Diabetes & Health Inequalities Programme Liverpool

Evaluation Report

May 2022


Mary Seacole House

NHS
Liverpool
Clinical Commissioning Group

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Section 1
Evaluation of Programme

Background

A collaborative bid was submitted by NHS and VCSE partners in Liverpool, to the North West Coast Clinical Network Diabetes and Health Inequalities programme, 2021. The bid was awarded **£139,946** for a pilot programme exploring health inequalities in diabetes with 16 priority groups. This report describes the learning and outcomes of the programme.

Programme Aims

- Create a community led diabetes programme in Liverpool engaging diverse groups facing health inequalities and at risk of diabetes
- Form a Community of Practice partnership between 16 VCSE delivery organisations, NHS commissioners and Liverpool Diabetes Partnership (NHS).

Programme Objectives

1. Co-ordinate action among partners to align with aims, principles of working and best practice
2. Create a community of practice which enables knowledge and skills sharing between different professional expertise and a continuous improvement culture
3. 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

Programme Approach

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- NHS Liverpool CCG co-ordinated bid, programme & evaluation
- Sought expressions of interest from community organisations (voluntary, community and social enterprise organisations) who work with priority communities identified – those with worse outcomes and at higher risk of diabetes.
- VCSE Organisations brought knowledge, contact and expertise of working with priority communities, devised and delivered projects aimed at prevention and management of diabetes
- Liverpool Diabetes Partnership (NHS team supporting people with diabetes) offered expertise to community organisations
- Formed a community or practice and partnership between NHS Liverpool CCG, and 16 community organisations
- Collectively agreed evaluation templates and tools to use to achieve consistency of reporting across the breadth of the programme


Luma Creations

16 Community Organisations & Communities

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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

LDP reflections

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- LDP trained staff at some of the groups and delivered sessions for some of the groups
- LDP referred people to the community groups
- Group members were supported to build up confidence to liaise with NHS, via visits to clinics etc..
- LDP saw Mutual benefit evident from the programme – exchange of learning
- DKAs – frequent – would like to explore if VCSE support appropriate
- Aim to continue links with groups they worked with in some cases

National / Local Strategic Priority Commitment	Delivered through this Programme
LTP 'People will get more control over their own health and more personalised care when they need it' and the NHS will improve supported self-management of conditions, including diabetes. ✓	Placed people in at risk groups at heart of designing and delivering programmes to successfully engage people in adopting healthy lifestyles to reduce diabetes and taking control of their risk. Enabled tailored approaches to care adapted to specific needs of groups involved.
LTP - improving upstream prevention, including reducing diabetes through obesity reduction. NHS Prevention Programme sets 5 priority areas which tackle the biggest risks of premature deaths including poor diet and obesity. ✓	Addressed primary and secondary prevention measures for groups known to be at higher risk and pre-diabetic people for whom accessing NHS services is difficult. Programme addressed knowledge, skills, diet, exercise etc.
LTP - expanding structured education and self-management of diabetes ✓	Reviewed with at risk community members how programmes can be adapted to meet their needs and to increase uptake and devised community based approaches to meet these goals.
LTP - taking more action to support reducing health inequalities and commits to partnering with voluntary, charity and social enterprise organisations supporting vulnerable and at risk groups ✓	Turned both of these commitments into reality. Harnessed skills and trusted connections of VCSE partners to work with communities experiencing health inequality and empower them to devise and deliver community led solutions to diabetes risk, with the support of clinicians and diabetes specialists.
Cheshire/Merseyside HCP- 'supporting people to live better quality lives by actively promoting the things that will have a positive effect on health and wellbeing and reduce reliance on services and working together with partners in local government and the voluntary sector to develop joined up models of care, outside of hospital, to give people the support they need in the right place, from the right professionals at the right time.' ✓	Made significant improvements in patients' ability to self manage their diabetes and prevent development, reducing reliance on services and also enabling early diagnoses. The programme developed effective partnerships between VCSEs, NHS LDP team and GPs to create reach and accessibility for excluded and at risk individuals.
Similarly the One Liverpool local health strategy sets out local plans to deliver on the NHS Long Term Plan including four key objectives which our proposals directly address:- • targeted action on inequalities, • empowerment and support for wellbeing, and • a radical upgrade in prevention and early intervention. ✓	Directly engaged people known to have worse outcomes in diabetes, including from ethnic minority communities, people with learning disabilities and sensory disabilities. All projects reported significant improvements in knowledge, skills and confidence to prevent and/or treat diabetes and wellbeing and also created staff and champions confident in their skills to share prevention and care knowledge with others, further boosting prevention outcomes.

The programme developed community capacity for diabetes health awareness, knowledge and skills exchange, by developing relationships between the VCSE partners and the NHS and between all partners. All of the projects focused on developing awareness, knowledge and skills and on sharing this widely in priority communities as well as those directly engaged.

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

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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

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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

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Key Outcomes 1

- **Significant knowledge and understanding gathered** about experiences of participants in being diagnosed with diabetes and the problems with the advice, information and management offered by the NHS. Identification of common themes arose around culture, disability, poverty, accessibility of information and services, knowledge and skills.
- All projects delivery was affected by Covid 2021/22
- **599.5 people were trained** in diabetes prevention and management comprised of
  - 111.5 staff
  - 66 volunteers
  - 422 peer support advocates
- People were supported to consult their GP and many **new cases of diabetes were identified**

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Key Outcomes 2

- **638 people were engaged** with more than once, eg at monthly sessions etc
- Of those attending regular sessions
  - **68-100% reported increased knowledge and understanding** of diabetes risks/prevention/ management (most groups 80%+)
  - **86% (548) people increased their levels of regular physical activity**
  - Increases in other **healthy lifestyle behaviours** eg diet reported*
  - Many participants reported **weight loss***
  - Participants reported **increased confidence & wellbeing***

*See individual project reports in section 2

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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.

Key Learning & Conclusions 1

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- NHS styles of information sharing are not reaching, or working for, priority groups. NDPP seen as unattainable for participants.
- Participants in all groups expressed difficulty with health information, care and services for lack of accessibility, ease of understanding, clarity and cultural sensitivity.
- Effective interventions required significant time investment and bespoke/creative ways to engage and build knowledge, skills and confidence in ways that were appropriate for the group and individual needs. This included verbal and visual learning, culturally appropriate content, women only sessions and a supportive, enjoyable environment
- Projects enabled participants to explore issues and propose solutions for themselves and to share with others, which was a more effective engagement and learning approach
- VCSE organisations supported individuals holistically to address issues affecting their health – almost all addressed poverty – many supported participants with wider training to improve life chances giving significant additional long term health benefits, tackling the social determinants of health
- Low engagement with NHS identified by most participants, community engagement regularly built a bridge to NHS and other services.
- Projects also supported participants with childcare, travel costs and interpreters as required

Key Learning & Conclusions 2

NHS Liverpool Clinical Commissioning Group

- Bespoke engagement approaches employed for different communities was effective in increasing understanding about diabetes and practical lifestyle approaches to avoid/manage the condition.
- Engaging in these ways identified both need and desire for both information in appropriate formats, engagement in appropriate styles and practical, accessible activity to embed the learning, affect behaviour change and allow knowledge and skills sharing in communities.
- The project was successful in building bridges to GPs & case finding.
- Accessible information and content is vital. Bespoke resources created could form a simplified accessible guide useable by many.
- The approaches were successful and could readily be applied to other long term conditions
- VCSEs valued the partnership approach to the programme
- All identified the short term funding as problematic in that the learning and experience of the year is then mostly lost as while some will continue in some ways to incorporate diabetes awareness into their work, all identified funding would be required to develop and continue the work.
- All groups identified the potential for the work to support other long-term conditions.

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Section 2A – Individual Project Evaluations
Working with ethnic minority communities

Chinese Wellbeing

Support mainly the older Chinese community in Liverpool with health and social issues including dementia, social care and wellbeing services

Participants:- Chinese community in Liverpool living with or at risk of type 2 diabetes

Aims & Objectives:-

- Empower community members to take control of diabetes self-care and prevention through participant led, targeted and evidence based action plans, tailored to need and linked to best practice.
- Raise awareness of diabetes prevention across the wider community and develop a CW Diabetes Peer Support Group.
- Recruit and train 2-part time Diabetes Champions from within the Chinese community.
- Tailor an 8-month programme aligned to the National Diabetes Programme to be delivered in Cantonese.

Chinese Wellbeing Project Delivery

- Developed an in-depth diabetes programme aligned to the National Diabetes Programme and tailored to the needs of the Liverpool Chinese community and enabling peer support.
- Recruited 2 volunteer Diabetes Champions one with 20 years experience as a Medical Social Worker in Hong Kong. facilitating a diabetes self-help group and visiting patients being discharged from hospital for assessment, education and management of their medical conditions, the vast majority including diabetes.
- The Project Support Officer is a senior care worker, has type 2 diabetes and has completed the National Diabetes Programme so was very familiar with the topics covered and has an understanding of how to manage the condition.
- The Champions reviewed guidance and literature from NHS, LDP and Diabetes UK to develop course content aligned to the national framework and cultural differences. The content was translated into Traditional Chinese and delivered in Cantonese.
- 12 participants attended 8 monthly online closed sessions (their preference given COVID fears).1-1 follow ups with goal setting and coaching took place via telephone or in home for those with hearing loss.
- 2 online taster sessions were held for 54 participants who couldn’t commit to the full course with a third session planned for c35 people.
- Facilitated a community talk by Drs Kan and Ho entitled Truths/Myths about Covid Vaccinations including the associated risks to people with diabetes if infected with Covid with 43 participants
- As agreed with all members of the Community of Practice, a before and after questionnaire was developed as a measure of the effectiveness of the programme and as an upfront guide for the content. A diabetes quiz was also completed as a baseline to knowledge and participants understanding.

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

Chinese Wellbeing Project Outputs

Paid staff	2 PTE plus Project Manager + Input from Comms Officer
Total number of paid people trained in diabetes	2 PTE
Total number of volunteers involved in delivery of the project	1
Total number of volunteers trained in diabetes	1
Volunteer Hours involved in project	10 hours
Total number of one-off events held / attended	2 taster sessions + 1 GP led session
Total number of workshops/sessions for ongoing engagement held	8 monthly sessions
Total number of people who you engaged with on a one-off e.g. at an event	132
Total number of people you engaged with more than once, e.g. at monthly sessions	12
Number of Bespoke resources created	2 posters, Session outline Presentation slides
Total number of people who increased their levels of regular physical activity	8 out of 12
Number of new connections with other VCSEs made during project	4 (connections established with the remaining group members through other VCSE networks)
Number of new connections to GP practices made during project	1 (Dr Ho Brownlow Group Practice)
Total other funding	Budget shortfall - £2264 paid from CW reserves.

Chinese Wellbeing Project Outcomes	Before intervention	After intervention
Increased understanding of the condition diabetes and risks arising from having diabetes	33%	100%
Increased understanding of signs of diabetes	42%	82%
Understanding of complications of diabetes	75%	92%
Understanding of causes of diabetes	50%	75%
Confidence in managing diabetes	75%	92%
Knowledge of prevention, management and reversal	92%	100%
Achieving personal goals – (took lots of 1-1 support)	N/A	83%
Access to information – provided info in Chinese and advised on good sources Information in first language Willingness to seek information from GP/NHS	 0% 8%	 100% 50%
Increased knowledge and skills for healthy lifestyle options		Increased among 84%
Knowledge of exercise duration aims	67%	100%
Participants eating more balanced healthier diet		75% had improved
Participants increasing their physical activity		75% had improved

Chinese Wellbeing
Wellbeing Outcomes

Participants completed SWEMWBS with the following results

	Before	After
Feel optimistic about future	84%	84%
Feeling useful	83%	75%
Feeling relaxed	83%	84%
Dealing with problems well all or some of time	58%	84%
Thinking clearly often or all the time	75%	100%
Feeling close to other people	84%	92%
Able to make up their own mind often or all the time	75%	100%

Chinese Wellbeing Learning & Reflections 1

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The charity X-PERT supply diabetes information booklets for the NDPP. They contacted Chinese Wellbeing to trial their new Mandarin online training module and App. Our Communications Officer who speaks both languages completed the program and provided feedback.

Chinese Wellbeing noted the mini booklets produced are not available in Cantonese. The minimum size of the print run was an issue at 250 x £5 and to date, we are awaiting a quote for the production of 100 booklets. These would be very useful for LDP and CW to distribute once the programme support has expired.

The session with Drs Kan and Ho whilst focused on Covid vaccinations, did get important key messages across to attendees about the higher risk of becoming seriously ill if not vaccinated and having diabetes. The session over ran due to an extended Q&A. Sessions held with GP's who speak Cantonese are very well received within the community and we were extremely appreciative of their support.

Whilst we were happy with our monthly programme attracting 12 participants, the majority of these were of retirement age (10). It is difficult to find the most appropriate time for younger age groups to attend and commit to an 8-month programme due to work commitments many being in hospitality and working unsociable hours. This group is an important audience to consider in the future as they are more likely to commit to making lifestyle changes.

Chinese Wellbeing Learning & Reflections 2

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The Chinese community is known to be at a high risk of developing type 2 diabetes. However, there is a lack of awareness of how to prevent diabetes and the early signs and symptoms. Due to cultural and language barriers many will not talk to their GP and find it difficult to access appropriate help and support.

There are many different health beliefs and systems and cultural barriers to joining activities particularly in talking openly about health matters in a group programme.

There are issues with digital access and often problems in transportation to place based sessions. This limits their motivation to committing to a programme.

Many people in the Chinese community work long hours in restaurants and supermarkets and therefore don't have much spare time to participate in health programmes.

Community of practice highly valued for sharing of experiences, support, accessible materials

The monthly session only allowed those who had been diagnosed as pre-diabetic or type 2 diabetes. There is a demand for running the course for family carers of people with diabetes so they can learn more about how to manage their loved one's condition.

Sustainable funding for VCSE organisations to enable the further development of community health programmes to meet the needs of Black, Asian and minority ethnic communities.

المركز العربي - ليفربول
Liverpool Arabic Centre

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Liverpool Arabic Centre

Liverpool Arabic Centre (LAC) is a charitable organisation developed by local people to advocate the social and economic well-being, improve the health and advance the education of the Arabic community whilst strengthening the awareness of the community within wider society through the celebration and promotion of all aspects of Arabic history, language, cultural heritage and identity.

Participants:-people from Arabic Communities, refugees and Asylum seekers including people whose first language is not English, with Type1 & Type2 Diabetes, carers, men and women, from all ages.

Aim - Tackling Diabetes health inequalities within the Arabic Communities, Refugees and Asylum seekers

Liverpool Arabic Centre Project Objectives

NHS Liverpool Clinical Commissioning Group

- Establish Community resources, health information & awareness about diabetes and healthy lifestyle.
- Work with a healthcare professional/partner, and organise an educational talk about diabetes, pre-diabetes, prevention and management.
- Create community champions and engage them with community, to reduce health inequality, empower people to make lifestyle changes in order to prevent and manage diabetes.
- Facilitate a discussion about diabetes to encourage community members to share their personal connections/experience to the disease.
- Encourage healthy lifestyle choices. Invite community members to participate in LAC healthy lifestyles activities.
- Provide translation throughout the project.
- To participate in meetings and share existing resources.
- Engage with Arabic community, refugees & Asylum seekers groups to identify barriers to accessing primary care services.
- Work with refugee and asylum seeker groups to ensure that they are not facing problems with GP registration.

Liverpool Arabic Centre Case Study

NHS Liverpool Clinical Commissioning Group

Client A who was a female in her early 20's and a single parent, with very limited family support network was referred to us by one of the participants in Sept. 2021. She had left the college without any qualification and had never worked. She had some family issues and marriage engagement breakdown, which led to depression. The young lady never had any counselling before and was reluctant to access our support, but due to the trust of the organisation and assurance from friends, she eventually did.

- LAC made an introduction one to one session with her, and encouraged her for some counselling sessions.
- Referred the client to GP & Granby Toxteth Development Trust for some counselling.
- Engaged her in our weekly women only physical activity.
- Offered her a volunteering opportunity with LAC.
- Supported her with some housing issues.
- Supported her to build confidence to manage challenges in a positive way.

Liverpool Arabic Centre Project Outputs

Whole time equivalents involved in delivery of project	0.3
Total number of paid people trained in diabetes	4
Total number of volunteers involved in delivery of the project	6 full time + 6 others
Total number of volunteers trained in diabetes	6
Volunteer Hours involved in project	630
Hours of input from LDP hospital team to project	42
Number of peer support advocates trained in diabetes	356
Total number of one-off events held / attended	12
Total number of workshops/sessions for ongoing engagement held	43
Total number of people who you engaged with on a one-off e.g. at an event	350
Total number of people you engaged with more than once, e.g. at monthly sessions	86
Number of Bespoke resources created	Multiple
Total number of people who increased their levels of regular physical activity	32
Number of new connections with other VCSEs made during project	5
Number of new connections to GP practices made during project	7

LAC Project Outcomes 1

1. Increased understanding of the condition diabetes and risks arising from having diabetes	Post participation, 85% (115 participants) said they have better understanding about diabetes, and they knew more about the risk arising from having diabetes.
2. Increased understanding of what causes diabetes	62.9% (85 participants) reported increased understanding about the causes of diabetes.
3. Increased understanding of how to reduce the risk of developing diabetes and/or managing diabetes	83.7% (113 participants) said they have better understanding of how to reduce the risk of developing/Manage diabetes.
4. Improved access to information, resources, programmes and treatment for diabetes for people with communication needs, particularly arising from disability or language needs.	We worked with partners, Diabetes lead, dietitians, Central Liverpool Primary Network lead and through CCG regular meetings and based on advice/ideas established Community resources, health information & awareness about diabetes and healthy lifestyle, contacts, translated leaflets etc. This information was shared during workshops, with other similar projects, LAC social media, and used throughout the project together with an educational Video our volunteers produced about healthy eating https://liverpoolarabiccentre.org.uk/2022/05/06/diabetes-community-champions/
5. Improved access NDPP and/or structured education for BAME groups, sensory impaired people and people with Learning Disabilities.	Throughout the workshops, our volunteers used laptop, projector, had access to internet and were able to share all information about diabetes (Type2) prevention, and promoted access to the National Diabetes Prevention. The volunteers used the National Diabetes Prevention website as an educational tool during the workshop's delivery, and encouraged all participants to use it. We did identify that there was a language barrier, but offered translation and support during the project and beyond.

LAC Project Outcomes 2

6.Increased knowledge and skills for healthy lifestyle options	53% (71 participants) started cooking healthy meals, after taking part in the project and build good knowledge about healthy eating lifestyle. Also, more people joined our physical activities that we deliver at Harthill Youth Centre & Fire fit Hub (Dance workshops, football and women only multiple physical activities).
7.Increased sharing of skills and knowledge with others in community	Our staff and volunteers equally worked as a hive to share their skills and knowledge that they build during the training and throughout the project participation and this was done by engaging with participants from different communities in their own language, using our bilingual volunteers, using different material such as visual materials, using pictures, images and translated materials.
8.Increase in healthy lifestyle behaviours and/or reducing risk factors eg obesity	Pre-participation 16% (22 participants out of 135), reported that they exercise and cook healthy food. 40% (55 participants out of 135), reported some change in healthy lifestyle and risk reduction, including increased in physical activity such as walking, exercising, improved flexibility, increased consumption of fruit and vegetables, cooking healthy food and decreased the consumption of dietary fat. As a result of the project, 13 women taking part in LAC weekly women physical activities, 11 Men taking part in LAC regular weekly traditional dance, held at Harthill youth centre.
9, Improvements in Mental Health / wellbeing	Directly supported 13 individuals with mental wellbeing issues. There was good evidence (Included on the mental health case study “4.3”) that the project’s approach and implementation have enabled mental health/wellbeing to be addressed. The project did not only improve the mental health/wellbeing of participants, but also achieved much more than this, and contributed to their career prospects and security of volunteering. There has been a genuine impact on clients’ wellbeing. Clients themselves provided evidence of their understanding of wellbeing and were able to give practical examples of how they were integrating this into aspects of their daily life.

LAC Learning and Reflection

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Social factors such as experiences and lifestyle are very important components of culture and health care. For example, Arabic community do not make frequent check-ups, their contacts with health professionals such as doctors, nurses etc are very limited and their food habit is very poor and through this partnership we have been able to make change on these habits, however this partnership work should be consistent rather than on ad hoc basis.

The partnership work between us as a voluntary community organisation, local CCG and other health professional was crucial to the success of this project to improving health care of the community, and the leadership of the project by us as a community organisation even made it even more success. The COVID-19 response was also a clear example of the importance of partnership work with community organisations across the country where the VCSE has mobilised its workforce to deliver support direct to where it was needed.

There is always a need for the diabetes awareness and promotion in order to be able to discover diabetes in the early stage and enable patients to be able to manage it, also healthy lifestyle is a great way to manage diabetes and prevent the onset of type 2 diabetes in the future, therefore spreading awareness about diabetes and other diseases can help save a life, but the big challenge for us is the sustainability and how do we keep the volunteers engaged with the local health service and Diabetes UK when the projects end.

LUMA CREATIONS

LUMA CREATIONS links with groups from diverse backgrounds, with a focus on Latin American background, using the arts as a focus of activity and participation.

Participants included people from Bolivia, Chile, Iraq, Mexico, Peru, Syria, UK, Jamaica, El Salvador and India. A large % of these were asylum seekers/refugees.
All were at risk of diabetes, or had a diagnosis of type 1 or 2 diabetes.

Aim and objectives

To raise awareness of diabetes causes, prevention and management

To deliver a series of creative workshops to two different groups and explore knowledge of diabetes, what causes it and how it can be prevented or managed

6 creative taster sessions and 10 creative sessions for two groups.

Drum workshops to women (50+) from across Liverpool. Many of these women do little or no physical activities and have various health conditions.

LUMA Project outputs	Number
Whole time equivalents paid by your organisation to be involved in delivery of the project - include staff and freelance etc.	2
Total number of paid people trained in diabetes	10
Total number of volunteers involved in delivery of the project	6
Total number of volunteers trained in diabetes	6
Volunteer Hours involved in project	88 + 22
Hours of input from LDP hospital team to project	2
Total number of peer support advocates trained in diabetes	6
Total number of one off events held / attended	6
Total number of workshops/sessions for ongoing engagement held	20
Total number of people who you engaged with on a one-off eg at an event	22
Total number of people you engaged with more than once, eg at monthly sessions etc..	37
Number of Bespoke resources created (please list them with brief description and if possible provide link to or attach them or save in the google folder – this can include flyers/education/info materials/recipe books/films/Q&As etc…	Developing 8 flash cards (not part of original project) We are sorting funds so they can be designed and printed
Total number of people who increased their levels of regular physical activity	32
Number of new connections with other VCSEs made during project	6
Number of new connections to GP practices made during project	3
Total 'In kind' match funding – eg if someone gave you room hire for free – please list	Room Hire - £800 Promotion - £450 Interpreting - £800

Luma Participant Feedback

NHS Liverpool Clinical Commissioning Group

"It is difficult to take part in activities because there is so many things I have to deal with but I want to do it."

"I think that dealing with diabetes is very hard so I want to be more active and healthier in the way I do things".

"I love drumming and I think everyone should do it because it's physical activity and you get to meet people and have fun and that has got to be good for your physical and mental health".

"I have been managing my diabetes since I can remember. I think we need lots more projects like this so people understand how important it is to deal with diabetes."

"I like being active and want to do more enjoyable things like music and writing. It makes me feel happier when I come here".

LUMA Outcomes	
1.Increased understanding of the condition diabetes and risks arising from having diabetes	60% had an increased understanding
2.Increased understanding of what causes diabetes	60% had increased understanding
3.Increased understanding of how to reduce the risk of developing diabetes and/or managing diabetes	Increased knowledge 15. 3 people with diabetes in the sessions (one volunteer), shared knowledge. In the mixed nationalities group the majority felt they had an increased understanding of how to manage diabetes. 50+ women's group had higher level of understanding already.
4.Improved access to information, resources, programmes and treatment for diabetes for people with communication needs, particularly arising from disability or language needs.	Creating flashcards as one of the biggest issues was not that they wanted the information in their language, but rather that they wanted the information in plain English.
6.Increased knowledge and skills for healthy lifestyle options	We are aiming to restart drum and movement workshops and have had a spike in interest from the participants who have attended our sessions in this project.
7.Increased sharing of skills and knowledge with others in community	See flashcards. We are filming one of our participants about her managing her diabetes, in April.
8.Increase in healthy lifestyle behaviours and/or reducing risk factors eg obesity	Joining ongoing group activities such as drumming, dance, etc We have done some additional sessions with walking tours

LUMA Creations Learning and Reflections

Participants mainly felt that there was too much information in standard diabetes materials, so they didn't read or digest it. Short bullet points and simplified language will be used to create concise flashcards, this would mean that translations would be easier to do.

People do not consider their health until something happens as they always think it is going to happen to someone else. When the lightbulb moment occurs, when they realise it doesn't always happen to someone else and they have to take responsibility for their health it is at times unexpected.

A few times there was a strong reluctance to consider the implications of continuing down unhealthy paths. Not so much unexpected, but more welcome, was the involvement of people to share experiences to ensure others didn't make the same mistakes (not necessarily regarding diabetes, a general health & wellbeing issue).

Working collectively always has more positives than negatives and working with the LCCG was extremely positive. At Luma Creations we believe in collaborative practice and learning from the other projects and organisations enriched our project and the experience of participants. An example being the training around prevention and managing diabetes – which was a starting point to various conversations.

One of the most helpful things was understanding more about what other projects did and how we can share experiences and practice. I think the problem is there's so much to do and not enough resources or time which means you have to make decisions about what to prioritise.

As with all short term projects, you get to a point where you understand what you need to do as an organisation, then the project ends and you try to put strategies in place but you do not have the resources.

Mary Seacole House

A mental health charity offering support and advice in emotional and practical matters, primarily for BAMER communities

NHS Liverpool Clinical Commissioning Group

Participants – BAMER community members and people with mental illness from deprived areas of the city, refugees and asylum seekers who were at risk of diabetes, pre-diabetic or had diabetes

AIMS:-

- undertake range of activities designed to target individuals at risk/borderline developing diabetes.
- raise awareness and educate people about diabetes and how it may be prevented or delayed
- develop awareness around diabetes within the community and promote wellbeing by training and having community ambassadors who can discuss issues in various formats and languages.

Objectives:- Deliver 5 x eight-week sessions.

- Healthy eating – dishes adapted culturally.
- Weekly health talk – diabetes & mental wellbeing / GP Q & A
- Weekly physical activity to join online – yoga / Bollywood.
- Weekly coffee and chat session - submit a picture of weekly walk and steps for the challenge.
- Training sessions - diabetes, health and wellbeing, cholesterol etc with LDP

Mary Seacole House Project delivery

NHS Liverpool Clinical Commissioning Group

- Focus groups with clients re challenges and needs, feedback on previous activity and interests. People expressed a keen interest to take control of their health and wellbeing.
- Staff/volunteer, peer leader training.
- Interpreters from different languages and dialects involved
- Contacted Local GP, diabetic nurses and a dietitian to help deliver health awareness sessions and worked together to develop suitable sessions specific to our service users, around food, culture and health.
- Training staff & volunteers -health & safety, first aid, mental health & IT.
- Preparation of materials, books and translated documents,
- Online activities such as Yoga, chair base exercise, and health talks
- Room hire in location within the community where people comfortable and safe to attend
- Event/Sessions
- Online Yoga and exercise classes / Healthy eating / Art Therapy / Virtual walking groups / Cooking sessions / Language support / Well-being awareness sessions / Training and courses
- Fitness smart bands to encourage and monitor steps encouraged people to not only compete with each other, pushed people to self-improve but most importantly promoted peer support, still posting daily steps on the whats app group and encouragement
- Healthy eating sessions with language support, cultural recipes, how to adapt and maintain healthier choices

Mary Seacole House Case study

NHS Liverpool Clinical Commissioning Group

" For me its always been about making small changes as they will eventually add up.

Big thanks to MSH family service for encouraging me to look after myself " Mrs A

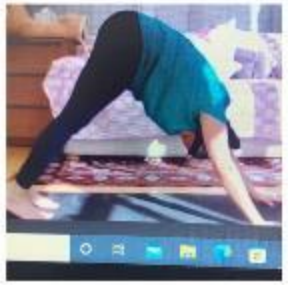
Mrs A suffers from type 2 diabetes, and she was struggling to lose weight in order to control it. After attending a few of our health awareness sessions, she agreed that she would accept a referral to a dietitian after discussing what it was and how it may help. Mrs A acknowledged that she had little dietary information to help her achieve weight loss and that her current weight was unhealthy and "embarrassing." She recognized that her glucose control was affected by large portions of chapati and rice and agreed to start improving dietary control by reducing her portion size by one-third during the week before her dietary consultation. Weight loss would also be an important first step in reducing her blood pressure.

MSH contacted the registered dietitian from diabetes UK by telephone and referred the patient for a medical nutrition therapy assessment with a focus on weight loss and im-proved diabetes control.

Mrs A's physical activity has increased since she joined our online Yoga and exercise classes. She is attending online and face to face exercise classes with her friends. Her social skills have improved which has increased her self-esteem. She feels that she has gained good knowledge about her condition after joining MSH health awareness sessions. She feels more confident about managing her diabetes.

Mary Seacole House Project outputs	Number
Whole time equivalents paid to be involved in delivery of the project -	0.75
Total number of paid people trained in diabetes	9
Total number of volunteers involved in delivery of the project	6 volunteers
Total number of volunteers trained in diabetes	10 volunteers
Volunteer Hours involved in project	720 hours
Hours of input from LDP hospital team to project	50
Total number of peer support advocates trained in diabetes	19
Total number of one-off events held / attended	5
Total number of workshops/sessions for ongoing engagement held	190
Total number of people who you engaged with on a one-off e.g. at an event	102
Total number of people you engaged with more than once, e.g. monthly	76
Number of Bespoke resources created	4, Monitoring forms, Recipes Translated documents, Video
Total number of people who increased their levels of regular physical activity	150 plus
Number of new connections with other VCSEs made during project	7
Number of new connections to GP practices made during project	5
Total ‘In kind’ match funding – eg if someone gave you room hire for free	We received some additional equipment for people to use to exercise
Total other funding(if you used this funding to raise other funds, or used another grant or vise versa please list and describe inc amount)	From this project we have been able to get some additional funding to maintain exercise groups / room hire

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 +

Mary Seacole Outcomes 1

1. Increased understanding of the condition diabetes and risks arising from having diabetes	After the first one of event we held with 45 people the monitoring showed that 39 had more understanding - this led to an increase of demand for the next on off event and who wanted to attend regular sessions. Being able to provide the information in the various languages provided the opportunity for people attending to ask questions and gain better insight into the condition and what causes it and why they may be more predisposed to the condition.
2. Increased understanding of what causes diabetes	As above
3. Increased understanding of how to reduce the risk of developing diabetes and/or managing diabetes	As above and 5 below
4. Improved access to information, resources, programmes and treatment for diabetes for people with communication needs, particularly arising from disability or language needs.	We provided interpreters who provided information along with the champions / staff we have been training on diabetes awareness. Attendees felt comfortable asking questions to both champions and staff and felt more supported by having a local GP attend the health talks. We have further developed excellent links with the diabetes team who have ran sessions with language support. This was imperative as attendees had multiple questions / concerns for both themselves and families.
5. Improved access to National Diabetes Prevention Programme (NDPP) and/or structured education for BAME groups, sensory impaired people and people with Learning Disabilities.	We have used information from the NDPP however found that concentrating on the information from the diabetes team and the evidence of BAMER groups being predisposed and looking into those factors and sedentary lifestyles attendees understood the risks relating directly to themselves and wanted to address this and improved their own lifestyle and wellbeing

Mary Seacole House Outcomes 2	
6. Increased knowledge and skills for healthy lifestyle options	Overall increase in healthy eating cooking changes as we adapted cultural food dishes and demonstrated how small easy changes can benefit the whole family without compromising the taste or food dishes
7. Increased sharing of skills and knowledge with others in community	The online groups and wapp groups increased sharing knowledge, increased peer support. The recipes where shared and additional family members and friends participated in the walking groups and recipe shares
8. Increase in healthy lifestyle behaviours and/or reducing risk factors eg obesity	The behaviour of attendees changed especially around physical activity, we provided fitness trackers and the attendees posted their steps on a daily basis – we didn't focus so much on 10,000 steps we focused on improvement and awarded with praise, support and weekly step boards and certificate of improvement. We had some of the group encouraging others, posting that they have lost weight, they are dancing whilst cooking. One lady went from 300 steps a day to currently over 4000 – overall all have improved their physical activity no matter how small
9. Improvements in mental health/wellbeing	We have video testimonials from some of the group saying how their physical and mental health has improved by both the sessions, the activities and after covid helping to reduce social isolation both online and when possible, through attending face to face session
10. Any other outcomes: Please describe these	Overall improvement in health and wellbeing, people taking ownership of their health, especially after covid and difficulties seeing medical services.

Mary Seacole House Learning and Reflections

From providing health sessions with one of the GPs, diabetes team and ourselves people who attended asked for more awareness sessions, especially with language support and around addressing health, dementia, first aid, and general training to gain further skills. We have been very pleased with the additional uptake and are running sessions whenever we can to maintain momentum, encourage people to be upskilled and promote health awareness. Providing language support and cultural awareness is essential to keep this going.

More funding will be required to run more face to face and online session with language provision as we had a bigger number of people expressing interest for future sessions and would need additional staff to cover this. What would be beneficial is for a longer funding period , as people have informed us that they would like to continue having monthly checks and health sessions

COVID problematic for delivery and participants' health had deteriorated due to lack of contact with medical professionals

There is a great need for continued work around Diabetes. This remains an important health concern within the BAMER community, and raising awareness, providing key information and treatment is vital to keep our communities safe and healthy. We have seen the impact of our work through our assessment of service users and from their feedback. Funding remains a barrier to future work. Speaking to Gps and other practitioners I have looked at getting health champions trained to do blood glucose, BMI checks, and general basic sessions to identify peaks and early intervention. Ideally a monthly drop in would benefit not only the services but would reduce people diabetes deteriorating, identify those who are not managing to control their diabetes and identify those who are borderline and address the issues. Some service users did not know they have diabetes (type2) or were borderline. Providing ongoing funding to deal with this in the community would again reduce strain on services as we could train people up and then if highlighted issues they can be referred asap to the teams to address.

We have proven that the intervention given by services people trust improves attendance, knowledge, awareness and has increased change and physical activities with peer support. Ideally it would be beneficial to continue and offer to wider groups of people, link in with Gps to refer their BAMER patients

Merseyside Polonia

- Merseyside Polonia aim to develop positive relations between the Polish Community and local residents.
- Participants - polish families, parents and children 0-5 at risk of diabetes
- AIM:- increase awareness of T2DM risks and consequences via educating and empowering Polish individuals to make healthier choices and changes in their lifestyle habits, (i.e. diet and physical activity, with a psychological and parenting style element.
- Objectives:-run sessions
  - introductory one-off sessions for only parents (x2),
  - 3 2-hour weekly sessions for parents and children,
  - 5 2-hour weekly sessions for parents and children,
  - 6 1-hour weekly sessions for parents and children run twice,
  - 5 2-hour weekly sessions for adults,
  - 1-hour one-off session for parents and adults

Merseyside Polonia Project delivery

NHS Liverpool Clinical Commissioning Group

- Created 3 course workbooks, weekly SMART goal sheets, 17 session plans for different groups (adult, parent & child) and 6 presentations, 2 facebook groups, social media posts, marketing (12 social media posts, 3 physical posters and leaflets), poster for parents to take home, traffic lights system with references to the amounts recommended for various age groups in Polish and English.
- Used a body composition scale to help the participants focus on the health aspect of the changes to keep motivated rather than the aesthetics (i.e. weight loss) with a 2-sided personal body composition tracker (in Polish) based on the machine guide
- Nutrition related information was posted in the Facebook groups (Malymi krokami ku zdrowej przyszlosci - Baby Seps to Healthy Furture which was set up in September 2022 https://www.facebook.com/groups/1236388113501601 Warsztaty ,,Nowy rozdzial'' www.facebook.com/groups/984318178848761/
- Established What's app group to share experience
- Bespoke resources created

Merseyside Polonia Project outputs	Number
Whole time equivalents paid by your organisation to be involved in delivery of the project - include staff and freelance etc.	2.5
Total number of paid people trained in diabetes	2.5
Total number of volunteers involved in delivery of the project	4
Total number of volunteers trained in diabetes	0
Volunteer Hours involved in project	100
Hours of input from LDP hospital team to project	0
Total number of peer support advocates trained in diabetes	0
Total number of one-off events held / attended	7
Total number of workshops/sessions for ongoing engagement held	26
Total number of people who you engaged with on a one-off e.g. at an event	38
Total number of people you engaged with more than once, e.g. monthly etc..	45
Number of Bespoke resources	43
Number of new connections with other VCSEs made during project	5
Number of new connections to GP practices made during project	1
Total ‘In kind’ match funding – eg if someone gave you room hire for free – please list	Merseyside Polonia office/equipment, other staff time
Total other funding(if you used this funding to raise other funds, or used another grant or vise versa please list and describe inc amount)	£2,468 Local Connection Fund

Merseyside Polonia Outcomes

1. Increased understanding of the condition diabetes and risks arising from having diabetes	All of the participants learned this (pre-questionnaires, during session information and questions)
2. Increased understanding of what causes diabetes	T2DM causes were interwoven in the each of the 6 sessions,introductory session, parents and children sessions
3. Increased understanding of how to reduce the risk of developing diabetes and/or managing diabetes	100% of the respondents answered 'definitely agree' or 'agree' when answering the question: ''Will you apply the information learned in the future?''.All adult participants as the sessions were aiming to reduce the T2DM risk by providing ideas, examples of behaviour changes, and goal setting tasks were to help establish them.
4. Improved access to information, resources, programmes and treatment for diabetes for people with communication needs, particularly arising from disability or language needs.	We provided references during the sessions, at social media group and Whatsapp group (recipes, portion sizes, Eatwell Guide, 5532 for under 5s), shared trustworthy sources of nutrition information & recipes in both Polish and English
5. Improved access to National Diabetes Prevention Programme (NDPP) and/or structured education for BAME groups, sensory impaired people and people with Learning Disabilities.	Created Polish materials
6. Increased knowledge and skills for healthy lifestyle options	Participants were surprised and willing to try different ways of cooking to reduce fat (stir-frying, using less oil), salt (steaming instead of boiling in water - taste is more pronounced, so no salt is needed), sugar (eg. making own sauce)

Merseyside Polonia Outcomes	
7. Increased sharing of skills and knowledge with others in community	100% of the respondents answered ‘definitely agree’ or ‘agree’ when answering the question: ‘’Will you apply the information learned in the future?’’.
8. Increase in healthy lifestyle behaviours and/or reducing risk factors eg obesity	Used SMART goal setting for vegetables, fibre, sugars, fats, salt, physical activity, and the majority of participants claimed they made changes, eg. adding tomatoes and lettuce for breakfast (increasing veg intake), adding nuts, seeds, bought wholegrain pasta, rice, kasha (increasing fibre intake), checking saturated and fat content in the products (reducing fat intake - during the session), eating whole cucumber not just a slice, comparing salt content in packaged food.
9. Improvements in mental health/wellbeing	Self-reported after each session wellbeing improved We used WEMWEBS as separate surveys showed that sessions improved wellbeing after 6 weeks of attending - we only surveyed 5 participants, and 4 answered questions positively that the sessions improved their wellbeing. During the online sessions one of the first slides asked about ‘’How do you feel’ to refer to mental wellbeing and self-regulation. Participants always were eager to share their emotional state and we received feedback that it was a wonderful idea to ask about it at the beginning of the sessions.
10. Any other outcomes: Please describe these	During the sessions participants were very engaged by asking questions about the food and nutrition, which is reflecting answers from the pre-participation questionnaire about what they wanted to achieve from the course, eg. ‘’additional knowledge’’, ‘’advice regarding healthy and ‘’quick’’ child nutrition’’, ‘’understanding nutrition better’’.

Merseyside Polonia Reflections

NHS Liverpool Clinical Commissioning Group

- COVID had an impact on delivery
- Referrals from GPs difficult to achieve would like to do this in future
- Community of Practice helpful but would have like to meet in person
- Clear demand and lots learned about effectiveness – needs to be a longer term programme
- Lots of potential wider benefits from focus on food, eg CVD and tooth decay

Merseyside Refugee Support Network / Asylum Link Merseyside / Faiths4Change

NHS Liverpool Clinical Commissioning Group

Participants:- refugees, asylum seekers, ethnic minority groups, people with disabilities/mental health issues at risk of or living with diabetes

AIM:-To connect with different priority groups to assess and enhance understanding and awareness of Diabetes (types/causes/how to manage and practical healthy eating and activity advice): including Refugees and Asylum Seekers, other Black and Ethnic minority residents & others with physical, learning and mental health issues.

Objectives -

- Train staff and volunteers involved in the project in the partner organisations
- Engage and deliver training and awareness sessions through groups, classes, outdoor/indoor and 1-2-1 activities
- Offer non-clinical but factual information about diabetes in safe/trusted environments

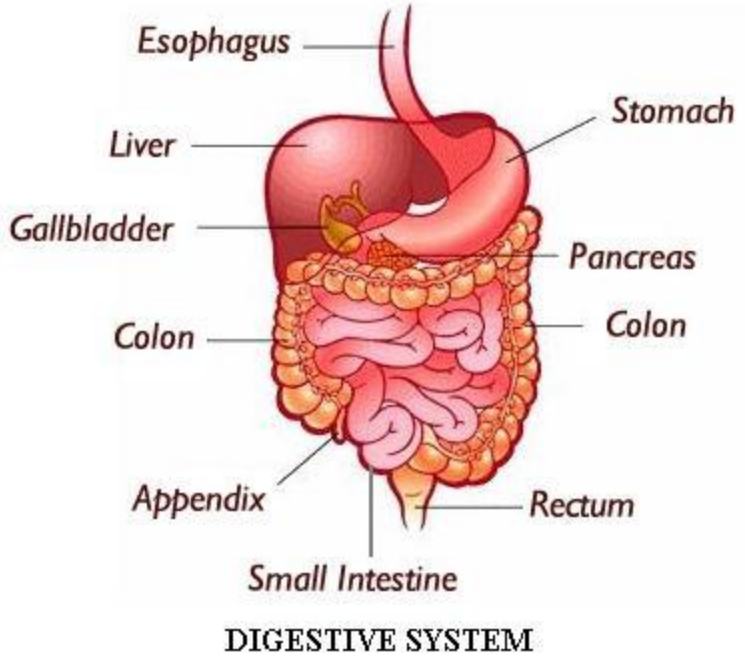
MRSN/ALM/F4C Project delivery

NHS Liverpool Clinical Commissioning Group

- Engaging through organisations trusted by at risk communities
- Training of organisations staff for indoor & outdoor outreach & engagement
- Development of bespoke appropriate language resources - worked with experienced ESOL Teacher and Interpreter Professional to develop appropriate, simplified training materials for classes, 1-2-1 and group work. and as post discussion resource
- Encouragement and support to join existing healthy activity sessions provided
- Support to access NHS help

- **MRSN** - 1-2-1 and small groups sessions over a period of months with 13 refugee service users, 10 declared a physical disability/mental ill health including some with diabetes or family member with diabetes. Ages 20-58. Nationalities including: Sudan, Sri Lanka, Lebanon, DRC, Iran, Palestine, Eritrea, Afghanistan.
- **ALM** –ESOL classes of Asylum Seekers and refugees at various language abilities. 19 mostly male, (+ 10 unrecorded in groups of lowest English language learners. Nationalities including: Syria, Sudan, Afghanistan, Somali, Eritrea). Age range from 21-52 years.
- **F4C** – worked with 12 people from different groups including Adelaide House, La Salle Kitchen Garden cooking/gardening group and Roots in the City gardening group. Comprised people with learning, physical disabilities or mental health issues and/or people from a BRM community – of whom 10=F and 2=M.

DIABETES: the system



We eat or drink carbohydrates

These make glucose

Glucose goes into our blood

We then need a hormone called insulin

Insulin is made in our pancreas

Insulin lets the glucose in our blood go into our cells and give our bodies energy

If you have diabetes, this system doesn’t work - glucose can’t get into your cells and it can build up in your blood

From MRSN/ALM Training resource

MRSN/ALM/F4C Project outputs	Number
Whole time equivalents paid by your organisation to be involved	0.6 (0.2 in each organisation)
Total number of paid people trained in diabetes	6
Total number of volunteers involved in delivery of the project	10
Total number of volunteers trained in diabetes	10
Volunteer Hours involved in project	30+
Hours of input from LDP hospital team to project	3+3
Total number of peer support advocates trained in diabetes	Sadly this didn't happen due to impact of covid restrictions on general delivery
Total number of one-off events held / attended	3+ lower level English classes
Total number of workshops/sessions for ongoing engagement held	Total = 27
Total number of people who you engaged with on a one-off e.g. at an event	42
Total number of people you engaged with more than once, e.g. at monthly sessions etc..	39
Number of Bespoke resources created	PowerPoint materials and handouts, Glossary of terms, Lesson Plan, Diagram/handouts
Total number of people who increased their levels of regular physical activity	12, 10 already did regular exercise
Number of new connections with other VCSEs made during project	4+
Number of new connections to GP practices made during project	n/a
Total 'In kind' match funding	£96 via f4C
Please list any other outputs here…	Increased staff and volunteer awareness of diabetes – risks and what to do!

MRSN/ALM/F4C Outcomes	
Increased understanding of the condition diabetes, causes, complications and ability to manage the condition	Awareness low among all participant groups about all aspects of diabetes. Each partner and varying settings saw an increased understanding of diabetes for at least 50% of respondents – some levels were higher due to language ability or more initial knowledge. Lower initial understanding among younger participants Different approaches in delivery were used - small group; classroom style and 1-2-1. Small group and 1-2-1 approaches have been more effective when using the questionnaires to capture participant responses. Questionnaires did not capture full responses from low level English participants but teachers report that sessions were well received and participants showed an increased level of understanding overall.
Increased understanding of what causes diabetes	Overall increase in understanding of the causes of diabetes through content and discussion on risk and types of diabetes and the factors which reduce risk eg health / appropriate eating (much discussion on carbohydrates). Younger participants had lower levels of initial awareness.
Confidence in managing diabetes	8 very confident; 21 reasonably confident; 3 not as yet confident Clear increase by majority. One participant who is diabetic had not been informed on how diet could affect diabetes. This was covered in depth with her as a result. The majority of participants demonstrated a better awareness of the risks of a diabetes diagnoses and of the serious implications of getting diabetes
Improved access to information, resources, programmes and treatment for diabetes for people with communication needs, particularly arising from disability or language needs.	All 44+ participants benefited from customised diabetes awareness training with organisation & people they trust. Any participant who felt they might be at increased risk of diabetes was advised to connect with their GP. Although language level has proved challenging, materials used had been customised for teachers, but the lowest level of language learners opted for a general whole class participation and learning.
Knowledge of prevention, management /reversal	Clear increase by majority. Knowledge shared through active delivery sessions around gardening, cooking and in classes

MRSN/ALM/F4C Outcomes	
Increased knowledge and skills for healthy lifestyle options	Increase Carbohydrates has been a big issue/revelation in relation to understanding diabetes and appropriate diets - many get the sugar message but not carbohydrates one. There are lifestyle, cultural and affordability issues which cannot be brushed aside for a speedy life changing option. All partners plan to follow up on this beyond the life of the project via health, gardening and cooking events. Our post questionnaires clearly demonstrated that participants were happy to try to change both fitness levels and healthy eating habits, if they didn't already consider them to be good. Some sessions included preparing meals with balanced portions, understanding how to limit carbohydrates. All participants enjoyed the meals and preparation and some reported being inspired to cook more healthy options at home – recipes are shared with participants. In sessions we also talked about portion sizes and reducing carbohydrate intake to a quarter of any meal. Collectively we have seen more participants who are keen to take part in weekly gardening/allotment and cycling activities to increase physical activity and grow healthy food. Cooking and gardening activities helped to illustrate elements of the content as well as sign posting to cycling, walking, allotment and tree planting physical activities. Also - At Adelaide house, where meals are provided, it was proposed to raise healthy eating/cooking at the next house meeting to see what could be done for healthier options to be provided.
Increase in healthy lifestyle behaviours and/or reducing risk factors eg obesity	Our post questionnaires clearly demonstrated that participants were happy to try to change both fitness levels and healthy eating habits, if they didn't already consider them to be good. Younger participants from asylum and refugee backgrounds tended to already be active (mainly by walking or other physical exercise) What makes the delivery and learning styles so effective is that the partners/staff/vols involved in delivering sessions were able to "personalise" elements of the training and engage participants in our own challenges such as: - Actively trying to cut down on sugar in tea and biscuits etc. and looking for more natural options for sweetness @F4C - MRSN and ALM participants suggesting more walking for staff and teachers! - Cutting down on cake – a little every day and/or RICE! - Staff also suggesting they might go to the GP and get checked out as some have risk factors - A volunteer (not outwardly with risk factors) sharing their experience of the shock of a **text** from GP stating they were at risk of type2 diagnoses risk. Engagement in garden activities and eating healthier options.

MRSN/ALM/F4C Learning & Reflections

Increased knowledge and skills among staff and community members important

Community of Practice valued for exchange of knowledge and experience

All 3 of our partners felt that this is just the beginning and that further work should take place - on diabetes and other health related initiatives that build on the trust that exists and by using different methodologies appropriate to different vulnerable client groups.

Covid affected delivery

Since lockdown 2020 – MRSN and ALM have working with different aspects of NHS and Public health to raise awareness and engage refugee and asylum communities on Covid as well as promoting vaccine awareness, take up and regular testing.

Adelaide House have asked if F4C could continue to deliver health related sessions or more on healthy eating and activity.

The Stroke Association and Ovarian Cancer Awareness have also been in contact with MRSN for help to raise awareness on these health matters - albeit unfunded.

SOLA Arts use creative approaches to support displaced people & people with mental distress

NHS Liverpool Clinical Commissioning Group

Participants

- predominantly from migrant and refugee backgrounds
- with enduring mental health difficulties
- limited knowledge of healthy cooking or food choices due to limited income and challenges around transferring traditional food / cooking into UK
- people on low income/benefits, who have sight impairment, hearing impairment, physical disabilities, complex health needs and cognitive difficulties.
- All at risk of or with a diagnosis of Type 2 diabetes.

AIM:-To improve people's choices around food and lifestyle and avert onset of Diabetes and improve health of people with Type 2 Diabetes.

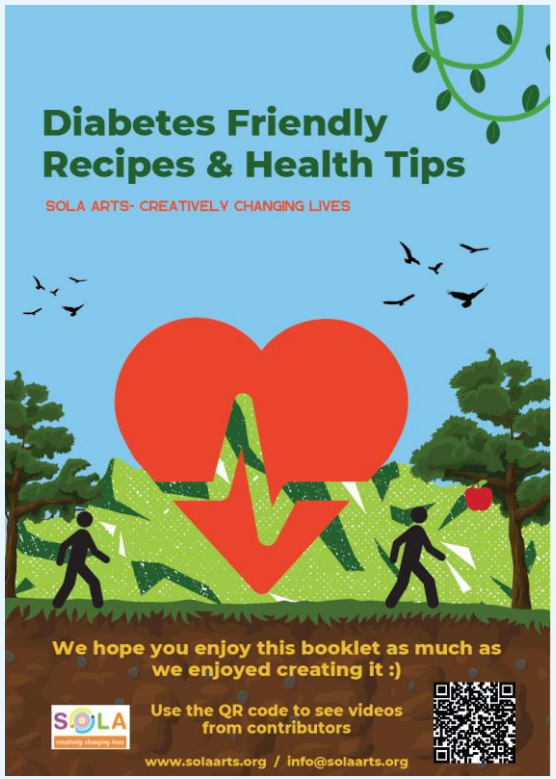
Objectives:-

- Creative engagement to increase understanding and skills for preventing and managing diabetes tailored to participant interest and need
- Urban Gardening and foraging- encouraging active lifestyle, outdoor activity and healthy food choices and making these related to Diabetes awareness and food choices. Include a Recipe Club creating quarterly newsletters, videos and sharing experiences of healthy choice recipes from across our communities.
- Weekly adults sessions resulting in a series of creatively focused info products to show and disseminate through a touring exhibition and workshops space using an activities van. Accompanied by Diabetes info sharing events and creatively engaging workshops using the van as a base for this mobile activity.
- Info sharing resources created by participants translated into different community languages. 4 x 6week creative programmes for 30 people plus 15 weeks of the mobile workshop and info sharing van touring the city region reaching a further 150 people through 30 events.

SOLA Arts Project delivery

NHS Liverpool Clinical Commissioning Group

- Co-production with beneficiaries to explore creative horticulture and food growing, different types of healthy choices around food & herb growing and other natural 'products' for healthier lifestyles and combat onset of Diabetes.
- Participants were supported through ESOL classes to understand language of Diabetes, share traditional and other recipes & make recipes more diabetes aware. Participants tested recipes in the creative growing groups, cooking and sharing our creations.
- Supported beneficiaries to understand portion sizes, impacts related to Diabetes and health impacts of processed foods.
- 2 foraging trips to explore easily findable foods, flowers and herbs that can be used for healthy food choices and had foraged food lunch which was delicious and converted even those most averse to more healthy lifestyle changes.
- We got active in the garden with gardening and other activities of a physical effort.
- Staff and volunteer training by the Diabetes Nurses and shared this knowledge with participants.
- Participants made videos about their experiences and with ideas for healthier living.
- Participants used the weekly art group to develop images based on the products they grew and harvested, learnt desktop publishing & IT skills to coproduce Diabetes Friendly Recipes and Health Tips booklet.
- Ran school holiday youth & family activities focused on healthy eating & non-cook food making, creative play and outdoor activity, sports and physically engaging activities.
- Cofacilitated a living exhibition and info booklet dissemination with participants and Castle Falafel mobile food stall. Took the van to 4 venues and gave vouchers for free diabetes friendly falafel wraps whilst sharing the recipe booklet in the local community. Participants had dialogue with people about diabetes and shared their inspirations and learnings about healthy choices.
- Shared over 30 social media posts (FB/Twitter/Instagram) about the project, it's outcomes and the recipe booklet and have an online presence for the booklet and videos on Youtube.
- Disseminated 350 booklets and related translated versions in the following languages; English, Farsi, Spanish, Mandarin, Arabic, Pushto, Somali.



SOLA Arts Project case studies

NHS Liverpool Clinical Commissioning Group

Participant seeking asylum at risk of diabetes and classed as obese had a cancer diagnosis. With only £35 weekly to live on he was finding healthy eating difficult relying on cheaper food options which have higher fats and sugars, and chemical based flavouring and preservatives. He was living with a state of depression. His treatment was postponed due to risks to his heart. Thanks to the project he began to eat healthily and walk every day, eventually losing 4 stone over the year. He has now been 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.

SOLA Arts Project outputs	Number
Whole time equivalents paid by your organisation to be involved in delivery of the project - include staff and freelance etc.	Staffing time- 0.4 – 0.6, Freelancers - 21 days Volunteers- 0.3 equivalent weekly
Total number of paid people trained in diabetes	8
Total number of volunteers involved in delivery of the project	4
Total number of volunteers trained in diabetes	4
Volunteer Hours involved in project	676
Hours of input from LDP hospital team to project	2
Total number of peer support advocates trained in diabetes	3
Total number of one-off events held / attended	6
Total number of workshops/sessions for ongoing engagement held	142
Total number of people who you engaged with on a one-off e.g. event	350
Total number of people you engaged with more than once, e.g. monthly	105
Number of Bespoke resources created	www.youtube.com/watch?v=mDBV7N5Ur_I&list=PLuuF-2kEA9wFIcpQ179qBY6BLLbyXjMmp (open access) 350 x Booklets & translation in 6 community languages
Total number of people who increased levels of regular physical activity	105
Number of new connections with other VCSEs made during project	4
Number of new connections to GP practices made during project	1
Total 'In kind' match funding – eg if someone gave you room hire for free –	Everyman & Playhouse Theatre; £4,900, Liverpool Lighthouse; workshop £200, Community Transport £1000
Total other funding(if you used this funding to raise other funds, or used another grant or vise versa please list and describe inc amount)	Total raised for match funding; £24,500 (DWP ESF; £12,500 & Liverpool Play Partnership/MPAC £12,000)

SOLA Arts Outcomes 1

1. Increased understanding of the condition diabetes and risks arising from having diabetes	Staff and volunteers undertook training session from Diabetes Nurses 50% of participants had active verbal conversations around diabetes, their concerns and for people living with Diabetes shared their needs explored positive options for their health. 350 people received Recipe & Health Tips booklet & learnt about diabetes & positive options.
2. Increased understanding of what causes diabetes	45 people had intensive greater understanding, 60 people gained basic understanding of causes through generic activity and dialogue 350 people having information shared via the booklet and 15% of these 350 people had lengthy conversation around causes of Diabetes.
3. Increased understanding of how to reduce the risk of developing diabetes and/or managing diabetes	350 people with increased awareness of how to reduce diabetes through the booklet and healthy tips sharing events, plus 105 people a lot more confident to manage risk of diabetes. 12 people with Type 2 Diabetes more confident to manage their condition based on post participation feedback.
4. Improved access to information, resources, programmes and treatment for diabetes for people with communication needs, particularly arising from disability or language needs.	455
5. Improved access to National Diabetes Prevention Programme (NDPP) and/or structured education for BAME groups, sensory impaired people and people with Learning Disabilities.	15

SOLA Arts Outcomes 2

6. Increased knowledge and skills for healthy lifestyle options	We had feedback form 40 people recognising increased healthy cooking/physical activity knowledge/cooking skills. We held regular eating and cooking sessions at SOLA with core participants.
7. Increased sharing of skills and knowledge with others in community	This happened through dissemination of the booklets for which 10 core participants cofacilitated this with staff and volunteers. Another 6 participants created Youtube videos and 25 participants were involved in developing the booklet shared in Youtube and social media as well as face-to-face.
8. Increase in healthy lifestyle behaviours and/or reducing risk factors eg obesity	People became involved in the physical activity in the creative growing gardening and foraging programme. People also took part in physical sports based activity and made lifestyle changes.
9.Improvements in mental health/wellbeing	We used the 5 ways to wellbeing as a guage- see below.
10. Any other outcomes: Please describe these	Fun times and empowerment for people often 'forgotten' in the health system eg people seeking asylum. Creative, social, language, IT, employability skills development was crucial and embedded within all aspects of the programme even to the end for events disseminating the booklet and through this developing social and English skills. We also supported volunteer internships and skilling up participants to cofacilitate activities in order to develop leadership and facilitation skills.

Sola Arts Learning and Reflections

NHS Liverpool Clinical Commissioning Group

Evidence that participants experienced the five ways to wellbeing through the project demonstrates wellbeing will have improved.

Partnership working valued - potential in the Community of Practice for future development

We believe that we have only just scratched the surface of what is needed.

To deliver a longer-term programme, it would be important to run longer programming and support and see notable change in people's lives

It would be helpful to have more funds to cover the heavy translation bill that comes with creation of the final products.

Meeting with partners face to face and having meetings on different days monthly to enable part time workers options for attending.

Funding of course is a notable area of need to enable delivery.

Women Reach Women CIC

NHS Liverpool Clinical Commissioning Group

Women Reach Women support South Asian women and their families in Liverpool.

Participants:- Bangladeshi women and girls (101) men and boys (31) some with disabilities, all Muslim at risk or with diagnosis of T1 or T2 diabetes.

Aim:- Take a community centred approach in reshaping and exploring creative ways in implementing culturally sensitive approaches for diabetes awareness and management amongst the first-generation Bangladeshi community.

Objectives:-

Stage1: Exploratory approach to understanding the problem - 3 focus groups & 10 interviews to understand challenges / barriers faced by first-generation Bangladeshi migrants concerning diabetes awareness and management.

Stage 2: Solution focussed, using patient and public involvement (PPI) to deliver diabetes awareness events.

Recruit 10 public contributors (PCs) from first-generation migrant Bangladeshi community. PCs to review & agree suitable culturally appropriate and sensitive resources for Bangladeshi community and suggest awareness raising events in the community informed by findings in stage 1.

Participant Views

NHS Liverpool Clinical Commissioning Group

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…..

Women Reach Women Project outputs	Number
Whole time equivalents paid by your organisation to be involved in delivery	1.5
Total number of paid people trained in diabetes	10
Total number of volunteers involved in delivery of the project	6
Total number of volunteers trained in diabetes	6
Volunteer Hours involved in project	604 hours over 12 months
Hours of input from LDP hospital team to project	3 hours
Total number of peer support advocates trained in diabetes	10
Total number of one-off events held / attended	3
Total number of workshops/sessions for ongoing engagement held	3 (PC training sessions)
Total number of people who you engaged with on a one-off e.g. event	132 (including 24 under 18 years old)
Total number of people you engaged with more than once, e.g. monthly	10 public contributors
Number of Bespoke resources created	Existing resources identified and used at the one-off events for diabetes awareness raising
Total number of people who increased their levels of regular physical activity	91% of participants felt they might be interested in being more active
Number of new connections with other VCSEs made during project	6

Women Reach Women Outcomes 1	
1.Increased understanding of the condition diabetes and risks arising from having diabetes	10 Public contributors reviewed LDP videos and identified Bengali resources 108 people at community events received various resources in Bengali to understand diabetes and the risks. 91% of participants recognised all the risk factors that could increase the risk of uncontrolled diabetes after event. Resources were sent via 'WhatsApp Diabetes group' to 62 people to be shared via WhatsApp.
2.Increased understanding of what causes diabetes	10 Public contributors reviewed LDP videos and identified Bengali resources to increase understanding of causes of diabetes. 108 people at events have received various resources in Bengali to increase their understanding of what causes diabetes. 63% of participants recognised the risks that can increase in developing type 2 diabetes after the event. Resources identified were sent via 'WhatsApp Diabetes group' to 62 people to increase their understanding of what causes diabetes. We anticipate that this factual information will be circulated/shared with their contacts via WhatsApp.
3.Increased understanding of how to reduce the risk of developing diabetes and/or managing diabetes	10 Public contributors reviewed LDP videos and identified Bengali resources to increase understanding of how to reduce the risk of developing diabetes and/or managing diabetes. 108 people at events have received various resources in Bengali to increase understanding of how to reduce the risk of developing diabetes and/or managing diabetes. Participants also took part in the quiz to help increase their understanding of reducing the risk of developing diabetes and/or managing diabetes. 100% of participants from the post questionnaire recognised that diabetes could be prevented and even reversed by healthy eating, exercise, and healthy body weight. Resources identified were sent via 'WhatsApp Diabetes group' to 62 people to increase understanding of reducing the risk of developing diabetes and/or managing diabetes. We anticipate that this factual information will be circulated/shared with their contacts via WhatsApp.

Women Reach Women Outcomes 2	
4.Improved access to information, resources, programmes and treatment for diabetes for people with communication needs, particularly arising from disability or language needs.	10 Public contributors reviewed LDP videos and identified Bengali resources 108 people at vents received hard copies of leaflets about healthy eating and diabetes explained in Bengali:https://diabetesmyway.nhs.uk/media/1704/health_eating_overview-_top_food_tips_dw1-1-_-ben.pdf https://diabetesmyway.nhs.uk/media/1714/diabetes-explained_dw_-beng.pdf (Bengali language) We have also shared website links of the https://diabetesmyway.nhs.uk/media/1704/health_eating_overview-_top_food_tips_dw1-1-_-ben.pdf (Bengali) Many other resources used and shared (see full report). Presented arrange of Bengali videos. 62 people have received via the 'WhatsApp Diabetes group' a range of resources: We anticipate that this factual information will be circulated/shared with their contacts via 'WhatsApp Diabetes group'.
5. Improved access to National Diabetes Prevention Programme (NDPP) and/or structured education for BAME groups, sensory impaired people and people with Learning Disabilities.	As mentioned above, we shared the link https://cm.mydiabetes.com/- Cheshire and Merseyside MyWay Diabetes and the available range of translated information at the community events and via the 'WhatsApp Diabetes group' to improve access to education programmes in Bengali.
6. Increase in healthy lifestyle behaviours and/or reducing risk factors eg obesity	At the community events, we demonstrate through the food being served the events what portion size of carbohydrates (1 cup rice) and protein (chicken/meat) and salad should look like. 108 people at the various community events have received resources in Bengali to increase healthy lifestyle behaviours and/or reduce risk factors. 84% of the participants completed the post questionnaire and stated that 30 minutes 5 days a week is what people with diabetes should aim to exercise for.

Women Reach Women Outcomes 3	
7. Increased knowledge and skills for healthy lifestyle options	91% of participants in post questionnaire stated they might be interested in being more active. 66% of participants in post questionnaire stated they might be interested in healthy eating. 79% of participants from the post questionnaire stated that they know 'loads' about healthy eating and its impacts on diabetes.
8.Increased sharing of skills and knowledge with others in community	81% of participants from the post questionnaire stated that they feel 'reasonably confident' on sharing information with other people about diabetes. The 10 public contributors trained in diabetes have taken on the responsibility of sharing the information gained in the community. 3 volunteers have set up walking groups to meet regularly and walk locally with interested participants. As part of the 'Know your Risk' results at the community events, 31 people were advised to see their GP. After the event, we had reporting's via the public contributors that 11 individuals received a 'pre-diabetic' diagnosis after visiting their GP based on the 'Know your Risk' results at the events. Resources identified were sent via 'WhatsApp Diabetes group' to 62 people to share diabetes/managing diabetes information. We anticipate that this factual information will be circulated/shared with their contacts via WhatsApp.
Other Outcomes	3 volunteers have set up walking groups to meet regularly and walk locally with interested participants. **At the community events, as part of the 'Know your Risk' results, 31 people were advised to see their GP. After the event, the public contributors reported that 11 individuals received 'pre-diabetic' diagnosis after visiting their GP based on the 'Know your Risk' results at the events.**

Women Reach Women Learning and Reflection

NHS Liverpool Clinical Commissioning Group

Significant body of evidence generated about views, experiences, barriers and needs of Bangladeshi community.

Participants wanted to talk and share their experiences was rewarding. Hearing first-hand from people living with diabetes and the importance of talking about the emotional impacts of diabetes as well as diet and physical activity.

We compiled a list of people (WhatsApp Diabetes group) interested in working with us in the future.

We plan to keep the WhatsApp Diabetes group updated by sharing with them on-going diabetes information – the public contributor's responsibility to source in-formation and share it.

Our next step is to submit grant applications for funding, drawing on the find-ings/feedback from this work, and explore physical activity ideas and healthy eating workshops.

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Section 2B – Individual Project Evaluations

Working with people with disabilities, mental health problems etc..

Independence Initiative

NHS Liverpool Clinical Commissioning Group

The Independence Initiative works with individuals, local agencies and the wider community to facilitate the long term rehabilitation of substance and alcohol misusers and provides support for their families' necessary needs, overcoming barriers and assisting re-integration.

Participants

57 people at risk of or with a diagnosis of type 2 diabetes, profiles:

- 67% reported recent housing insecurity (street homeless, temporary accommodation or staying with friends within last 3 years)
- 96% reported long-term substance misuse
- 83% reported recent involvement in criminal justice system (incarcerated in secure estate within last 3 years)
- 89.5% reported long-term mental ill-health (> 3 years)
- 65% reported other long-term health conditions (> 3 years)

Independence Initiative Project Aims

NHS Liverpool Clinical Commissioning Group

1. Increased understanding of the condition diabetes and risks arising from having diabetes
2. Increased understanding of what causes diabetes
3. Increased understanding of how to reduce the risk of developing/ managing diabetes
4. Increased knowledge and skills for healthy lifestyle options
5. Increased sharing of skills and knowledge with others in community
6. Increase in healthy lifestyle behaviours and/or reducing risk factors eg obesity
7. Improvements in mental health/wellbeing

Independence Initiative Project Objectives

NHS Liverpool Clinical Commissioning Group

- Introduce diabetes awareness raising activity into all 1-2-1 and group activities.
- Include dedicated section in our ‘Healthy Eating’, ‘Horticulture’ and Community Pantry programmes / also group briefings for Cycling, Gym, Football and ‘Walk and Talk’ Groups.
- Introduce information on the causes of diabetes into all 1-2-1 and group activities.
- Include dedicated section in our ‘Healthy Eating’, ‘Horticulture’ and Community Pantry programmes / also group briefings for Cycling, Gym, Football and ‘Walk and Talk’ Groups.
- Introduce information on reducing and managing risks of diabetes into all 1-2-1 and group activities.
- Include dedicated section in our ‘Healthy Eating’, ‘Horticulture’ and Community Pantry programmes / also group briefings for Cycling, Gym, Football and ‘Walk and Talk’ Groups.
- Include dedicated section on healthy lifestyle options in our ‘Healthy Eating’, ‘Horticulture’ and Community Pantry programmes / also group briefings for Cycling, Gym, Football and ‘Walk and Talk’ Groups.
- Ensure all group and household activities include scope for informal sharing of knowledge via facilitated group discussions and promotion of literature.
- Encourage and enable involvement in groups and activities that promote healthy behaviours
- Provide 1-2-1 support that defines and targets behavioural priorities for individuals
- Targeted work with GPs to reduce prescribing of high-sugar substances

Independence Initiative Case study

NHS Liverpool Clinical Commissioning Group

Male age 52

Morbidly obese, immobile using a walking stick for support, a schizophrenic, sleep apnoea, prescribed methadone, long history of dependent alcohol use. JH had total lack of awareness of how his lifestyle choices and diet would /are impacting on his physical health.

He very rarely walked, never mind exercised and his drinking choices would be fizzy pop or energy drinks (if not alcohol). JH embarked on the diabetes course at The Indy, primarily to raise his awareness around the condition and how he could improve diet and lifestyle choices.

He joined the healthy eating course as he wanted to improve his diet/cooking/ shopping skills. He was used to just eating fast sugars, takeaways, cereals, chocolate bars etc. During the time he spent with staff we noticed he was using the toilet frequently and gulping down drinks. This was a red flag. 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 sent for blood test, the results confirmed that JH 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 that we had on offer through our 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 for support). 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.

Independence Initiatives Project outputs	Number
Whole time equivalents paid by your organisation to be involved in delivery of the project - include staff and freelance etc.	0.2
Total number of paid people trained in diabetes	4
Total number of volunteers involved in delivery of the project	1
Total number of volunteers trained in diabetes	1
Volunteer Hours involved in project	36
Hours of input from LDP hospital team to project	0
Total number of peer support advocates trained in diabetes	0
Total number of one-off events held / attended	4
Total number of workshops/sessions for ongoing engagement held	27
Total number of people who you engaged with on a one-off e.g. event	21
Total number of people you engaged with more than once, e.g. monthly	57
Total number of people who increased their levels of regular physical activity	32
Number of new connections with other VCSEs made during project	1
Number of new connections to GP practices made during project	1

Independence Initiative Outcomes	
1. Increased understanding of the condition diabetes and risks arising from having diabetes	72% overall (41 people). From people we supported regularly/1-2-1 - 100% reported improved understanding.
2. Increased understanding of what causes diabetes	72% overall (41 people). From people we supported regularly/1-2-1 - 100% reported improved understanding.
3. Increased understanding of how to reduce the risk of developing diabetes and/or managing diabetes	68% of people reported increased understanding of how to reduce the risk of developing diabetes. 4% of the overall cohort reported increased understanding of how to manage Type 2 diabetes. Mainly 1-2-1 sessions on this. For our cohort, the key considerations often came back to sugar consumption. For many people either withdrawing or abstinent from substance misuse, 'substitution' behaviours can kick in and excessive sugar consumption is common. We also continued to address some of the issues around high sugar content in some of the prescribed drugs commonly used in substance misuse treatment. We were careful throughout about the tone (a key part of the training we gave to our staff) as anxiety levels are often very high in our cohort and triggering crises was clearly something we needed to avoid.
6. Increased knowledge and skills for healthy lifestyle options	51% reported improved knowledge arising from our healthy cooking programmes. 58% reported increased understanding of the links between fitness, lifestyle and diabetes.
7. Increased sharing of skills and knowledge with others in community	Core to this has been the regular programmes of healthy cooking sessions which included the risks associated with diabetes and the connections between healthy food choices, preparation, cooking options and diabetes (along with other diet and obesity related risks). Shopping skills and awareness is big factor for our cohort and making the decision to cook rather than 'takeaway' forms part of this. For many, the decision to cook food rather than buying pre-prepared food represents a key intermediate outcome, which is indicative of an improvement in underlying knowledge. We have no 'metric' to capture this yet, an important challenge for future programmes.
8. Increase in healthy lifestyle behaviours and/or reducing risk factors eg obesity	81% of participants improved their levels of physical activity during the programme. We set out activities that allowed people to improve activity at a range of levels.

Improving Wellbeing

CONNECT	
Connecting is a key element of all of our engagement projects, addressing isolation and the mental health challenges it brings	Our active groups provided numerous opportunities for connection and discussion of diabetes as a risk. Particularly after lockdown, the visible impact on people of enjoying human contact was evident. Perhaps the most striking example related to the small cohort (10) of local residents we engaged who are facing extreme mental health challenges. Using Pantry membership as a foundation to facilitate small, short episodes of discussion about diabetes had a clearly positive impact. All 10 reported back on this positively via survey.
BE ACTIVE	
We ran a number of groups as listed.	As well as the outputs listed above, what we noticed was the extent to which people began taking control and having input into activities and agendas. They were able to plan for increased activity very much on their own terms as the barriers to initial involvement were overcome.
TAKE NOTICE	
We encouraged people to 'enjoy the moment' during our sessions	During group activities and the healthy cooking sessions we encouraged people to be aware of what they and others were doing, but especially chose to emphasise the need to 'enjoy the moment' – whatever that may be – laughter, observation of an incident, a new flavour or dish. This was challenging for some people – being focused inwards on problems and negativity is a difficult barrier to overcome for some.
KEEP LEARNING	
At the heart of it all	The majority of participants reported back on the thrill of learning – forgotten for many. All aspects of the project encouraged learning – about diabetes, about mental health and other aspects of physical health, about the local area and new activities.
GIVE	
Group organisation	A core of those involved in group activity self-selected as group leaders and volunteers for activity groups. We had one volunteer who was particularly keen to make the connection between health (inc diabetes but wider mental and physical health) and exercise and has become the biggest advocate amongst our resident group. He supports and encourages others to get involved on their own terms.

Independence Initiative Learning and Reflections

NHS Liverpool Clinical Commissioning Group

Real potential for this, although viewing this as a longer-term initiative would help people to ‘commit’ to the idea of a community of practice more fully. We remain interested in the issues faced by other communities and would be keen to continue to understand these more especially in a very practical way.

Engaging a group of 10 people resident in a local mental health facility and using food, healthy cooking, the Pantry and Diabetes awareness as part of the engagement was a positive development and unforeseen

Being able to plan a longer-term programme via which we could see through changes and get a clearer picture on their impacts rather than short=term outcomes would be ideal.

We were encouraged by the partnership. There seems to be a solid balance between the rigour and structured approach typically required when working with the NHS (or other large institutional partners) and the flexibility that allows the VCSE to provide the kinds of highly flexible support that really does ‘personalise’ relations.

Merseyside Society for Deaf People

MSDP provide specialist services and support for people who are d/Deaf, Deaf-blind or hard of hearing.

Participants:- Profoundly Deaf people who were born Deaf and whose primary language is British Sign Language, deaf people whose primary language is English, Deafened, Hard of Hearing and Deaf Blind people.

Aim:- To increase awareness of Diabetes and make information more accessible within the Deaf Community.

MSDP Project delivery

NHS Liverpool Clinical Commissioning Group

Objectives:

- To increase awareness and understanding of Diabetes within the D/deaf community by training 20 MSDP staff and volunteers with Liverpool Diabetic Partnership.
- To ensure Diabetes information is provided in an accessible format to the D/deaf community. Deliver a simplified presentation about Diabetes and how to effectively manage the disease face to face with BSL interpreters to 50 members of the community.
- Create a quiz to collect data from the Deaf Community in relation to their Diabetes awareness at the start of the project.
- Identify 3 Diabetes champions who will be responsible for signposting D/deaf or hard of hearing people to support and provide information.
- Signpost 10 D/deaf community members to information or refer to their GP for Diabetes support.
- 30 Community members will access sessions focused on lifestyle changes to reduce the risk of Diabetes.
- Information shared on Social Media in an accessible format for Deaf People to reach 500 people.
- 2 online deaf awareness sessions will be delivered to 20 officers in partnership organisations.

MSDP Project Case Study

NHS Liverpool Clinical Commissioning Group

- One Deaf gentleman was diagnosed with Type 2 Diabetes during lockdown.
- Following an on-line meeting with his Doctor he was referred to the Ingeus NHS Diabetes project based in Birmingham called ‘Healthier You’. The meetings are run remotely on Zoom.
- The course covers most aspects of diabetes and is an ongoing project. The gentleman passed the information on to our team as a recommendation of the course for Deaf people. Ingeus were happy to arrange for a sign language interpreter for each meeting. The course is run remotely every third week, which gives some time for the instructions to be followed. Due to the presence of an interpreter the gentleman feels he has learnt a lot from the information provided but also from other participants sharing their experiences.
- He is now managing his Diabetes well but doesn’t understand why he had to participate in a meeting held from Birmingham when he himself is based in Liverpool. He feels Liverpool should have the same facilities.

MSDP Project outputs	Number
Whole time equivalents paid by your organisation to be involved in delivery of the project - include staff and freelance etc.	0.1
Total number of paid people trained in diabetes	17
Total number of volunteers involved in delivery of the project	2
Total number of volunteers trained in diabetes	4
Volunteer Hours involved in project	20
Hours of input from LDP hospital team to project	2
Total number of peer support advocates trained in diabetes	0
Total number of one-off events held / attended	4
Total number of workshops/sessions for ongoing engagement held	0
Total number of people who you engaged with on a one-off e.g. at an event	27
Total number of people you engaged with more than once, e.g. at monthly sessions	15+
Number of Bespoke resources created	Presentation for Deaf Community
Total number of people who increased their levels of regular physical activity	15
Number of new connections with other VCSEs made during project	9

MSDP Outcomes	
Increased understanding of the condition diabetes and risks arising from having diabetes	100% of attendees to the coffee morning and presentation reported increased understanding of diabetes and associated risks.
Increased understanding of what causes diabetes	100% of attendees reporting increased understanding of causes of diabetes from presentation and simplified leaflets
Increased understanding of how to reduce the risk of developing diabetes and/or managing diabetes	57 people attended the face to face training and 100% reported an increased understanding on how to prevent diabetes including changes to lifestyle. Information we posted on social media had over 15 shares and 1000 views.
Improved access to information, resources, programmes and treatment for diabetes for people with communication needs, particularly arising from disability or language needs.	The Diabetes UK booklet was translated into a more accessible (picture based and simple language) PowerPoint for the Deaf Community. Videos were uploaded onto our Social Media platforms about Diabetes and we also shared video links from YouTube which are translated into British Sign Language and developed by RNID, Sign Health and other Deaf Centres.
Increased knowledge and skills for healthy lifestyle options	Members from the Deaf Community reported that they now have an increased understanding of the traffic light system used on packaging and have therefore been choosing healthier options, which in turn has helped them to control their Diabetes as well as to lose weight.
Increased sharing of skills and knowledge with others in community	BAME voluntary groups liked our visual presentation which we shared. Information we posted on social media had over 15 shares and 1000 views.
Increase in healthy lifestyle behaviours and/or reducing risk factors eg obesity	See case study.

MSDP Learning and Reflections

NHS Liverpool Clinical Commissioning Group

There continues to be a demand in making information more accessible for the Deaf Community. NHS information needs to be made accessible for Deaf people.

MSDP's involvement in the programme opened a new network of VCSE organisations including providers supporting minority communities. We utilised the opportunity to raise Deaf Awareness amongst the programme's network and as a result we have seen an increase in the number of Deaf people coming to our Duty Service who require International Sign Language.

MSDP will to continue to provide updates where possible to the Community via BSL video on Social Media but unfortunately this does not reach out to everyone and therefore there are many gaps in the knowledge and management of Diabetes.

Bradbury Fields

Bradbury Fields enable blind, partially sighted and people with dual sensory impairments to achieve their potential, giving them the ability to contribute to the social and economic fabric of their local communities.

Participants:- Blind & visually impaired people at risk or with a diagnosis of diabetes

Aim:-To provide diabetes health training sessions fully accessible for visually impaired people.

Objectives:-

- To equip participants to manage their diabetes.
- To ensure participants are aware of aids that are available and accessible to them to help them to manage their condition.
- To set up regular support groups at the Bradbury Centre that are topic lead by course participants.

4 cohorts joined 2.5 hour sessions designed with LDP covering medication, diet, exercise and knowledge. Sessions were face to face as this is the way people with sight loss report that they can understand and learn.

Bradbury Fields case study

NHS Liverpool Clinical Commissioning Group

Gill, pictured here with her guide dog Goldie said the course was “really helpful and informative”. Since taking part in the course she has stopped eating toast after her breakfast cereal. She loves butter but has found a good tasting healthier alternative. She has cut the portion size of her vegetables after being told on the course that carrots and other vegetables can contain a lot of sugars.

In addition to these lifestyle changes Gill is sharing her knowledge with her family and friends who have or are at risk of getting diabetes.

Since taking part in the course Phil has taken up swimming, chair based exercise and is walking a lot more, he is determined to loose weight! He received advice on his medication from the Liverpool Diabetes Partnership and has also cut the portion size of his food.

Lynn learnt about spacing her medication out at intervals and she has been putting what she had learnt into practice. As a result she has more energy and has taken on an allotment as she does not like walking or group exercise, but thought the digging would give her lots of exercise!

Bradbury Fields Project outputs	Number
Whole time equivalents paid by your organisation to be involved in delivery of the project - include staff and freelance etc.	0.25
Total number of paid people trained in diabetes	25 (all staff via zoom)
Total number of volunteers involved in delivery of the project	1
Total number of volunteers trained in diabetes	1
Volunteer Hours involved in project	15
Hours of input from LDP hospital team to project	20
Total number of peer support advocates trained in diabetes	4 (paid staff)
Total number of one-off events held / attended	5
Total number of workshops/sessions for ongoing engagement held	4
Total number of people who you engaged with on a one-off e.g. at an event	58
Total number of people you engaged with more than once, e.g. at monthly sessions etc..	32
Number of Bespoke resources created	0 – All sessions were live.
Total number of people who increased their levels of regular physical activity	1
Number of new connections with other VCSEs made during project	29

Bradbury Fields Outcomes

1. Increased understanding of the condition diabetes and risks arising from having diabetes	100% most commented this was the best training that they had ever received, due to interactive way sessions were delivered. Many had previously attended courses that were mostly Power point style visual demonstrations that are not accessible if you have a visual impairment.
2. Increased understanding of what causes diabetes	100% of participants left with a much better understanding. Staff who attended training learnt a great deal, many had no prior knowledge.
3. Increased understanding of how to reduce the risk of developing diabetes and/or managing diabetes	32 people who felt more confident to manage their diabetes based on post participation feedback. Everyone who participated felt more confident. 58 people increased their knowledge of diabetes (25 staff, 1 volunteer, 32 participants) –service users and staff got something out of the course.
4. Improved access to information, resources, programmes and treatment for diabetes for people with communication needs, particularly arising from disability or language needs.	Even though our planned training courses have come to an end we are still liaising with the CCG team to provide information in large print, braille and pre-recorded audio formats.
5. Improved access NDPP and/or structured education for BAME groups, sensory impaired people, people with LD.	The Liverpool Diabetes Team have offered to run drop-in clinics here at the Bradbury Centre for our visually impaired service users. This is an excellent outcome for us and one that has been welcomed by our service users.

Bradbury Fields Outcomes

6. Increased knowledge and skills for healthy lifestyle options	100% reported having more knowledge and understanding of the need to eat and cook more healthily. This was the area that most interested our service users. They were very surprised to learn that an ideal portion of cereal was the measure presented in variety packs! Most had been eating possibly 4 times that amount. If you are visually impaired and unable to read the nutritional information, then the sharing of this knowledge is very important. Talking scales were recommended as an aid to help achieve the correct portion size. At the request of participants, we will be running in our follow up sessions demonstrations of air fryers etc. Also of interest was the ratio of protein, carbohydrates and vegetables on an ideal plate.
7. Increased sharing of skills and knowledge with others in community	The Visually Impaired community in Liverpool is very close knit – word will spread to those in need of our support, and we are committed to delivering 4 diabetes support sessions in the next 12 months, which we may look to secure additional funding for.
8. Increase in healthy lifestyle behaviours and/or reducing risk factors eg obesity	One service user who attended the first and last course reported that he had increased his level of physical activity (walking). Again, physical activity is something that many visually impaired people find difficult. We encouraged the participants to come to one of our physical activity taster days at the Bradbury Centre to encourage people to try activities such as Tandem Cycling, guided running, cricket, swimming and gym sessions.

Bradbury Fields Learning and Reflections

NHS Liverpool Clinical Commissioning Group

There is demand in our community, however, our difficulty would be setting aside staff time to enable us to run a programme in the future. Like most in the voluntary sector, we are stretched. We will be searching for funding to enable us to deliver sessions in a similar way and supplement these sessions with diabetes drop in clinics led by the LDP.

All 4 cohorts are keen to join a support group. We can try to get funding from a Charitable Trust to cover the ongoing cost of this

We want to work with colleagues in Primary Care to raise awareness of our sessions so their blind and partially sighted patients can be referred. Many have lost limbs and are not keen to come out of the house. We need to target people before they reach this stage

Perhaps there would be an opportunity to work with sighted volunteers who themselves had diabetes to help support our service users.

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New Beginnings – Improving Lives CIC

NBIL support individuals in poverty providing responsive support, advocacy and onward referrals

Participants: people who don't usually present to services including hostels, HMO's, low income families and ethnic minority communities.

Aim: Educate and support individuals at risk of diabetes or with a diagnosis of diabetes.

NBIL Project Objectives/delivery

NHS Liverpool Clinical Commissioning Group

- Provide free physical activity sessions for older men & women, for men in recovery or using drugs
- 14 week healthy cooking course on a budget with women from minority ethnic backgrounds, inclusive for all cultures including Muslims, vegetarian and vegan diets.
- Offering 121 support & sign posting to other services, including registering with a GP.
- Social event giving advice and guidance around diabetes and living a healthy life with good nutritional food and physical activities, glucose & BP monitoring.
- Second session in south Liverpool was for males in recovery or actively using drugs. We had a larger number of males recently diagnosed with diabetes due to their lifestyle. Most males had not been registered at a GP for a considerable time. Healthy eating is a huge barrier for most of the men due to living in Hostels or not having the finances to buy good food. Some also don't have the skill set to cook healthy affordable foods. Through education and meeting the needs of our Male recipients we offered slow cooking machines and affordable low cost healthy foods through our community store.
- We worked closely with South Liverpool primary care network and their BAME lead to ensure we provided correct & factual information and our groups were accessible to all.

NBIL Project Case Study

NHS Liverpool Clinical Commissioning Group

"The cookery classes at the PAL Multicultural Centre have been invaluable to me and my baby daughter, Dolly.

The sessions have given me the opportunity to ensure she is part of a community. She is of mixed British and Indian heritage, and at just six months old she now has friends of all different backgrounds.

On top of this, it has been great to learn new healthier ways of cooking and eating.

I believe wholeheartedly that it is incredibly important that we use education to help people make healthier lifestyle choices, and together with her grandmother, we now have lots of tasty, healthy recipes to help wean Dolly on to solid foods.

Thank you NBIL. We love our Wednesdays!

Jennifer

NBIL Project outputs

Whole time equivalents paid by your organisation to be involved in delivery of the project - include staff and freelance etc.	4
Total number of paid people trained in diabetes	3
Total number of volunteers involved in delivery of the project	4
Total number of volunteers trained in diabetes	2
Volunteer Hours involved in project	344
Hours of input from LDP hospital team to project	0 – could not attend
Total number of peer support advocates trained in diabetes	3
Total number of one-off events held / attended	1 (pending March 29th)
Total number of workshops/sessions for ongoing engagement held	86
Total number of people who you engaged with on a one-off e.g. at an event	135
Total number of people you engaged with more than once, e.g. at monthly sessions	54
Number of Bespoke resources created (please list them with brief description and if possible, provide link to or attach them or save in the google folder – this can include flyers/education/info materials/recipe books/films/Q&As etc…	Flyers. We are going to create a cook book from our cookery programme
Total number of people who increased their levels of regular physical activity	54
Number of new connections with other VCSEs made during project	4
Number of new connections to GP practices made during project	0
Total 'In kind' match funding – eg if someone gave you room hire for free	Pal centre free room hire

NBIL Outcomes

1.Increased understanding of the condition diabetes and risks arising from having diabetes	95% of all attendee had an increased understanding of diabetes and risks. They learnt about dietary and physical exercise to also reduce the risk of getting diabetes. This was done by holding Physical, educational and practical courses for service users
2.Increased understanding of what causes diabetes	95% reported an increased understanding of what causes diabetes 5% claimed they already knew the material but a refresher cause was needed to get back into eating more healthy and reducing the risks after covid.
3.Increased understanding of how to reduce the risk of developing diabetes and/or managing diabetes	95% of all attendee had an increased understanding of diabetes and risks. They learnt about dietary and physical exercise to also reduce the risk of getting diabetes
4. Improved access to information, resources, programmes and treatment for diabetes for people with communication needs, particularly arising from disability or language needs.	100% of our physical activity class speak English however our Cookery course was attended by women of different nationalities were English is not their first language. In feedback sessions they reported finding it easier to understand if it was a practical session over several weeks rather then reading material. We provided written information in English which was translated by the PAL centre. We also used picture boards to make it easier to understand.
6.Increased knowledge and skills for healthy lifestyle options	Our cookery class is were we learnt to cook healthy foods and using ingredients to still have flavoursome food without using salt this was very important to some of the communities who accessed our sessions as they batch cook and use a lot of high fat contents including salts. We learnt that the food could be flavoursome without adding unnecessary salts.
7.Increased sharing of skills and knowledge with others in community	Creating cookbook from cookery sessions to share
8.Increase in healthy lifestyle behaviours and/or reducing risk factors eg obesity	Our participants are now working out 2 x per week were their physical exercise was previous 0

NBIL Learning & Reflections

NHS Liverpool Clinical Commissioning Group

- Many participants can't read and need visual guides
- Poverty is one of the main barriers to healthy eating and cooking from scratch
- Knowledge about ingredients and cooking significant barrier – most relied on takeaways and cheap processed food. Can support people to overcome this by focusing on simple kitchen materials and fast healthy meals.
- Public transport a barrier for some groups due to MH or past association with gangs
- Sharing with other groups helpful
- We will be continuing with two of the programmes and looking for external funding to help keep them running. Whilst we have engagement /change it is important to keep that going to see some real life changes.

Daisy Inclusive UK

A disability led charity supporting those who are vulnerable, young people with disabilities and their families through sports, music, education, employment, disability hate crime, social readiness and support to provide a personalised pathway to help people reach their true potential and become active members of their community.

Participants :- Disabled, vulnerable and disadvantaged people many with mental and physical disabilities including visual impairment, loss of sight, downs syndrome, autism, global delay, learning difficulties, cerebral palsy and seizures, anxiety & depression.. A high percentage are over-weight and physically unfit with poor diet and at risk/ with a diagnosis of diabetes.

Aim: - Increase awareness of T2 diabetes and look at how it can be managed or how we can reduce the risk of developing the disease amongst beneficiaries and staff. To encourage healthy lifestyle choices and monitor progress in our project entitled ‘Healthy Body, Healthy Mind’

Objectives:- For beneficiaries to -

- Have an awareness of what diabetes is and of some of the complications it can cause.
- Have an awareness of the risk factors which may increase the likelihood of developing the illness.
- Know the risk factors which we can control and understand that by making positive changes to our diet and lifestyle we can reduce the risk of developing Type 2 diabetes
- Develop personal plans and monitor weight and waist measurements for those who would like to participate in this aspect of the project

Daisy Inclusive Project outputs

Whole time equivalents paid by your organisation to be involved in delivery	1.2
Total number of paid people trained in diabetes	5
Total number of volunteers involved in delivery of the project	6
Total number of volunteers trained in diabetes	5
Volunteer Hours involved in project	200
Hours of input from LDP hospital team to project	3
Total number of peer support advocates trained in diabetes	5
Total number of one off events held / attended	2
Total number of workshops/sessions for ongoing engagement held	82
Total number of people who you engaged with on a one-off eg at an event	181
Total number of people you engaged with more than once, eg at monthly sessions etc..	56
Number of Bespoke resources created	Personal development plans
Total number of people who increased their levels of regular physical activity	42
Number of new connections with other VCSEs made during project	5
Number of new connections to GP practices made during project	6
Total 'In kind' match funding - eg if someone gave you room hire for free - please list	£700 (Onward Homes)
Total other funding (if you used this funding to raise other funds, or used another grant or vise versa please list and describe inc amount)	£5425.00 (matched by Daisy Inclusive)

Participant Feedback

NHS Liverpool Clinical Commissioning Group

I now feel confident to look after my own health and to help others. I have lost weight and feel good.

My Dad and my fiancée have diabetes. I have learned that the things that are important for them are also important for me - to reduce my chance of getting type 2 diabetes

It has been a confidence booster to see the results, knowing that I can lose wight and feel better about myself. I will continue with my goals.

I have enjoyed learning about diabetes, the risks and what I can do to prevent it.

Daisy Inclusive Outcomes 1	
Increased understanding of the condition diabetes and risks arising from having diabetes	>90 percent of respondents showed an increased knowledge of what diabetes is and could identify some of the risks.
Increased understanding of what causes diabetes	100% of course participants could name some of the causes of diabetes and recognise causes from a list
Increased understanding of how to reduce the risk of developing diabetes and/or managing diabetes	Most participants felt they had learnt how to prevent the risk of type 2 diabetes (i.e. by exercising & healthy eating). All demonstrated an increase in their knowledge of how to reduce the risk of developing diabetes. All participants said they enjoyed the project and gave multiple examples of what they enjoyed such as healthy eating, exercising, working at our allotment and doing sports.
Improved access to information, resources, programmes and treatment for diabetes for people with communication needs, particularly arising from disability or language needs	We shared information from diabetes UK, NHS and LDP– distributing booklets and printed information such as ‘Eating Well’ ‘Active at Home’ meal planners and ideas for healthy snacks and food swaps. We have made beneficiaries aware of online training such as ‘Understanding Type 2 Diabetes’ in February 2022
Improved access to information, resources, programmes and treatment for diabetes for people with communication needs, particularly arising from disability or language needs	We shared information from diabetes UK, NHS and LDP– distributing booklets and printed information such as ‘Eating Well’ ‘Active at Home’ meal planners and ideas for healthy snacks and food swaps. We have made beneficiaries aware of online training such as ‘Understanding Type 2 Diabetes’ in February 2022

Daisy Inclusive Outcomes 2	
Improved access to National Diabetes Prevention Programme (NDPP) and/or structured education for BAME groups, sensory impaired people and people with Learning Disabilities.	We have sought to highlight this prevention programme and this has been raised with our cohort and with carers as appropriate. Some have sought Doctors appointments and blood tests.
Increased knowledge and skills for healthy lifestyle options	All participants bar one (this person already has a healthy diet) said they are eating healthy food because of what they have learnt throughout this programme. Also, all people now know that exercise greatly effects diabetes which has increased their amount of physical activity they take part in.
Increased sharing of skills and knowledge with others in community	We now display healthy eating and exercise advice within our main hall and close to the community café. Some participants reported being able to help others with advice for healthy lifestyles, we help each other as a group for support in making the healthy choices in our day to day lives.
Increase in healthy lifestyle behaviours and/or reducing risk factors e.g. obesity	All participants who had goals such as: feeling better about themselves, loosing weight and being more active – met their goals as they reported that they are taking part in more exercise sessions, feel more confident, eating more healthily and their final weigh-in results showed they had lost weight through the project.
Improvements in mental health/wellbeing	Beneficiaries who chose to work with personal development plans showed improvements in their mental health and wellbeing score as a result of this program.
Other	Instigated Healthy Eating options in Community Cafe

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

Daisy Learning and Reflections

NHS Liverpool Clinical Commissioning Group

In order to continue with the success of this project, additional funding would be required to cover staff, heating, cooking and food costs.

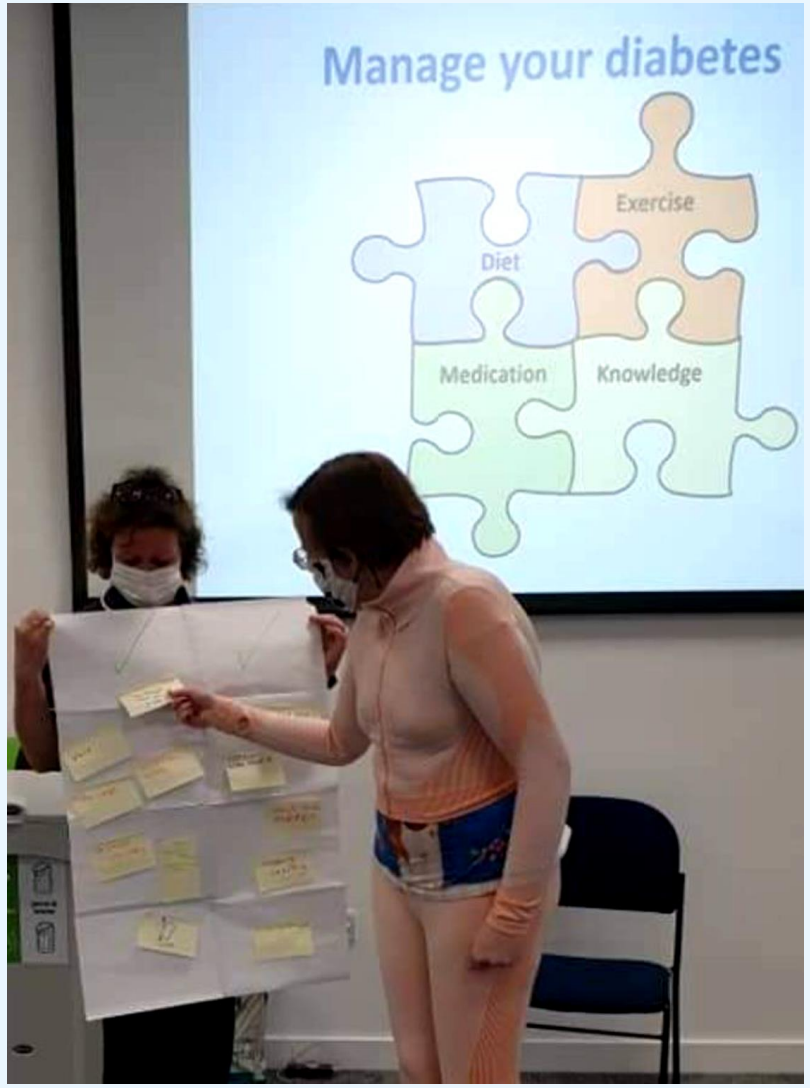
Further training for all staff would be beneficial.

This proactive approach at minimal cost will save the NHS substantial amounts in the future.

Mencap Liverpool and Sefton

NHS Liverpool Clinical Commissioning Group

- Local, independent charity promoting equality for people with a learning disability - helping them to discover new opportunities, make new friends, and feel valued and safe in their community.
- Participants:- adults with Learning Disabilities at risk of diabetes, with a diagnosis of pre-diabetic or with Type 2 diabetes
- Aim:-to empower adults with a learning disability, to better understand the risks of diabetes, enable them to avoid these risks and equip them to educate their peers.
- Objectives:-
  - Train 8-10 members to understand diabetes and the risks
  - Develop a presentation with our trained participants which they could then deliver to their peers and external agencies
  - Equip our staff team with better understanding of diabetes to improve their own health outcomes and increase their confidence when encouraging members



Mencap Project delivery

NHS Liverpool Clinical Commissioning Group

- 8 Weekly 2 hour face to face training workshops with appropriate content
- Input from LDP and specialists eg dietician, foot nurse
- Walking group
- Covid testing advice and support
- Creating accessible course content
- Delivering training workshops
  1. What this course is about - is it for you?
  2. Ground rules and creating a safe space
  3. What is diabetes, signs and symptoms
  4. Diet
  5. Feet
  6. Getting active
  7. Medication
  8. Annual review
  9. Recap
  10. Evaluation and celebration

Mencap Project outputs

Whole time equivalents paid by your organisation to be involved in delivery	0.2
Total number of paid people trained in diabetes	3
Total number of volunteers involved in delivery of the project	1 regular volunteer plus our 8 champions (peer advocates)
Total number of volunteers trained in diabetes	1 regular volunteer plus our 8 champions (peer advocates)
Volunteer Hours involved in project	12 hours (sessions attended by regular volunteer)
Hours of input from LDP hospital team to project	This could be as much as 100 hours in total as we had at least 2 members of the team involved in delivery and prep each week.
Total number of peer support advocates trained in diabetes	12, although we anticipate 8 will continue as trainers/champions
Total number of one off events held / attended	2
Total number of workshops/sessions for ongoing engagement held	10 sessions of 2 hours
Total number of people who you engaged with on a one-off eg at an event	12 people attended the intro session or one of the follow up presentations
Total number of people you engaged with more than once, eg at monthly sessions etc..	12 people attended the workshops more than once with a total of 106 hours between them
Number of Bespoke resources created	2
Total number of people who increased their levels of regular physical activity	100% of the 12 regular attendees have reported increasing their regular physical activity

Mencap Project Outcomes	Before intervention	After intervention
Increased understanding of the condition diabetes	20%	40%
Increased understanding of signs of diabetes	40%	100%
Understanding of complications of diabetes/risks of diabetes	Low	100%
Understanding of causes of diabetes	Mixed	100%
Confidence in managing diabetes	20%	100%
Knowledge of prevention, management and reversal	40%	100%
Increased knowledge and skills for healthy lifestyle options	20%	80%
Knowledge of exercise duration aims	80% (20% thought exercise not recommended)	100%
Participants eating more balanced healthier diet a. Once a month or less b. Once a week c. Twice a week d. Most days 20%	 60% 20% 20%	 80% 20%
Participants increasing their physical activity a. Once a month or less b. Once a week c. Twice a week d. Most days 60%	 20% 20% 60%	 20% 80%
Confidence in sharing information about diabetes with others	20% very confident	100% very confident 80% had shared info

Mencap Liverpool Learning and Reflections

Carers lack the time and support to make healthy choices for themselves and so even where they have the knowledge and/or skills, they will still struggle to support those they care for, to make healthy choices

Accessibility of information is the primary challenge for people with Learning Disabilities

It's very common for people with a learning disability to grow up in poverty and also for the people who support them to also lack the money, skills and awareness needed to make healthy choices. Everyone working on the project was aware of the need to suggest affordable and easy to access changes, so that participants wouldn't mentally 'disengage'.

8 people will continue in their role as champions and 20 future sessions are planned.

Women's Health Information & Support Centre

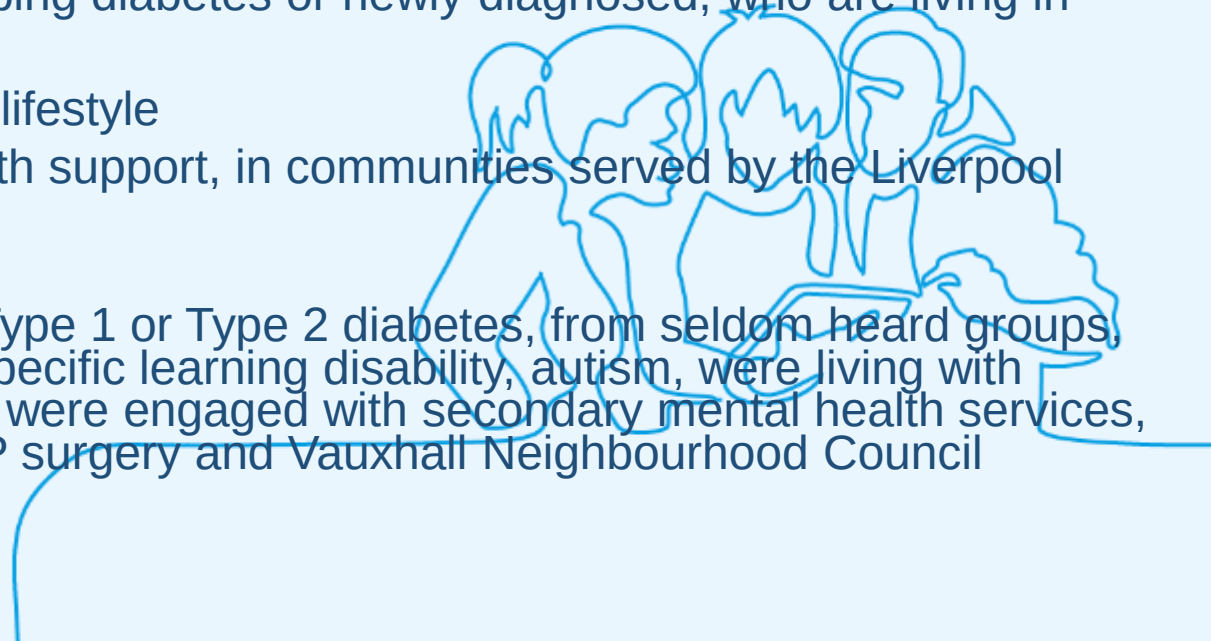
Charity dedicated to improving the health and wellbeing of women and their families

AIM:- Provide Diabetes information & support to women, focus on improving mental health & wellbeing

Objectives:-

- Improving access to mental health and psychological support for women at risk of developing diabetes or newly diagnosed
- Increasing opportunities for women impacted by financial poverty, where access to health and wellbeing support is severely restricted
- Improving outcomes for women at risk of developing diabetes or newly diagnosed, who are living in the most deprived communities
- Providing opportunities to encourage a healthier lifestyle
- Deliver support to women who need mental health support, in communities served by the Liverpool Central Primary Care Network

- Participants:-
  - Women at risk, with a diagnosis of pre-diabetic Type 1 or Type 2 diabetes, from seldom heard groups, severe and enduring mental health diagnoses, specific learning disability, autism, were living with financial hardship / poverty / unemployed, Some were engaged with secondary mental health services, one statutory homeless. Referrals taken from GP surgery and Vauxhall Neighbourhood Council foodbank



WHISC Project delivery

NHS Liverpool Clinical Commissioning Group

- Delivered 3 x six-week programme of taught sessions, including activities, workbooks, group discussions and personal reflective work within our centre and on outreach at a GP surgery
- Delivery by WHISC staff member who is also a qualified nutritionist
- Provided One to one mental health support sessions
- Delivered single Diabetes sessions on an outreach basis at Vauxhall Neighbourhood Council, working with partners, our outreach worker and tutor to engage with women from North Liverpool who were involved with our health lifestyles programme. The Diabetes session was delivered twice at the request of women participants.
- Facilitated podiatry referrals x3
- Worked with GP surgery and foodbank to identify participants and relocated session to reduce travel needs – cost a barrier
- Referrals made for debt advice and housing problems
- Provided food vouchers and travel costs

WHISC Project outputs	Number
Whole time equivalents paid by your organisation to be involved in delivery of the project - include staff and freelance etc.	
Total number of paid people trained in diabetes	1
Total number of volunteers involved in delivery of the project	2
Total number of volunteers trained in diabetes	0
Volunteer Hours involved in project	
Hours of input from LDP hospital team to project	2
Total number of peer support advocates trained in diabetes	0
Total number of one-off events held / attended	2
Total number of workshops/sessions for ongoing engagement held	32
Total number of people who you engaged with on a one-off e.g. at an event	12
Total number of people you engaged with more than once, e.g. at monthly sessions etc..	12
Number of Bespoke resources created	1
Total number of people who increased their levels of regular physical activity	12
Number of new connections with other VCSEs made during project	1
Number of new connections to GP practices made during project	1
Total ‘In kind’ match funding – eg if someone gave you room hire for free	VNC & Princes Park Health Centre provided rooms

WHISC Project case study 1

NHS Liverpool Clinical Commissioning Group

Woman B – is 65 and homeless when she began the course. She had lived a transient lifestyle, was living with an Autism spectrum diagnosis and recovering from decades of addiction. She had spent a lot of time in prison, due to an exceptionally traumatic history and had neglected her physical health. She was very isolated and very anxious. She was mistrustful of health services, due to previous experiences.

Since receiving support from WHISC she has :-

- registered with a 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 an assessment of care and support needs
- understood the risk of diabetes
- attends the foodbank at Vauxhall Neighbourhood Council and is getting more fruit and vegetables in her diet
- 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!

WHISC Project case study 2

NHS Liverpool Clinical Commissioning Group

Woman A has lived in Liverpool for 3 years – has a diagnosis of T2 diabetes, but was not engaged with clinical support and didn't know what was available to her. Due to poor mental health and language barriers, she found it difficult to engage with mainstream services. Urdu is her first language. Her son was struggling in school due to the language barrier. A single parent with 3 teenage sons, she is in receipt of Universal Credit and struggling to afford food, especially healthy food.

The WHISC Diabetes Project supported her with all of these issues.

- Paid for bus fares so she could attend the support sessions.
- found an ESOL class for her and her son at the PAL Centre.
- arranged for an interpreter to attend school so mum and her son, could explain how much he was struggling.
- Gave her Aldi vouchers to assist in the short term and signposted her to NBIL, another project partner's food pantry which she now attends enjoying better quantity and quality of more affordable food, really close to home.

WHISC Project Outcomes	Please describe how you achieved this outcome -
1. Increased understanding of the condition diabetes and risks arising from having diabetes	Of the 8 participants who returned the after questionnaire, 5 reported they were reasonably or very confident of managing diabetes or reducing their chance of getting diabetes. All but one had a diagnosis of diabetes or knew they were at risk of developing this.
2. Increased understanding of what causes diabetes	All had increased their understanding of what causes diabetes
3. Increased understanding of how to reduce the risk of developing diabetes and/or managing diabetes	All participants who returned questionnaires had increased understanding of how to reduce the risk of developing diabetes and how to manage diabetes.
4. Improved access to information, resources, programmes and treatment for diabetes for people with communication needs, particularly arising from disability or language needs.	All participants advised they had improved access to information. However, some stated they would like further information around food and recipes to control blood sugar. Two participants have specific learning disability and asked if they could repeat the course again. Both of these women spent time with the wider staff team, including specific mental health support. Sharing what they had learned, advising on improvements they had made to healthy eating, lifestyle, and successes.
5. Improved access to (NDPP) and/or structured education	All given information about the NDPP and have received specific support from BAME and Learning Disability services.
6. Increased knowledge and skills for healthy lifestyle options	6 women said they would be confident or reasonably confident in being able to manage or prevent Diabetes
7. Increased sharing of skills and knowledge with others in community	6 women said they would be very or reasonably confident sharing what they have learned with others. For the women in the Vauxhall area sessions, all improved their fitness by participating in exercise and activity 2-3 times per week. They are having shared breakfast, using health foods to regulate their blood sugar and have asked for more sessions around Diabetes with a particular focus on recipes and menu plans There is a food bank at the VNC each Friday and we will be offering a programme, learning and growing food and medicinal herbs for health as an extension to the Diabetes programme over 8 weeks. We will also be delivering the same programme at WHISC allotment in Liverpool 8.
8. Increase in healthy lifestyle behaviours and/or reducing risk factors eg obesity	Women have continued with increased health lifestyle, improved access to exercise at both WHISC and within the community and increased awareness of the factors associated with Diabetes risk.

WHISC Learning and Reflections

Difficult for many women to engage with health services when they are not community based, for so many reasons. Offering Diabetes support in communities and services, which women are familiar with and comfortable attending, can be the catalyst to change and engaging with NHS support. Partnership - CofP useful in raising understanding of cultural factors and building network between organisations. LDP advice raised knowledge of where people can get support for diabetes in NHS

From the women we have worked with, we have identified they had little knowledge of Diabetes beforehand and how to prevent this or manage when they have a diagnosis. Women often engage with community services on a frequent basis, so will feel more confident in asking questions when they know they can access the service more easily. Shared learning has always been vital to WHISC delivery, it is the strength of women learning together, and forming friendships, which enables the sharing of information and development of new skills an essential feature of what we do.

There will always be a demand for Diabetes work within our service, as women affected by gendered poverty and poor mental health would struggle to engage with health services. Women told us due to poverty and choosing between eating and providing essentials for their children, choosing healthy meals and making time for their wellbeing is far down their agenda.

We would be able to run sessions throughout the year, if funding was available. Would also be able to provide women with Listening Ear support, if they were struggling to manage their mental health and a diagnosis of diabetes / pre-diabetic. Women told us that they are offered gym memberships to improve their health and wellbeing from Primary Care partners. However, this means having to find time, money and appropriate clothes to be able to engage with gym membership. In addition, if women are struggling with confidence and self-esteem, attending a gym on their own may be far outside their current level of comfort. Providing services specifically to encourage women to better manage their health and wellbeing, requires new thinking, community resources and a commitment for all of us to work together, to reduce the barriers women face in making improvements to their health.

Perspective Theatre Company

NHS Liverpool Clinical Commissioning Group

Aims:-

To illustrate the causal linkage between the chaotic lifestyles associated with drug and alcohol mis-use in the context of poor diet and lack of exercise and the development of type 2 diabetes, and to recognise how to help prevent the disease.

Improve general perception and understanding of the factors involved in the development and progression of the disease and how to avoid these factors.

Objectives:- Using drama workshops and discussions in bail hostels..

- To provide access to agencies and organisations involved in the prevention, treatment and management of type 2 diabetes.
- Practical advice/information around diet and attainable targets for life-style adjustments and changes.
- Provide a manageable and realistic exercise regime tailored to each individual participant.
- Recognise the early signs of diabetes.
- How to implement simple steps to reduce the chances of developing diabetes.

Participants:- People in Bail Hostels in transition from prison back into mainstream society.

Experiencing: Poor educational attainment., Complex health conditions/needs and especially mental health, Sociological issues resulting in conflict and aggression towards others, history of violent domestic backgrounds which are often ongoing, mistrust and contempt for all authority including medical/pastoral ones.

Perspective Theatre Participant Feedback

NHS Liverpool Clinical Commissioning Group

Overwhelmingly positive and emotional:

“I can relate to the presentation. It brought me to tears.”

“Excellent. Entertained, highlighted and informed.”

We had many similar comments reported and written. We cannot provide case studies or photographs due to Home Office stipulations.

Perspective Theatre Company Project outputs	Number
Whole time equivalents paid by your organisation to be involved in delivery of the project - include staff and freelance etc.	2
Total number of paid people trained in diabetes	2
Total number of volunteers involved in delivery of the project	4
Total number of volunteers trained in diabetes	1
Volunteer Hours involved in project	64
Hours of input from LDP hospital team to project	3
Total number of peer support advocates trained in diabetes	2
Total number of one-off events held / attended	10
Total number of workshops/sessions for ongoing engagement held	0
Total number of people who you engaged with on a one-off e.g. at an event	150
Total number of people you engaged with more than once, e.g. at monthly sessions etc..	0
Number of Bespoke resources created	Q&A'S Booklets dealing with prevention and management.
Total number of people who increased their levels of regular physical activity	35
Number of new connections with other VCSEs made during project	2

Perspective Theatre Outcomes	
Increased understanding of the condition diabetes and risks arising from having diabetes	15% reported better understanding following the session
Increased understanding of what causes diabetes	15% reported better understanding following the session
Increased understanding of how to reduce the risk of developing diabetes and/or managing diabetes	15% reported better understanding following the session
Improved access to information, resources, programmes and treatment for diabetes for people with communication needs, particularly arising from disability or language needs.	Using bespoke created drama workshop and discussion to address issues- 150
Increased knowledge and skills for healthy lifestyle options	100% Better insight into how to adjust diet and increase exercise and where to access information/assistance.
Increased sharing of skills and knowledge with others in community	Participants discussing and exploring the many different facets and dimensions of diabetes, confident will be enacted and continued when they leave the Criminal Justice System and re-join families and friends.
Increase in healthy lifestyle behaviours and/or reducing risk factors eg obesity	Feedback indicates 35 participants increased physical activity. We know empirically our workshops trigger introspection often the first step to changed behaviour. The managers have drawn-up keep-fit & dietary-advice sessions & told us workshops provided an added impetus and immediacy which transfers directly to each participant.
Improvements in mental health/wellbeing	Managers of the units told us with parameters they use to measure changes/improvements in the mental-health of their charges, our input was well-received, motivational and refreshing.

Perspective Theatre Learning and Reflection

We unveiled a large amount of uninformed people; mis-information and confusion surrounding diabetes is rife.

Resources are always an issue, but the ‘prevention/cure’ trope applies, not just in health and quality of life terms, but in an economic context. A micro-equation with a CCG programme like this on one side weighed against the cost of the untreated undiagnosed diabetes without the programme would I’m sure illustrate cost-effectiveness.

The multi-attack approach works, swamping diabetes with a broadside from every angle and bringing a road-map to combat the illness.

Ignorance is awful. This project radiates hope and positivity from every direction.

Acknowledgements & Contact

NHS Liverpool CCG would like to thank all the organisations, volunteers and participants for their work and achievements in the project and North West Coast Clinical Network for funding and support.

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