity for rural clinicians to engage face to face with specialist faculty, share local experience and strengthen professional networks.

The initial case conferencing activity delivered during 2025 was intentionally modest in scale, functioning as a demonstration phase that allowed participating practices and the wider region to assess feasibility, acceptability and clinical value. Feedback from practices was strongly positive, with early outcomes reinforcing the suitability of the model for rural settings.

This demonstration period also strengthened WSD's subsequent application for a Translational Research Grant (TRGS) from the Ministry of Health. While an earlier application did not progress beyond the proposal stage, learnings from that process informed a stronger resubmission. WSD was therefore particularly pleased to be successful on the second application and is grateful to ACI for its partnership on the grant, which now underpins the next phase of implementation.

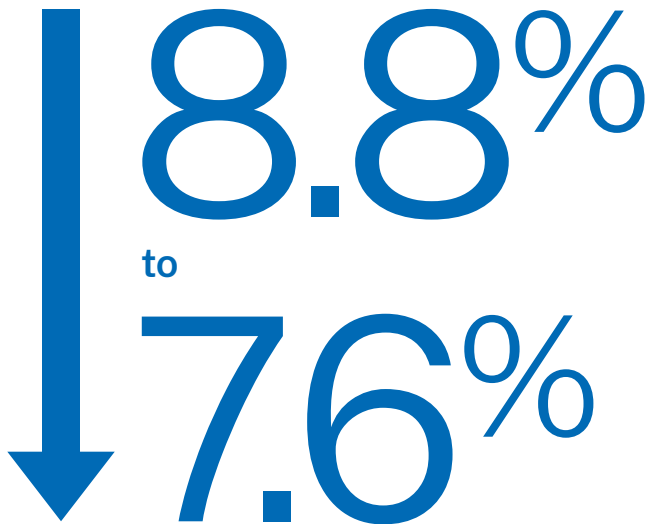
Model of Care and Delivery

The WSD Model of Care has been adapted for rural delivery through eCARE to ensure feasibility within busy general practice environments. A dedicated booking platform enables practices to select from two multidisciplinary case conferencing teams with different session times, improving flexibility and uptake.



CONNECTED CARE

Early evaluation demonstrated a reduction in HbA1c from



During each case conference, patients attend with their GP, practice nurse and any other relevant support people, and connect virtually with a WSD endocrinologist and diabetes educator via the HealthDirect platform. This shared consultation model preserves the central role of general practice while providing timely specialist input.

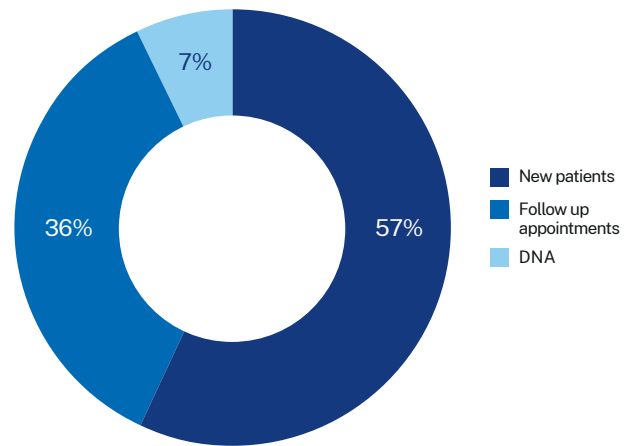
To support efficient, data informed discussion, GPs and practice nurses complete a structured pre case conference referral, including pathology results, clinical measurements, current medications and, where available, CGM reports. This preparation enables focused clinical dialogue, practical management planning and immediate skill transfer to the local care team.

Activity and Early Outcomes

eCARE continued throughout 2025, with 41 virtual case conferences delivered between 1 January and 16 December, engaging four general practices across Western NSW.

The model has been shared nationally, including presentation as a poster at the Australasian Diabetes Congress. Early evaluation demonstrated a reduction in HbA1c from 8.8% to 7.6% (-1.2%, $p < 0.001$), indicating meaningful clinical improvement in a population with historically limited access to specialist diabetes care.

Figure 16: Distribution of eCARE case conferences by appointment type, 2025



Education and Capacity Building

Beyond individual patient consultations, eCARE functions as a workforce development and capacity building platform for rural clinicians. Participating practices are supported to access the WSD Masterclass Series and the myINTERACT education library, extending learning beyond the case conference itself.

In June 2025, this engagement was further strengthened through delivery of a dedicated face to face Rural Masterclass in Dubbo, reinforcing relationships, peer learning and regional capability. The demonstration phase of eCARE, including delivery of the Rural Masterclass, was supported through partnerships with industry, with Novo Nordisk, Lilly and Abbott contributing funding support. These partnerships enabled WSD to test and refine the model in a real world rural context. WSD will continue to engage industry as partners as the program evolves, and a Rural Masterclass is planned again in 2026.

Looking Ahead

The rural application of the eCARE model has been approved for formal evaluation in 2026, supported by a secured Translational Research Grant. A stepped wedge cluster randomised trial will test the model at scale and examine clinical, workforce and system outcomes.

Future implementation will include expanded use of Health2Sync and other integrated digital tools to support rural services and their patients, building on



early evidence that digitally enabled, collaborative models of care can improve outcomes while strengthening local capability and sustainability.

Peri-operative Care (PAC Collaboration)

Dr Jeremy Knott, Advanced Trainee

Dr Rajini Jayaballa, Clinical Lead

Peri-operative Assessment Clinics (PAC) at Blacktown and Mount Druitt Hospitals are a clear example of how the WSD Model of Care integrates with hospital-based services to improve access, timeliness and safety for people with type 2 diabetes undergoing surgery.

Background and Rationale

The PACs at Blacktown and Mount Druitt hospitals have long identified patients with suboptimal glycaemic control - typically reflected by substantially elevated HbA1c measured at the PAC visit - and referred them to the diabetes service for assessment and stabilisation prior to acceptance for surgery. This practice reflects established evidence linking sub-optimal glycaemic control with increased peri-operative risk and poorer post-operative outcomes.

As the WSD Model of Care matured, this peri-operative cohort was identified as an opportunity to apply a more integrated and proactive approach. Patients referred from PAC already represented a substantial component of WSD outpatient referrals; however, traditional sequential processes - separate referrals, delayed pathology and waiting for first specialist review - introduced avoidable delays at a critical point in the surgical pathway.

Model Design and Collaboration

The collaboration was established after seeking and receiving approval from the WSLHD Human Research Ethics Committee, enabling WSD and PAC to formally evaluate, analyse and report outcomes arising from this integrated peri-operative model as part of a quality-improvement program.

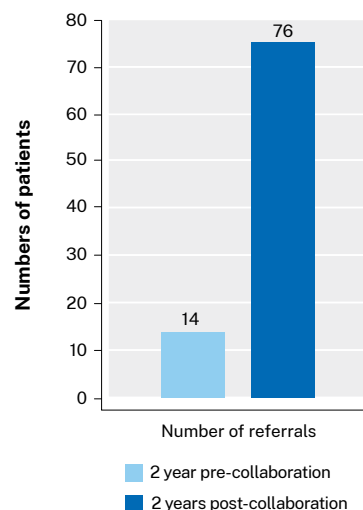
WSD and PAC then worked jointly to embed the WSD pre-clinic intervention model within routine peri-operative workflows. Under this arrangement, PAC applies a CGM and completes the required pathology work-up at the time of referral, rather than waiting

for the diabetes clinic appointment. This redesign reduced waiting time for patients and enabled earlier, data-informed assessment and optimisation.

In parallel, WSD collaborated with PAC and surgical services to establish shared guidance for referral and surgical acceptance. It was agreed that patients with an HbA1c greater than 7.5% would be referred to WSD for optimisation prior to surgery. Consistent with WSD practice, assessment of glycaemic readiness for surgery is based on CGM-derived metrics – particularly the Ambulatory Glucose Profile (AGP) – allowing a more nuanced assessment of glycaemic stability than HbA1c alone and supporting individualised recommendations regarding surgical clearance.

The collaboration is supported through regular multidisciplinary engagement between PAC, WSD and surgical services, enabling shared decision-making, pathway refinement and continuous improvement.

Figure 17: Number of referrals to WSD for peri-operative diabetes management before and after collaboration



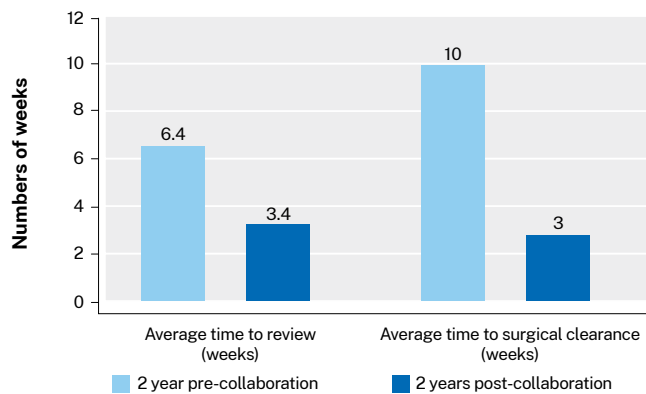
Activity and Access

Following implementation of the collaboration, referrals to WSD for peri-operative diabetes management increased substantially, reflecting clearer pathways and increased clinician confidence:

- Referrals increased from 14 in the two years prior to collaboration to 76 in the two years post-collaboration.



Figure 18: Average time to diabetes review and surgical clearance before and after collaboration



Timeliness of Care

The collaboration delivered measurable improvements in timeliness of assessment and surgical readiness:

- Average time to review decreased from 6.4 weeks to 3.4 weeks.
- Average time to surgical clearance decreased from 10 weeks to 3 weeks.

These improvements reduced delays attributable to diabetes management and supported more predictable progression to surgery.

Clinical Quality and Outcomes

The integrated model delivered improvements in clinical quality and safety:

- Surgical clearance rate improved to 73.7%.
- CGM utilisation increased to 68.7%, supporting more precise peri-operative glycaemic optimisation.
- No diabetes-related post-operative complications were recorded among patients managed through the collaboration.

Knowledge Translation and Sustainability

The PAC collaboration and its outcomes were presented at Perioperative Medicine 2025, as well as diabetes scientific meetings, supporting dissemination of learning across disciplines. The collaboration remains active and continues as part of routine peri-operative care.

This peri-operative collaboration demonstrates how the WSD Model of Care can be consistently

applied across hospital-based services — aligning specialist expertise, digital tools and multidisciplinary collaboration to improve outcomes while reducing system inefficiency.

Glycaemic and Liver Integration in Diabetes Evaluation (GLIDE) study

Dr Jeremy Knott, Advanced Trainee

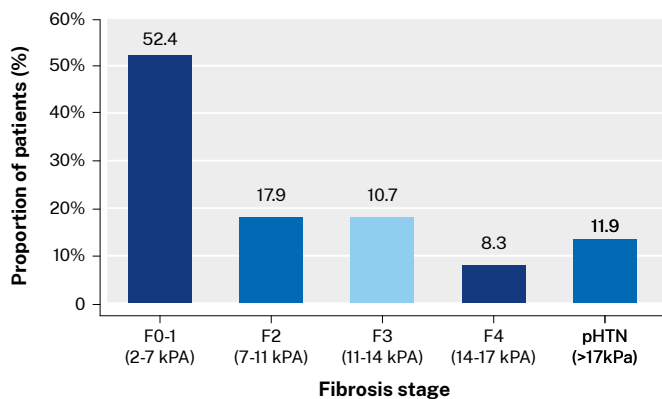
Metabolic-associated fatty liver disease (MAFLD) represents one of the most common and clinically significant comorbidities in people with type 2 diabetes mellitus (T2DM), yet remains under-recognised in routine diabetes care, particularly in individuals with normal liver enzymes. Progressive liver fibrosis is the key determinant of long-term outcomes, including cirrhosis, hepatocellular carcinoma and liver-related mortality. Recognising this gap, the Western Sydney Diabetes (WSD) service introduced a structured liver fibrosis screening pathway in August 2023, embedding routine Fibrosis-4 (Fib-4) scoring into a dedicated multidisciplinary T2DM care model, with further transient elastography (FibroScan) for patients at risk.

Between 1 August 2023 and 31 July 2024, 814 consecutive patients with T2DM were reviewed within the WSD service, of whom 119 (14.6%) met Fib-4 screening criteria (≥ 1.45) and were referred for further assessment. Among those who underwent FibroScan ($n = 84$), the burden of clinically significant liver disease was substantial. Nearly half (48.8%) demonstrated fibrosis stage $\geq F2$, while 31.0% met criteria for advanced fibrosis ($\geq F3$) (Figure 1). Mean liver stiffness was 10.4 ± 1.8 kPa, and steatosis was also highly prevalent, with 56% exhibiting controlled attenuation parameter (CAP) values >260 dB/m, consistent with at least moderate hepatic steatosis. Liver stiffness correlated strongly with body mass index, age and Fib-4 score, while steatosis correlated with BMI and glycaemic control. Liver enzymes, HbA1c and platelet count did not reliably discriminate fibrosis severity, reinforcing the limitations of traditional biochemical screening strategies in this population.

This audit demonstrated that systematic liver fibrosis screening can be feasibly and effectively integrated into a dedicated diabetes care model, revealing a high prevalence of previously unrecognised clinically significant liver disease. Embedding Fib-4 calculation into routine workflows, with targeted use of transient elastography, allowed efficient risk stratification. As



Figure 19: Liver fibrosis stages assessed by transient elastography in type 2 diabetes (n = 84, August 2023–July 2024)



the prevalence of T2DM continues to rise, scalable models that integrate liver disease screening into diabetes services may play a critical role in reducing downstream complications, including cirrhosis and hepatocellular carcinoma.

This study has been submitted as an abstract for the upcoming International Diabetes Federation –Western Pacific Region conference in August 2026.

High Risk Foot Service (HRFS)

Dr Rajini Jayaballa, Clinical Lead

The High Risk Foot Service (HRFS) delivers coordinated, multidisciplinary care across podiatry, endocrinology, vascular surgery and infectious diseases, supported by regular bi-monthly multidisciplinary team (MDT) meetings. Wherever possible, patients are reviewed by multiple specialties during a single visit, improving care coordination, reducing fragmentation, and enhancing the patient experience.

In 2025, the weekly HRFS clinic delivered 391 appointments (81 new and 310 follow-up), with a 25% did-not-attend (DNA) rate. While non-attendance remains a challenge in this high-risk population, the service continues to mature through a hybrid model of virtual and face-to-face delivery, strengthened engagement with general practitioners, and increasing use of WSD's digital solutions to support continuity of care.

The Blacktown HRFS has undergone significant development over recent years. The integration of virtual and in-person clinics, supported by consistent

MDT collaboration, has improved flexibility in service delivery and access for patients with complex needs.

The podiatry service has been a central pillar of the HRFS. In 2022, podiatry was formally recognised as a standalone Department of Podiatry, and in December 2023 the department was awarded the General Manager's Award for Achieving Goals and Outcomes.

Leadership has now transitioned to Clare McDonogh, and under her leadership the various specialties are coming together in an increasingly cohesive and integrated way. The service has also been an early adopter of Patient-Reported Experience Measures (PREMs) and Patient-Reported Outcome Measures (PROMs) within WSLHD since 2021, consistently demonstrating strong patient-reported outcomes and experiences.

Together, these developments reflect the HRFS's evolution into a mature, digitally enabled, multidisciplinary service that supports high-risk patients with complex foot disease while strengthening integration across primary, community and hospital-based care.

Type 1 Diabetes (T1D) Services

The Type 1 Diabetes (T1D) clinic is a newly established service within WSD, designed to strengthen shared care between specialist services and general practice. While best practice recommends that people living with T1D are managed by an endocrinologist, the reality is that many patients continue to receive most of their care in general practice. This clinic responds directly to that gap.

The model focuses on upskilling general practitioners to confidently manage stable people with T1D, while ensuring specialist input for complex or unstable cases. Advanced diabetes technologies, including automated insulin delivery systems integrated with CGM, are routinely used to optimise glycaemic outcomes and support education for both patients and clinicians.

A core principle of the clinic is the timely transition of well-managed patients back to GP-led care. This approach supports continuity in the community, builds GP capability, and preserves specialist clinic capacity for patients with higher complexity, ensuring appropriate throughput and sustainability of the service.

In 2025, the fortnightly T1D clinic delivered 355 appointments (84 new and 271 follow-up), with a 19.5% did-not-attend (DNA) rate. Together, these



In 2025, the fortnightly T1D clinic delivered

355

appointments with a 19.5% did-not-attend rate.

early activity data demonstrate strong demand for the service and reinforce the value of a model that balances specialist oversight with deliberate GP capacity building.

Dedicated Aboriginal Diabetes Clinics – GWAHS Partnership

Ana Murugesan, Nurse Practitioner

Dr Jeremy Knott, Advanced Trainee

Aboriginal and Torres Strait Islander communities experience a disproportionate burden of type 2 diabetes, earlier complications and significant barriers to culturally safe care.

In response, WSD, in partnership with the Greater Western Aboriginal Health Service (GWAHS), local GPs and WSLHD, delivers a dedicated diabetes clinic for Aboriginal people at Mount Druitt Community Health Centre (MDCHC).

The clinic was established following clear signals from local data and community feedback. Mount Druitt has the highest Aboriginal population in the Blacktown local government area and was experiencing high non attendance at mainstream diabetes clinics, driven largely by clinic location and the absence of culturally specific models of care. The dedicated clinic was co designed with Aboriginal leadership through an Aboriginal steering committee, ensuring cultural safety was embedded as a core design principle.

The clinic applies the same WSD integrated Model of Care used across WSD services, adapted to a culturally specific setting. Care is delivered through a culturally informed, multidisciplinary team, with an Aboriginal chronic care nurse embedded to support trust, continuity and navigation of both clinical care and key social determinants such as transport, housing and financial stress. General practice case conferencing is used more selectively than in other WSD clinics, reflecting local referral patterns and



WSD Advanced Trainee Dr Jeremy Knott, RMO Shenaya Hitheshi Mendir, Senior Dietitian Victoria Silvestro and WSLHD Aboriginal Chronic Care Nurse Shirley Brown.

engagement constraints. Practical access barriers are addressed through clinic location, transport support via the Integrated Team Care program, and regular outreach and case conferencing with GWAHS. Non attendance on the day of clinic remains a challenge, often reflecting the complexity of patients' social circumstances and resulting in unused clinic capacity.

Where patients can engage consistently, clinical outcomes are very strong, reinforcing the effectiveness of the WSD model when delivered in a culturally safe context. Overall experience reinforces several consistent lessons for integrated care with Aboriginal communities: cultural safety must be central, community leadership must be sustained, and practical barriers must be addressed alongside clinical care.

The model aligns with the Closing the Gap Priority Reforms, the NSW Aboriginal Health Plan 2024–2034 and the NSW Health Aboriginal Health Strategy and has been recognised through publication on the ACI Exchange as a transferable, place based model of culturally safe diabetes care.

WSD will continue to strengthen this model through deeper Aboriginal leadership, broader general practice engagement and ongoing evaluation to support sustainability and scalability across Western Sydney and beyond.

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Integrated Care – inTouch

Jaybee Serrano, Senior Credentialed Diabetes Educator

The inTouch Integrated Care Program links primary care, hospital specialists, community services and aged care to support people with complex and multi-morbid needs.

Within the WSD Model of Care, inTouch provides care navigation beyond diabetes, coordinating community nursing, allied health services and rapid outreach for patients requiring additional support, while WSD retains responsibility for specialist diabetes management. This partnership enables care to be delivered closer to home, improves coordination across services, and reduces avoidable emergency department presentations.

The inTouch role and its integration with WSD clinical services are described in more detail earlier in this document, particularly within the Clinical Engagement section outlining the Thursday Complex Type 2 Diabetes Clinic at MDCHC.



Enablers

Enablers are the functions and roles that allow prevention, clinical, community and system initiatives to operate at scale, with consistency and impact across Western Sydney.

Within Western Sydney Diabetes (WSD), this work is led by Sumathy Ravi, Program Manager, Heloise Tolar, eEngagement and Education Manager, and Dr Gideon Meyerowitz-Katz, Epidemiologist. Much of their contribution is embedded throughout the preceding sections of this document and is therefore not repeated in detail here.

This section draws together a small number of enabling activities that sit most clearly within their remit and are not covered elsewhere. Collectively, these functions – program management, communication and engagement, evaluation, research and resource mobilisation – provide the backbone that supports and sustains WSD’s broader prevention and integrated care model.

In addition, WSD’s Administration Team underpins all aspects of delivery and functions as the operational machinery of the service. The team supports clinic scheduling, patient and GP bookings, event registration, logistics, procurement, and equipment and resource management. They also provide essential support for recruitment, onboarding and personnel processes, and are often the first point of contact for patients, partners and visitors. Their professionalism and welcoming presence in the front office are central to the day-to-day functioning of WSD. While this contribution could equally sit within an Our Team section, it is acknowledged here as a core enabling function without which WSD’s work would not operate effectively.

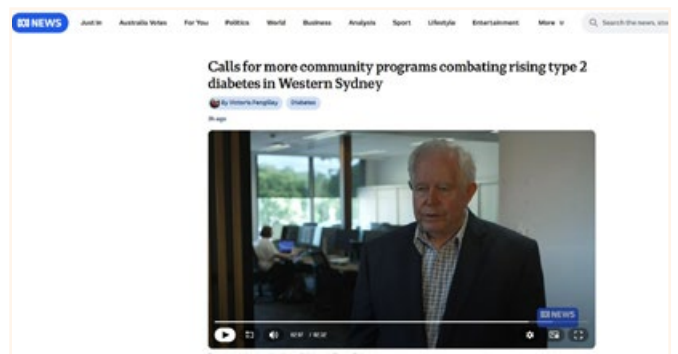
COMMUNITY AND PROVIDER ENGAGEMENT

Heloise Tolar, eEngagement and Education Manager

Effective Communication in Public Awareness of Diabetes

Effective communication and public engagement are central enablers of WSD’s prevention and care agenda across Western Sydney.

As eEngagement and Education Manager, Heloise Tolar leads this work in close collaboration with the WSD team and partners. Her role focuses on building community awareness of diabetes risk, prevention and management, while supporting healthcare providers to engage more effectively with patients and communities.



WSD Director Prof Glen Maberly getting interviewed by the ABC on the need for expanded community programs to address the rising prevalence of type 2 diabetes in Western Sydney.



Key Activities and Campaigns

1 Major Awareness Campaigns

Planning and delivery of major initiatives including Western Sydney Changing Diabetes (WSCD), National Diabetes Week and World Diabetes Day, with a focus on early detection, physical activity, lifestyle change and the use of telehealth to improve access.

2 Targeted Communication for Priority Populations

Development of tailored communication strategies for priority populations, including Aboriginal and Torres Strait Islander communities and culturally and linguistically diverse groups such as Arabic, Pasifika, South Indian, Chinese and Filipino communities. This work also supports place-based initiatives such as Healthy Living Toongabbie.

3 Media and Digital Engagement

Oversight of WSD's digital, online and print communication channels to ensure consistent, timely and high-quality messaging. Social media platforms, particularly Facebook and LinkedIn, are used strategically to extend reach across the community and among healthcare professionals. This includes promotion of educational forums such as the Masterclass Series 2025.

4 Collaboration with Partners

Close collaboration with partners including WentWest (WSPHN), Novo Nordisk and Workers Lifestyle Group (WLG), and their communications and marketing teams, to support WSCD activities and diabetes detection initiatives.

5 Educational Resource Development

Development and coordination of educational videos, digital resources and written materials that contribute to WSD's growing resource library, including content hosted on platforms such as myINTERACT. These resources support both community education and the delivery of initiatives led by the WSD core team and Alliance partners.

6 Public Events and Forums

Promotion of public events and community forums, preparation of articles for local and sector media, and use of established media relationships to amplify diabetes awareness and prevention messages.



Article on the Aboriginal Clinic at Mount Druitt. (l-r) WSD Advanced Trainee Jeremy Knott, RMO Shenaya Hitheshi Mendir, Senior Dietitian Victoria Silvestro and WSLHD Aboriginal Chronic Care Nurse Shirley Brown.



An article in the Greater Blacktown News on WSD working with Health2Sync.



EVALUATION

Dr Gideon Meyerowitz-Katz, Epidemiologist

Evaluation of the Western Sydney Diabetes Model of Care

WSD has undertaken a staged, practice-embedded evaluation of its digitally enabled, integrated Model of Care for people with complex or poorly controlled type 2 diabetes referred from general practice. The evaluation program is designed to assess patient outcomes, service efficiency, and the extent to which the model builds capability within primary care.

An initial retrospective cohort evaluation, undertaken in 2023 and published in 2025, assessed outcomes for patients managed through the WSD model and subsequently discharged back to general practice. This evaluation demonstrated statistically and clinically significant improvements in glycaemic control within 3–6 months of engagement. Mean HbA1c decreased by approximately 1.4 percentage points, accompanied by substantial improvements in CGM metrics, including increased time in range and reduced exposure to hyperglycaemia. These improvements occurred without an increase in total daily insulin dose, indicating more effective and targeted therapy rather than escalation of treatment intensity. The evaluation also demonstrated increased uptake of evidence-based therapies and positive feedback from patients and general practitioners regarding engagement, confidence, and shared care (see Publications section).

A subsequent 2025 evaluation led by a WSD AT examined outcomes occurring earlier in the care pathway, specifically during the interval between referral from general practice and first specialist review. This real-world observational evaluation focused on a structured pre-clinic activation pathway delivered as part of routine care, reframing what is traditionally a passive waiting period as an opportunity for early engagement and activation.

Adults with type 2 diabetes referred for specialist assessment because of persistently suboptimal glycaemic control completed a standardised pre-clinic work-up delivered primarily by specialist diabetes education nurses, often in a group setting. This work-up included completion of outstanding pathology, early initiation of CGM, access to a patient-oriented digital diabetes self-management application (Health2Sync), and a brief self-reflection survey to identify patient priorities and perceived barriers to care. Importantly, no formal structured education

This evaluation demonstrated statistically and clinically significant improvements in glycaemic control within

3–6

months of engagement.

program or specialist-led medication intensification occurred prior to first medical review.

Glycaemic status at referral was characterised using HbA1c, which averaged 10.3%, indicating marked hyperglycaemia at entry to the pathway. CGM data collected in the two weeks prior to first specialist review demonstrated clinically meaningful improvement in glycaemic profiles before any specialist consultation or medication escalation. At first review, CGM metrics showed a mean glucose management indicator (GMI) of approximately 8.1% and a mean time in range (3.9–10.0 mmol/L) of 48%. Importantly, time spent in tighter glycaemic ranges increased, while exposure to marked hyperglycaemia (>13.9 mmol/L) was materially reduced. Time below range remained minimal (<1%), indicating that early improvement occurred without excess hypoglycaemia.

Over half of participants reported dietary changes following early CGM initiation, with smaller proportions reporting increased physical activity or improved medication adherence. Acceptability of early CGM use was high, with most participants reporting a positive experience. Together, these findings demonstrate that a substantial proportion of glycaemic improvement can occur before specialist assessment, driven by early patient activation through CGM exposure and minimal educator-led support.

Taken together, these evaluations demonstrate that the WSD Model of Care delivers improved short-term glycaemic outcomes through early activation, while enabling more efficient use of specialist resources and strengthening general practice capability through shared care and case conferencing. The evidence to date shows that low-intensity, digitally enabled interventions positioned early in the care pathway can reduce therapeutic inertia and ensure that specialist



consultations occur on a more informed and clinically productive footing.

From a system perspective, these intermediate outcomes indicate improved value for money, with earlier gains in glycaemic control achieved through scalable inputs that reduce downstream resource use and maximise the impact of limited specialist capacity.

Building on this foundation, WSD will undertake a formal stepped-wedge randomised evaluation in Western NSW in 2026 to test the effectiveness, scalability, and sustainability of the model across diverse settings. This next phase will extend evaluation beyond intermediate CGM-based outcomes through linkage with routinely collected health data, enabling assessment of longer-term system impacts including hospital utilisation and broader cardiometabolic risk indicators.

Building on Success: WSD's Research Evolution

WSD has continued its trajectory as a leading research hub in diabetes care throughout 2025. Building on five years of transformation from disconnected projects to a unified research centre, WSD has delivered significant advances in diabetes research, secured major funding, and expanded its evidence base for innovative care models. This year has seen WSD cement its position as a driver of nationally significant diabetes research while maintaining strong community connections and clinical impact.

Strategic Research Priorities

WSD's 2025 research agenda has focused on three key areas: evaluating innovative models of care through rigorous clinical trials; building sustainable data infrastructure for long-term research; and translating evidence into practical solutions for diabetes management across Western Sydney and rural NSW.

These priorities have guided successful grant applications, new research partnerships, and the expansion of WSD's academic contributions.

Major Research Projects

eCARE: Transforming Rural Diabetes Care

Case Conferencing; Activating General Practices; Rural NSW; Enhancing Diabetes Services

eCARE represents WSD's commitment to addressing diabetes disparities in rural NSW, where diabetes rates are the highest in the state. This collaborative initiative

with Western NSW LHD and other rural partners aims to empower rural GPs and community healthcare providers through advanced training and resources.

In 2025, eCARE achieved major milestones:

- \$492,500 grant awarded from the NSW Health Translational Research Grant Scheme, enabling a comprehensive evaluation of the program's impact;
- Successful pilot engagement with 4 GP clinics in rural NSW, establishing proof-of-concept for the model;
- Masterclass delivered to rural healthcare providers, building capacity and engagement across the region; and
- Ethics approval submitted for a planned stepped-wedge cluster randomized controlled trial in 2026, which will provide rigorous evidence for the effectiveness of the eCARE model.

The eCARE project brings together an impressive coalition of partners including MetaDiab, Western NSW LHD and PHN, the Rural Doctors Network, ACI, and the University of Sydney. This collaborative approach ensures that research findings translate directly into improved care for rural communities.

SCALE Trial: Advancing Digital Self-Management

The SCALE trial represents a significant step forward in evaluating digital health solutions for diabetes management in primary care. This stepped-wedge cluster randomized controlled trial is examining the effectiveness of the Gro-Aus mobile application in supporting patient self-management and improving diabetes outcomes.

Key achievements in 2025:

- Ethics approval granted, enabling the trial to proceed
- 10 GP practices recruited across Western Sydney, demonstrating strong primary care engagement
- 134 patients enrolled, surpassing initial recruitment targets
- 6 GP clinics actively using the Gro-Aus app, with 4 additional clinics to commence in early 2026
- BMJ Open publication, detailing the trial protocol and methodology

The SCALE trial exemplifies WSD's commitment to rigorous evaluation of digital health interventions. By working directly with GP practices and patients, the trial generates real-world evidence that can inform diabetes care policy and practice across Australia.



WEAR-IT Trial: Evaluating Wearable Technology

Alongside SCALE, WSD has progressed the WEAR-IT randomised controlled trial, examining the role of wearable technology in diabetes management. This trial has successfully published its protocol in *BMJ Open*, establishing the methodological foundation for this important evaluation. The trial demonstrates WSD's ability to simultaneously manage multiple complex research projects while maintaining scientific rigour.

PANDA Trial: Nature Prescription for Metabolic Health

The PANDA (Physical Activity and Nature in Diabetes Avoidance) trial, funded by the NHMRC and developed in collaboration with Professors Astell-Burt and Feng from UOW and UNSW, began recruiting in 2025. This innovative randomized trial examines whether nature prescription can reduce metabolic disease risk in at-risk populations.

To support this important work, WSD hired a dedicated research nurse in 2025, ensuring the trial has the clinical support needed for successful recruitment and follow-up. The PANDA trial represents WSD's investment in preventive approaches and environmental factors in metabolic health.

Research Infrastructure and Data Systems

WSD Diabetes Registry Launch

A major development in 2025 was the launch of WSD's diabetes registry, establishing infrastructure for longitudinal research and continuous quality improvement. This registry represents a significant investment in WSD's research capacity and will enable long-term studies of diabetes outcomes, treatment patterns, and service effectiveness.

Innovatively, WSD has incorporated artificial intelligence tools to streamline data entry and improve data quality within the registry. This AI-assisted approach reduces administrative burden while ensuring comprehensive data capture for research purposes. The registry positions WSD to contribute to national diabetes research initiatives and track outcomes over time.

Lumos Linkage Project

In partnership with the NSW Ministry of Health and Hunter Medical Research Institute, WSD commenced

a new evaluation project using the Lumos linked dataset. This project enables sophisticated analysis of WSD's service impact by linking clinical data with broader health system information. The Lumos linkage provides insights into hospital presentations, medication use, and long-term outcomes that would be impossible to capture through clinical records alone.

This collaboration demonstrates WSD's commitment to robust evaluation methodology and willingness to subject its services to independent assessment using state-level administrative data.

Publication Success

WSD's research productivity remained strong in 2025, with several high-impact publications:

- Clinical evaluation of digital innovation in the *Journal of Medical Internet Research: Diabetes*, reporting the successful outcomes from the 2022 evaluation of WSD's integrated CGM and virtual care model
- Two *BMJ Open* papers detailing the protocols for the SCALE and WEAR-IT trials, establishing the methodological rigour of these important studies
- Perspective piece on prediabetes in the *Medical Journal of Australia*, providing national leadership on this critical issue and influencing policy discussions
- Diabetes and frailty research in the *Australasian Journal of Ageing*, contributing evidence on the intersection of these important conditions

These publications demonstrate the breadth of WSD's research portfolio and its contributions to both clinical and policy literature.

Major Grant Applications

THE GP CARE Project

WSD led a landmark grant submission to the Medical Research Future Fund (MRFF) in 2025: THE GP CARE project, a \$2.5 million application to develop and evaluate a novel Model of Care for CVRM health in primary care.

This ambitious proposal brings together:

- Leading national researchers across diabetes, cardiovascular and kidney health
- 4 Primary Health Networks providing practice-level implementation support
- 2 Local Health Districts ensuring integration with hospital services



- National health organizations including Diabetes Australia, Kidney Health Australia, the Heart Foundation, and the National Association of Diabetes Centres
- A comprehensive evaluation framework to generate evidence for national scale-up

THE GP CARE represents WSD's vision for integrated chronic disease management and demonstrates the organisation's capacity to lead complex multi-stakeholder research initiatives. The application positions WSD as a national leader in developing evidence-based models of care.

Research Capacity Building

Supporting Higher Degrees

WSD's commitment to building research capacity through postgraduate supervision continued in 2025:

Sumathy Ravi, WSD's Program Manager, is approaching completion of her PhD with the University of Sydney. Working part-time while fulfilling her management role, Sumathy has made exceptional progress under the supervision of the Sydney Health Literacy Lab. Her qualitative evaluations of diabetes and virtual care have already resulted in multiple publications, and she is on track to submit her thesis in 2026. Her work has been widely presented at national and international conferences.

Victoria Silvestro, WSD's Senior Dietitian, commenced her PhD in 2025, adding to the organisation's growing complement of staff undertaking higher degrees. Victoria's research will focus on nutrition interventions in diabetes management, combining her extensive clinical expertise with academic rigour.

WSD continues to demonstrate that staff can successfully pursue research qualifications while contributing to the organisation's clinical and program work, creating a culture of inquiry and evidence-based practice.

Sydney Health Literacy Lab Partnership

WSD has maintained its close collaboration with the Sydney Health Literacy Lab throughout 2025, expanding into new areas of research. A particularly innovative project has examined the use of AI scribes to improve patient understanding of clinical consultations. This work explores how emerging technologies can enhance health literacy and support patient-centred care, aligning with WSD's commitment to accessible, understandable diabetes services.

The Health Literacy Lab partnership exemplifies WSD's interdisciplinary approach, bringing together expertise in health communication, digital health, and clinical diabetes care to address real-world challenges in patient engagement.

Looking Ahead

As 2025 concludes, WSD has established a robust research program that combines rigorous evaluation, innovative technology, and strong partnerships. The organisation has secured significant funding, expanded its research infrastructure, and maintained its commitment to generating evidence that improves diabetes care in Western Sydney and beyond.

The planned commencement of the eCARE cluster randomised control trial in 2026, continued recruitment in SCALE and PANDA, analysis of registry data, and outcomes from THE GP CARE application will position WSD for another year of research excellence. With multiple staff pursuing higher degrees and strong collaborations with leading research institutions, WSD's research capacity continues to strengthen.

WSD's research agenda remains firmly focused on practical questions that matter to patients, clinicians, and health services: How can we deliver effective diabetes care in rural and underserved communities? What role should digital health play in diabetes management? How can we integrate care across primary and specialist services?

These questions drive WSD's research priorities and ensure that evidence translates into improved outcomes for people living with diabetes.



RESEARCH AND PUBLICATIONS

**Dr Gideon Meyerowitz-Katz, MPH PhD,
Epidemiologist**

Academic Publications 2025

Highlight: Publication on WSD Model of Care

This year WSD published a significant peer-reviewed study in *JMIR Diabetes: Digital Innovation and Integrated Care in People With Diabetes in Western Sydney: Retrospective Cohort Study*.

Authored by Mahfuza U, Meyerowitz-Katz G, Rasheed R, Dick H, Maberly G, and Jayaballa R, the study evaluated the real-world impact of WSD's Model of Care with its digital initiatives and integrated care pathways. The findings demonstrated significant improvements in clinical outcomes and coordinated care for people living with diabetes. This publication not only strengthens the evidence base underpinning WSD's digital transformation work but also helps position WSD as a national leader in scalable, data-driven models of diabetes care.

1. Shahidi M, deCourten B, Glennan J, Assange J, Seng-Lim K, Maberly G, Brinkworth G, Meyerowitz-Katz G. *Implementing a Scalable, Personalised, Behaviour Change digitAL hEalth programme in Primary Care for type 2 diabetes treatment: The SCALE cluster-randomised study protocol*. *BMJ Open*. 2025; 15(10):e101531.
2. Hobden B, Fakes K, Halcomb EJ, Wallis K, Maberly G, Seng-Lim K, Doran C, Oldmeadow C, Meyerowitz-Katz G, Soenen S, Zwar N. *Wearables Integrated Technology to support healthy behaviours in general practice patients with type 2 diabetes (WEAR-IT): Study protocol for a cluster randomised controlled trial*. *BMJ Open*. 2025; 15(10):e105399.
3. Ravi S, Meyerowitz-Katz G, Yung C, Ayre J, McCaffery K, Maberly G, Bonner C. *Effect of virtual care in type 2 diabetes management – a systematic umbrella review of systematic reviews and meta-analysis*. *BMC Health Services Research*. 2025; 25(1):348.
4. Mahfuza U, Meyerowitz-Katz G, Rashid R, Dick H, Maberly G, R. J. *Digital Innovation and Integrated Care: Improving the Effectiveness of Type 2 Diabetes Care in Western Sydney, Australia*. *JMIR Diabetes* 2025; 10:e64832
5. Meyerowitz-Katz G, Parry S, Hng T-M, Cheung W, Gibson A, Hibbert E, Ling K-S, Maberly G, Baur LA, Twigg SM. *Prediabetes: The Looming Burden For Australia*. *Medical Journal of Australia*. 2025; Accepted.
6. Meyerowitz-Katz G, McDonagh J, William S, John R, Hng T-M, McLean M, Bul M, Lindley R, Ferguson C. *Examining HbA1c in frail older adults: a linked data cohort study*. *Australasian Journal of Ageing*. 2025; Accepted.
7. Lin S, Deed G, Khoo C, Murfet G, Barclay A, Maberly G, Blackie A, Peng W, Andrikopoulos S. *Integrating Diabetes Specific Nutritional Formulas into Diabetes*. *Diabetology*. 2025; Submitted.
8. Moore JK, Rayner C, Skinner SR, Wynne K, Cavve BS, Fraser B, Ganti U, McAllister C, Meyerowitz-Katz G, Nguyen T, Ravine A, Ross B, Russell DB, Saunders LA, Siafarikas A, Pang KC. *Cass Review does not guide care for trans young people*. *Med J Aust*. 2025; 223(7):331-7.
9. Huang Y-N, Chen J-C, Li P-H, Hsu M-Y, Cheng C-W, Meyerowitz-Katz G, Su P-H. *Comparative ocular outcomes of tirzepatide versus other anti-obesity medications in people with obesity*. *Communications Medicine*. 2025; 5(1):329.
10. Wilkinson J, Heal C, Antoniou GA, Flemyng E, Ahnström L, Alteri A, Avenell A, Barker TH, Borg DN, Brown NJL, Buhmann R, Calvache JA, Carlsson R, Carter L-A, Cashin AG, Cotterill S, Färnqvist K, Ferraro MC, Grohmann S, Gurrin LC, Hayden JA, Hunter KE, Hyltse N, Jung L, Krishan A, Laporte S, Lasserson TJ, Laursen DRT, Lensen S, Li W, Li T, Liu J, Locher C, Lu Z, Lundh A, Marsden A, Meyerowitz-Katz G, Mol BW, Munn Z, Naudet F, Nunan D, O'Connell NE, Olsson N, Parker L, Patetsini E, Redman B, Rhodes S, Richardson R, Ringsten M, Rogozińska E, Seidler AL, Sheldrick K, Stocking K, Sydenham E, Thomas H, Tsokani S, Vinatier C, Vorland CJ, Wang R, Al Wattar BH, Weber F, Weibel S, van Wely M, Xu C, Bero L, Kirkham JJ. *Assessing the feasibility and impact of clinical trial trustworthiness checks via an application to Cochrane Reviews: Stage 2 of the INSPECT-SR project*. *Journal of clinical epidemiology*. 2025; 184:111824.
11. Lin C-M, Chen J-C, Meyerowitz-Katz G, Huang Y-N, Su P-H. *Unexpected cardiovascular risks of glucagon-like peptide-1 receptor agonist and aspirin co-administration in individuals with obesity, with and without type 2 diabetes: A propensity score matched cohort study*. *Diabetes, Obesity and Metabolism*. 2025; 27(4):1980-91.



The WSD team at Australasian Diabetes Congress on the Gold Coast.

WSD Team Academic Presentations 2025

Highlights

National Conference Spotlight: WSD Presents at the Australian Diabetes Congress (ADC) 2025

Dr Rajini Jayaballa, Victoria Silvestro, and Jaybee Serrano were invited to deliver a dedicated two-hour presentation at the ADC 2025 on *Transforming Type 2 Diabetes Management – The Impact of CGM and Technology*.

As one of the key sessions opening the four-day congress, the presentation attracted strong attendance and engagement from clinicians, researchers, and industry partners. The session showcased Western Sydney's leadership in digital health innovation, highlighting real-world outcomes, service transformation initiatives, and practical strategies for integrating CGM, and emerging technologies into routine care.

The overwhelmingly positive reception reflects the growing national interest in WSD's work and reinforces WSD's role as a leader in shaping the future of diabetes care in Australia.

Showcasing Leadership in Digital Diabetes Care: National Webinar Presentation

Building on WSD's growing national presence, Dr Rajini Jayaballa was invited to deliver a one-hour, sole-

presenter webinar as part of the NADC Primary Care Webinar Series, titled *Transforming Type 2 Diabetes Care Through Technology: Insights from Western Sydney Diabetes*.

This presentation further showcased WSD's leadership in digital innovation and its practical application in Type 2 diabetes care. The strong engagement from clinicians across Australia underscored the sector's recognition of WSD's pioneering work and its relevance to contemporary T2 diabetes management.

Helen Dick

Maberly G, Dick H, Silvestro V, Pujawiyatna W. *Cracking the Code: Managing Diabetes When Control is Poor – A live Case Conference*. Rural Type 2 Diabetes Masterclass, Dubbo, June 2025.

Dick H. *eCARE: Case conferencing; Activating General Practices; Rural NSW; Enhanced Diabetes Services*. Poster Presentation, Australasian Diabetes Congress, Gold Coast, Australia, August 2025.

Dick H, Serrano J. *Digital Solutions*. WSPHN/WSD Planning meeting, December 2025.

Dick H. *WSD Digital Tools*. eCARE Planning Meeting, Orange, November 2025.

Sarah Driscoll

Driscoll S. *Early Detection & the 2kg Challenge*. WSPHN, March 2025.

Driscoll S. *2kg Challenge*. Cumberland City Council, March 2025.



Driscoll S. *WSD Diabetes Prevention Initiatives*. WSLHD Population Health, March 2025.

Driscoll S. *Diabetes Prevention Initiatives in Western Sydney*. Ministry of Health, Centre for Population Health, March 2025.

Driscoll S. *2kg Challenge*. NBMLHD Population Health, March 2025.

Driscoll S. *2kg Challenge*. Charles Perkins Centre, March 2025.

Driscoll S. *2kg Challenge*. Pasifika Preventing Diabetes Program, April 2025.

Driscoll S. *2kg Challenge*. Leaders Alliance Meeting, May 2025.

Driscoll S. *2kg Challenge*. Diabetes Australia, May 2025.

Driscoll S. *2kg Challenge*. WSLHD inTouch Community Care, May 2025.

Driscoll S. WSCD. Blacktown Workers, July 2025.

Driscoll S. *2kg Challenge*. WSLHD Population Health, July 2025.

Driscoll S. Diabetes prevention and health promotion programs. Graduate Certificate in Diabetes Education & Management Program, UTS, August 2025.

Driscoll S. *Early evaluations of the 2kg Challenge – a public health initiative tackling pre-diabetes in Western Sydney*. ICH, Program Evaluation Skills – Learning by Doing Program, September 2025.

Driscoll S. *Early Detection & Pre-Diabetes*. Masterclass, September 2025.

Driscoll S. *Diabetes Prevention Health Outcomes Action Plan and 2kg Challenge*. SLHD Population Health, September 2025.

Driscoll S. *Prediabetes: Rising to the 2kg Challenge*. BMDH Diabetes Education Day, October 2025.

Driscoll S. *Early Detection and the 2kg Challenge*. Cumberland City Council Safety Day, October 2025.

Driscoll S. *2kg Challenge updates and plans*. WSPHN/WSD team meeting, November 2025.

Driscoll S. Primary Prevention. WSPHN/WSD Planning, December 2025.

Driscoll S. *2kg Challenge, Summary & Next Steps*. Ministry of Health, Centre for Population Health, December 2025.



Steven Chen from Health2Sync ran the Digital Technology Masterclass alongside WSD's Victoria Silvestro, Dr Rajini Jayaballa, Sian Bramwell and Jaybee Serrano.

Dr Rajini Jayaballa

Jayaballa R. *Transforming Type 2 Diabetes Care Through Technology: Insights from Western Sydney Diabetes*. NADC Primary Care Diabetes Webinar, July 2025.

Jayaballa R, Silvestro V, Serrano J. *Transforming Type 2 Diabetes Management – the impact of CGM and Technology*. Australian Diabetes Congress, Gold Coast, Australia, August 2025.

Jayaballa R. *Highlights from ADA 2025*. Blacktown Endocrinology Departmental Meeting, June 2025.

Jayaballa R. *Secondary Prevention and Management*. WSPHN/WSD Planning meeting, December 2025.

Jayaballa R. *Thyroid disease*. Advanced Trainee Education, Blacktown Endocrinology Department, October 2025.

Jayaballa R. *WSD Model of Care*. Charles Perkins Centre, March 2025.

Wu A, Knott J, Ong TY, Badasu U, Ranote P, Jayaballa R, Maberly G, Lal R. *Improving perioperative glycaemic control through collaborative care*. Perioperative Medicine SIG meeting, Wellington, New Zealand, November 2025.

Jayaballa R, Silvestro V, Chen S, Serrano J. *Using Technology to Enhance Care - Health2Sync*. Sydney Masterclass, Parramatta NSW, September 2025.

Dr Jeremy Knott

Knott J. *Obesity: recent advances and future perspectives*. Blacktown & Mount Druitt Departmental Meeting, Blacktown Hospital, Sydney, Australia, March 2025.



Aruni Ratnayake presenting at Masterclass.

Knott J. *Cystic fibrosis-related diabetes*. Blacktown & Mount Druitt Departmental Meeting, Blacktown Hospital, Sydney, Australia, October 2025.

Knott J. *The expanding role of SGLT-2 inhibitors and finerenone in type 2 diabetes*. Western Sydney Masterclass 2025 virtual session, Blacktown Hospital, Sydney, Australia, August 2025.

Knott J. *Endocrinology journal club*. Blacktown Hospital, Sydney, Australia, April & September 2025.

Knott J, Meyerowitz-Katz G, Maberly G. *Assessing the impact of a pre-clinic intervention in a dedicated integrated model of diabetes care*. Australian Diabetes Congress, Gold Coast, Australia, August 2025.

Knott J. *Grave's Disease in Pregnancy*. Westmead Endocrinology Grand Rounds, Westmead Hospital, Sydney, Australia, October 2025.

Wu A, Knott J, Ong TY, Badasu U, Ranote P, Jayaballa R, Maberly G, Lal R. *Improving perioperative glycaemic control through collaborative care*. Perioperative Medicine SIG meeting, Wellington, New Zealand, November 2025.

Aruni Ratnayake

Ratnayake A. *Diabetes in Western Sydney & WSD Culture & Place-based approach*. Graduate Certificate in Diabetes Education & Management Program, UTS, May 2025.

Ratnayake A. *Let's talk about preventing diabetes*. Literacy for Life Foundation Mount Druitt Program, June 2025.

Ratnayake A. *Auburn diabetes initiative*. Cumberland Community Exchange Network, June 2025.

Ratnayake A. *WSD Place-based diabetes approach*. Auburn diabetes leadership forum, July 2025.

Ratnayake A. *Walking groups*. WSD Masterclass, September 2025.

Ratnayake A. *Auburn diabetes initiative*. Auburn Community Network Forum, October 2025.

Ratnayake A. *Culture and Place-based populations*. WSPHN/WSD Planning Meeting, December 2025.

Sumathy Ravi

Ravi S. *Listening to patients: how we learn from what patients say and what they don't?* Rural Masterclass, Dubbo, June 2025.

Ravi S. *Codesigned Diabetes Priorities Questionnaire (DPQ) to meet the needs of people with diabetes in*



Sumathy Ravi with her poster at ADC.



Western Sydney. Deep Dives. Community Primary Health Care Advisory Group, Faculty of Medicine and Health, The University of Sydney, July 2025.

Ravi S. *Co-designed Priority Setting Tool: Enhancing proactive care for people with type 2 diabetes*. Oral Presentation, Australasian Diabetes Congress, Gold Coast, Australia, August 2025.

Ravi S. *Co-designed Priority Setting Tool: Enhancing proactive care for people with type 2 diabetes*. Poster Presentation, Australasian Diabetes Congress, Gold Coast, Australia, August 2025.

Ravi S. *Enhancing Patient Engagement*. WSD Masterclass 2025, PARKROYAL Parramatta, September 2025.

Ravi S. *A Patient-Centred Diabetes Priorities Questionnaire (DPQ)*. Leeder Centre for Health Policy, Economics and Data, Higher Degree Research (HDR) Showcase, The University of Sydney, October 2025.

Ravi S. *A Patient-Centred Diabetes Priorities Questionnaire (DPQ): Development and Implementation*. Sydney Health Literacy Lab (SheLL) Symposium, The University of Sydney, December 2025.

Professor Glen Maberly

Maberly G. Western Sydney Diabetes program, Zimbabwe First Lady Visit to WSLHD, Blacktown Hospital, February 2025

Maberly G. WSD Leaders Alliance Meeting -*The 2kg Challenge: Changing the Future of Diabetes* in Western Sydney, Blacktown Workers, May 2025

Maberly G, Helen Dick, Victoria Silvestro and Dr Wilson Pujawiyatna, *Cracking the Code: Managing Diabetes When Control is Poor – A live Case Conference*, Rural Type 2 Diabetes Masterclass, Dubbo, June 2025

Maberly G. *Digital First: Transforming Type 2 Diabetes Care Through Technology*, Rural Type 2 Diabetes Masterclass, Dubbo, June 2025

Maberly G. *Turning Back the Rising Tide of Diabetes – Let's Act Now!* Diabetes and Obesity Clinical Academic Group, Royal Prince Alfred Hospital, Sydney, July 2025

Maberly G. Session Chair, *Transforming Type 2 Diabetes Management – the impact of CGM and Technology*. Australian Diabetes Congress, Gold Coast, August 2025.



Prof Glen Maberly presenting at the DOCAG forum.

Maberly G. *CVRM and Beyond-Reframing Diabetes Care for Today's Reality*, Mount Druitt Medical Practitioners Association (MDMPA) Biannual Conference, Bowral, August 2025

Maberly G. *GLP-1A, Weight Loss, and Lean Body Mass – Why quality of weight loss matters*, BMDH Department Meeting, September 2025

Maberly G. *Diabetes Together: How Western Sydney Diabetes is supporting General Practice*; Diabetes Tech & Talk Conference; DOMTRU, Campbelltown Hospital, October 2025

Alexander Wu, Jeremy Knott, Tsui-Yiu Ong, Uday Badasu, Puneet Ranote, Rajini Jayaballa, Glen Maberly, Rajni Lal, *Improving perioperative glycaemic control through collaborative care*, Perioperative Medicine SIG meeting, Wellington, New Zealand, November 2025

Jaybee Serrano

Maberly G, Silvestro V, Chen S, Serrano J. *Better with Digital: Tools that are changing how we care – and share*. Rural Diabetes Masterclass, Dubbo NSW, June 2025.

Serrano J. *Insulin in Practice: Turning Glucose Insights into Safer, Smarter Care*. Sydney Masterclass virtual, September 2025.



Jayaballa R, Silvestro V, Chen S, Serrano J. *Using Technology to Enhance Care-Health2Sync*. Sydney Masterclass, Parramatta NSW, September 2025.

Serrano J, Bramwell S. *Enhancing Diabetes Care through Digital Innovations: Embedding the Health2sync App in the WSD Model of Care*. Australian Diabetes Congress, Gold Coast, Australia, August 2025.

Serrano J, Dick H. *Digital Solutions*. WSPHN/WSD Planning meeting, December 2025.

Mahsa Shahidi

Shahidi M. Presentation. Australasian Diabetes Congress, Gold Coast, Australia, August 2025.

Victoria Silvestro

Silvestro V, Jayaballa R, Serrano J. *Transforming T2DM management: the impact of CGM and technology*. Symposium, Australian Diabetes Congress, Gold Coast, Australia, August 2025.

Silvestro V, Bramwell S, Serrano J, Meyerowitz-Katz G, Jayaballa R, Gibson A, Maberly G. *Appetite for Change: Exploring Patient Interest Towards Dietetic Referral In Western Sydney*. Poster Presentation, Australian Diabetes Congress, Gold Coast, Australia, August 2025.

Silvestro V. *Food for Thought: Navigating Nutrition*. University of Technology Sydney webinar, 2025.

Silvestro V. *Food for Thought: Navigating Nutrition in Low SES, CALD, and Low Health Literacy Groups*. University of NSW webinar, 2025.

Silvestro V. *Digital Versus Dietitian: Can an App Empower Smarter Self-Management*. CPC Metabolic Health Initiative Launch, 2025.

Maberly G, Dick H, Silvestro V, Pujawiyatna W. *Cracking the Code: Managing Diabetes When Control is Poor – A live Case Conference*. Rural Type 2 Diabetes Masterclass, Dubbo, June 2025.

Maberly G, Silvestro V, Chen S, Serrano J. *Better with Digital: Tools that are changing how we care – and share*. Rural Diabetes Masterclass, Dubbo NSW, June 2025.

Jayaballa R, Silvestro V, Chen S, Serrano J. *Using Technology to Enhance Care-Health2Sync*. Sydney Masterclass, Parramatta NSW, September 2025.

RESOURCE MOBILISATION

Sumathy Ravi, Program Manager

WSD demonstrated remarkable progress in resource mobilisation throughout 2025, driving impactful programs and partnerships that addressed critical aspects of diabetes care. Below is an overview of key projects that have been funded with pharmaceutical and community organisation support.

1 eCARE and Rural Masterclass Program

- Secured multi-stakeholder collaboration involving Abbott, Lilly and Novo Nordisk to enhance diabetes care in rural NSW;
- Leveraged \$90,000 per year for two years to implement virtual case conferencing and rural Masterclass sessions; and
- Integrated virtual and in-person education, empowering rural healthcare providers to improve care delivery.

2 Masterclass Series 2025

- Continued the highly successful Masterclass Series, attracting more than 1000 health professionals in 2025, with sponsorships of \$15,000 received from five pharmaceutical companies - Novo Nordisk, Abbott, Eli Lilly, Boehringer-Ingelheim and Sanofi; and
- Expanded resources to include a proposed rural live Masterclass, enhancing accessibility to best-practice management strategies for underserved regions.

3 Educational Video Production

- Raised \$30,000 in sponsorships from Abbott, Eli Lilly and Novo Nordisk, to produce 25 additional educational videos, expanding an already robust library of over 150 resources; and
- Educational videos, targeted towards healthcare professionals and patients, are being distributed via GoShare Healthcare, myINTERACT and NADC platforms, strengthening self-management and professional capacity in diabetes care.



RESOURCE MOBILISATION

4 Diabetes Quality Improvement Program

- Partnered with Lilly to secure \$60,000 funding for a two-year project in General Practices.
- This initiative designed to address the high prevalence of diabetes and obesity in Western Sydney. With a focus on empowering GPs, the project aiming to integrate technology and benchmarking tools like PenCS to identify care gaps and implement improvements through coordinated care and data-driven strategies.

5 Centre of Excellence for CGM in T2D

- Advanced CGM adoption through partnerships with Abbott and integration with Health2Sync's app, emphasising personalised coaching and real-time data use.
- Secured \$20,000 annually for two years to sustain CGM-related education and advocacy, expanding the impact across Western Sydney, rural NSW, and internationally.

6 Western Sydney Changing Diabetes

The Western Sydney Changing Diabetes initiative, a public private-civic collaboration between WSD, Workers Lifestyle Group (WLG) and Nordisk Novo. In 2022 the WLG Board pledged an investment of \$500,000 for five years and this has been matched by Novo Nordisk. In 2025 this supported the programs described under the Early Prevention and Risk Reduction section.

WLG also sponsored WSD events at the Workers Blacktown Club including the two Alliance meetings.



List of Contributors 2025

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Barry Thorson, Literacy for Life Foundation

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Marina Sarkis, Network Manager, Diabetes and Endocrine

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Ebru Caylak, Targeted Early Intervention Project Manager, Australian Anatolian Community Services

Osman Goreli, Multicultural Community Liaison Officer, Auburn Polica Area Command

Ziba Gulzari, Community Development Project Officer & Group Worker (Afghan), NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS)

Deb Gurung, Nepalese Community Leader

Anita Hanna, Director Policy and Programs, Western Sydney Community Forum

Figen Karahan, Association Coordinator/Secretary NSW Turkish Welfare Association

Pratima Khadka, Nepalese Community Representative

Ernest Kulauzovic, Community Engagement Specialist, Auburn Ruth Everuss Aquatic Centre

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Jenny Ye, G'Day Neighbour

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Dean Paningbaton, Accredited Practising Dietitian/ Sports Dietitian (Treasurer)

Vanessa Manalo, Registered Nurse (Secretary)

Jade Cadelina, Technologist (Public Relations Officer and Public Officer)

Imelda Provideo, Community Leader (Committee member)

Rhea Balmaceda, Dietitian/Exercise Physiologist (Committee member)

Julie Chio-Nunez OAM, Community Leader

John Cruz, Consumer Representative

Dr Belinda Lorenzo, General Practitioner/President Philippine-Australian Medical Association

Fe Maramara, Consumer Representative

Tess Sayas, Community Leader

Nelia Sumcad, Philippine-Australian Community Services Inc

GENERAL PRACTICE

Over 800 General Practitioners have partnered with WSD, too many to list here, but special mention to GPs who have recently helped with strategic planning include:

Dr Hani Bittar, GP Lead, HealthiCare

Dr Wallid Jammal, Principal GP, Hills Family General Practice, Castle Hill

Dr Helen Keteku-Adu, PGK Medical, Colebee

Dr Johnny Khoury, Principal GP, Darcy Road Surgery

Dr Kean Seng Lim, Principal GP, Mount Druitt Medical Centre, Mount Druitt

Dr Kim Loo, GP, Riverstone Family Practice

Dr Sharon Mur, GP, Riverstone Family Practice

Dr Mourad Nosir, Principal GP, NAS Advanced Medical Centre

Dr Jaspreet Saini, Clinic Director, HealthiCare

Dr Shanthini Seelan, Principal GP, Bridgeview Medical Centre, Toongabbie
Dr Thava Seelan OAM, Principal GP, Bridgeview Medical Centre, Toongabbie
Dr Raouf Selim, Principal GP, NSA Advanced Medical Centre
Dr Yan Shen, GP, Auburn Central Medical Centre
Dr Johnathan Zhang, Principal GP, Auburn Central Medical Centre

HEALTHY LIVING TOONGABBIE INC.

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Dr Mani Manoharan, Endocrinologist, Liverpool Hospital, SWSLHD (Vice President)
Dr Thava Seelan (OAM), Bridgeview Medical Practice Toongabbie (Treasurer)
Nidhivanan Paranthaman, Academy of Kalari Australia (Committee member)
Neha Patel, Pharmacist, Barone Pharmacy Woodcroft (Committee member)
Dr Lumina Titus, Bridgeview Medical Practice Toongabbie (Committee member)
Dr Shanthini Seelan, Bridgeview Medical Practice Toongabbie
Padmanabhan Karamil (Public Officer)
Geetha Bhat, consumer representative
Monica Boules, Chief Pharmacist, Toongabbie Discount Drug Store
Josefin Charles, Credentialed Diabetes Educator
Dharmarajah Dharmakumar, HRF Counselling
Anton Fernando, President, Australian Tamil Chamber of Commerce
Raji Jayadev, Dietitian
Andrew Kaye, Pharmacist Good Price Pharmacy Warehouse Toongabbie
Pratheeba Kittumani, IT
Prasad Mallesh, eSoft Technologies
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Rani Sundar, Practice Nurse
Jenet Thevarajah, CDE
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David Cheng, Sales Manager HCP, Abbott Diabetes Care

Boehringer Ingelheim

Amanda Driffill, NSW HRS Outer West – Cardio, Renal, Metabolic

Eli Lilly

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Mark Scott, Public Affairs Specialist, Patient Access, Public Affairs and Policy
Ana Svensson, VP Clinical, Medical & Regulatory
Katherine Tocchino, Public Affairs & Communications, Team Lead

Sanofi

Stephanie Harper Medical Manager -EP & Diabetes

AstraZeneca

Kainaaz Choksey, Key Account Manager -Renal and Metabolic

MASTERCLASS 2025 SERIES

See myINTERACT for a full list of over 40 faculty including short Bios.

For more information on WSD, visit www.westernsydneydiabetes.com.au

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Natalie Wischer, OAM, Chief Executive Officer

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Megan Cobcroft, Director Prevention Programs

George Leipnik, Director, Strategy and System Priorities

Leah Marks, Project Officer, Child and Family Programs, Centre for Population Health

Emma Quinn, Principal Analyst/Lead – Data and Evaluation, Centre for Population Health

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Hon Stephen Bali, MP State Member for Blacktown

Hon Chris Bowen, MP Federal Member for McMahon

Hon Dr Mike Freelander, MP Federal Member for Macarthur

Hon Dr Hugh McDermott, MP State Member for Prospect

Hon Ms Dai Le, MP Member for Fowler

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Shelley Somi, NUM, ICCP

Minhong Supa, Diabetes Educator, Blacktown

Saba Tedla, CDE, Auburn

Vivien Yiu, Dietitian, Auburn

Wei Zhang, CDE, Westmead

Annie Zhou, Diabetes Educator, Auburn



Megha Patel, Hewan Workineh and Helen Dick at Masterclass.

GLOSSARY

ACI Agency for Clinical Innovation	OOS Occasions of Service
ADC Australasian Diabetes Congress	UNSW University of NSW
AT Advanced Trainee	UON University of Newcastle
BMDH Blacktown and Mount Druitt Hospitals	UOW University of Wollongong
CDE Credentialed Diabetes Educator	USYD University of Sydney
CGM Continuous Glucose Monitoring	UTS University of Technology Sydney
CVRM Cardiovascular-Renal-Metabolic	VMO Visiting Medical Officer
ED Emergency Department	WLG Workers Lifestyle Group
EMT Executive Management Team	WNSWLHD Western NSW Local Health District
EN Enrolled Nurse	WNSWPHN Western NSW Primary Health Network
FADSN Filipino Australian Diabetes Support Network	WSD Western Sydney Diabetes
GDM Gestational Diabetes Mellitus	WSCD Western Sydney Changing Diabetes
GP General Practitioner	WSLHD Western Sydney Local Health District
GWAHS Greater Western Aboriginal Health Services	WSPHN Western Sydney Primary Health Network
HLT Healthy Living Toongabbie	WSU Western Sydney University
HRFS High Risk Foot Service	
ICH Integrated and Community Health	
MBS Medicare Benefits Schedule	
MDCHC Mount Druitt Community Health Centre	
MOH Ministry of Health	
MRFF Medical Research Future Fund	
NADC National Association of Diabetes Centres	
NDSS National Diabetes Service Scheme	



Western Sydney Diabetes
 Integrated and Community Health
 Level 3 Administration and Education Building
 Blacktown Hospital Campus

For more information about WSD please visit the website below. To speak with us, or to make an enquiry, please contact WSD Program Manager, Sumathy Ravi via email at Sumathy.Ravi@health.nsw.gov.au

westernsydneydiabetes.com.au

