**Population Health Case Studies**

**Diabetes Engagement Programme**

**What was the issue we were trying to resolve/why was it needed?**

The issue they were trying to resolve was the low levels of uptake of referrals to the national Empower diabetes programme among diabetic patients, particularly South Asian women in the Daneshouse and Stonyholme post code areas of Burnley. This was needed because data showed a high number of diabetes diagnoses in this demographic, and improving awareness and referrals could enhance diabetes care and management in the community.

**Who was it aimed at?**

The project was aimed at:

* **South Asian Women**: Specifically targeting South Asian women diagnosed with type 2 diabetes in the last 12 months, residing in the Danes House and Stonyholm areas.
* **Community Leaders**: Local community faith and volunteer leaders were also involved to help spread key messages within the community.
* **Diabetic Patients**: Overall, the project aimed to engage diabetic patients within the Burnley East PCN to improve their awareness and management of diabetes.

**Summary of the project**

* **Objective**: Increase awareness of diabetes and referrals to the national Empower programme among South Asian women in the Danes House and Stonyholm post code area.
* **Initial Workshop**: Conducted a community workshop with over 60 attendees, including local community faith volunteer leaders, to spread key messages about diabetes.
* **Six-Week Programme**: Designed a series of workshops for patients diagnosed with type 2 diabetes in the last 12 months. The programme included interactive sessions, lifestyle advice, cooking demonstrations, health checks, and relaxation techniques.
* **Feedback and Results**: Positive feedback from participants, increased referrals to the Empower programme, and improved understanding and management of diabetes among attendees.
* **Next Steps**: Continued engagement with participants through peer-to-peer support

groups and additional health events.

**Who was involved – partnership approach for example?**

* **PCN Team**: Farooq, Sarah, Hazel, and Lucy worked together on the project.
* **Local Community**: Community faith volunteer leaders and local residents were engaged through workshops.
* **Local Trusts and Organizations**: ELHT Up and Active, Alpha Balance, Outdoor for All Sort, and local community champions contributed to the workshops and activities.
* **Healthcare Professionals**: Farooq and Seraj led the sessions, with Hazel providing IT and digital support.
* **ICB**: The Integrated Care Board (ICB) supported the project proposal and its implementation

**When did it start/finish (is it ongoing)?**

The project started with the first cohort and has completed two cohorts so far. The third cohort is planned to be completed around Christmas time. The project is ongoing, with plans for further Women's Health events and continued engagement with the participants.

**What area was/is it delivered in?**

The project was delivered in the Burnley East area, specifically targeting the Danes House and Stonyholme post code areas.

**How did the team go about delivering it?**

The team delivered the project through a series of steps:

* **Community Workshop**: They organized a large community workshop event with over 60 attendees, including local community faith volunteer leaders. The workshop focused on diabetes awareness, complications, risk factors, and lifestyle management. It was interactive, with quizzes and participant-led discussions. 1 2 3 4
* **Six-Week Programme**: They identified 44 patients diagnosed with type 2 diabetes in the last 12 months from the South Asian background in the targeted post code areas. Patients were contacted individually by phone to ensure engagement. The programme included weekly two-hour sessions covering various topics such as lifestyle advice, cooking demonstrations, diabetes complications, and self-care activities. 5 6 7 8
* **Engagement and Adaptability**: The team ensured cultural sensitivity and flexibility, allowing family members to attend and delivering workshops in different languages. They adapted materials to accommodate participants' needs, such as using more pictures for those who couldn't read or write English. 9 10 11 12
* **Sustainability**: They maintained ongoing contact with participants through peer-to-peer support groups and additional health events.

**What were the main outcomes/impacts for people?**

The main outcomes and impacts for people included:

* **Increased Referrals**: There was a significant increase in referrals to the national empower programme.
* **Liver Surveillance**: 14 participants underwent liver scans, identifying several individuals at risk of liver fibrosis, leading to onward referrals and monitoring.
* **Improved Understanding**: Participants showed a 45.6% increase in understanding of diabetes and a 37.9% increase in their ability to manage their condition.
* **Positive Feedback**: 93% of participants rated the course as very helpful, and 73% rated it as excellent.
* **Engagement and Retention**: Participants were highly engaged, with 17 completing the programme, and they expressed satisfaction and positive changes in their lifestyle and diet.
* **Peer Support**: Ongoing peer-to-peer support and additional health events helped sustain engagement and reinforce the knowledge gained.

**Are there any comments/statements from people it helped?**

There are several comments and statements from people it helped:

* One participant mentioned that they learned a lot from the course and shared the information with their diabetic parents and sibling, expressing gratitude for the course.
* Another participant highlighted the positive impact on their lifestyle and diet, stating that they made changes and were very happy with the course.
* A participant appreciated the cooking programme, finding it interesting and healthy.
* Several participants expressed overall satisfaction and happiness with the course, noting improvements in their understanding and management of diabetes.