Appendices

Appendix 2: Progress made within the Living Well Workstreams

<table>
<tr><th>Workstream</th><th>Key Successes/Progress</th></tr>
<tr><td>Data</td><td>➢ Development of a disease dashboards
➢ Working towards a standardised format and expectation reporting metrics
➢ Primary care Network and GP Practice level data pack regularly (monthly & quarterly) circulated to GP practices to support patient education on disease risk factors and referrals to the National Diabetes Prevention Programme.</td></tr>
<tr><td>Core prevention</td><td>➢ National Diabetes Prevention Programme
o Kirklees continues to achieve referral trajectory.
o Review of patients completing the course found 38% of patients reversed their prediabetes after course completion
➢ Cardiovascular Prevent Strategy being finalised.
➢ Cardiovascular Action Plan to support strategy drafted with some actions already in progress.
➢ NHS health checks service review started with a view to commission a new specification from 1st April 2025, with a view to target most at risk population within the available resource.</td></tr>
<tr><td>Community Involvement including the Community Champions</td><td>➢ Diabetes Project Completed – Evaluation Received from Kirklees Third Sectors Leaders. Healthwatch Report also completed, which analyses information to support future transformation with the view and needs of Kirklees residents to be met.
o The aims of the project: -
▪ was to work with community groups to have conversations with people living in our local communities and to deliver activities around type 2 diabetes with a particular focus on health inclusion groups and in specific geographical areas across North and South Kirklees.
▪ The main aim was prevention – reduction in number of people diagnosed with type 2 diabetes and support and improvement of self-management for those with type 2 diabetes.
o To achieve the aims the community champions and the voluntary sector were asked; -
▪ To hold community-based conversations to raise awareness and offer advice and signposting to individuals, groups, at events and in other community settings.
▪ To use smaller groups to deliver healthy lifestyle activity and awareness messaging.
▪ To set up peer support groups in South & North Kirklees
➢ Cardiovascular Community Champions training delivered – focusing on hypertension.
➢ Community Champions training and using blood pressure machines to raise awareness and signpost people to the correct services – hoping to identify those with undiagnosed hypertension and prevent heart attack or stroke.
➢ Focus on sustainability for VCSE partners</td></tr>
<tr><td>Secondary Prevention</td><td>➢ National & Regional Diabetes Project - Type 2 Diabetes path to Remission Programme – contribution to the successful achievement of the West Yorkshire system wide trajectory
➢ National & Regional Type 2 diabetes in Young– Year 1 completed – planning for year 2 in progress and evaluation of year 1 to be completed. 430 patients attended an extra appointment to received further care for their diabetes.
➢ Local Project - new structured education programme delivered by local provider. To be evaluated.
➢ Regional Pulmonary Rehabilitation funding to support local service – implementation of project demonstrated 50% reduction in waiting list within one quarter and the average waiting time is now under 6 weeks</td></tr>
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	➢ CVD Hypertension target – Kirklees progressing towards the National 80% Target – Kirklees currently at 69.73% (CVD Prevent Data May 20204) which is the highest in West Yorkshire and is also above the West Yorkshire system percentage of 67.56% and the National percentage of 67.20%. Other CVD metric currently being assessed.