Diabetes & Health Inequalities Programme Liverpool

January 2023


Mary Seacole House

Collaborative Programme - VCSE, CCG, LDP

NHS Liverpool Clinical Commissioning Group

Aims & Objectives

- Community led
- Engage diverse groups
- Form a Community of Practice
- Empower community members to take control of diabetes self-care and prevention through participant led, targeted and evidence based actions, tailored to need and linked to best practice

16 Community Organisations & Communities

NHS Liverpool Clinical Commissioning Group

People from Ethnic Minority Communities

- Chinese Wellbeing – Chinese community
- Liverpool Arabic Centre – Arabic community
- Luma Creations – BAME communities including Latin Americans
- Mary Seacole House – BAME communities
- Merseyside Polonia – Polish Families
- Merseyside Refugee Support Network / ALM / F4C – Refugees/asylum seekers
- Sola Arts – refugees/asylum seekers
- Women Reach Women – south Asian women

People with Disabilities / Mental Health Problems etc

- Bradbury Fields – Blind/partially sighted people
- Daisy Inclusive – people with disabilities
- Independence Initiative – people with long term substance misuse / homeless / prison
- Mencap Liverpool & Sefton – people with Learning Disability
- MSDP – D/deaf people
- New Beginnings – homeless people / BAME women
- Perspective Theatre Company – People in Bail Hostels / homeless
- WHISC – Women with mental distress

Kensington Vision – Liverpool community radio - promotion among wider community

糖尿病的種類

- 二型糖尿病
- 最常見的類型，佔患者百分之九十至九十五
- 多為中年以上的人士
- 有家族歷史、肥胖、飲食習慣欠佳或缺乏運動的人士
- 由於胰島素分泌不足或身體使用胰島素的能力減弱
- 發病較慢
- 病徵較不明顯，部分患者初期並不察覺
- 多達 50% 的二型糖尿病病例可以預防或延遲
- 透過改變飲食、適當運動、 減重，預防或推遲患上二型糖尿病

華人身心健康
CHINESE WELLBEING

Participant Views

NHS Liverpool Clinical Commissioning Group

WRW CIC Women Reach Women

Attitudes and beliefs about diabetes:

"It's something that you have to live with, it's not killing you. It doesn't give me any problems, so I think it's fine, all I know is that the doctors have said that I have it and I just go along with it, but I still enjoy everything I want to do because it isn't causing me problems, so why should I stop eating my favourite food"

Management of diabetes:

"The doctors say, eat low carb and do exercise, but little do they know about how we live our life. Rice is part of us; it keeps us connected to our home country; it has much im-portance in our diet, every Bangladeshi household eats rice every day and eats it at least two times a day, and it's the norm. So you tell me, how is someone supposed to stop that suddenly?"

Family role and involvement:

"I was diagnosed with gestational diabetes, and, three years later, doctors told me I had type 2 diabetes. I found it hard to manage my diet, living with my in-laws, husband, and children. They didn't have diabetes, so it was difficult for me to cook something separate for myself; I cooked for the family. Having to restrict my diet made me feel isolated in from everyone; when I was at family events, I felt like I was a burden"

Attitudes and beliefs about diabetes:

"I don't know why it happened, but everything happens because of Allah's plan, so I accept this, it is Allah's plan. I pray that it is easy for me to live with, that's all I can do…..

5 Themes

- Poverty
- Knowledge
- Skills
- Accessibility
- Cultural Issues

Themes Through early engagement groups identified 5 common themes which existed as barriers to achieving better outcomes. All groups identified with most of these, tailoring delivery in response.

Poverty

- Cost of healthy food / getting to healthy food
- Lack of cooking facilities / equipment
- Travel costs too high to attend sessions

Knowledge

- Misconceptions prevail around diabetes / diet / exercise etc
- Low knowledge of risks, signs, & management
- Some prediabetic / diabetic participants felt had no advice / info given
- Low knowledge of healthier diet options/ ingredients / exercise requirements
- Don't know who to get information / advice from

Skills

- Lack of shopping & cooking skills
- Low literacy
- Lack of skills among carers/ supported living providers

Accessibility

- Information not in required language / format / style
- NHS not trusted
- NHS engagement not appropriate for community members
- People in hostels/supported living etc don't have control over diet etc.

Cultural Issues

- NHS services & advice not culturally appropriate
- NHS not trusted / used as source of information / low engagement with NHS
- Cooking / meal expectations not adapted

Approaches devised to address themes & barriers

NHS Liverpool Clinical Commissioning Group

- Creative engagement & education techniques which actively involved participants in exploring issues & solving them
- Growing food, group recipe creation/cooking which met cultural & social requirements
- Creation of information in people's first language / format appropriate to their disability & workshops to explore the issues
- Learning to shop & cook on limited resources/ equipment, connection to pantries / low cost food schemes / equipment
- Training of staff, volunteers & peer champions to spread knowledge
- Appropriate ways to be active, that met the needs & interest of participants such as cycling & gardening
- Support & education with people with mental health/substance misuse issues at risk/with diabetes
- Group discussions, walks & online classes & activities appropriate to groups needs
- One to one support and goal setting/reviewing
- Support with wider needs / barriers eg social determinants / childcare / travel

Approaches devised to address themes & barriers

NHS Liverpool Clinical Commissioning Group

The projects developed a significant knowledge base of the difficulties people in their communities experience in NHS support around diabetes and the effective ways to overcome these.

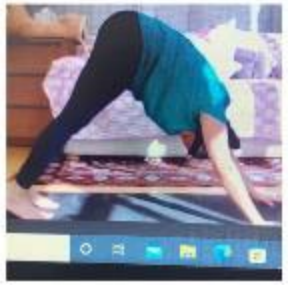
- Creative engagement & education techniques which actively involved participants in exploring issues & solving them
- Growing food, group recipe creation/cooking which met cultural & social requirements
- Creation of information in people's first language / format appropriate to their disability & workshops to explore the issues
- Learning to shop & cook on limited resources/ equipment, connection to pantries / low cost food schemes / equipment
- Training of staff, volunteers & peer champions to spread knowledge
- Appropriate ways to be active, that met the needs & interest of participants such as cycling & gardening
- Support & education with people with mental health/substance misuse issues at risk/with diabetes
- Group discussions, walks & online classes & activities appropriate to groups needs
- One to one support and goal setting/reviewing
- Support with wider needs / barriers eg social determinants / childcare / travel

Summary of Key Outputs Across 16 Partners

NHS Liverpool Clinical Commissioning Group

Whole time equivalents involved in delivery	16.7
Total number of volunteers involved in delivery	78
Volunteer Hours involved in project	3571
Hours of input from LDP hospital team to project	235
Total number of one off events held / attended	77
Total number of workshops/sessions for ongoing engagement held	839
Total number of people engaged with on a one-off eg at an event	1642
Total number of people engaged with more than once, eg monthly	638

Mary Seacole House Physical Activity Outcomes



	Beginning of project	Middle of project	End of project
Total Number of Participants	45	67	120+
Total number of days each week participants are physically active	1	1-3	2-4
Total minutes of physical activity undertaken per week (average)	30-60	75-100	120 +

NHS
Liverpool
Clinical Commissioning Group

Key Outcomes 1

- **Significant knowledge and understanding gathered**
- **599.5 people were trained** in diabetes prevention and management
- People supported to consult GP and **new cases of diabetes identified**

Project case studies

Participant seeking asylum

at risk of diabetes + obese + cancer + depression

£35 weekly to live on

relying on cheap/unhealthy food

Cancer treatment postponed due to risks to heart.

Thanks to project began to eat healthily and walk every day, eventually losing 4 stone over the year. Now able to proceed with cancer treatment.

One participant mainly ate toast and custard and has now been eating fresh food and lost two dress sizes.

NHS Liverpool Clinical Commissioning Group

Key Outcomes 2

- **638 people were engaged with more than once**
- Of those attending regular sessions
  - **68-100% reported increased knowledge and understanding** of diabetes risks/prevention/ management (most groups 80%+)
  - **86% people increased their levels of regular physical activity**
  - Increases in other **healthy lifestyle behaviours**
  - **Weight loss**
  - **Increased confidence & wellbeing**

Daisy Physical Activity Outcomes

NHS Liverpool Clinical Commissioning Group

	Beginning of project	Middle of project	End of project
Total Number of Participants	50	50	50
Total number of days each week participants are physically active	1	3	5
Total minutes of physical activity undertaken per week (average)	15 mins	1.5 hours	2.5 hours

NHS
Liverpool
Clinical Commissioning Group

Key Outcomes 3

- ✓ **116 Bespoke resources** created and shared
- ✓ Most groups shared information more widely in their communities too – via word of mouth and social media for example
- ✓ **86 new connections between VCSEs** formed, enabling mutual support and referrals
- ✓ Links between LDP and VCSE created mutual benefit and some lasting arrangements of support
- ✓ **26 new connections** made between **VCSEs & GP practices**
- ✓ An **additional £43,603** was brought in by community organisations using the funding to draw in other funds.

Independence Initiative Case study

NHS Liverpool Clinical Commissioning Group

Male age 52

Morbidly obese, immobile using a walking stick, schizophrenic, sleep apnoea, prescribed methadone, long history of dependent alcohol use. Very inactive, drank fizzy pop/energy drinks/alcohol. Diet of fast sugars, takeaways, cereals, chocolate bars etc. No awareness of how lifestyle and diet impacting health. Joined programme at The Indy to learn about condition and improve lifestyle.

He joined the healthy eating course as he wanted to improve his diet/cooking/ shopping skills. Staff noticed he was using the toilet frequently and gulping down drinks. Staff chatted to him regarding symptoms of diabetes and his disclosed he has tingling in his hands and feet.

Referral to GP with staff support and confirmed he was type 1 diabetic. He was determined after this diagnosis, not to add to the list of health complications that he already had.

He embraced the pathways on offer through diabetes project, this included, walking group, a referral to a NHS trainer to help keep him motivated and a weekly weigh in to date he has lost two and a half stone and is no longer using walking stick. He joined a local gym with the support of another peer from the in/house diabetes group and they met three times a week at 8:00am (as gym was less busy at this time due to their anxiety).

He has found the confidence due to his increased mobility to now also take part in the canoeing club and cycle club that we have on offer for our diabetes project. Previously his weight would have been a massive barrier and his low confidence and social anxiety.

Key Learning & Conclusions 1

NHS Liverpool Clinical Commissioning Group

- NHS styles of information not working
- Effective interventions required significant time investment and bespoke/creative ways to engage
- Projects enabled participants to explore issues and propose solutions for themselves and to share with others – more effective
- VCSE organisations supported individuals holistically
- Low engagement with NHS identified by most participants - community engagement regularly built a bridge to NHS and other services.

WHISC Project case study 1

NHS Liverpool Clinical Commissioning Group

Woman B – 65 homeless, Autism, recovering from decades of addiction. Spent a lot of time in prison, due to exceptionally traumatic history and neglected health. Very isolated and anxious. She was mistrustful of health services, due to previous experiences.

Since receiving support from WHISC she has :-

- registered with GP and is attending health appointments
- gained a tenancy in sheltered accommodation
- referred to Mary Seacole House project partner for a mental health advocate and is now engaged with secondary mental health support
- referrals to Citizens Advice Liverpool for benefit checks and Careline for care/support needs
- understood the risk of diabetes
- attends foodbank at Vauxhall Neighbourhood Council and is eating more fruit and vegetables
- attends exercise sessions provided by WHISC at the VNC and is learning to hula hoop. She has found a new love for exercising with other women!

Key Learning & Conclusions 2

NHS Liverpool Clinical Commissioning Group

- Bespoke engagement effective
- Engaging in these ways identified both **need and desire**
- Built bridges to GPs & case finding happened
- Accessible information and content is vital.
- Approaches successful and could readily be applied to other long term conditions
- VCSEs valued the partnership approach to the programme
- All identified short term funding as problematic

Acknowledgements & Contact

Thanks to all the organisations, volunteers and participants for their work and achievements in the project and North West Coast Clinical Network for funding and support.

Report

https://www.liverpoolccg.nhs.uk/media/5443/liverpool-diabetes-health-inequalities-prog-evaluation-report-final.pdf

For further information contact

Sarah.Dewar@liverpoolccg.nhs.uk